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	10/25/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419848. Complaint IN00419848- No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: October 25, 2023 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 6 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 3, 2023.	F 0000		
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jodi Deann Sanders | Administrator | 11/20/2023

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

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	Based on record review and interview, the facility failed to ensure a resident received adequate treatment who exhibited an increase in behaviors, wandering, and hallucinations for 1 of 3 residents reviewed (Resident B). Finding includes: Review of a facility reported incident, dated 10/17/23, indicated it was reported to staff that Resident B had made inappropriate comments to a female resident who resides at the facility. Resident B's record was reviewed on 10/25/23 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a decline in thinking and problem solving that often makes daily life and independent living difficult along with a person with psychosis had trouble figuring out what is real and what is not), hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there), and depression (a group of conditions associated with the elevation or lowering of a person's mood). A quarterly Minimum Data Set (MDS) assessment, dated 8/6/23, indicated the resident had moderate cognitive deficit and required assistance of two persons for transfers, toilet use, and personal hygiene. A care plan, dated 12/6/22, indicated Resident B was at risk for elopement related to history of attempts to leave facility. Interventions included, but were not limited to, wander guard and distract resident from wandering. A care plan, dated 3/10/22 with a revised date of	F 0744	**F744 Treatment /Services for Dementia** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan of resident B was reviewed and revised to include goals and approaches to addressing the resident diagnosed with Dementia. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected. Medical records of all the residents diagnosed with Dementia were audited, to ensure a corresponding care plan is included for the resident diagnosed with Dementia. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? IDT to review resident behaviors and discuss with the physician if pharmacological interventions are appropriate for treating the behaviors so that resident is able to attain/maintain their highest practical physical, mental and	11/23/2023

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	7/10/23, indicated Resident B had auditory and visual hallucinations related to dementia. Interventions included, but were not limited to, psychiatric (psych) eval and treat as needed, meds as ordered, and redirect resident away from female resident's room. A care plan dated 3/10/22 with a revised date of 10/6/23, indicated Resident B received antipsychotic medication related to behavior management, hallucinations, and dementia with psychotic disturbances. Resident B wanders halls and goes into other rooms. Interventions included, but were not limited to, staff to redirect resident when wandering, administer psychotropic medication and monitor side effects and effectiveness every shift. A physician order, dated 1/17/23, with a discontinue date of 4/4/23, indicated to administer Seroquel (antipsychotic medication) 12.5 milligram (mg) by mouth at bedtime related to dementia with psychotic disturbances. A physician order, dated 12/6/22, indicated to place a wander guard (bracelet that residents wear that monitor doors and a technology platform that should send safety alerts in real time) on at all times; and check placement and function every shift. Review of progress note, dated 3/17/23 at 5:44 p.m., indicated Resident B was told by staff that a female resident (Resident C) did not want visitors and Resident B began to hit and kick the staff member. Resident B cursed at the staff member and the resident had to be redirected by a different staff member. Review of progress note, dated 6/4/23 at 5:27 p.m.,		psychosocial well-being. SSD to monitor residents to ensure that any residents experiencing increased behaviors or receiving psych medications are referred to psych services as needed. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? SSD/designee will conduct a weekly audit x4 weeks, monthly x3 months. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: Nov. 23, 2023	

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	indicated Resident B was asking staff to let him outside. The resident was roaming the halls looking for open doors. Review of progress note, dated 6/18/23 at 10:09 a.m., indicated Resident B was exit seeking and asked staff to let him out the door. Review of progress note, dated 6/28/23 at 4:51 a.m., indicated Resident B had increased confusion. The resident was frequently going into the wrong rooms and was noted to have increased anger. Review of progress note, dated 7/10/23 at 11:03 a.m., indicated Resident B had made inappropriate sexual comments to a therapy female staff member when she entered his room. Review of progress noted, dated 7/11/23 at 10:00 p.m., indicated Resident B had been taken out of Resident C's room twice during the shift due to Resident C not wanting him in her room. Resident B believes that Resident C was his wife. Review of progress note, dated 7/14/23 at 12:09 p.m., indicated the Social Service Director (SSD) had to re-direct Resident B out of Resident C's room. SSD indicated Resident B believed Resident C was his wife who was deceased. He also believed he was an employee of the facility that had been laid off. Review of care plan conference review, dated 7/19/23 at 7:59 a.m., indicated Resident B required re-direction away from another resident's room. The record lacked physician notification and no new recommendations or orders. Review of progress note, dated 7/21/23 at 9:59			

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	p.m., indicated Resident B was adamant about going into Resident C's room. The resident got upset with staff that he couldn't enter her room. Review of progress note, dated 8/17/23 at 3:56 p.m., indicated Resident B was sitting by an exit door down the 200 hall and pushed the handle and door several times. Review of progress note, dated 8/20/23 at 12:15 a.m., indicated Resident B wanted to get out and go to town. Staff attempted to re-direct the resident but a few minutes later the staff heard the front door alarm and found the resident in lobby with the front door open and wander guard alarm sounding. Review of progress note, dated 9/3/23 at 8:52 p.m., indicated Resident B was in Resident C's room again this evening and staff tried to remove him from her room. The resident indicated to the staff they could not tell him what to do. Staff indicated Resident C did not want him in her room. Review of behavior note, dated 9/5/23 at 2:12 p.m., indicated no recommendations were made at this time to change medication for Resident B. Review of progress note, dated 9/29/23 at 9:22 p.m., indicated Resident B was exit seeking and was able to open two doors but did not get outside of the building. Review of behavior note, dated 10/4/23, indicated Resident B wanted staff to take him outside and drop him off at the highway, so that he could get away. Review of progress note, dated 10/6/23 at 2:34 p.m., indicated Resident B had been going to each			

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	door of the facility and hitting the doors trying to open them. Review of progress note, dated 10/6/23 at 3:26 p.m., indicated Resident B continued to look for ways out of the facility and the medical director was notified. A new order was obtained for antipsychotic medication at bedtime. A physician order, dated 10/6/23, indicated Seroquel 25 mg by mouth at bedtime related to dementia with psychotic disturbance. The record indicated the resident had been off this medication for 6 months prior to re-starting on this date. A health status note, dated 10/7/23 at 3:50 p.m., indicated Resident B was playing with an imaginary string and he thought bugs were on the floor. Review of progress note, dated 10/11/23 at 11:11 p.m., indicated Resident B was refusing to come out of Resident C's room. The resident became aggressive with staff and indicated he was not coming out of the room. Review of behavior note, dated 10/15/23 at 10:20 p.m., indicated Resident B had attempted to exit the main entrance door and he grabbed a staff member's private parts and made inappropriate sexual comments and gestures to her. Staff attempted to re-direct the resident and were unsuccessful. The resident also made suggestive comments and expressions to other staff members as well. Review of behavior note, dated 10/16/23 at 4:44 a.m., indicated Resident B was awake the entire night shift and continued to make			

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	provocative/sexual comments to staff. Review of behavior note, dated 10/16/23 at 8:35 a.m., indicated Resident B was in his wheelchair in the hallway and indicated there were one-inch bugs in the therapy hallway. The resident proceeded to grab at the air to try to catch the bugs. Review of behavior note, dated 10/17/23 at 8:58 a.m., indicated Resident B was in therapy and indicated he was seeing cats and dogs running around outside. Review of change of condition note, dated 10/17/23 at 7:33 p.m., indicated Resident B was barely sleeping and he thought another resident was his late wife. Resident B had dementia and was a known exit seeker and did not re-direct easily. The facility may transfer the resident for additional psych services. Review of progress note, dated 10/19/23 at 4:05 p.m., Resident B was transferred to a psych facility for treatment. During an interview on 10/25/23 at 10:50 a.m., Resident C indicated she had remembered Resident B coming into her room one day not long ago and he began to talk to her. She indicated he had made sexual comments to her. Staff came into her room and removed Resident B from her room. Resident C indicated he had come into her room several times before and she knew that she reminded him of his late wife. Resident C indicated there were times she didn't want him in her room. During an interview on 10/25/23 at 11:00 a.m., Registered Nurse (RN) 3 indicated Resident B's dementia had gotten worse over time and he had			

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	an increase in exit seeking and an increase in behaviors and making sexual comments to staff. She indicated the resident liked to visit Resident C and he believed she was his late wife. RN 3 was not sure if Resident B was on Psych services. During an interview, on 10/25/23 at 11:05 a.m., Speech Language Pathologist indicated Resident B was exit seeking and would often ask staff for rides or where he could get a car. She indicated she was aware Resident B thought that Resident C was his deceased wife and he liked to visit her room often. She indicated he had been exit seeking since coming to the facility, but she had noticed an increase in exit seeking behaviors. During an interview, on 10/25/23 at 11:53 a.m., SSD indicated she had been at the facility for a little over a month and she had noticed that Resident B was not receiving psych services and had not been seen by psych previously. She had sent a referral for him to start services when he returned to the facility. She indicated she did not know why he wasn't referred previously, and there were several other residents who needed referrals sent as well. She indicated when a resident was on psych medication or increased behaviors they should be referred. The SSD indicated she was aware that Resident B liked to visit with Resident C often. During an interview, on 10/25/23 at 2:15 p.m., Director of Nursing (DON) indicated Resident B was not on psych services and she wasn't sure if the previous SSD had requested the referral, and she didn't know where that documentation would be. On 10/25/23 at 3:10 p.m., the Administrator provided a document, dated 8/22, titled, "Behavior			

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	Assessment/Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, "1. The facility will provide, and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental, and psychological well-being ...6. The facility will comply with regulatory requirements related to use of medications to manage behavioral changes ...Cause identification:1. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes ... (5) change related to medications ...." 3.1-37			
F 0940 SS=D Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on interview and record review, the facility failed to ensure abuse training was completed for 2 of 4 employees reviewed and lacked documentation of ongoing abuse training after a reported abuse allegation. Findings include: On 10/25/23 at 11:15 a.m., during an interview with	F 0940	**F940 Training Requirements** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Employees #5, #6, and #7 were immediately trained in Abuse & Neglect Policy.	11/23/2023

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	Employee 5, the employee indicated if she was made aware of an abuse situation between residents, she would immediately report the incident to the head nurse. Maybe the ombudsman if there were signs but was not sure. If she witnessed physical abuse, she would immediately tell someone. The employee indicated she received a little training in abuse when she first started, two months ago but not very much. She indicated she had not received any training in abuse prevention or reporting since she was hired. On 10/25/23 at 11:25a.m.,during an interview with Employee 6, the employee indicated she had worked at the facility for about a month. The employee indicated she did not receive any abuse training when she was hired. She indicated she would remove the residents if she witnessed abuse and call for help and report it. She indicated she had not received any training in abuse prevention or reporting since she was hired. On 10/25/23 at 11:40 a.m., during an interview with Employee 7, the employee indicated she had worked at the facility for about 90 days. She indicated she did not receive training in abuse when she was in orientation at the facility or any training since being hired. If she witnessed any resident-to-resident abuse, she would get help and separate them first. She indicated she had not received any training in abuse prevention or reporting since she was hired. On 10/25/23 at 1:00 p.m., the Administrator provided three documents titled General Orientation Acknowledgment form and one document titled, General employee orientation checklist. Three of the forms were initialed next to resident abuse. One document was signed by the		2 How other residents having the potential to be affected by the same deficient practice will be identified? No residents were affected by the alleged deficient practice; however, all residents have the potential to be affected. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 100% of all employees were in-serviced on Abuse & Neglect Policy. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? Administrator/designee will monitor Abuse & Neglect Policy Training for weekly for 3 weeks, monthly times 3 months and quarterly. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's monthly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is	

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	employee but was not initialed under abuse policy and lacked evidence the employee had been trained in abuse prevention and reporting during orientation. On 10/25/23 at 1:00 p.m., the Administrator provided an undated Inservice record, titled Teachable moment, walking rounds, laundry, shower rooms, resident rights, Relias, attendance, progressive discipline, care-resident, PPE, wound care. An Inservice dated 8/18/23, titled teachable moment, resident mail, or packages. An Inservice dated 10/2/23, titled meds at bedside, weight days and charting. An Inservice dated, 10/2/23, titled narcotics and counting. An Inservice dated 10/3/23, titled bowel protocol-new, schedule and changes to scheduling, on call. Inservice records lacked documentation of abuse training after a reported incident of an allegation of abuse, or documentation of ongoing abuse training after orientation. On 10/25/23 at 10:00 a.m., the DON provided a document, titled, "Resident Abuse, Neglect and Exploitation" dated September 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...b. Training ... i. Provide training for new employees through orientation and with ongoing training programs training will include but is not limited to ...ii. Documentation of training of EHC employees will be maintained with in-service records in the campus ...d. Identification ...ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal ...iii. The shift Supervisor or Manager is identified as responsible for initiating and or continuing the reported process, as follows ...iv. IMMEDIATELY notify the Executive Directo. If the Executive		achieved. 5 Completion date: Nov. 23, 2023	

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	Director is absent, they may appoint a designee ...i. The Executive Director or designee must notify the resident(s)' physician(s) and family/resident representative ...ii. The Executive Director is responsible for ...1, notification to the State Department of Health ...and other agencies, which include the ombudsman ...Protection ...ii, Moving the resident to another room ...iii, Providing 1:1 monitoring, as appropriate ...v. Implement discharge process immediately, if resident is danger to self or others ...." 3.1-13(b) 3.1-14(k)			