STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155859	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BEECH GROVE	501 N 17TH AVE BEECH GROVE, IN 46107

(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 a State Residential Licensure Survey. Survey dates: December 10, 11, 12, 13, 16, 17, & 18, 2024 Facility number: 000391 Provider number: 155859 AIM number: 100274990 Census Bed Type: SNF/NF: 47 Residential: 26 Total: 73 Census Payor Type: Medicare: 3 Medicaid: 34 Other: 10 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 20, 2024.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 1/10/25.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to ensure a physician's ordered skin tear treatment was followed for 1 of 3 residents reviewed for skin integrity. Wound dressings were not dated and initialed and the	F 0684	**F684 Quality of Care** – *It is the consistent practice of this provider to ensure a physician order treatments are followed.* **What corrective action will be accomplished for those**	01/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Benson	Executive Director	01/08/2025

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	dressing change was continued beyond the physician's orders.(Resident 6) Findings include: During an observation on 12/10/24 at 10:45 a.m., Resident 6 was observed sitting in her wheelchair in the hall near her room. Resident 6's left mid-shin area was observed. A dry and intact tan colored dressing, approximately two inches by three inches, was observed covering the mid-shin area. The dressing lacked any documentation that indicated when and who had applied the dressing to the resident's shin area. During an interview at that time, Resident 6 indicated she was unsure when or why the dressing had been applied to her leg. On 12/12/24 at 1:15 p.m., Resident 6 was observed in her room and was sitting in her recliner with both legs elevated. Resident 6's left mid-shin area was observed. A dry and intact tan colored dressing, approximately two inches by three inches, was observed covering the mid-shin area. The dressing lacked any documentation that indicated when and who had applied the dressing to the resident's shin area. During an interview at that time, Resident 6 indicated she was unsure when the staff had applied the dressing to her leg. During an observation with RN 3 on 12/12/24 at 1:35 p.m., Resident 6 was observed sitting in her recliner with both legs elevated. Resident 6's left mid-shin area was observed. A dry and intact tan colored dressing, approximately two inches by three inches, was observed covering the mid-shin area. The dressing lacked any documentation that indicated when and who had applied the dressing to the resident's shin area. During an interview at that time, RN 3 indicated the dressing should have		**residents found to have been affected by the alleged deficient practice.** The physician was notified and the treatment order for Resident 6 was discontinued and updated to reflect ongoing preventative measures. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken.** All residents with skin treatment orders have the potential to be affected by the same alleged practice. All residents with physician skin treatment orders were reviewed and validated and accurately followed. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur.** The Director of Nursing services in-serviced Licensed nursing staff on the facility Skin Tear policy and the Change in Residents Condition or Status policy. Additionally, the IDT team will audit each skin change of condition from the previous day in the morning clinical meeting to ensure physician was notified and the treatment orders are accurate,	

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	indicated the date and who had applied the dressing to Resident 6's mid-shin area. RN 3 indicated the shin skin tear was "considered healed several weeks ago" and since that time, the dressings were still being applied to Resident 6's mid-shin area as a preventative measure as per Resident 6's family request. On 12/12/24 at 12:15 p.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, anemia, generalized weakness, dementia, restless leg syndrome, tremors, and a potential for impaired skin integrity. The Quarterly Minimum Data Set (MDS) assessment, dated 11/17/24, indicated Resident 6 was severely cognitively impaired and indicated Resident 6 had a skin tear. Resident 6's care plan, revised on 1/12/23, indicated the resident had potential for impaired skin integrity. The care plan was reviewed and considered current through 2/16/25. The care plan indicated Resident 6's skin would be kept clean and intact. Physician orders included, but were not limited to, "monitor skin tear to lower left leg daily and change bordered foam dressing daily and as needed until healed...start date: 10/7/24..." Resident 6's Skin Assessments included, but were not limited to, the following: - Skin assessment, dated 10/5/24, indicated Resident 6 had a new left lower leg skin tear, approximately five centimeters in length, physician was notified, treatment order was in place, and staff were to monitor the area.		updated or need revision. **How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur.** To ensure ongoing compliance, the DNS/Designee is responsible for the completion of the wound care physician orders audit tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	- Skin assessment, dated 11/23/24, indicated Resident 6 had no impairments with skin integrity. - Skin assessment, dated 11/27/24, indicated Resident 6 had no impairments with skin integrity. - Skin assessment, dated 11/30/24, indicated Resident 6 had no impairments with skin integrity. - Skin assessment, dated 12/7/24, indicated Resident 6 had no impairments with skin integrity. - Skin assessment, dated 12/11/24, indicated Resident 6 had no impairments with skin integrity. A review of the November 2024 Treatment Administration Record (TAR) record indicated that staff had monitored the left shin skin tear and had applied a new dressing to the left shin area on a daily basis from 11/1/24 through 11/30/24. A review of the December 2024 TAR record indicated that staff had monitored the left shin skin tear and had applied a new dressing to the left shin area on a daily basis from 12/1/24 through 12/12/24. The clinical record lacked documentation that indicated a physician's prescribed treatment order to discontinue the daily dressing changes for a healed skin tear was followed. The physician was not notified and a new treatment order received prior to the continued dressing treatments having been applied to a healed skin tear from 11/24/24 through 12/12/24. During an interview on 12/12/24 at 3:40 p.m., the Director of Nursing Services (DNS) indicated Resident 6's left mid-shin skin tear was identified on 10/5/24 and the physician prescribed dressing			

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	changes were applied. When the skin tear was considered healed on 11/23/24, staff should have contacted the physician to obtain a revised treatment plan. All treatment dressings were to include the date and who had applied the dressings. On 12/12/24 at 2:15 p.m., the DNS provided a copy of the Envive Healthcare Policies and Procedures Manual: Subject-Skin Tears policy, dated August 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...apply the ordered dressing and secure...label with date and initials to top of dressing..." On 12/16/24 at 9:05 a.m., the DNS provided a copy of the Envive Healthcare Policies and Procedures Manual: Change in Resident's Condition or Status policy, dated August 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Our facility promptly notifies the resident, his or her attending physician...of changes in the resident's medical/mental condition and/or status...nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to document the drug dispositions for 1 of 2 residents reviewed for closed records. (Resident 47) Finding includes:	F 0755	**F755 Pharmacy Services** – *It is the consistent practice of this Provider to properly document drug dispositions of discharged residents.* **What corrective action will be accomplished for those**	01/10/2025

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	On 12/13/24 at 12:36 p.m., Resident 47's clinical record was reviewed. The diagnoses included, but were not limited to, hypertension, cerebral infarction (stroke), and hyperlipidemia (high cholesterol). A physician's order summary report of medications, dated for active orders as of 9/17/24, included but were not limited to: - hydralazine HCL 25 milligrams (mg) for hypertension (high blood pressure) - atorvastatin calcium 80 mg for lowering cholesterol - carvedilol 3.125 mg for hypertension - hydrochlorothiazide 12.5 mg for hypertension The Envive Discharge Summary document, was initiated on 9/16/24 in anticipation for Resident 47's planned discharge. A review of the document indicated Resident 47's current medications were to be sent home with the resident on her scheduled discharge date of 9/17/24. The record included Resident 47's current medications; however, it lacked the actual number of pills per medication that were to be provided to the resident upon her discharge. The clinical record lacked a completed drug disposition record for Resident 47 upon her discharge from the facility. During an interview on 12/13/24 at 1:15 p.m., RN 3 indicated Resident 47 was discharged home on 9/17/24 and the facility lacked a drug disposition record for Resident 47 medications.		**residents found to have been affected by the alleged deficient practice.** Resident 47 was discharged from the facility and no longer resides at the facility. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken.** All residents that will be discharged from this Provider have the potential to be affected by the same alleged practice. The Director of Nursing provided an in-service to Licensed Nursing staff on the resident discharge process and the proper documentation of drug dispositions. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur.** The Director of Nursing provided an in-service to Licensed Nursing staff on the resident discharge to home process and the proper documentation of drug dispositions. Additionally, the IDT team will audit each resident discharge from the previous day in the morning clinical meeting to ensure the facility discharge process was followed and all drug	

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	During an interview on 12/16/24 at 11:46 a.m., the Director of Nursing Services (DNS) indicated Resident 47's current medications were sent home with the resident. The DNS indicated she was unsure of the number of pills for each specific medication that were sent home with the resident or how many were returned to the pharmacy. The DNS indicated the facility lacked a drug disposition record for Resident 47's medications. On 12/16/24 at 9:05 p.m., the DNS provided an undated copy of the Discharge Medications policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...discharge medications are counted or the volume of liquid estimated and the following information is entered on the discharge medication documentation form...date...name and strength of each medication...quantity or amount...facility will adhere to the rules and regulations of their specific State Health Department..." 3.1-25(s)		dispositions were properly documented. If an error is identified in the discharge process, the DNS will re-inservice identified staff member and/or discipline any ongoing non-compliance to the facility policy. **How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur.** To ensure ongoing compliance, the DNS/Designee is responsible for the completion of the drug disposition audit tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure foods were maintained and served in a sanitary and safe manner for 4 of 4 observations. Staff hair was not covered while in the kitchen food preparation and serving area. (Dietary Manager) Findings include:	F 0812	**F812 Food Procurement/Sanitation** – *It is the consistent practice of this Provider to ensure foods are maintained and served in a sanitary and safe manner.* **What corrective action will be accomplished for those residents found to have been**	01/10/2025

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	1. The initial kitchen tour was conducted with the Dietary Manager (DM) on 12/10/24 from 9:00 a.m. to 9:20 a.m. The DM was observed walking through out the kitchen area and near the food preparation table where the noon meal was being prepared. The DM was observed to have multiple loose facial chin hairs approximately one-fourth inch to one-half inch in length. The chin hairs were observed to not be covered. 2. During a follow up kitchen observation on 12/10/24 from 11:25 a.m. to 11:45 a.m., the DM was observed at and near the steam table where the noon meal foods were being held. The DM was observed taking and recording the noon meal food temperatures. The DM was observed to have multiple loose facial chin hairs approximately one-fourth inch to one-half inch in length. The chin hairs were observed to not be covered. 3. Prior to the noon meal service on 12/10/24 from 12:15 p.m. to 12:45 p.m., the DM was observed at and near the steam table that was located in the main dining room area. The DM was taking and recording the starting food temperatures for the foods being held at the steam table. The DM was observed to have multiple loose facial chin hairs approximately one-fourth inch to one-half inch in length. The chin hairs were observed to not be covered. 4. During a follow up observation on 12/10/24 from 12:50 p.m. to 12:55 p.m., the DM was observed in the main dining room area where the steam table was located. The steam table held the noon meal foods. The DM was observed taking the ending food temperatures. The DM was observed to have multiple loose facial chin hairs approximately one-fourth inch to one-half inch in		**affected by the alleged deficient practice.** The identified Dietary staff member (DM) shaved the identified chin stubble hair to ensure foods were maintained and served in a sanitary and safe manner. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken.** All residents served food from the Providers Kitchen had the potential to be affected by the same alleged practice. The identified Dietary staff member (DM) shaved the identified stubble chin hair to ensure foods were maintained and served in a sanitary manner. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur.** The Executive Director provided an in-service to dietary staff regarding requirements and proper use of hair and beard nets. Additionally, hair nets will be placed at each entry door to the kitchen. Mirrors will be placed at each kitchen entry so staff can check proper placement of beard and/or hairnet to ensure all hair is properly covered.	

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	length. The chin hairs were observed to not be covered. During an interview on 12/10/24 at 1:00 p.m., the DM indicated staff hair was to be kept covered while in the kitchen and when working with resident foods. On 12/11/24 at 10:45 a.m., the Director of Nursing Services provided a copy of the Envive Healthcare Policies and Procedures Manual: Preventing Foodbourne Illness-Employee Hygiene and Sanitary Practices policy, dated August 2024, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Hair Nets ...beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens..." On 12/10/24 at 3:00 p.m., a review of the Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24, effective November 13, 2004, indicated, "...food employees shall wear hair restraints such as...hair coverings or nets...that are designed and worn to...effectively keep their hair from contacting...exposed food..." 3.1-21(i)(2) 3.1-21(i)(3)		**How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur.** To ensure ongoing compliance, the ED/Designee is responsible for the completion of the Kitchen sanitation tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure a soiled utility room lock was repaired for 1 of 1 soiled utility rooms observed. Findings included:	F 0921	**F921 Safe Functional Sanitary Comfortable Environment** – *It is the consistent practice of this Provider to ensure that soiled utility rooms are properly locked.* **What corrective action will be**	01/10/2025

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	On 12/10/24 at 10:00 a.m., observed the door to the Soiled Utility Room between Room 150 and Room 152 to be unlocked. An observation of the lock to the door was missing numerical key pads and the door latch was taped to prevent the door from locking when the door closed. In the unlocked room, a barrel labeled trash, three barrels labeled soiled linen, and two barrels containing items in biohazard bags were observed. The door to the Soiled Utility Room had a sign which read, "Restricted Area, Authorized Personnel Only". During an interview on 12/10/14 at 10:05 a.m., Qualified Medication Aide (QMA) 2 indicated the door should have been locked, but the lock was broken and there should have been a work order for it. During an interview on 12/10/24 at 10:22 a.m., the Director of Nursing (DON) indicated the door should have been locked. On 12/10/24 at 2:03 p.m., the DON provided, a copy of CDC Infection Control, Regulated Medical Waste, dated 1/8/24, and indicated it was the current policy in use by the facility. A review of the document indicated, "...Any facility that generates regulated medical wastes should have a regulated medical waste management plan to ensure health and environmental safety as per federal, state, and local regulations..." 3.1-19(f)		**accomplished for those residents found to have been affected by the alleged deficient practice.** The door lock to the soiled utility room was immediately replaced with a new working lock. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken.** All residents in this specific unit have the potential to be affected by the alleged deficient practice. The door lock was immediately replaced with a new working lock. **What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur.** The ED/Maintenance Director provided staff with in-service on proper process of completing work orders once any building or equipment issue is identified. Work orders are compiled electronically through the TELS work order system. Electronic notification is provided to the maintenance team and then documented once completed. **How the corrective action(s) will be monitored to ensure the alleged deficient practice will**	

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			not recur. To ensure ongoing compliance, Maintenance Director and/or Designee is responsible for the completion of the operating door lock audit tool weekly times 4 weeks, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 10, 11, 12, 13, 16, 17 and 18, 2024 Facility number: 000391 Residential Census: 26 Envive of Beech Grove was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 1/10/25.	