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	02/28/2023

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00400152, IN00401609, IN00402401, and IN00402621. Complaint IN00400152 - No deficiencies related to the allegations are cited. Complaint IN00401609 - No deficiencies related to the allegations are cited. Complaint IN00402401 - No deficiencies related to the allegations are cited. Complaint IN00402621 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: February 20, 21, 22, 23, 24, 27, and 28, 2023 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 40 Total: 40 Census Payor Type: Medicare: 9 Medicaid: 18 Other: 13 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 Recertification and State Licensure with a Complaint Survey IN IN00402621 completed on February 20, 21, 22, 23, 24, 27, and 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of. 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	03/27/2023

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.

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	02/28/2023

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
	Quality review completed on March 13, 2023.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	02/28/2023

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
	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure the dignity of a resident was maintained for 1 of 16 residents reviewed for dignity (Resident 6). Findings include: During a random observation, on 2/20/23 at 11:32 a.m., Hospice Aide 31 and Certified Nursing Assistant (CNA) 13 were observed talking in hallway outside of Resident 6's room. Hospice Aide 31 was observed to enter the resident's room without knocking. CNA 13 was observed to stand in the doorway of the resident's room and continued to converse with the hospice aide. CNA 13 then walked into resident's room without knocking and the two staff continued to carry on a personal conversation while standing over resident in her bed. The conversation was not related to the resident's personal care. During a random observation, on 2/23/23 at 10:06 a.m., two unidentified facility staff were observed to enter the resident's room without knocking. The staff were carrying linens. The staff immediately closed the door behind them. Resident 6's record was reviewed on 2/24/23 at 11:51 a.m. The census indicated the resident had been admitted to the facility on 8/1/17, for diagnoses which included, but were not limited to, coronary artery disease (a disease in which there is a narrowing or blockage of the coronary	F 0550	**F550 – Resident Rights/Exercise of Rights** **SS=D** *"The facility failed to ensure the dignity of a resident was maintained for 1 of 16 residents reviewed for dignity (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 assessed and was not adversely 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 potential to be 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?**	03/28/2023

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	02/28/2023

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
	arteries) and congestive heart failure (occurs when the heart muscle doesn't pump blood as well as it should). The census indicated the resident had been admitted to hospice (end of life care) services on 1/24/20. An annual Minimum Data Set (MDS-a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 1/3/23, indicated the resident had severe cognitive deficit and was unable to complete the assessment interview. During an interview, on 02/27/23 at 8:53 a.m., CNA 20 indicated the procedure for entering a resident's room was to knock and wait to be told you are welcome to come in. During an interview, on 2/27/23 at 8:58 a.m., CNA 21 indicated the policy was to knock and get permission to enter a room before going in. There were situations where the residents could be hard of hearing and they have to pop their head in the door to make sure the resident was aware they were knocking at their door. One should never enter a room without knocking first. On 2/24/23 at 3:20 p.m., the Vice President of Clinical Services (VPCS) provided a document, dated 9/2022, titled, "Resident Rights," and indicated it was the policy current being used by the facility. The policy indicated, "...Policy Interpretation and Implementation...These rights included the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity...." 3.1-3(a)		· All staff will be in-serviced on: o "Resident Rights" - knocking on resident doors and receiving permission to enter prior to going into resident rooms. **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 round and observe staff entering 5 resident rooms three times a week x4 weeks, then twice a week x8 weeks, then weekly x 3 months to ensure staff are observing resident rights and specifically knocking on resident doors and receiving permission to enter prior to going into resident rooms. 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:** 03/28/2023	

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	02/28/2023

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 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for 2 of 16 residents (Residents B and 38) for residents observed for call light placement. Findings include: 1. During an initial pool interview on 2/21/23 at 9:23 a.m., Resident B indicated she had fallen many times since residing in the facility to include 3 times that morning. Her roommate had called for staff to come help her as she was unable to reach her call light. She did not routinely need assistance with transfers to and from her wheelchair or to and from the toilet but this week she had been dizzy and her blood pressure was "up." Resident B indicated she would usually yell for staff to assist her versus using her call light as she was unable to reach it across the room, and staff did not answer the "buzzers" very fast. Resident B's call light was observed coiled up and hanging off the railing on the side of the bed. Resident B's record was reviewed on 2/22/23 at 1:33 p.m. Diagnoses on Resident B's profile included, but were not limited to, Alzheimer's disease, Parkinson's disease, and repeated falls. Resident B's electronic medical record (EMR) indicated the resident had 9 recent falls to include, 11/7/22, 11/9/23, 11/27/22, 12/23/22, 1/1/23, 1/6/23,	F 0558	**F558 – Reasonable Accommodations Needs/Preferences SS=D** *"The facility failed to ensure call lights were within reach for 2 of 16 residents (Residents B and 38) for residents observed for call light placement."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents B and 38's call lights were placed within reach. **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 potential to be affected by this alleged deficient practice. · DNS and designee visited all residents to ensure all call lights	03/28/2023

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	02/28/2023

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
	1/12/23, and two times on 12/21/22. A 3/23/22 care plan for falls visible in the EMR, indicated Resident B was at risk for falls/injury due to high risk medication use, a history of falls, impaired cognition/safety awareness, dementia, and Parkinson's disease. The goal was for the resident to not sustain serious injury. Care plan intervention updates included, 8/8/22 call light within reach. A quarterly Minimum Data Set (MDS) assessment completed on 1/5/23 assessed the resident as having the ability to make herself understood and to understand others. Brief Interview for Mental Status (BIMS) score of 15/15 indicated cognitively intact. Extensive assistance of one person physical assist for bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene. Supervision of one person physical assist for walking in room, and locomotion off unit. Extensive assistance of 2 or more persons physical assist for toilet use. Mobility devices included a wheelchair and walker. Resident B had 2 or more falls since the last assessment. 2. During an initial tour observation on 2/20/23 at 11:53 a.m., Resident 38 was observed lying in bed on her left side facing the hallway, the call light was looped on the right side the bed behind her back hanging between the bedrail and mattress out of sight and reach of the resident. A second observation on 2/20/23 at 12:02 p.m., call light remained out of reach behind the resident's back. A third observation of the resident on 12/20/23 at 12:10 p.m. when Certified Nursing Assistant (CNA) 17 left the room, resident was in the same position on her left side facing the door, the call light remained on the rail behind her back. A fourth observation on 2/20/23 at 2:07 p.m., the call		were within reach. No deficiencies noted. **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 staff will be in-serviced on: o "Call Lights policy" - ensuring resident call lights are within reach **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 or designee will audit 5 residents three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure resident call lights are within reach. 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:** 03/28/2023	

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	02/28/2023

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
	light button was exchanged for a pressure call pad, within reach of the resident. On 2/21/23 at 10:38 a.m., Resident 38 observed lying on her right side facing inside of room, call pressure pad hanging down between the mattress and bedrail out of reach of the resident. On 2/24/23 at 9:15 a.m., Resident 38 observed laying on her left side facing the hallway door, call light looped on the bedrail behind the resident's back out of sight and reach. Resident 38's record was reviewed on 2/22/23 at 9:53 a.m. Diagnoses on Resident 38's profile included, but were not limited to, Parkinson's disease, catatonic disorder (behavioral disorder marked by an inability to move normally), and convulsion disorder with seizures. A quarterly MDS, completed on 1/26/23, assessed the resident as having the ability to make herself understood and to understand others. A BIMS score of 8 indicated moderate impaired cognition. The resident required extensive assistance of 2 or more persons physical assist for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. The resident required extensive assistance of one person physical assist for eating. The resident had no mobility devices and was always incontinent of bowel and bladder. A fall care plan for Resident 38, dated 11/25/22, indicated at the resident was at risk for falls/injury due to seizures. The goal was for the resident to be free of falls. Interventions included call light within reach. During an interview on 2/20/23 at 12:16 p.m., CNA			

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	02/28/2023

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
	13 indicated, the resident could not sit up on her own or readjust the bed independently. During an interview on 2/23/23 at 9:17 a.m., the Assistant Director of Nursing (ADON) indicated, the resident would use the call light at times, not sure if intentional or not, but she never asked for anything. On 2/24/23 at 3:20 p.m., the Vice President of Clinical Services provided a Call Lights policy, dated 8/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident lights will be answered in a timely manner. 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location ....5. Hand bells will be provided for alert dependent residents when positioned out of reach of permanent call light when needed ...." 3.1-3(v)(1)			
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only			

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	02/28/2023

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
	at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to address grievances in a manner which could be tracked for 3 of 3 months reviewed for grievance resolutions of the Resident Council and 2 of 2 residents reviewed for call light response (Residents B and 38). Findings include: Resident Council minutes were provided by the Activity Director (AD) on 2/21/23 at 2:46 p.m. The	F 0565	**F565 –** *Resident/Family Group and Response* **SS=D** *"The facility failed to address grievances in a manner which could be tracked for 3 of 3 months reviewed for grievance resolutions of the Resident Council and 2 of 2 residents reviewed for call light response (Residents B and 38)."*	03/28/2023

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	02/28/2023

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
	minutes for the 3 months reviewed indicated the following concerns by the Resident Council: a. Not enough staff for showers. b. Call lights taking too long to be answered by staff. During the Resident Council meeting, on 2/24/23 at 2:00 p.m., the residents indicated the facility had not been fully addressed, resolved, nor acted promptly upon the grievances of not enough staff for showers and call lights taking too long to be answered by staff. During an interview with the Activities Director (AD), on 2/21/23 at 2:50 p.m., she indicated she took minutes for the Resident Council meetings and then spoke with the Social Services Director, who was the facility's grievance officer, the department heads, and staff about the Resident Council's concerns. Showers and call light concerns had been brought up at the Resident Council meetings. The facility department's response was, the showers would be audited by the Assistant Director of Nursing and residents' preferences checked. Education would be provided to staff on shower procedures. Call lights were audited. The Director of Nursing had not seen a call light longer than 20 minutes and would reaudit and check wait times.Resident Council Minutes dated December 15, 2022, indicated not enough staff for showers. Current concerns included call lights not being answered without waiting a long time. The department's response was call lights were audited. The Director of Nursing (DON) has not been seen a light longer than 20 minutes. We will re-audit and check wait times. Documentation under group interview asked, "Do you feel you get the help and care you need without waiting a long term,		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident call light response was reviewed with all staff. · Resident Council concerns reviewed for past 6 months. All issues have been addressed. **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. · Resident Council concerns reviewed for past 6 months. All issues have been addressed. **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 staff will be in-serviced on: o "Call Lights policy" - ensuring resident call lights are answered timely · DNS and ED will be in-serviced on:	

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	02/28/2023

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
	does staff respond to call lights timely?" The response was no. Old business indicated, in November 2022 call lights not answered timely. Resident Council Minutes, dated 1/11/23, indicated call lights were not being answered appropriately. Documentation under group interview asked, "Do you feel you get the help and care you need without waiting a long term, does staff respond to call lights timely?" The response was no. During an interview on 2/23/23 at 3:30 p.m., the DON indicated she had followed up on resident concerns with call lights but doing audits and monitoring response times on off hours. She had not documented her follow up. On 2/24/23 at 3:20 p.m., the Vice President of Clinical Services provided a Call Lights policy, dated 8/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Purpose: To respond to residents' requests and needs in a timely and courteous manner. Guidelines: Resident lights will be answered in a timely manner. 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location ....5. Hand bells will be provided for alert dependent residents when positioned out of reach of permanent call light when needed ...." On 2/24/23 at 3:25 p.m., the Vice President of Clinical Services provided and identified a document as a current facility policy, titled "Resident Council," dated 8/2022. The policy indicated, " ...Policy Statement ...The facility supports residents' right to organize and		o "Resident Council" – following up on grievances **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?** · Administrator/designee will audit the grievances and log book 3x weekly for 4 weeks, 2x weekly for 8 weeks then weekly x 3 months to ensure all grievances are addressed. · DNS or designee will audit 5 residents three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure resident call lights are answered timely. 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:** 03/28/2023	

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	02/28/2023

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
	participate in the Resident Council ...1. The purpose of the Resident Council is to provide a forum for: ...a. Residents, families and resident representatives to have input in the operation of the facility ...b. Discussion of concerns and suggestions for improvement ...5. A Resident Council Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern ...6. The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI committee, if applicable (i.e., the issue is of serious nature or if there is a pattern, etc.) ...." 3.1-3(l)			
F 0572 SS=D Bldg. 00	483.10(g)(1)(16) Notice of Rights and Rules §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident			

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	02/28/2023

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
	with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; Based on interview and record review, the facility failed to ensure staff provided ongoing communication to residents about their resident rights through the Resident Council and family groups meetings for 3 of 3 months of resident council meetings reviewed. Finding includes: Resident Council minutes were provided by the Activity Director (AD) on 2/21/23 at 2:46 p.m. The Resident Council minutes lacked documentation that resident rights were reviewed during the resident council meetings for 3 of 3 months reviewed. The AD indicated she was unaware the residents' rights should have been reviewed at the meetings with the residents. The residents were provided the residents rights with their admission paperwork to read, and the Resident Rights were posted in the facility, but she was not aware the residents' rights should have been reviewed at resident council meetings. On 2/27/23 at 10:24 a.m., the Administrator (ADM) provided and identified a document as a current facility policy, titled "Resident Rights," dated 9/2022. The policy indicated, "Employees shall treat all residents with kindness, respect, and dignity...Policy Interpretation and Implementation...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ...b. be treated with respect, kindness, and dignity...j. be informed about his or her rights and	F 0572	**F572 - Notice of Rights and Rules** **SS=D** *"The facility failed to ensure staff provided ongoing communication to residents about their resident rights through the Resident Council and family groups meetings for 3 of 3 months of resident council meetings reviewed."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · All residents provided resident rights. **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 potential to be affected by this alleged deficient practice. · All residents were reviewed	03/28/2023

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	02/28/2023

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
	responsibilities...." 3.1-4(a)		and resident rights provided. **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 and ED will be in serviced on the following o "Resident Rights" – Providing resident rights to Resident Council and Family Group meetings. **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?** · ED/Designee will audit all Resident Council meetings and 3 Family Meetings weekly for 6 months to ensure Resident Rights are being provided during Resident Council and Family Group meetings. 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:** 03/28/2023	

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	02/28/2023

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 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS-a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment for 2 of 19 residents' MDS assessments reviewed (Resident 6 and 25). Findings include: 1. Resident 6's record was reviewed on 2/23/23 at 11:51 a.m. The census indicated the resident had initially been admitted to the facility on 8/1/17 and had been admitted to hospice (end of life care) services on 1/24/20. An annual MDS assessment, dated 1/3/23, indicated the resident received hospice services, but lacked documentation of a terminal prognosis (the likely outcome or course of a disease). During an interview, on 2/27/23 at 9:56 a.m., the MDS Coordinator indicated she was not aware that the resident's prognosis had to be coded as yes, for having 6 months or less to live. On 2/27/23 at 10:10 a.m., the MDS Coordinator provided a document, dated October 2019, titled, "CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," and indicated it was the policy currently being used by the facility. The policy indicated, "...J1400: Prognosis...Definitions: ...Under the hospice program benefit regulations,	F 0641	**F641** **SS=A** *"Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS-a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment for 2 of 19 residents' MDS assessments reviewed (Resident 6 and 25)."* **Commitment to Correct:** · Facility commits to education and monitoring of MDS nurse on accuracy of Minimum Data Set assessments. **Date of completion:** 03/28/2023	03/28/2023

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	02/28/2023

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
	a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record...Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs it's normal course...Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 2, yes: if the record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services...."2. Resident 25 was a Centers for Medicare/Medicaid (CMS) system selected resident for restraints. Resident 25's record was reviewed on 2/20/23 at 10:54 a.m. The quarterly Minimum Data Set (MDS) assessment, dated 12/2/22, indicated the resident had a moderate cognitive impairment and a physical restraint used in a chair or out of bed that was used less than daily. On 2/20/23 at 12:10 p.m., Resident 25 was observed in the dining room, eating lunch, no physical restraints were observed on Resident 25 nor in his wheelchair. During an interview, on 2/21/23 at 9:59 a.m., Resident 25 indicated he did not have a physical restraint on himself nor on his wheelchair. On 2/21/23 at 10:19 a.m., Certified Nursing Assistant (CNA) 13 indicated she was not aware of a restraint for Resident 25. The Vice President of Clinical Services (VPCS) indicated, on 2/21/23 at 10:24 a.m., Resident 25 did not have a restraint and was a coding error on the			

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	02/28/2023

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
	MDS assessment. The MDS Coordinator had modified the MDS assessment, and the modification assessment was ready for export. On 2/22/23 at 2:43 p.m., the MDS Coordinator indicated she had discovered Resident 25's MDS assessment coding error, on 2/20/23, when she was completing the survey entrance conference paperwork and had made the MDS modification assessment for Resident 25 at that time. A copy of Section P of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by the MDS Coordinator on 2/22/23 at 3:35 p.m. The manual indicated, " ...P0100: Physical Restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body ...Coding instructions: code 0. Not used, 1. Used less than daily, or 2. Used daily ...."			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record	F 0679	**F679 – Activities Meet**	03/28/2023

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	02/28/2023

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
	review, the facility failed to provide activities to a dependent 1 of 1 resident reviewed that was incapable of self-initiated activities (Resident 38) and failed to consistently provide evening activities for 2 of 3 residents reviewed for activities (Residents 21, and 19). Findings include, 1. During a random observation on 2/20/23 at 11:53 a.m., Resident 38 was observed lying in bed on her left side facing the doorway to the hall in a fetal position, wearing a hospital gown, and a throw covering her up to her shoulders. The room was dark with the lights off and blinds closed, no television (TV) or radio on. When spoken to the resident opened her eyes but did not engage in conversation. No activity calendar in the room. Random observations of the resident without activity involvement on 2/20/23, a. On 2/20/23 at 12:10 p.m., observation of Certified Nursing Assistant (CNA) 17 opening the resident's door and leaving resident's room. Room observed to be dark with no lights on, blinds closed, no radio or TV for stimulation, resident remained laying in same position in bed facing doorway. b. On 2/20/23 at 12:51 p.m. observation of Resident 38 remained laying in same position in bed facing doorway. Room observed to be dark with no lights on, blinds closed, no radio or TV for stimulation, c. On 02/20/23 at 2:07 p.m., resident observed in bed lying on right side. Room observed to be dark with no lights on, blinds closed, no radio or TV for stimulation. d. On 2/20/23 at 3:07 p.m., the physician was observed leaning over resident while she lays in bed. Room dark, no TV or radio for stimulation.		**Interest/Needs Each Resident SS=D** *"Based on observation, interview, and record review, the facility failed to provide activities to a dependent 1 of 1 resident reviewed that was incapable of self-initiated activities (Resident 38) and failed to consistently provide evening activities for 2 of 3 residents reviewed for activities (Residents 21, and 19)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents 21 and 19 were provided evening activities. · Resident 28 was provided 1 on 1 activities. **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 receiving activities have the potential to be affected by this alleged deficient practice. · All residents were reviewed to ensure residents incapable of self-initiated activities were provided 1 on 1 activities.	

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	02/28/2023

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
	Random observations of the resident without activity involvement on 2/21/23, a. On 2/21/23 at 8:45 a.m., observation of Resident 38 lying in bed on right side curled into fetal position facing the interior of the room. Blinds closed, lights off, no TV or radio playing. b. During an observation on 2/21/23 at 9:01 a.m., Licensed Practical Nurse (LPN) 16 observed in resident room, indicated had just finished administering bolus tube feeding. Resident observed to be lying in bed on right side in fetal position facing the interior of the room. Room dark, no radio, no TV, blinds to outside closed. c. On 2/21/23 at 10:38 a.m., Resident 38 observed still laying on right side in fetal position facing interior of room. No TV or radio, room dark. d. On 2/21/23 at 12:20 p.m., Resident 38 observed lying flat in bed facing the interior of room in fetal position. Blinds closed, no TV or radio, room dark. e. On 2/21/23 at 1:28 p.m., Resident 38 observed lying flat in bed facing the interior of room in fetal position. Blinds closed, no TV or radio, room dark. Random observations of the resident without activity involvement on 2/22/23, a. On 2/22/23 at 8:46 a.m., Resident 38 observed lying flat in bed facing the interior of the room in fetal position, forehead against the side rail. Blinds closed, lights off and room dark, no TV or radio on. b. On 2/22/23 at 9:42 a.m., resident observed in a Broda chair (tilt in space positioning wheelchair) near the nurse's station positioned against the wall behind another resident. On 2/24/23 at 9:15 a.m., Resident 38 was observed laying on her left side in bed facing the doorway, fetal position, blinds closed and room dark, TV off.		· Evening activities are being provided for all residents wanting to participate in evening activities. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur.** · Activity Director and all activity staff will be in-serviced on: o "Activities Program" **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?** · ED will audit 5 residents needing 1 on 1 activities or evening activities three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure residents are receiving 1 on 1 activities and evening activities as requested and/or needed. 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.	

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	02/28/2023

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
	Resident 38's record was reviewed on 2/22/23 at 9:53 a.m. Diagnoses on Resident 38's profile included, but were not limited to, depression, Parkinson's disease, and encephalopathy (brain disease that alters brain function or structure.) A physician's order, dated 11/25/22, indicated, may participate in overall activity plan. A physician's order, dated 11/25/22, indicated may participate in activities, social, nursing, restorative and psychosocial program as tolerated. A psychiatry visit note, dated 2/20/23, indicated resident presents as depressed, with flat affect. Treatment plan: provide a supportive environment to allow resident to vent negative feelings. An admission MDS (Minimum Data Set), completed on 11/30/22, assessed the resident as having the ability to make herself understood and to understand others. A BIMS (Brief Interview for Mental Status) score of 8 indicated moderate impaired cognition. Very important to listen to music and somewhat important to do things with groups of people and to do her own activities. Extensive assistance of 2+ persons physical assist for bed mobility, transfers, and locomotion on and off the unit. A personal preferences care plan for Resident 38, dated 11/30/22, indicated, she had personal preferences regarding her care that were important to her. She had a desire to participate in group activities, enjoyed 1on 1 activities, and enjoyed independent activities. Her goal was to attend her activities of choice throughout her stay. Interventions included, she would be offered 1 on 1 activities throughout her stay, her		**5.** Date of completion: 03/28/2023	

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	02/28/2023

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
	desires/personal preferences would be honored within the parameters of safe care through next review, she enjoyed country and rock and roll music, and offer her an activity calendar. During an interview on 2/22/23 at 3:04 p.m., Resident 38's son indicated his mother was always lying in bed when he visited. He had never seen her out of the room to an activities, and he had never seen the TV on or a radio in her room playing her favorite TV shows or music. During an interview on 2/23/23 at 9:17 a.m., the Assistant Director of Nursing (ADON) indicated, the resident was not always in bed, but there were times she would struggle and not want to get up. When staff did get the resident up, she was put into a Broda chair and taken to activities although she did not always participate. Socialization included staff sitting with her at meals, and the activity department would try to paint her nails or read her the newspaper. The ADON indicated, the TV was never on as Resident 38 did not like it, she was not sure about music. During an interview on 2/23/23 at 9:48 a.m., the Activity Director indicated the resident used to go to group activities. Now staff provided 1 on 1 with the resident in her room to include attempting to paint her nails, and nursing staff fed her. Activity staff occasionally provided music to the resident from their cell phones during visits. The resident did not have a radio, the son had not been asked to bring one and staff had extra that she could have been provided. Review of activity documentation in EMR (electronic medical record) with the Activity Director indicated activities were not personalized, there was the same activity category for all			

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	02/28/2023

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
	residents. Resident 38 documented as participated 2/13/ and 2/22, refused all other days in 14 day look-back. Activity Director indicated to her knowledge 1 on 1 meant music; no other documentation of activities offered. 2. During an interview, on 2/21/23 at 9:26 a.m., Resident 21 indicated she enjoys participating in the activities in the morning. The activity person goes home during the week around 3:00 p.m., to 4:00 p.m., and there was nothing much after that. Her roommate would try to get activity started in the evening if they had access to the games in the activity area. The games were usually locked up. Resident 21's record was reviewed on 2/22/23 at 10:59 a.m. The profile indicated the resident's diagnoses included, but were not limited to, morbid (severe) obesity and metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). An admission Minimum Data Set (MDS-a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 5/18/22, indicated the resident had no cognitive deficit. A care plan, dated 5/19/22, indicated the resident desired to participate in group activities and independent activities. Interventions included, but were not limited to, the resident would attend my activities of choice throughout my stay and her preferences would be honored. 3. During an interview, on 2/20/23 at 2:50 p.m., Resident 19 indicated there were no activities in the evenings. One of the other residents would organize games, because there were no activity people after 4:00 p.m. Two nights a week they			

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	02/28/2023

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
	would have a person here until 6:00 p.m., or 7:00 p.m., The residents usually at least try to organize a game of Sorry in the evenings, but that was usually all that is available to them. Most times they do not have access to the games or items they would like, because they had been locked in the activity room. Resident 19's record was reviewed on 2/23/23 at 2:08 p.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a condition that can affect the brain and spinal cord, causing a wide range of potential symptoms, including problems with vision, arm or leg movement, sensation or balance). An annual Minimum Data Set (MDS-a federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) assessment, dated 10/17/22, indicated the resident had no cognitive deficit. A care plan, dated 10/18/22, indicated the resident enjoyed computer games, desired to participate in group activities and independent activities. Interventions included, but were not limited to, the resident would attend my activities of choice throughout my stay and her preferences would be honored. During an interview, on 2/23/23 at 9:50 a.m., Activity Assistant 19 indicated the activities end daily after the 3:30 p.m., activity on all days. They did have an evening activity from 6:00 p.m., to around 7:00 p.m., on Wednesdays and Fridays. The resident should have access to the activity room unlocked after hours so that the residents can help themselves to any games they wish to play.			

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	02/28/2023

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
	During an interview, on 2/23/23 at 10:37 a.m., the Activity Director (AD) indicated they do have evening activities scheduled 2 days weekly with staff, and games should be left out for the residents to get on other days. The activity staff will always ask residents if they want any specific items left out before they leave. Staff had to be cautious, and lock items up, because of the confused residents, to protect them from getting items that could prove a hazard to them. If the residents who desired to have after hours activities requested a certain item, they would make it available. During an interview, on 2/23/23 at 11:18 a.m., the Executive Director (ED) indicated the activity department offered activities on evenings 2 days a week. The residents could organize their own, after hours, activities and there should be items available for them to play after hours. They could request items to be left out for any after hours activities. On 2/22/23 at 2:37 p.m., Activity Assistant 19 provided an activity calendar, dated February 2023, and indicated it was the calendar currently being used by the facility. The calendar indicated the last activity of each day was scheduled at 3:30 p.m. The last daily scheduled activity, varied from day-to-day. On Wednesday and Friday of each week, an activity was scheduled at 6:00 p.m. The activity for each of the evenings indicated "Games." On 2/23/23 at 11:10 a.m., the ED provided a document, dated 8/2022, titled, "Activities Program," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and			

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	02/28/2023

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
	Implementation...2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. 3. The Activities Program is ongoing and includes facility-organized group activities...12. Individualized and group activities are provided that: a. Reflect the schedules, choices, and rights of the residents; b. Are offered at hours convenient to the residents, including evenings, holidays, and weekends; c. Reflect the...personal preferences of the residents...." 3.1-33(a) 3.1-33(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure a resident received timely assessment, nursing services, documentation, treatment, and diagnostic testing after a weight fell onto her foot in the therapy gym, resulting in dark discoloration and pain to the right foot for 1 of 16 residents reviewed for non-pressure skin conditions (Resident 3). Findings include, During an initial pool interview on 2/20/23 at 2:48 p.m., Resident 3 indicated she had a "black toe"	F 0684	**F684 – Quality of Care** **SS=D** *"Based on observation, interview, and record review, the facility failed to ensure a resident received timely assessment, nursing services, documentation, treatment, and diagnostic testing after a weight fell onto her foot in the therapy gym, resulting in dark discoloration and pain to the right foot for 1 of 16 residents reviewed for non-pressure skin conditions*	03/28/2023

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	02/28/2023

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
	due to an accident the prior week while in the therapy gym when she was working with weights. When staff stood her up to ambulate, a weight rolled off her lap and fell onto her right foot causing bruising and pain to her right 3rd toe. She did not think the toe was broken but did not remember having an x-ray. The toe hurt at times and was tender but did not throb. On 2/21/23 at 9:49 a.m., Resident 3's right foot was observed with Licensed Practical Nurse (LPN) 16 who indicated she was unaware the resident had an injury to her toe. The entire right 3rd toe was observed to have dark purple and blackish discoloration, the top of the right foot below the toe had an area of dark discoloration measuring approximately 2" (inches) in length (L) x (by) 1.5" in width (W), with no edema. The bottom of the right foot below the middle toe was observed with dark discoloration measuring approximately 1" L x ¾" W. When LPN 16 attempted to move the right middle toe, the resident had a swift intake of breath and jerked her foot, indicating it hurt. Resident 3 indicated she took routine pain medication for arthritic and overall pain. On 2/22/23 at 10:52 a.m., observation of Resident 3's right foot with the Director of Nursing (DON) and Regional Vice President of Nursing Services (RVPNS). The right foot was observed to have dark discoloration on the entire middle toe, extended down onto top of the foot measuring approximately 3" L x 2"- 2.5" W, and extending approximately 1" below the tow on back of the foot. When asked if she could move her toes the resident was able to move the middle toe in a twitch and indicated less pain today. Resident 3's record was reviewed on 2/20/23 at 3:32 p.m. Diagnoses on Resident 3's profile		*(Resident 3)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 3 has been assessed and has received nursing services, documentation, testing and treatment for non-pressure skin condition. **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 non-pressure skin conditions have the potential to be affected by this alleged deficient practice. · All residents with skin conditions were reviewed to ensure assessments, nursing services, documentation, testing and treatments are in place as needed. **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 "Accidents/Incidents/Investigation"	

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	02/28/2023

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
	included, but were not limited to, Pick's disease (type of frontotemporal dementia), Parkinson's disease, polyosteoarthritis (arthritis in five or more joints at the same time), polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body) and generalized anxiety disorder. A quarterly MDS (Minimum Data Set) completed on 2/9/23, assessed the resident as having the ability to make herself understood and understood by others, a BIMS score 15/15 indicated cognitively intact, required extensive assistance of one person physical assist for bed mobility, transfers, toilet use, and personal hygiene, and required limited assistance of one person physical assist for walking in the room. The resident used mobility devices including a wheelchair and walker. The resident had no falls since the prior assessment, and no ulcers, wounds, or skin areas. Physician's orders, dated 2/26/22, indicated, a. Diclofenac Sodium Gel 1 % (topical nonsteroidal anti-inflammatory drug used to treat arthritic pain) apply to left shoulder topically every 6 hours as needed for pain. b. Hydrocodone-Acetaminophen tablet (narcotic pain relief) 5-325 mg (milligram) give 1 tablet by mouth two times a day related to low back pain. c. Diclofenac Sodium tablet delayed release 75 mg give 1 tablet by mouth two times a day related to other specified arthritis. d. Acetaminophen tablet 325 mg give 2 tablet by mouth every 4 hours as needed for pain/fever. The Medication Administration Record (MAR), dated February 2023, indicated Resident 3 was not administered Tylenol prn (as needed) for pain.		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?** · DNS/designee will complete an audit on 5 residents with non-pressure related skin conditions three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure assessments, nursing services, documentation, testing and treatments are in place as needed. 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:** 03/28/2023	

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	02/28/2023

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
	Weekly skin assessments, dated 1/29/22, 1/31/22, 2/6/22, 2/14/22, and 2/20/22, indicated no discolorations or impairments in skin integrity. Skilled Documentation Notes in the electronic medical record (EMR), dated 2/16/23, 2/17/23, 2/18/23, 2/19/23, 2/20/23, and 2/21/23, section for skin/wound documentation was left blank with no identified issues. Physical Therapy Notes, dated 2/13/23 - 2/20/23, lacked documentation related to the resident dropping a weight on her right foot or having reported a sore toe to physical therapist (PT) 14 who was working with the resident when the incident happened. Review of Resident 3's Progress Notes, dated 2/1/23 - 2/20/23, indicated resident record lacked documentation related to a discolored or injured toe on the right foot. Review of care plans for Resident 3 on 2/22/23 at 9:07 a.m., indicated no documentation related to an injured right foot or bruised toe. During an interview on 2/21/23 at 10:02 a.m., Registered Nurse (RN) 15 indicated she was the nurse routinely assigned to care for Resident 3. She was unaware of the injury to the resident's toe until that morning. She had not yet observed or followed up at that time, she was just going to speak with therapy. During an interview, on 2/21/23 at 10:06 a.m., PT 14 indicated she was told the day before in therapy that Resident 3 had hurt her toe. One day last week the resident had a weight wrapped in a blanket on her lap, and when she stood up it fell in front of her foot, but she did not think it hit the			

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	02/28/2023

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
	resident's toe. The day prior PT 14 had observed Resident 3's toe and the resident stated it was from the incident last week. During the conversation she told Resident 3 she was not sure how the toe injury could have been last week's incident as the weight had been wrapped in a blanket. PT 14 had observed the bruised toe, but she had not reported to nursing as she assumed they already knew. During an interview on 2/21/23 at 10:11 a.m., Certified Nursing Assistant (CNA) 13 indicated she had cared for Resident 3 the day before providing am care including dressing her, but she did not see a bruised toe. During an interview on 2/21/23 at 10:12 a.m., CNA 12 indicated, Resident 3 had told her either last Thursday 2/16 or Friday 2/17 she hurt her toe in therapy when she was working with weights. CNA 12 indicated she had reported the incident and injured toe to LPN 22 who was supposed to speak to the DON. She thought they had written an incident report. During an interview on 2/22/23 at 10:20 a.m., LPN 22 indicated she had worked until 2:00 p.m. on Friday 2/17. Right before shift change CNA 12 reported to her therapy had put a weight on Resident 3's lap and it rolled down onto her toe. LPN 22 informed the DON who told her to go ahead and leave and the evening nurse would follow up. She did not document the injury. On Saturday 2/18 when she worked, LPN 22 was told therapy said that was not what happened, and the resident's foot was not injured by a weight. Although LPN 22 was assigned to Resident 3 that day, she did not look at the resident's toe, and had not spoken with the			

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	02/28/2023

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
	resident regarding her toe until 2/22/23. Staff had obtained an x-ray order on 2/21, the results had come back the evening before but she had not read the results and placed it in the folder for morning meeting. During an interview on 2/22/23 at 10:25 a.m., the Assistant Director of Nursing (ADON) indicated, the interdisciplinary team (IDT) had discussed Resident 3 having an injured toe and x-rays being done that morning during morning meeting, but they did not discuss the findings. Upon review of an electronic report from a contracted x-ray company, ADON indicated the x-ray report was pending. The ADON indicated she had been made aware Resident 3 was complaining of having a toe being injured in therapy on Friday 2/17. The right middle toe was observed to be pink, a little bit red, looked like it might bruise, but no pain. On Monday 2/20 she again observed the resident's toe and it as a little redder and slightly bruised, no pain. On 2/21 the resident had complained of pain, and her toe was observed to have faded purple discoloration, gestured approximately 3". With the resident's complaints of pain of 2 on a scale of 10, they had notified the physician and got an order for Norco (narcotic pain medication) as needed for pain, and orders for a foot x-ray. During an interview on 2/22/23 at 10:31 a.m., the DON indicated, she had found out about Resident 3's toe around noon on Friday 2/17/23. She was told Resident 3 reported to her something rolled off her lap onto her foot, and the toe was pinkish red. Resident 3 told the DON during therapy she had a weight in a blanket, and it rolled off when she stood up. The resident denied pain at the time. The DON went to question therapy about			

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	02/28/2023

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
	the incident but did not see them, so she once again asked the resident if she was in pain and the resident denied pain. The DON filled out information on an internal incident report to be reviewed with the IDT on 2/20. On 2/20 the DON observed Resident 3's foot in the afternoon and the right middle toe was a little redder, some yellowing, but she did not see any injury. She had not looked at the resident's foot since 2/20 as the ADON was the wound person. On 2/21 the nurse indicated Resident 3 was voicing pain and discomfort, so the nurse notified the physician and got orders to get an x-ray, monitor for 7 days, and give the pain medication Norco. The foot x-ray results were not back yet. On 2/22/23 at 2:45 p.m., LPN 16 indicated Resident 3's right foot x-rays had been completed the prior evening, but the results were still pending. She indicated she was told the x-ray had poor imaging and it was being retaken that day. On 2/22/23 at 2:52 p.m., the DON indicated, the x-ray technician had returned to retake the resident's foot x-ray as the person reading the results was not happy with the image. On 2/23/23 at 9:01 a.m., LPN 16 indicated Resident 3's x-ray had returned and there were no fractures. Review of the x-ray result indicated, no fracture or dislocation of the 3rd digit. There is mild degenerative joint disease seen. There was not fracture, dislocation, or soft tissue swelling. No osteomyelitis seen. On 2/23/23 at 2:40 p.m., the DON provided an Accidents/Incidents/Investigation policy, dated 8/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "All accidents or incidents involving residents, employees, visitors, or vendors, etc.,			

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	02/28/2023

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
	occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident ...5. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident ..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure an effective fall management program by documenting nurse's notes of the fall for 1 of 3 residents reviewed for accidents (Residents B). Findings including: On 2/20/23 at 12:27 a.m., Resident B was observed in the dining room, seated in a Broda chair (tilt in space positioning wheelchair), moving/rocking herself back and forth with her feet.	F 0689	**F689 – Free of Accident Hazards/Supervision/Devices SS=D** *"Based on observation, interview, and record review, the facility failed to ensure an effective fall management program by documenting nurse's notes of the fall for 1 of 3 residents reviewed for accidents (Residents B)."* **1. What corrective action(s)**	03/28/2023

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	02/28/2023

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
	During a random observation on 2/20/23 at 3:01 p.m., Resident B was sitting in a Broda chair leaning over from the waist reaching for personal items. Her room was cluttered with personal items around the bed, between the bed and window, on and under the bed, on the floor, stacked around her side of the room, and partially filled open containers of food and fluids were on the over the bed table and sitting in the trash can. On 2/21/23 at 9:11 a.m., Resident B was observed alone in the activity room, sitting at a small round table with her eyes closed and forehead laying on a newspaper on the table. During an initial pool interview on 2/21/23 at 9:23 a.m., Resident B indicated she had fallen many times since residing in the facility to include 3 (three) times that morning. Her roommate had called for staff to come help her as she was unable to reach her call light. She did not routinely need assistance with transfers to and from her wheelchair or to and from the toilet but this week she had been dizzy and her blood pressure was "up." Resident 23 indicated she would usually yell for staff to assist her versus using her call light as she was unable to reach it across the room, and staff did not answer the "buzzers" very fast. On 2/23/23 at 9:33 a.m., Resident B was observed sitting on the edge of the bed, her Broda chair in front and facing her, knees touching front of chair. Resident B gestured to the cushion in her Broda chair and indicated the cushion and seat in the Broda were lower than the bed. She had told staff the seat was lower and therefore made it harder to transfer, but they had told her the seat was not lower and had not changed it. Resident then gestured to the locks on the Broda chair and indicated they were too far back for her to reach		**will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B's nurse's notes were updated. **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 falls have the potential to be affected by this alleged deficient practice. · Falls for the past 6 months were reviewed to ensure documentation and fall management program in place. · All residents reviewed to ensure fall risk assessments 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?** · All licensed clinical staff will be in-serviced on: o "Fall Program Guidelines" – fall risk assessments completed and falls documented in nurses notes.	

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	02/28/2023

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
	so she could unlock and move the chair back. The resident was observed to lean forward and reach for the locks unsuccessfully while on the edge of the bed. Resident B's room was observed to be free of excessive clutter and changed with bed now positioned parallel to and against the wall. Resident B indicated she was not sure why her room was rearranged but staff had come in the night before and moved or thrown away her belongings stating it had to be cleaned up. Resident indicated she had new signs on the closet and bathroom door that said call before fall. Resident 23's record was reviewed on 2/22/23 at 1:33 p.m. Diagnoses on Resident Bs' profile included, but were not limited to, Alzheimer's disease, Parkinson's disease, and repeated falls. A quarterly MDS (Minimum Data Set) completed on 1/5/23 assessed the resident as having the ability to make herself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated cognitively intact. The resident had no signs or symptoms of delirium, behaviors, or rejection of care. The resident required extensive assistance of one person physical assist for bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene. The resident required supervision of one person physical assist for walking in room, and locomotion off unit. The resident required supervision and set up help only for walking in corridor. The resident required an extensive assistance of 2 or more persons physical assist for toilet use. The resident used mobility devices including a wheelchair and walker and had 2 or more falls since the last assessment with no major injury. Physician's orders, dated 8/10/22, indicated anti		**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 new residents and 5 residents with falls three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure an effective fall management program is in place with fall risk assessments complete and falls documented in nurses notes. 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:** 03/28/2023	

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	02/28/2023

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
	roll backs to wheelchair due to fall intervention every shift. Green balance cushion to wheelchair, check placement every shift. Observations during the survey process indicated no anti roll backs to resident's chair. Egg crate cushion versus gel cushion observed in wheelchair. A Fall Risk Assessment, dated 12/23/22, indicated incorrect scoring on number of falls, resulting in the resident being documented as a low risk for falls. Resident B's electronic medical record (EMR) indicated the resident had 9 recent falls to include, a. On 11/7/22 fell while ambulating independently and when turning got dizzy and fell. The record lacked documentation of time documented, nurse's note of fall with root cause or new intervention, 72 hour follow up or IDT note visible in EMR, or care plan update. b. On 11/9/23 found on floor in bathroom. The record lacked documentation of time documented, nurse's note of fall with root cause or new intervention, 72 hour follow up visible in EMR, or care plan update. c. On 11/27/22 found on floor in front of Broda chair. The record lacked documentation of time documented, nurse's note with root cause or new intervention, or 72 hour follow up visible in EMR. A late IDT note, on 12/1/22, indicated all interventions in place. d. On 12/23/22 fall identified by neuro checks in EMR. The record lacked documentation of nurse's notes of fall with root cause or new intervention, a 72 hour follow up or IDT note visible in EMR, or care plan update. The DON indicated resident had no fall on this date. e. On 1/1/23 fell while reaching for items on the floor. The record lacked documentation of time documented and nurse's note of fall with root			

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	02/28/2023

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
	cause or new intervention, 72 hour follow up visible in EMR. On 1/3/23 an IDT note indicated the resident fell and interventions were in place. The record lacked a care plan update. f. On 1/6/23 found on floor in front of Broda chair. The record lacked documentation of time documented, nurse's note of fall with root cause or new intervention,72 hour follow up or IDT note visible in EMR, or care plan update. g. On 1/12/23 found on floor in room. The record lacked documentation of time documented, nurse's note with root cause or new intervention, 72 hour follow up or IDT visible in EMR, or care plan update. h. On 2/21/22 at 8:20 a.m. found on floor in room yelling for help. The record lacked documentation of nurse's note with root cause or new intervention, 72 hour follow up, IDT note, or neuro checks visible in EMR. i. On 2/21/22 at 7:15 p.m., resident found sitting on floor in front of Broda chair. The record lacked documentation of nurse's note with root cause or new intervention, 72 hour follow up, IDT note, or neuro checks visible in EMR. A nurse's note, dated 1/3/23 at 9:59 a.m., indicated IDT reviewed fall for resident, all intervention in place. The resident record lacked documentation a new fall intervention had been added, and current interventions were not in place. A behavior notes, dated 1/5/23 at 10:30 a.m., indicated Social Service Director (SSD) offered to give resident a rosary and to bless chair and resident agreeable. SSD reported chair had been blessed and devil was gone. Occupational Therapy (OT) attached rosary beads to chair, and resident reported chair was okay to use and sit in. Resident record indicated care plan for rosary beads to chair. Resident chair observed			

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	02/28/2023

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
	throughout the survey without rosary beads. On 2/23/23 at 10:30 a.m., the Director of Nursing (DON) provided internal risk management incident report notes, not accessible in the EMR nurse's notes or to the physician (MD) for follow up. The interdisciplinary team (IDT) note documentation did not consistently identify time of falls, root cause of falls, new interventions, or MD and resident representative notification. IDT note of new fall interventions if documented were not carried forward to the resident care plan. A 3/23/22 care plan for falls visible in the EMR, indicated Resident B was at risk for falls/injury due to high risk medication use, a history of falls, impaired cognition/safety awareness, dementia, and Parkinson's disease. The goal was for the resident to not sustain serious injury. Care plan intervention updates included, a. 3/23/22 anticipate and meet the resident's needs, ensure pathways are free of clutter, keep personal items within reach, encourage resident to avoid sudden changes in position, follow facility fall protocol, non-skid/gripper socks and provide adequate lighting. b. 5/12/22 remove lap tray per therapy order. c. 6/7/22 provide me with a reacher/grabber. d. 8/8/22 call light is within reach, and anti-rollbacks to wheelchair. e. 8/15/22 check orthostatic blood pressure (low blood pressure that happens when standing up from sitting or lying down) every shift. f. 9/18/22 ensure my assistive mobility device is within reach. g. 10/11/22 labs as ordered. h. 11/17/22 alarm on bathroom door and remove walker from room when not in use. i. 11/29/22 when resident is sleepy staff is to place resident in bed and not in chair.			

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	02/28/2023

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

The resident record lacked documentation the care plan was updated with new interventions for falls that occurred on 12/23/22, 1/1/23, 1/6/23, 1/12/23, and two times on 12/21/22, or that new interventions were initiated, and personalized. Existing interventions were not observed to be implemented to include pathways free of clutter, call light within reach, anti-rollbacks on wheelchair, orthostatic blood pressure twice daily, alarm on bathroom door, remove walker from room when not in use, and putting resident into bed when sleepy.

During an interview on 2/23/23 at 9:22 a.m., the Assistant Director of Nursing (ADON) indicated, if a resident had an unobserved fall, staff would get the nurse to fully assess the resident, take vital signs, assess for range of motion of the extremities with or without pain. If the resident had full range of motion, the resident would be assisted back into a chair or bed. An incident report was documented with notes describing the fall. If a resident fall was unwitnessed or if the resident hit his/her head, neurological (neuro) checks were documented on paper and put on the clip board for staff to fill out, the fall was documented on the shift sheet, and 72 hours of follow up was documented in the IDT notes by the DON. All assessment documentation and notification of the family and MD was in the EMR. Care plans were updated by the MDS nurse. Falls were reviewed every morning by IDT for 72 hours and care plans updated at that time.

On 2/23/23 at 2:40 p.m., the DON provided a Fall Program Guidelines policy, dated 12/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: To screen all residents to identify possible risk

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	02/28/2023

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
	factors that could place a resident at risk for falls, evaluate those risks, implement interventions to reduce risk and monitor the interventions for effectiveness ...Procedures: 1. The resident will be assessed for fall risk upon admission and quarterly. 2. Interventions will be implemented if resident is determined to be at risk. 3. Should a fall occur, the nurse shall complete an assessment of the resident and circumstances surrounding the fall incident. The Interdisciplinary [IDT] should determine root cause and evaluate to ensure appropriate interventions are implemented. 4. The attending physician or medical director in the absence of the attending physician and the responsible party should be notified. 5. The resident care plan should be revised to reflect any new or change in interventions. 6. Effectiveness of interventions will be monitored through the Clinically at-Risk program." This Federal tag relates to Complaint IN00402621. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	02/28/2023

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
	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. A. Based on observation, interview, and record review, the facility failed to ensure the kitchen was cleaned, staff sanitized their hands appropriately, food items were labeled and dated, the cleaning solution in the QUAT buckets tested appropriately, and food temperatures were monitored for 1 of 2 kitchen observations; and the facility failed to ensure pureed food items were prepared in a sanitary manner, and staff wore a beard restraint while preparing food in the kitchen for 1 of 2 kitchen observations. B. Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene for 1 of 2 dining room service observations and failed to ensure food was covered when transported for 1 of 2 observations of food delivery of hall tray service. Findings include: A1. During the initial kitchen tour with the Dietary Manager (DM), on 2/20/23 at 10:15 a.m., the DM washed her hands for less than (<) ten seconds, turned off the faucet with her bare hand, and then began the tour of the kitchen. The flooring throughout the kitchen, dry storage room, walk-in refrigerator, and walk-in freezer were	F 0812	**F812 – Food Procurement, Store/Prepare/Serve-Sanitary SS=E** *A. "Based on observation, interview, and record review, the facility failed to ensure the kitchen was cleaned, staff sanitized their hands appropriately, food items were labeled and dated, the cleaning solution in the QUAT buckets tested appropriately, and food temperatures were monitored for 1 of 2 kitchen observations; and the facility failed to ensure pureed food items were prepared in a sanitary manner, and staff wore a beard restraint while preparing food in the kitchen for 1 of 2 kitchen observations."* *B. "Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene for 1 of 2 dining room service observations and failed to ensure food was covered when transported for 1 of 2 observations of food delivery of hall tray service."*	03/28/2023

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	02/28/2023

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
	observed soiled, dingy, and littered with dried food particles, fresh food items, paper debris, plastic utensils, and condiment cups. The flooring had a heavy soilage buildup with black residue at the cove bases, around the floor drains, under and around the steam table, under the food preparation area, under the storage shelving units, and underneath, as well as, behind the appliances. A yellow-brown greasy build-up was observed on the front and down the sides of the of the stove, oven, and refrigerator. The inside of the refrigerator was soiled with food debris and a spilled drink substance on the bottom, and the refrigerator contained unlabeled and undated bag of four boiled eggs, an undated opened package of bologna, an undated container of low-fat yogurt, an undated opened eight-pound container of macaroni salad, and an undated opened one-gallon container of relish. The walk-in refrigerator contained an undated and unlabeled tray with nine cups filled with milk or juices and two pitcher containers of unlabeled and undated juice. Dietary aide (DA) 4 was observed to wash her hands for < 10 seconds and turned off the faucet with her bare hand, then went to the food preparation area and began cutting strawberries for the residents' lunch dessert of strawberry fluff. The DM tested the sanitizing solution concentration in the chemical sanitizing solution bucket with quaternary ammonium compound (QAC) (cleaning and disinfection solution) test strip. The DM indicated the QAC test strip had read zero for no sanitizing solution in the quat bucket but the sanitizing solution in the bucket should have tested at least 150-200 ppm (parts per million) of QAC.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · No residents were found to have been 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 potential to be affected by deficient practice. · All residents reviewed and none were affected by the alleged deficient practice. · All kitchen staff will be in-serviced on: o "Food Storage and Receiving" o "Hygiene" **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 current and new kitchen staff will be in-serviced on: o "Food Storage and Receiving" o "Hygiene" **4. How the corrective action will be monitored to ensure the deficient practice will not recur**	

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	02/28/2023

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
	Review of the food temperatures log dated February 2023, with food temperatures documented through 2/16/23 and the remainder of the dates blank. The DM indicated the cook should have documented food temperatures on the log for every meal and she was unable to find the kitchen cleaning logs for February 2023 with the most current cleaning log dated 1/24/23. During an interview, on 2/20/23 at 10:40 a.m., the DM indicated staff were supposed to sweep and mop the kitchen flooring twice daily at 2 p.m. and 7 p.m. and document on the cleaning log that the assignment completed. The steam table leaked and caused the kitchen floor tiles underneath to crumble into pieces and the moldy food substance on the crumbled tiles next to the steam table was a chicken nugget. The dry storage room floor had cranberry juice concentrate spilled, on Thursday, 2/16/23, when a delivery of food was made. The refrigerator should be cleaned weekly or when soiled. The food items should be dated and labeled when opened or when the containers of juice were made. Staff should wash their hands for at least twenty seconds and turn off the faucet with a paper towel. She and the dietary aide had just been nervous and forgot to wash their hands long enough and should have turned off the faucet with a paper towel. On 2/20/23 at 3:04 p.m., the Executive Director (ED) provided and identified a document as a current facility policy, titled "Kitchen Sanitation," dated 12/2022. The policy indicated, "...The food service area shall be maintained in a clean and sanitary manner...Policy Interpretation and Implementation...1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches,		**i.e., what quality assurance program will be put into place?** · ED/designee will audit the kitchen three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure the kitchen is cleaned, staff sanitize their hands appropriately, food items are labeled and dated, the cleaning solution in the QUAT buckets is tested appropriately, food temperatures are monitored, pureed food items are prepared in a sanitary manner, and staff wear beard restraints while preparing food in the kitchen. · ED/designee will audit the dining room service and meal tray delivery three times a week x8 weeks, then twice a week x4 weeks, then weekly x3 months to ensure staff perform hand hygiene in the dining room and to ensure food is covered when transported during delivery of hall tray service." 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:** 03/28/2023	

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	02/28/2023

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
	flies and other insects...2. All utensils, counters, shelves and equipment shall be kept clean...3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions...4. Sanitizing of environmental surfaces must be performed with one of the following solutions: ...b. 150-200 ppm quaternary ammonium compound (QAC)...6. Between uses, cloths and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizing solution will be changed at least once per shift or if solution becomes cloudy or visibly dirty...16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime...17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment...." The ED, on 2/20/23 at 3:04 p.m., provided and identified a document as a current facility policy, titled "Temperatures," dated 12/2022. The policy indicated, "...The facility will maintain proper temperature control to prevent food borne illness...1. Hot foods that are potentially hazardous will be held for service at or above 135 degrees Fahrenheit, and cold foods at or below 41 degrees Fahrenheit...8. Temperatures should be monitored and recorded on the Weekly Temperature Record prior to the start of and throughout meal service to ensure adequate holding temperatures are maintained...."			

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	02/28/2023

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
	The Vice President of Clinical Services (VPCS), on 2/21/23 at 10:00 a.m., provided and identified a document as a current facility policy, titled "Food Storage and Receiving," dated 12/2022. The policy indicated, "...Foods shall be received and stored in a manner that complies with safe food handling practices...8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ('use by' date)...." A2. During an observation in the facility kitchen of pureed food preparation, on 2/23/23 at 11:18 a.m., Cook 18 was observed with a full beard without a beard restraint. Cook 18 began plating food for the residents' lunch service. Cook 18 indicated he did not have on a beard restraint and did not realize he needed to wear a beard restraint while pureeing and preparing food in the kitchen. During an interview, on 2/23/23 at 12:08 p.m., the Dietary Manager (DM) indicated staff, who have facial hair or full beards, should wear beard restraints when in the kitchen. On 2/23/23 at 2:35 p.m., the Dietary Manager (DM) provided and identified a document as a current facility policy, titled "Food Preparation Service," dated 8/2022. The policy indicated, "...7. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food...." B1. During a continual dining observation in the main dining room, on 2/20/23 at 11:54 a.m. to 12:38 p.m., Dietary Aide (DA) 32 was observed to touch her face and adjusted her face mask. Without cleaning her hands, she opened a can of soda for a resident, poured tea into a cup, placed sweetener into the tea, and served the tea to a resident. She touched a resident's back and asked			

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	02/28/2023

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
	what he wanted to drink. Without cleaning her hands, DA 32 adjusted her face mask and pulled up her pants with both hands, then grabbed Styrofoam cups, poured tomato juice into three cups and served three residents the juice. DA 32 placed her hands in her pockets, while she was talking with a resident then prepared and served two residents drinks without sanitizing or washing her hands. Certified Nursing Assistant (CNA) 20 was observed to touch her necklace, eyeglasses, face, and face mask, then assisted with a spoon a resident with eating their lunch without hand sanitation. During an interview, on 2/20/23 at 3:00 p.m., the Executive Director (ED) indicated, staff should sanitize or wash their hands before and after preparing and serving drinks and meals to the residents. B2. On 2/20/23 at 12:47 p.m., during observation of lunch hall tray pass, staff were observed serving trays to the residents in their rooms with the strawberry fluff dessert cups uncovered on the lunch trays. During an interview, on 2/20/23 at 12:55 p.m., the Dietary Manager indicated, all food should be covered before leaving the kitchen and the dietary staff should have covered the dessert cups with plastic wrap before the food trays were transported to the residents' rooms. The ED, on 2/20/23 at 3:04 p.m., provided and identified a document as a current facility policy, titled "Hygiene," dated 9/2022. The policy indicated, "...Policy...Guideline for Handwashing/Hand Hygiene...Purpose...Handwashing is the single most important factor in preventing transmission			

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	02/28/2023

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
	of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR)...1. All health care worker shall utilize hand hygiene frequently and appropriately...Health Care Workers shall use hand hygiene at times such as: ...a. Reporting to work; before/after eating; after smoking, toileting, blowing nose, coughing, sneezing, etc. ...b. Before/after preparing/serving meals, drinks...c. Before/after having direct physical contact with residents...Procedures...1. Hand Washing...c) Wash well for 15-20 seconds, using rotary motion and friction...f) Turn off faucet with paper towel to avoid recontamination hands from the faucet...." The VPCS, on 2/21/23 at 10:00 a.m., provided and identified a document as a current facility policy, titled "Distribution," dated 12/2022. The policy indicated, "...11. Prepared food will be transported to other areas either covered or in covered containers/enclosed carts. Food and beverage items should be covered when being taken down a hall or to another unit or floor...." 3.1-21(i)(1) 3.1-21(i)(3)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any	F 9999	**F9999 – PERSONNEL** "Based on record review and interview, the facility failed to ensure reference checks had been completed for newly hired employees for 5 of 10 employee records reviewed."	03/28/2023

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	02/28/2023

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
	convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure reference checks had been completed for newly hired employees for 5 of 10 employee records reviewed. Findings include: Review of the employee records (State Form 5440) was completed on 2/28/23 at 9:27 a.m. The form lacked documentation of the following: a. Housekeeping Aide 25's record indicated a hire date of 1/1/22. The record lacked documentation of any reference checks having been completed upon hire. b. Dietary Aide/Cook 26's record indicated a hire date of 1/31/23. The record lacked documentation of any reference checks having been completed upon hire. c. Certified Nursing Assistant (CNA) 27's record indicated a hire date of 1/24/23. The record lacked documentation of any reference checks having been completed upon hire. d. Certified Nursing Assistant (CNA) 28's record indicated a hire date of 2/13/23. The record lacked documentation of any reference checks having been completed upon hire. e. Certified Nursing Assistant (CNA) 29's record indicated a hire date of 2/13/23. The record lacked documentation of any reference checks having been completed upon hire.		**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 potential to be affected by the alleged deficient practice. · BOM audited all employees to ensure reference checks 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?** · BOM and ED will be in-serviced on: o "HR-101: Pre-Employment Reference Checks" **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?**	

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	02/28/2023

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
	During an interview, on 2/28/23 at 1:14 p.m., the Business Office Manager (BOM) indicated she had not completed the reference checks, on the new employees. On 2/28/23 at 1:35 p.m., the BOM provided a document, dated 8/1/21, titled, "HR-101: Pre-Employment Reference Checks," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: All applicants for employment must undergo a thorough screening of their former employment...Types of References: Appropriate reference and/or background checks consist of: former employer references...."		· BOM/designee will audit all new hires weekly x6 months and ongoing to ensure reference checks have been completed. 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:** 03/28/2023	