STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIE		715 N	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0000					
F 0684	Licensure Survey. Investigation of Co Complaint IN0044 deficiencies related F684. Survey dates: Nov Facility number: 0 Provider number: AIM number: 1000 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type Medicare: 2 Medicaid: 22 Other: 9 Total: 33 These deficiencies accordance with 4 Quality review cor 483.25	155699 379970 e: reflect State Findings cited in	F 0000	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepared executed solely because it is required by the position of Fe and State Law. The Plan of Correction is submitted to rest o the allegation of noncomplicited during the Annual Surve conducted November 8, 2024 Please accept this Plan of Correction as the provider's credible allegation of compliant as of December 18, 2024. The provider respectfully requests review with paper compliance be considered in establishing the provider is in substantial compliance.	ement facts th on . The d and deral epond fance ey
SS=D Bldg. 00	review the facility	vation, interview, and record failed to follow physician's residents reviewed for resident C)	F 0684	Tag F684 Quality of Care "Facility failed follow physicial orders for 1 of 16 residents. Facility failed to follow up on reported resident's concerns	
LABORATOI	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
Sarah Jac	kman		HFA		12/02/2024

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 12/09/2024

DEPARTMEN' CENTERS FOI		RM APPROVED B NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
11112 12111	or continuonon	155699	B. WING		<u> </u>	11/08/	
		100000				1 1700	2021
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
ENIVIVE	OE HARTEORD OF	TV			MILL ST		
EINVIVE	OF HARTFORD CI	T		ПАКІГ	ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	B. Based on intervi	ew and record review, the			of 16 residents reviewed for		
	facility failed to foll	low up on reported resident's			resident choice."		
	concerns for 1 of 16	6 residents reviewed for					
	resident choices. (R	lesident B)			1: What corrective action(s) w	ill be	
					accomplished for those reside	ents	
	Findings include:				found to have been affected b	y the	
					deficient practice?		
	A. During an interv	view on 11/1/24 at 1:51 p.m.,			• 2 residents have been affect	ed	
	Resident C's represe	entative indicated the resident			by the alleged deficient practi-	ce.	
	had problems with s	swelling in his lower			Resident C was immediately	1	
	extremities. The re-	sident had requested			corrected during the survey.		
	compression wraps	for his bilateral lower legs			Resident B's concern was		
	some time back, but the facility had not provided				addressed upon notification.		
	the compression wr	raps. The resident's			·		
	representative indic	ated he had asked the nurse			2: How other residents having	g the	
	again on 11/1/24 fo	r compression wraps for the			potential to be affected by the	-	
	resident's bilateral l	ower legs to help with the			same deficient practice will be	;	
	ongoing swelling in	the resident's lower legs and			identified and what corrective		
	feet. During an obs	servation at the time of			action will be taken.		
	interview, the reside	ent's bilateral legs and feet			- Residents with conce	rns	
	were elevated in his	s recliner, moderately swollen,			and residents with newly acqu	uired	
	and without compre	ession wraps.			physician orders have the pot		
					to be affected by the alleged		
	During an observati	ion on 11/6/24 at 4:20 p.m., the			deficient practice.		
	resident was seated	on the side of his bed. His			All resident concerns have be	een	
	feet were bare, and	his pant legs were pulled up as			addressed and physician orde	ers	
	the resident looked	at his legs and feet.			are completed as ordered.		
	Compression wraps	were not in place. Moderate			·		
		with tight skin in the resident's			3: What measures will be put	into	
		and feet. The resident's			place or what systemic chang		
		cracked. He indicated his			will be made to ensure that th		
		ive had asked the facility			deficient practice does not red		
	_	ler for the compression wraps			·		
		t, but so far no one had used			DNS/ designee will ensure		
		raps on his legs and feet since			physician orders are being		
	he had been at the f				executed and resident concer	ns	
					are addressed timely by		

11/6/24 and 11/7/24.

Review of the Treatment Administration Record

indicated the compression wraps were applied on

physicians.

Education and training

were provided to clinical staff by

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMP	LETED
		155699	B. W	ING		11/08	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			MILL ST		
ENVIVE	OF HARTFORD CI	ITY			ORD CITY, IN 47348		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG	REGULATORY O.	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Danisland Claratinia	-1			the Executive Director.		
		al record was reviewed on			Education provided:	1.4.	
		n. Diagnoses included chronic			o Resident Change in Con	dition	
		insufficiency, stage 3 chronic			o Physician Notification		
	kidney disease, and	l retention of urine.			4		
	Comment of the cities of				4: How the corrective action		
	Current physician orders included application of compression wraps to the bilateral legs every day				monitored to ensure the de		
					practice will not recur i.e.,		
	_	and removal of ace wraps			quality assurance program	i wiii be	
	daily at bedtime, da	ated 11/5/24.			put into place? (Ongoing		
	A	Data Cat (MDC)			compliance in QAPI)		
		um Data Set (MDS)			- DNS/designee will co	•	
	assessment, dated 9/10/24, indicated the resident was cognitively intact. He required substantial				daily monitoring through th		
		ff for toileting, showering, and			clinical care meeting and t		
	lower body dressin				physician orders/communi		
	lower body dressin	g.			monitoring tool to ensure t	-	
	A current core plan	a, dated 5/21/24, included a risk			concerns and orders are to followed for proper monitor	-	
	-	e related to stage 3 chronic			procedure 5 days a week f	-	
		diuretic use. Interventions			1 .		
	*	e for and notify the provider of		weeks, 3 days a week for 4 weeks			
		symptoms of fluid overload			and 2 days a week for 4 weeks, then monthly in QAPI for 6		
	_	erventions lacked compression			months.		
		ral lower extremities.			- DNS/designee will rando	mly	
					audit 5 resident charts or 1	-	
	A Nurse's Note, da	ted 11/1/24 at 2:56 p.m.,			census weekly for physicia		
		ent requested compressions			completion monitoring tool		
	wraps for his bilate				ensure that any concerns a		
					orders are to being followe		
	A Nurse's Note. da	ted 11/4/24 at 9:43 a.m.,			proper monitoring procedu		
		ent requested compression			days a week for 4 weeks,		
	wraps for his legs.				a week for 4 weeks and 2	•	
					week for 4 weeks, then mo	-	
	A Nurse's Note, da	ted 11/5/24 at 9:07 a.m.,			QAPI for 6 months.	, ···	
		ere received for compression					
	wraps to the reside	-			- DNS/designee	will be	
	_ ^				responsible for ensuring pl		
	During an observat	tion at the time of interview on			orders/ communication mo		

11/7/24 at 12:35 p.m., the resident was in bed and

indicated no one had applied compression wraps

compliance for 6 months. The

results of these audits will be

DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED				
	155699	B. WING	11/08/2024				

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		A. BU B. W	JILDING ING	00	COMPLI 11/08/2	
	PROVIDER OR SUPPLIER			715 N N	ADDRESS, CITY, STATE, ZIP COD MILL ST ORD CITY, IN 47348		
(X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR to his legs and feet or requested several day and feet were without during the observation swollen. During an interview 11/7/24 at 1:05 p.m. provided the resident 11/7/24 and the resident and the resident of the provided that the resident of the provided that the resident of the provided that the resident lower extremities during the familiar with the resident lower extremities. It compliant when car through the resident no compression was observation. She was an order to wear completed. During an interview DON indicated order signed off by the number of the provided that the physician orders. The standards of practice to the provided that the physician about the physician about the physician about the physician about the provided that the physician are sufficient to the provided that the pro	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION even though they were ays ago. The resident's legs ut compression wraps in place ton and remained moderately of at the time of observation on a, CNA 9 indicated she had at's care on 11/6/24 and dent did not have compression g those dates on her shift. He ession wraps on his lower the interview. She was very sident's care and had never on wraps anywhere in his always had swelling in his He was cooperative and the was provided. She looked the dates and his room with the state of the compression to the compression of the compression the interview. She was very to the interview of the compression of the compres		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% not achieved, an action plan w be developed. The facility threshold the QAPI program, will review, update, and make changes to DPOC as needed for sustaining substantial compliance for no lithan 6 months.	is ill ough the	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. W	NG		11/08/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8		715 N N			
ENVIVE	OF HARTFORD CI	TY			ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ll record was reviewed on					
	•	. Diagnoses included					
		ar region (a painful condition					
		e nerve roots in the lower					
	-	d or irritated), chronic kidney					
	disease stage 3, and adult failure to thrive.						
	Physician's orders included buprenorphine						
	(narcotic pain medication) transdermal patch 5						
		ır (mcg/hr) apply weekly				ļ	
		acetaminophen (for pain) 8 hour					
		elease 650 milligrams (mg) daily					
		naproxen (for pain) 500 mg					
	• .	12/13/23), tramadol (for pain)					
	100 mg twice a day						
	_	mg every 4 hours as needed					
		rted 4/19/24), and tramadol 50					
		as needed for pain (started					
	4/20/24).						
	The Minimum Data	a Set (MDS) assessment, dated					
		the resident was cognitively					
		scheduled and PRN pain					
	medications.	-					
		was initiated on 5/22/24 and				ļ	
		Interventions included the					
	_	ter analgesics as per orders				ļ	
	*	d revised 5/6/22). Evaluate the					
	-	n interventions. Review for					
	-	tion of symptoms, dosing				ļ	
		ent satisfaction with results,					
	-	al ability and impact on				ļ	
		5/6/22). Notify physician if				ļ	
		successful or if current				ļ	
		ficant change from residents					
	past experience of p	pain (initiated 5/6/22).					
	A Nurse's Note, dat	red 11/4/24 at 9:21 a.m.,					
		nt had increased leg pain and					
		moreagea 128 pain and					

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PRINTED: 12/09/2024 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			O	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	r í	E SURVEY PLETED
		155699	B. WING			8/2024
	PROVIDER OR SUPPLIE		715 N I	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348	•	
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI		COMPLETION
	`			CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	
TAG	_	R LSC IDENTIFYING INFORMATION y gabapentin (used for pain for	TAG	DEFICIE (CT)		DATE
	certain nervous cor					
	The medication add	ministration record for				
	November 2024 in	dicated the resident had a pain				
	level of 7 of 10 wh	en her buprenorphine				
	transdermal patch v	was applied on 11/7/24.				
	The resident's clini	cal record was reviewed on				
	11/8/24 at 9:30 a.m	n. for a follow-up to the resident's				
	request about gaba	pentin. No documentation of a				
	new order or a resp	oonse from the physician was				
	found.					
	During an interview	w, on 11/8/24 at 10:10 a.m.,				
	Licensed Practical	Nurse (LPN) 7 indicated if the				
	family or resident r	requested anything from the				
	physician, she wou	ld fax the physician, put it in				
	the doctor's book o	n what was requested, and				
	document the reque	est in the progress notes. After				
	24 hours if nothing	was done, she would check on				
	_	waiting for a response from the				
		ld place the request on the				
	_	et and ask the oncoming nurse				
	to follow up on the	request to the physician.				
	_	w, on 11/8/24 at 10:24 a.m.,				
	- ·	RN) 8 indicated she would				
	document in the nu	rses notes about the resident's				
	_	at the physician's notification.				
	_	on the 24-hour sheet. If she				
		ext day, someone else should				
	follow up on the pl	nysician's response.				
		w, on 11/8/24 at 3:41 p.m., the				
		g indicated how soon a request				
		l-up on depended on the				
	_	ted the resident had several				
	medications for pai	in, and the resident's physician				

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had changed this past week due to a change in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. W	ING		11/08/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R.		715 N N			
ENVIVE	OF HARTFORD CI	ΤΥ			ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		r. The resident's prior physician					
		v to respond to the facility's					
	requests. No one had followed up on the resident's request to try gabapentin as far as she						
		try gabapentin as far as she					
	knew.						
	A current facility policy, dated 8/2022, titled						
		of Condition," provided by the					
	_	4:43 p.m., indicated the					
		CY It is the policy of this					
	•	iges in resident condition will					
	be communicated to	_					
	family/responsible p	party, and that appropriate,					
	timely, and effective	e intervention takes place.					
	PROCEDURE 3.	Non-Urgent Medical Change					
	c. If unable to reacl						
		party, all calls to physicians or					
		ily/responsible party					
		s will be documented in the					
		If the physician has not					
	_	the end of the shift, the					
	_	ll be notified for follow-up. e.					
		attending physician or					
		e Medical Director will be					
		e and intervention for the condition g. The licensed					
	_	or the resident will continue					
	-	umentation in the medical					
		ntil the resident's condition					
	has stabilized."						
	This citation relates	to complaint IN00444162.					
	3.1-37(a)						
	,						
F 0756	483.45(c)(1)(2)(4)	(5)					
SS=D	Drug Regimen Re	view, Report Irregular, Act					
Bldg. 00	On						
		and record review, the facility	F 07	756	Tag F756 – Drug Regimen Re		12/18/2024
	failed to ensure pha	rmacy recommendations were			"Facility failed to ensure pharm	nacy	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. WI	NG		11/08/	/2024
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					MILL ST		
ENVIVE	OF HARTFORD CI	TY		HARTF	ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reviewed and addre	essed in a timely manner for 2			recommendations were review	ved .	
	of 5 residents review	wed for unnecessary			and addressed in a timely mar	nner	
	medications (Resid	ent 16 and Resident 18).			for 2 of 5 residents reviewed for	or	
					unnecessary medications."		
	Findings include:						
					1: What corrective action(s) w		
	_	nical record was reviewed on			accomplished for those reside		
		n. Diagnoses included aphasia			found to have been affected b	-	
	_	infarction, depression,			deficient practice? (Correct all	eged	
	disorientation, and anxiety disorder.				deficient practice)		
					 2 resident was affected by the 	е	
	Physician's orders i	-			alleged deficient practice.		
	(antianxiety) 0.5 mg (milligrams) two tablets every				Resident 16 and Resident 18	3	
	4 hours as needed (PRN) for anxiety/agitation				had medication regimen revie	wed	
	(started 10/27/24) and lorazepam 0.5 mg every 6				by physician and RPH immedi	ate	
	hours PRN anxiety/	/agitation (started 8/5/24 and			upon notification.		
	discontinued 10/27/	/24).			2: How other residents having	the	
					potential to be affected by the		
		e Minimum Data Set (MDS)			same deficient practice will be		
	assessment, dated 8	3/28/24, indicated the resident			identified and what corrective		
	was severely cognit	tively impaired.			action will be taken. (How to		
					protect like residents).		
		nistration record for August			 Residents with pharma 	асу	
		resident was given lorazepam			recommendations have the		
	-	5:04 p.m. and 11:05 p.m., 8/7/24			potential to be affected by the		
	at 11:24 a.m., and 8	3/12/24 at 9:03 p.m.			alleged deficient practice.		
					All current inhouse residents		
		nen review, completed on			were audited by the DNS. No		
		orazepam 0.5 mg give every 6			issues needing addressed at t	his	
	hours PRN anxiety/	/agitation started on 8/5/24 was			time.		
	a PRN order for a p	sychotropic drug and was			Residents will have medicate	on	
	limited to 14 days,	except if the prescribing			regimen's reviewed and updat	ed	
	*	d that it was appropriate for			timely.		
	the PRN order to be	e extended beyond 14 days.					
		tion of the PRN order was to be			3: What measures will be put i	nto	
	documented by the	prescriber in the resident's			place or what systemic change	es	
	medical record.				will be made to ensure that the		
					deficient practice does not rec	ur?	
	A medication admir	nistration record for September			(Actions taken, education,		
		resident was given lorazepam			training, to prevent it from		

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155699	B. WING		11/08/2024
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF P	PROVIDER OR SUPPLIEF	₹		MILL ST	
ENVIVE	OF HARTFORD CI	TY		ORD CITY, IN 47348	
				1	T
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	at 1:56 p.m. and 10:18 p.m.,		happening again). SSD	
	_	m., 9/17/24 at 9:09 p.m., 9/18/24		• The DNS was educated on t	
		4 at 10:32 p.m., 9/21/24 at 7:11		Drug Regimen Review Policy	by
	p.m., and 9/28/24 a	t 1:5 / a.m.		clinical support.	
		16.0.1		- Education and trainir	_
		nistration record for October		were provided to clinical staff	by
		resident was given 0.5 mg		DNS.	
	lorazepam on 10/18/24 at 10:35 p.m., 10/26/24 at			Education provided:	
	7:28 p.m., and 10/27/24 at 1:46 p.m.			o Drug Regimen Review	
	A medication regimen review, completed on			4: How the corrective action w	vill be
		lorazepam 0.5 mg give every 6		monitored to ensure the defici	
	· ·	/agitation started on 8/5/24 was		practice will not recur i.e., wha	
		esychotropic drug and was		quality assurance program wil	
		except if the prescribing		put into place? (Ongoing	1 50
	_	d that it was appropriate for		compliance in QAPI)	
	-	e extended beyond 14 days.		- DNS/designee will comp	lete
		tion of the PRN order was to be		daily monitoring through the	
		prescriber in the resident's		clinical care meeting and Drug	,
	medical record.	preserior in the resident's		Regimen Review monitoring to	
	medicai iccoia.			ensure that any resident is	001 10
	The nurses notes la	cked documentation of		reviewed regularly for proper	
		on and response to the 8/19/24		monitoring procedure and that	t the
		cation regimen reviews.		physician will be notified daily	
	and 10/21/27 medic	auton regimen reviews.		the medication recommendati	
	A Nurse's Note dat	ted 10/27/24 at 3:27 p.m.,		addressed. 5 days a week for	
		lorazepam order for 0.5 mg		weeks, 3 days a week for 4 w	
		as discontinued. A new order		and 2 days a week for 4 week	
		g every 4 hours PRN		then monthly in QAPI for 6	.5,
		as started and lacked a stop		months.	
	date.	as started and tacked a stop		monuis.	
				- DNS/designee will b	e
	2. Resident 28's clir	nical record was reviewed on		responsible for the Drug Regi	
		. Diagnoses included anxiety		Review monitoring compliance	
	disorder and conges	-		6 months. The results of these	
	alsorder and conge	our o mourt iuituio.		audits will be reviewed by the	
	Physician's orders i	ncluded lorazepam 0.5 mg		committee overseen by the	Ser 1
	-	for anxiety/agitation (started		Executive Director. If a thresh	old
		epam 0.5 mg two times a day		of 95% is not achieved, an ac	
	1130127) and ionaze	pam 0.5 mg two unics a day	I	I or 30 /0 is not achieved, all ac	uon

(started 11/4/24).

plan will be developed. The

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155699	B. W	ING		11/08/	2024
	PROVIDER OR SUPPLIER		-	715 N M	NDDRESS, CITY, STATE, ZIP COD MILL ST ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	8/9/24, indicated the cognitively impaire A medication admit 2024 indicated the result of the second of the secon	nistration record for August resident was given lorazepam at 7:05 p.m. and 8/15/24 at 6:00			facility through the QAPI programility review, update, and make changes to the DPOC as need for sustaining substantial compliance for no less than 6 months.		
	8/19/24, indicated le hours PRN anxiety/	nen review, completed on orazepam 0.5 mg give every 6 agitation started on 7/30/24 cop date or for longer duration riate.					
		nistration record for October resident was given lorazepam at 3:54 p.m.					
		acked documentation of the on and response of the 8/19/24 a review.					
	DON indicated the review would have physician for review clipped until she red	y, on 11/8/24 at 3:38 p.m., the pharmacy's medication regimen been sent to the resident's v. She usually kept the reviews received a response. She had and did not have a physician					
	the DON on 11/8/24 Regimen Review," written report is pro- seven working days policy, with a copy physician's response	blicy, dated 2020, provided by 4 at 4:43 p.m., titled "Drug indicated the following: "A byided to the physician within 5 or according to facility to the facilityThe e is documented in the cist review record or elsewhere					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VHQC11 Facility ID: 000290

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155699	B. WI	NG		11/08/	2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S BLANGE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	provides a written re facility within one n copy of the report is	dical recordThe physician esponse of the report to the month after the report is sent. A skept by the facility until the esponse is returned"					
F 0758 SS=D Bldg. 00	Use	Psychotropic Meds/PRN					
	review, the facility to non-pharmacological attempted prior to the needed (PRN) psychresidents reviewed for (Resident 16 and Resident 16 and Resident 16 and Resident 16 rested in the needed (PRN) psychresidents reviewed for Resident 16 and Resident 16 and Resident 16 rested in the needed part of the needed prior to the neede	al interventions were the administration of an as thoactive medication for 2 of 5 for unnecessary medications.	F 07	758	Tag F758- Free from Unnec. Psychotropic Meds/PRN Use "Facility failed to ensure non-pharmacological intervent were attempted prior to the administration of an as needed (PRN) psychoactive medicatio 2 of 5 residents reviewed for unnecessary medications (Resident 16 and Resident 28) 1: What corrective action(s) wi accomplished for those resider found to have been affected by deficient practice? • 2 residents were affected by alleged deficient practice.	n for " Il be nts y the	12/18/2024
	with his eyes gazing Resident 16's clinica 11/7/24 at 11:52 a.n	g at the television. al record was reviewed on a. Diagnoses included aphasia anfarction, depression,			 Resident 16 and 28 had appropriate interventions enter into EMR. 2: How other residents having potential to be affected by the 		
	Physician's orders in (antianxiety) 0.5 mg 4 hours PRN for and 10/27/24), lorazepan	·			same deficient practice will be identified and what corrective action will be taken. - Residents with an orde for PRN psychotropic medicati have the potential to be affected.	on	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VHQC11 Facility ID: 000290

If continuation sheet Page 11 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		155699	B. WING		11/08/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		MILL ST		
ENVIVE	OF HARTFORD CI	TY	HARTFORD CITY, IN 47348			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		xetine (antidepressant) delayed		by the alleged deficient practi	ce.	
	release 90 mg daily	(started 10/22/24).		All residents with PRN		
				psychotropic medication orde	rs	
	-	e Minimum Data Set (MDS)		were audited by the DNS for		
		/28/24, indicated the resident		appropriate interventions. No		
		ively impaired. He was		concerns identified at this time	e.	
	_	for oral hygiene, toileting				
		ygiene, showering/bathing,		3: What measures will be put		
		dy dressing, rolling left and		place or what systemic chang		
		sitting to lying and lying to		will be made to ensure that th		
	sitting, and transfer	S.		deficient practice does not red		
				The DNS was educated by cl	inical	
	A care plan for the behavior of calling 911 for			support consultant on the		
		of pressing his call light was		Psychotropic Medication Use		
		d revised on 9/18/24. The		policy with concentration on,	out	
		led the following: Care givers	not limited to,			
		interaction and attention and		non-pharmacological approac	ches	
	_	he resident when passing by		to minimize the need for		
		24 and revised on 9/18/24).		medication.		
	Discuss the resident	t's behavior with him and		 Education and training 	ng	
	explain/reinforce w	hy the behavior is		was provided to clinical staff b	ру	
		r unacceptable (initiated		DNS, including:		
		9/18/24). Monitor behavior		o Psychotropic Medication Use		
		ot to determine underlying				
		ation, time of day, persons		4: How the corrective action v		
	·	ions. Document behavior and		monitored to ensure the defic		
	potential causes (in	itiated 5/31/24).		practice will not recur i.e., who		
				quality assurance program wi	ll be	
	_	use of antianxiety medication		put into place? (Ongoing		
		of anxiety disorder was initiated		compliance in QAPI)		
		sed on 7/10/24. The goals		- DNS/designee will comple	ete	
		nt will show decreased number		daily monitoring through the		
	-	ety though the next review date		clinical care meeting and PRI	١	
	· ·	17/10/24 and revised 8/29/24).		Psychotropic Medication		
		ncluded the following:		monitoring tool to ensure that	any	
		iety medications as ordered by		resident with behavior sympton	oms	
	the physician. Mon	itor for side effects and		is getting non-pharmacologica	al	
	effectiveness every	shift (initiated 7/10/24).		interventions for proper monit	oring	
				procedure 5 days a week for	4	
	A medication admir	nistration record for August		weeks 3 days a week for 4 w		

AND PLAN OF CORRECTION DENTIFICATION NUMBER 155699 NAME OF PROVIDER OR SUPPLIER ENVIVE OF HARTFORD CITY (X4) ID SIMMARY STATEMENT OF DEFICINCIE PREFIX (EACH DEPICINCY MUST BE PRECEDED BY PULL TAG 2024 indicated the resident was given lorazepam 0.5 mg on 8/5/24 at 5.40 p.m. and 11:40 p.m., indicated the resident was having a mixely. The physician ordered PRN forazepam 0.5 mg every 6 hours. A Nurse's Note, dated 8/5/24 at 5.04 p.m., indicated the resident was having a lot of anxiety/agitation and a PRN forazepam was given. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/5/24 at 1:24 a.m., indicated the resident was given a PRN forazepam for anxiety/agitation and providence of the color of administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/6/24 at 1:24 a.m., indicated the resident was given a providence of the color of anxiety/agitation and the resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/7/24 at 1:24 a.m., indicated the resident was given a providence of the line list procedure of the line list procedure of the line list procedure of the resident was given and providence of the providence of the line list procedure of the providence of the line list procedure of the providence of the line list procedure of the line	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY			
STREET ADDRESS, CITY, STATE, ZIP COD 716 N MILL ST HARTFORD CITY (M4) ID SUMMARY STATEMENT OF DEFICIENCIE (PRETED STATE OF COMPLETION) AND SUMMARY STATEMENT OF DEFICIENCIE (PRETED STATE OF COMPLETION) AND SUMMARY STATEMENT OF DEFICIENCIE (PRETED STATE OF COMPLETION) AND SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PROPERTY. AND SUMMARY STATEMENT OF DEFICIENCIE (PRETED STATE OF COMPLETION) AND SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PROPERTY. AND SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PROPERTY. AND SUMMARY STATEMENT OF DEFICIENCY MIST BE PRECEDED BY FULL PROPERTY. A DEFICIENCY MIST BE PRECEDED BY FULL PROPERTY. A Nurse's Note, dated 8/5/24 at 5-03 p.m., indicated the resident was having a six of an antempted prior to administration of the PRN medication. A Nurse's Note, dated 8/5/24 at 5-03 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation and a PRN lorazepam for anxiety/agitation. The resident's chinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's chinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated 8/6/24 at 8.58 a.m., indicated the resident was given and PRN lorazepam for anxiety/agitation. The resident's chinical record lacked interventions attempted prior to administration of the PRN medication. No behavior so rinterventions were marked on the behavior monitoring and interventions report on deministration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on deministration of the PRN medication.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
ENVIVE OF HARTFORD CITY IN MILL ST HARTFORD CITY, IN 47348 IN MALL ST HARTFORD CITY, IN HART CITY, I			155699	B. WING		11/08/2024		
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Ox 10 PREFIX GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG GEOGLATORY (OR IS: CIDINATIVE) (NITOMATION) DATE 2024 indicated the resident was given lorazepam 0.5 mg on \$8/524 at 5.04 p.m. and 11:05 p.m., and 12:04 m.m. and \$1/224 at 9.03 p.m. A Nurse's Note, dated \$8/5/24 at 5.01 p.m., indicated the resident was having auxiety. The physician ordered PRN lorazepam 0.5 mg every 6 hours. A Nurse's Note, dated \$8/5/24 at 5.04 p.m., indicated the resident was having a lot of anxiety/agitation and a PRN lorazepam was given. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on \$8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident solinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated \$8/7/24 at 11:24 a.m., indicated the resident's clinical record lacked interventions report on the properties of the properties of the properties of	NAME OF F	PROVIDER OR SUPPLIEF	ę.	715 N I	MILL ST			
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A Nurse's Note, dated 8/5/24 at 5:01 p.m., indicated the resident was having anxiety. The physician ordered PRN lorazepam 0.5 mg every 6 hours. A Nurse's Note, dated 8/5/24 at 5:04 p.m., indicated the resident was having a lot of anxiety/agitation and a PRN lorazepam was given. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated 8/5/24 at 11:05 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/6/24 at 8:58 a.m., indicated the resident was sleeping soundly and would not awaken to take medications. A Nurse's Note, dated 8/6/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions were marked. A Nurse's Note, dated 8/724 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on		_	•		then monthly in QAPI for 6			
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The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/6/24 at 8:58 a.m., indicated the resident was sleeping soundly and would not awaken to take medications. A Nurse's Note, dated 8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on					-			
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			g and interventions report on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	00	COMPL	ETED
		155699	B. WING		_	11/08/	2024
	PROVIDER OR SUPPLIER		7	'15 N M	DDRESS, CITY, STATE, ZIP COD IILL ST ORD CITY, IN 47348		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		D I			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		'AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		d 8/12/24 at 9:03 p.m.,					
	indicated the reside	nt was given a PRN lorazepam					
	for anxiety/agitation	n. The resident's clinical record					
	lacked interventions	s attempted prior to					
	administration of th	e PRN medication.					
		foring and interventions report					
		d no resident behaviors were					
	oosei ved and no int	erventions attempted.					
	A medication admir	nistration record for September					
		resident was given lorazepam					
		at 1:56 p.m. and 10:18 p.m.,					
	_	n., 9/17/24 at 9:09 p.m., 9/18/24					
	at 6:12 a.m., 9/20/2	4 at 10:32 p.m., 9/21/24 at 7:11					
	p.m., and 9/28/24 at	t 1:57 a.m.					
		10/11/04 . 1.56					
		ed 9/11/24 at 1:56 p.m.,					
		nt was given a PRN lorazepam					
	lacked interventions	n. The resident's clinical record					
	administration of th						
	administration of th	e i Kiv medication.					
	No behaviors or int	erventions were marked on the					
		g and interventions report on					
	9/11/24.						
		0/44/04 42 ==					
		e 9/14/24 at 10:57 p.m.,					
		nt was given a PRN lorazepam					
		n. The resident's clinical record					
	lacked interventions						
	administration of th	e rkin medication.					
	The behavior monit	oring and interventions report					
		d no resident behaviors were					
		rentions were marked.					
		red 9/17/24 at 9:09 p.m.,					
		nt was given a PRN lorazepam					
	for anxiety/agitation	n. The resident's clinical record	1	l			

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Event ID:

VHQC11 Facility ID: 000290

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/08/2024	
	PROVIDER OR SUPPLIER		715 N N	ADDRESS, CITY, STATE, ZIP COD MILL ST FORD CITY, IN 47348	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	lacked interventions administration of th				
		erventions were marked on the g and interventions report on			
	indicated the reside				
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		erventions were marked on the g and interventions report on			
	indicated the reside				
		erventions were marked on the g and interventions report on			
	indicated the reside	ed 9/28/24 at 1:57 a.m., nt was given a PRN lorazepam n. The resident's clinical record			

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Event ID:

VHQC11 Facility ID: 000290

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION lacked interventions attempted prior to administration of the PRN medication. A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348 (X5) COMPLETION DEFICIENCY DATE
NAME OF PROVIDER OR SUPPLIER ENVIVE OF HARTFORD CITY STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Iacked interventions attempted prior to B. WING STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348 (X5) COMPLETION DEFICIENCY DATE
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) COMPLETION DEFICIENCY) DATE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Lacked interventions attempted prior to COMPLETION TAG DEFICIENCY) DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE lacked interventions attempted prior to
lacked interventions attempted prior to
administration of the PRN medication.
The behavior monitoring and interventions report
on 9/28/24 indicated no resident behaviors were
observed. No interventions were marked.
A medication administration record for October
2024 indicated the resident was given 0.5 mg
lorazepam on 10/18/24 at 10:35 p.m., 10/26/24 at
7:28 p.m., and 10/27/24 at 1:46 p.m.
7.20 p.m., and 10/27/21 at 1.10 p.m.
A Nurse's Note, dated 10/18/24 at 10:35 p.m.,
indicated the resident was given a PRN lorazepam
for anxiety/agitation. The resident's clinical record
lacked interventions attempted prior to
administration of the PRN medication.
The behavior monitoring and interventions report
on 10/18/24 indicated no resident behaviors were
observed. No interventions were marked.
A Nurse's Note, dated 10/26/24 at 7:28 p.m.,
indicated the resident was given a PRN lorazepam
for anxiety/agitation. The resident's clinical record
lacked interventions attempted prior to
administration of the PRN medication.
The behavior monitoring and interventions report
on 10/26/24 indicated no resident behaviors were
observed. No interventions were marked.
2 Duning on absence tion on 11/4/24 at 10:14 and
2. During an observation on 11/4/24 at 10:14 a.m.,
Resident 28 was sitting up in a wheelchair in her
room with her eyes open.
During an observation on 11/6/24 at 3:57 p.m., the
resident was lying in bed with her eyes closed.
resident was tying in oed with her eyes closed.
During an observation on 11/7/24 at 8:30 a.m., the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. W	ING		11/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R		715 N M			
FN\/I\/F	OF HARTFORD CI	TV			ORD CITY, IN 47348		
		· ·		17,000			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident was lying i	n bed in with her eyes closed.					
	D 11 . 201 11 1						
		al record was reviewed on					
		. Diagnoses included anxiety					
	disorder and conges	stive neart failure.					
	Physician's orders	ncluded lorazepam 0.5 mg					
	1 -	for anxiety/agitation (started					
	1 -	10.5 mg two times a day (started					
		exyzine pamoate (used for					
		ce a day (started 2/15/24 and					
	discontinued 11/4/2						
	discontinued 11/4/24).						
	A significant change MDS assessment, dated						
		e resident was moderately					
	cognitively impaire	•					
		sistance with toileting hygiene,					
	l -	ing, upper body dressing, and					
	_	g to lying and lying to sitting.					
		on the staff for transfers.					
	A care plan with a f	focus on the resident's					
	restlessness, nervou	isness, and other anxiety					
	1	nxiety disorder was initiated on					
		on 8/28/24. The interventions					
		ing: Encourage the resident to					
		ties of choice (initiated 1/15/24					
). Give meds as ordered					
	(initiated 1/8/24 and	d revised 1/15/24).					
		nistration record for October					
		resident was given lorazepam					
	0.5 mg on 10/4/24 a	at 3:54 p.m.					
	A Niumaala Niata di-t	and 10/4/24 at 3:54					
		red 10/4/24 at 3:54 p.m.,					
		nt was given a PRN lorazepam					
	lacked interventions	n. The resident's clinical record					
	administration of th						
	aummistration of th	E I KIN HICUICAUOII.					

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Event ID:

VHQC11 Facility ID: 000290

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00		E SURVEY LETED B/2024		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF No behaviors or int behavior monitoring 10/4/24. During an interview Licensed Practical I giving any PRN me be attempted. The m progress note of the interventions. During an interview Registered Nurse (I PRN medications, t the expiration date s interventions are ap	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION erventions were marked on the g and interventions report on 7, on 11/8/24 at 10:10 a.m., Nurse (LPN) 7 indicated prior to edications, interventions should hurse should always put in a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	Director of Nursing should be attempted psychoactive medic supply documentati prior to the administ for the residents. A current facility poby the DON on 11/3 "Psychotropic Medicollowing: "Nonare used (unless constitutions)."						
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention						

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Event ID:

VHQC11 Facility ID: 000290

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PRINTED: 12/09/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039		
	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			155699	B. W	ING		11/08	/2024
	NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
				MILL ST				
	ENVIVE (OF HARTFORD CI	TY		HARTE	FORD CITY, IN 47348		
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDED'S BLANCE CORRECTION			(X5)
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
	TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
			on, interview, and record	F 0	880	Tag F880 – Infection Prevention	n &	12/18/2024
			failed to utilize infection	1 0	000	Control	JII W	12/10/2024
		-	trol procedures during insulin			"Facility failed to utilize infection	'n	
		-	of 4 residents reviewed for			prevention and control proced		
			tration. (Residents 16 and 7)			1 -		
		medication adminis	tration. (Residents 16 and 7)			during insulin administration for	or Z	
		T' 1' ' 1 1				of 4 residents reviewed for		
		Findings include:				medication administration."		
		•	n medication administration			1: What corrective action(s) wi	ll be	
		observation on 11/6	5/24 at 10:56 a.m., RN 5			accomplished for those reside	nts	
		removed Resident 1	6's insulin aspart Flexpen 100			found to have been affected b	y the	
		units/milliliter(mL)	from the compartment in the			deficient practice? (Correct all	eged	
		top drawer of the m	edication cart where the			deficient practice)		
		insulin pens for the	residents on the 200 unit were			• 2 residents were affected by	the	
		stored. She remove	ed the unsealed pen cap, did			alleged deficient practice.		
			per stopper of the multi-dose			Nurse that was administering		
			ne pen needle to the insulin			those medications was	,	
		-	orimed and dialed to 11 units			immediately educated on clea	nina	
			liding scale insulin. The skin			rubber stoppers on insulin per	_	
			an alcohol pad, and the insulin			Tabber dispport on meanin per		
			abcutaneously in the resident's			2: How other residents having	the	
		right lower abdome	_			potential to be affected by the	, uic	
		rigin lower abdome.	11.			same deficient practice will be		
		Resident 16's alinia	al record was reviewed on			•		
			n. Diagnoses included, type 2			identified and what corrective		
		_				action will be taken. (How to		
		diabetes meintus Wi	ith diabetic neuropathy.			protect like residents).		
		Command with the state of				- All residents that requ		
			orders, dated 5/8/24, included			insulin have the potential to be		
			ion solution 100 units/mL -			affected by the alleged deficie	nt	
		-	taneously with meals and			practice.		
			ion solution 100 units/mL -			All current inhouse residents		
			scale subcutaneously with			were audited for appropriate ir	nsulin	
		meals.				pen administration and		
						manufacturer guidelines for		
		-	n medication administration			cleaning before administration	. No	
		observation on 11/6	5/24 at 11:20 a.m., RN 5			further action needed at this ti		
			's Humalog KwikPen (insulin)					
			or 100 units/mL from the					
			top drawer of the medication			3: What measures will be put i	nto	
			-					

cart where the insulin pens for the residents on

place or what systemic changes

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. W	ING		11/08/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			MILL ST		
ENVIVE	OF HARTFORD C	TY	_		ORD CITY, IN 47348		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		tored. She removed the			will be made to ensure that th	-	
		did not cleanse the rubber			deficient practice does not rec	cur?	
		i-dose pen, and attached the			(Actions taken, education,		
	-	nsulin pen. The pen was			training, to prevent it from		
	-	to a total of 7 units for			happening again). DNS/SSD		
		ng scale insulin. The skin was			The DNS was educated on I	Flex	
		cohol pad, and the insulin was			pen use and procedure with		
		taneously in the resident's left			concentration on, but not limit		
	upper arm.				to, cleansing rubber cap befor	re	
					putting on the needle.		
		al record was reviewed on			 Education and trainir 	•	
	-	m. Diagnoses included, type 2			were provided to the clinical s	taff	
	diabetes mellitus with other circulatory				by the DNS.		
	complications.				Education provided:		
					o Insulin pen manufacturer		
		n's order, dated 11/27/23,			instructions		
	_	injection solution 100 units/mL					
	- inject 5 units sub	cutaneously with meals.			4: How the corrective action w	/ill be	
					monitored to ensure the defici	ent	
		n's order, dated 12/13/23,			practice will not recur i.e., wha		
	included Humalog	KwikPen solution pen-injector			quality assurance program wi	ll be	
		ect as per sliding scale			put into place? (Ongoing		
	subcutaneously bef	fore meals and at bedtime.			compliance in QAPI)		
					- Infection		
	-	w on 11/6/24 at 11:30 a.m., RN 5			Preventionist/DNS/designee v	vill	
		d have cleansed the rubber			complete daily monitoring thro	ough	
		sulin pen injectors prior to			observation and insulin pen		
	attachment of the n	needles during the medication			monitoring tool to ensure that	any	
	administration obs	ervations, because they were			resident with an insulin pen		
	pierced multiple tii	nes since they were opened for			administration is being observ	ed .	
	administration of the	ne medication. This should			for proper practicing procedur	e 5	
	have been done for	infection prevention.			days a week for 4 weeks, 3 da	ays	
					a week for 4 weeks and 2 day	's a	
	During an interview	w on 11/7/24 at 3:04 p.m., the			week for 4 weeks, then month		
	Vice President of C	Clinical Operations indicated the			QAPI for 6 months.		
	insulin pens should	have been cleansed prior to					
	attachment of the n	needle according to the			- Infection		
	manufacturers' gui				Preventionist/DNS/designee v	vill	
					be responsible for the Insulin		
	A current documer	nt, last revised on 2/2023, titled			monitoring compliance for 6		
			1				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155699		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) date survey completed 11/08/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD MILL ST	
ENVIVE	OF HARTFORD CI	ΓΥ		ORD CITY, IN 47348	
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION "Insulin Aspart FlexPen INSTRUCTIONS FOR USE," provided by the Administrator on 11/7/24 at 3:03 p.m., indicated the following: "Preparing your Insulin Aspart FlexPen A. Pull off the pen cap Wipe the rubber stopper with an alcohol swab"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) months. The results of these audits will be reviewed by the committee overseen by the	DATE
				Executive Director. If a thresh of 95% is not achieved, an ac plan will be developed. The facility through the QAPI prog	tion ram,
	"INSTRUCTIONS KwikPen injection single-patient-use p provided by the Adı p.m., indicated the f Pen Step 1:Pull	r, last revised on 7/2023, titled FOR USE HUMALOG n, for subcutaneous use 3 mL en (100 units per mL)," ministrator on 11/7/24 at 3:03 following: "Preparing your the Pen Cap straight off eal with an alcohol swab"		will review, update, and make changes to the DPOC as nee for sustaining substantial compliance for no less than 6 months.	ded
	reviewed 2/24/24 ar the Cleveland Clinic https://my.cleveland 7923-insulin-pen-in included the follow instructions for prep include: 1. Wash y of the insulin pen	delinic.org/health/treatments/l jections. The guidance ing: "Step-by-step paring your insulin pen rour hands. 2. Remove the cap 4. Wipe the rubber stopper e. 5. Attach a new pen needle			
	3.1-18(a)				
F 9999					
Bldg. 00	each employee of a prior to employmen include a tuberculin	ination shall be required for facility within one (1) month t. The examination shall skin test, using the Mantoux), administered by persons	F 9999	Tag F9999 – Final Observation "Facility failed to accurately document the administration are results of mandatory tuberculiskin tests performed on 4 of 5 employee files reviewed"	and n

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155699	B. W	ING		11/08/	/2024
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF F	PROVIDER OR SUPPLIEF	8		715 N N			
ENIVIVE	OF HARTFORD CI	T∨			ORD CITY, IN 47348		
LINVIVE	- HAITTFORD OF	1 1		HARTE			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	on of training from a			1: What corrective action(s) w		
		ed course of instruction in			accomplished for those reside		
		lin skin testing, reading, and			found to have been affected b	-	
		previously positive reaction			deficient practice? (Correct all	eged	
		The result shall be recorded			deficient practice)		
		duration with the date given,			O residents were affected by	the	
	1	hom administered. The			alleged deficient practice.		
		must be read prior to the			[
	employee starting w	vork.			2: How other residents having	the the	
	Th:4-4 1				potential to be affected by the		
	This state rule was	not met as evidenced by:			same deficient practice will be		
	D 1 1	. 1:4 : 4 6 774			identified and what corrective		
	Based on record review and interview, the facility failed to accurately document the administration				action will be taken. (How to		
	I -				protect like residents).		
		atory tuberculin skin tests			- All residents have the		
		1 4 of 5 new employee files			potential to be affected by the		
	,	1 Nurse Aide (CNA) 3, CNA 6,			alleged deficient practice.		
		RN) 5, and Social Services			All current inhouse staff was		
	Director (SSD))				addressed by the BOM for TB	iesi	
	Findings include:				documentation. All staff	tion	
	Findings include:				appropriate for TB documenta	แบบ	
	Employee records	provided by the Administrator			was updated as appropriate.		
		a.m., were reviewed on 11/6/24					
	at 3:34 p.m.	a.m., were reviewed on 11/0/24			3: What measures will be put i	into	
	u. 5.57 p.m.				place or what systemic change		
	An employee tuber	culosis (tb) form for CNA 3			will be made to ensure that the		
		th test was performed on			deficient practice does not rec		
		4/5/24. A second step tb test			(Actions taken, education,	ui :	
		1/17/24 and read on 4/19/24.			training, to prevent it from		
		red did not include the times			happening again). SSD/DNS		
	administered or rea				• The DNS was educated on t	he	
					Tuberculosis screening –		
	An employee th for	m for CNA 6 indicated a first			Administration and Interpretati	ion	
		formed on 1/29/24 and read on			of Tuberculin Skin Test policy		
		step th test was performed on			including proper documentation	n.	
	2/14/24 and read on	-			- Education and trainin		
	administered did no				were provided to clinical staff	•	
	administered or rea				the DNS.	,	
					Education provided:		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155699	B. WING		11/08/2024	
		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	L		MILL ST		
ENVIVE	OF HARTFORD CI	ТҮ	HARTFORD CITY, IN 47348			
	1		<u> </u>	- ,		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	TAG		DATE	
	1 2	m for the SSD indicated a first		o Tuberculosis screening –		
	step tb test was performed on 3/11/24 and read on 3/14/24. A second step tb test was performed on			Administration and Interpretat		
		4/8/24. The tests administered		of Tuberculin Skin Test policy		
		times administered or read.		4: How the corrective action w	وط الن	
	did not include the	times administered or read.		monitored to ensure the defici		
	An amplayed the for	m for RN 5 indicated a first				
		Formed on 7/10/24 at 11 a.m.		practice will not recur i.e., who		
		A second step that test was		quality assurance program wi put into place? (Ongoing	li ne	
		24 and read on 7/26/24. The		compliance in QAPI)		
	-	1 7/24/24 did not include the		- DNS/designee will comp	plete	
		The tests did not include the		monitoring during the hiring	nete	
	times read.	The tests did not include the		process for proper TB testing		
	times read.			procedure 5 days a week for	4	
	During an interview	y, on 11/8/24 at 10:10 a.m., LPN		weeks, 3 days a week for 4 w		
	_	tb test is given and read, the		and 2 days a week for 4 week		
		on date, lot number, company,		then monthly in QAPI for 6	λο,	
	_	te of the wheal and who gave it		months.		
	_	ted. The time must be		monuis.		
		ust be read within 72 hours.		- DNS/designee wi	ll he	
	documented us it in	ust be read within 72 hours.		responsible for TB Test,	ii be	
	During an interview	y, on 11/8/24 at 10:24 a.m., RN 8		monitoring compliance of the	line	
	_	test is given and read, the		list procedure for 6 months. T		
		size of the wheal, who		results of these audits will be		
	_	he date, and the time must be		reviewed by the QA committe	e	
	documented.	,		overseen by the Executive		
				Director. If a threshold of 95%	is	
	During an interview	y, on 11/8/24 at 1:19 p.m., the		not achieved, an action plan v		
		est should have the time and		be developed. The facility th		
		hen given and read as they are		the QAPI program, will review	_	
		to 72 hours of administration.		update, and make changes to		
				DPOC as needed for sustaini		
	A current facility po	olicy, dated 8/2024, provided		substantial compliance for no	-	
	by the Administrate	or on 11/8/24 at 2:09 p.m., titled		than 6 months.		
	"Tuberculosis Scree	ening - Administration and				
	Interpretation of Tu	berculin Skin Test (TST),"				
	_	ring: "Document the				
		on in the resident or employee				
	medical record: f. D	Date and time the TST was				
		time the TST results were				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR	R MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155699			B. WING		11/08/2024		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF HARTFORD CITY			STREET ADDRESS, CITY, STATE, ZIP COD 715 N MILL ST HARTFORD CITY, IN 47348				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interpreted"						

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