STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 00 B. WING	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00444162. Complaint IN00444162 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: November 1, 4, 6, 7, and 8, 2024 Facility number: 000290 Provider number: 155699 AIM number: 100379970 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 2 Medicaid: 22 Other: 9 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 18, 2024.	F 0000	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 Annual Survey conducted November 8, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 18, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care A. Based on observation, interview, and record review the facility failed to follow physician's orders for 1 of 16 residents reviewed for resident choices. (Resident C)	F 0684	Tag F684 Quality of Care "Facility failed follow physician's orders for 1 of 16 residents. Facility failed to follow up on reported resident's concerns for 1	12/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Jackman	HFA	12/02/2024

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	B. Based on interview and record review, the facility failed to follow up on reported resident's concerns for 1 of 16 residents reviewed for resident choices. (Resident B) Findings include: A. During an interview on 11/1/24 at 1:51 p.m., Resident C's representative indicated the resident had problems with swelling in his lower extremities. The resident had requested compression wraps for his bilateral lower legs some time back, but the facility had not provided the compression wraps. The resident's representative indicated he had asked the nurse again on 11/1/24 for compression wraps for the resident's bilateral lower legs to help with the ongoing swelling in the resident's lower legs and feet. During an observation at the time of interview, the resident's bilateral legs and feet were elevated in his recliner, moderately swollen, and without compression wraps. During an observation on 11/6/24 at 4:20 p.m., the resident was seated on the side of his bed. His feet were bare, and his pant legs were pulled up as the resident looked at his legs and feet. Compression wraps were not in place. Moderate swelling was noted with tight skin in the resident's bilateral lower legs and feet. The resident's bilateral shins were cracked. He indicated his resident representative had asked the facility about getting an order for the compression wraps for his legs and feet, but so far no one had used any compression wraps on his legs and feet since he had been at the facility. Review of the Treatment Administration Record indicated the compression wraps were applied on 11/6/24 and 11/7/24.		of 16 residents reviewed for resident choice." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • 2 residents have been affected by the alleged deficient practice. • Resident C was immediately corrected during the survey. Resident B's concern was addressed upon notification. 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. - Residents with concerns and residents with newly acquired physician orders have the potential to be affected by the alleged deficient practice. • All resident concerns have been addressed and physician orders are completed as ordered. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • DNS/ designee will ensure physician orders are being executed and resident concerns are addressed timely by physicians. - Education and training were provided to clinical staff by	

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	Resident C's clinical record was reviewed on 11/6/24 at 4:58 p.m. Diagnoses included chronic peripheral venous insufficiency, stage 3 chronic kidney disease, and retention of urine. Current physician orders included application of compression wraps to the bilateral legs every day shift for prevention and removal of ace wraps daily at bedtime, dated 11/5/24. A quarterly Minimum Data Set (MDS) assessment, dated 9/10/24, indicated the resident was cognitively intact. He required substantial assistance from staff for toileting, showering, and lower body dressing. A current care plan, dated 5/21/24, included a risk for fluid imbalance related to stage 3 chronic kidney disease and diuretic use. Interventions included to observe for and notify the provider of observed signs and symptoms of fluid overload (5/21/24). The interventions lacked compression wraps to the bilateral lower extremities. A Nurse's Note, dated 11/1/24 at 2:56 p.m., indicated the resident requested compressions wraps for his bilateral legs. A Nurse's Note, dated 11/4/24 at 9:43 a.m., indicated the resident requested compression wraps for his legs. A Nurse's Note, dated 11/5/24 at 9:07 a.m., indicated orders were received for compression wraps to the resident's legs. During an observation at the time of interview on 11/7/24 at 12:35 p.m., the resident was in bed and indicated no one had applied compression wraps		the Executive Director. Education provided: o Resident Change in Condition o Physician Notification 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? (Ongoing compliance in QAPI) - DNS/designee will complete daily monitoring through the clinical care meeting and the physician orders/communication monitoring tool to ensure that any concerns and orders are to being followed for proper monitoring procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DNS/designee will randomly audit 5 resident charts or 10% of census weekly for physician order completion monitoring tool to ensure that any concerns and orders are to being followed for proper monitoring procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DNS/designee will be responsible for ensuring physician orders/ communication monitoring compliance for 6 months. The results of these audits will be	

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	to his legs and feet even though they were requested several days ago. The resident's legs and feet were without compression wraps in place during the observation and remained moderately swollen. During an interview at the time of observation on 11/7/24 at 1:05 p.m., CNA 9 indicated she had provided the resident's care on 11/6/24 and 11/7/24 and the resident did not have compression wraps on him during those dates on her shift. He did not have compression wraps on his lower extremities during the interview. She was very familiar with the resident's care and had never seen any compression wraps anywhere in his room. The resident always had swelling in his lower extremities. He was cooperative and compliant when care was provided. She looked through the resident's drawers and his room with no compression wraps found during the observation. She was not aware the resident had an order to wear compression wraps. During an interview on 11/7/24 at 1:13 p.m., the DON indicated orders should not have been signed off by the nurse before the treatment had been completed. During an interview on 11/7/24 at 3:02 p.m., the Vice President of Clinical Services indicated the facility lacked a policy regarding following physician orders. The facility followed nursing standards of practice.B. During an interview, on 11/4/24 at 8:54 a.m., Resident B indicated her pain patch was no longer working. She was glad LPN 11 was working that day as LPN 11 had notified the physician about the resident's increased pain and was waiting to hear what the physician decided.		reviewed by the QA committee overseen by the Executive 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 substantial compliance for no less than 6 months.	

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	Resident B's clinical record was reviewed on 11/6/24 at 3:21 p.m. Diagnoses included radiculopathy lumbar region (a painful condition that occurs when the nerve roots in the lower back are compressed or irritated), chronic kidney disease stage 3, and adult failure to thrive. Physician's orders included buprenorphine (narcotic pain medication) transdermal patch 5 micrograms per hour (mcg/hr) apply weekly (started 10/17/24), acetaminophen (for pain) 8 hour arthritis extended release 650 milligrams (mg) daily (started 10/23/24), naproxen (for pain) 500 mg twice a day (started 12/13/23), tramadol (for pain) 100 mg twice a day (started 4/20/24), acetaminophen 650 mg every 4 hours as needed (PRN) for pain (started 4/19/24), and tramadol 50 mg every 24 hours as needed for pain (started 4/20/24). The Minimum Data Set (MDS) assessment, dated 10/25/24, indicated the resident was cognitively intact. She received scheduled and PRN pain medications. A care plan for pain was initiated on 5/22/24 and revised on 4/18/23. Interventions included the following: Administer analgesics as per orders (initiated 5/6/22 and revised 5/6/22). Evaluate the effectiveness of pain interventions. Review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition (initiated 5/6/22). Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain (initiated 5/6/22). A Nurse's Note, dated 11/4/24 at 9:21 a.m., indicated the resident had increased leg pain and			

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	had requested to try gabapentin (used for pain for certain nervous conditions). The medication administration record for November 2024 indicated the resident had a pain level of 7 of 10 when her buprenorphine transdermal patch was applied on 11/7/24. The resident's clinical record was reviewed on 11/8/24 at 9:30 a.m. for a follow-up to the resident's request about gabapentin. No documentation of a new order or a response from the physician was found. During an interview, on 11/8/24 at 10:10 a.m., Licensed Practical Nurse (LPN) 7 indicated if the family or resident requested anything from the physician, she would fax the physician, put it in the doctor's book on what was requested, and document the request in the progress notes. After 24 hours if nothing was done, she would check on it again. If she was waiting for a response from the physician, she would place the request on the 24-hour report sheet and ask the oncoming nurse to follow up on the request to the physician. During an interview, on 11/8/24 at 10:24 a.m., Registered Nurse (RN) 8 indicated she would document in the nurses notes about the resident's complaint and about the physician's notification. She would place it on the 24-hour sheet. If she was not there the next day, someone else should follow up on the physician's response. During an interview, on 11/8/24 at 3:41 p.m., the Director of Nursing indicated how soon a request should be followed-up on depended on the request. She indicated the resident had several medications for pain, and the resident's physician had changed this past week due to a change in			

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	the medical director. The resident's prior physician was sometimes slow to respond to the facility's requests. No one had followed up on the resident's request to try gabapentin as far as she knew. A current facility policy, dated 8/2022, titled "Resident Change of Condition," provided by the DON on 11/8/24 at 4:43 p.m., indicated the following: "POLICY... It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place. PROCEDURE... 3. Non-Urgent Medical Change... c. If unable to reach the physician or family/responsible party, all calls to physicians or exchanges and family/responsible party requesting callbacks will be documented in the medical record. d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow-up. e. If unable to contact attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition... g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized." This citation relates to complaint IN00444162. 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to ensure pharmacy recommendations were	F 0756	Tag F756 – Drug Regimen Review “Facility failed to ensure pharmacy	12/18/2024

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	reviewed and addressed in a timely manner for 2 of 5 residents reviewed for unnecessary medications (Resident 16 and Resident 18). Findings include: 1. Resident 16's clinical record was reviewed on 11/7/24 at 11:52 a.m. Diagnoses included aphasia following cerebral infarction, depression, disorientation, and anxiety disorder. Physician's orders included lorazepam (antianxiety) 0.5 mg (milligrams) two tablets every 4 hours as needed (PRN) for anxiety/agitation (started 10/27/24) and lorazepam 0.5 mg every 6 hours PRN anxiety/agitation (started 8/5/24 and discontinued 10/27/24). A significant change Minimum Data Set (MDS) assessment, dated 8/28/24, indicated the resident was severely cognitively impaired. A medication administration record for August 2024 indicated the resident was given lorazepam 0.5 mg on 8/5/24 at 5:04 p.m. and 11:05 p.m., 8/7/24 at 11:24 a.m., and 8/12/24 at 9:03 p.m. A medication regimen review, completed on 8/19/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 8/5/24 was a PRN order for a psychotropic drug and was limited to 14 days, except if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days. Rationale and duration of the PRN order was to be documented by the prescriber in the resident's medical record. A medication administration record for September 2024 indicated the resident was given lorazepam		recommendations were reviewed and addressed in a timely manner for 2 of 5 residents reviewed for unnecessary medications." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Correct alleged deficient practice) • 2 resident was affected by the alleged deficient practice. • Resident 16 and Resident 18 had medication regimen reviewed by physician and RPH immediate upon notification. 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. (How to protect like residents). - Residents with pharmacy recommendations have the potential to be affected by the alleged deficient practice. • All current inhouse residents were audited by the DNS. No issues needing addressed at this time. • Residents will have medication regimen's reviewed and updated timely. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? (Actions taken, education, training, to prevent it from	

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	0.5 mg on 9/11/24 at 1:56 p.m. and 10:18 p.m., 9/14/24 at 10:57 p.m., 9/17/24 at 9:09 p.m., 9/18/24 at 6:12 a.m., 9/20/24 at 10:32 p.m., 9/21/24 at 7:11 p.m., and 9/28/24 at 1:57 a.m. 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. A medication regimen review, completed on 10/21/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 8/5/24 was a PRN order for a psychotropic drug and was limited to 14 days except if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days. Rationale and duration of the PRN order was to be documented by the prescriber in the resident's medical record. The nurses notes lacked documentation of physician notification and response to the 8/19/24 and 10/21/24 medication regimen reviews. A Nurse's Note, dated 10/27/24 at 3:27 p.m., indicated the PRN lorazepam order for 0.5 mg started on 8/5/24 was discontinued. A new order for lorazepam 1 mg every 4 hours PRN anxiety/agitation was started and lacked a stop date. 2. Resident 28's clinical record was reviewed on 11/7/24 at 9:27 a.m. Diagnoses included anxiety disorder and congestive heart failure. Physician's orders included lorazepam 0.5 mg every 6 hours PRN for anxiety/agitation (started 7/30/24) and lorazepam 0.5 mg two times a day (started 11/4/24).		happening again). SSD • The DNS was educated on the Drug Regimen Review Policy by clinical support. - Education and training were provided to clinical staff by DNS. Education provided: o Drug Regimen Review 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? (Ongoing compliance in QAPI) - DNS/designee will complete daily monitoring through the clinical care meeting and Drug Regimen Review monitoring tool to ensure that any resident is reviewed regularly for proper monitoring procedure and that the physician will be notified daily until the medication recommendation is addressed. 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DNS/designee will be responsible for the Drug Regimen Review monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The	

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	A significant change MDS assessment, dated 8/9/24, indicated the resident was moderately cognitively impaired. A medication administration record for August 2024 indicated the resident was given lorazepam 0.5 mg on 8/13/24 at 7:05 p.m. and 8/15/24 at 6:00 p.m. A medication regimen review, completed on 8/19/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 7/30/24 required a 14 day stop date or for longer duration if clinically appropriate. A medication administration record for October 2024 indicated the resident was given lorazepam 0.5 mg on 10/4/24 at 3:54 p.m. The Nurse's Notes lacked documentation of the physician notification and response of the 8/19/24 medication regimen review. During an interview, on 11/8/24 at 3:38 p.m., the DON indicated the pharmacy's medication regimen review would have been sent to the resident's physician for review. She usually kept the reviews clipped until she received a response. She had missed this review and did not have a physician response. A current facility policy, dated 2020, provided by the DON on 11/8/24 at 4:43 p.m., titled "Drug Regimen Review," indicated the following: " ...A written report is provided to the physician within seven working days or according to facility policy, with a copy to the facility ...The physician's response is documented in the Consultant Pharmacist review record or elsewhere		facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	in the resident's medical record ...The physician provides a written response of the report to the facility within one month after the report is sent. A copy of the report is kept by the facility until the physicians signed response is returned ...." 3.1-25(i)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, interview, and record review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of an as needed (PRN) psychoactive medication for 2 of 5 residents reviewed for unnecessary medications. (Resident 16 and Resident 28) Findings include: 1. During an observation, on 11/4/24 at 9:20 a.m., Resident 16 rested in bed with his eyes closed. On 11/6/24 at 3:59 p.m., the resident rested in bed in bed with his eyes closed and leaned right. On 11/7/24 at 12:43 p.m., the resident rested in bed with his eyes gazing at the television. Resident 16's clinical record was reviewed on 11/7/24 at 11:52 a.m. Diagnoses included aphasia following cerebral infarction, depression, disorientation, and anxiety disorder. Physician's orders included lorazepam (antianxiety) 0.5 mg (milligrams) two tablets every 4 hours PRN for anxiety/agitation (started 10/27/24), lorazepam 0.5 mg every 6 hours PRN anxiety/agitation (started 8/5/24 and discontinued	F 0758	Tag F758- Free from Unnec. Psychotropic Meds/PRN Use "Facility failed to ensure non-pharmacological interventions were attempted prior to the administration of an as needed (PRN) psychoactive medication for 2 of 5 residents reviewed for unnecessary medications (Resident 16 and Resident 28)." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • 2 residents were affected by the alleged deficient practice. • Resident 16 and 28 had appropriate interventions entered into EMR. 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. - Residents with an order for PRN psychotropic medication have the potential to be affected	12/18/2024

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	10/27/24), and duloxetine (antidepressant) delayed release 90 mg daily (started 10/22/24). A significant change Minimum Data Set (MDS) assessment, dated 8/28/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, personal hygiene, showering/bathing, upper and lower body dressing, rolling left and right, moving from sitting to lying and lying to sitting, and transfers. A care plan for the behavior of calling 911 for basic needs instead of pressing his call light was initiated 5/31/24 and revised on 9/18/24. The interventions included the following: Care givers to provide positive interaction and attention and to stop and talk to the resident when passing by him (initiated 5/31/24 and revised on 9/18/24). Discuss the resident's behavior with him and explain/reinforce why the behavior is inappropriate and/or unacceptable (initiated 5/21/24 and revised 9/18/24). Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes (initiated 5/31/24). A care plan for the use of antianxiety medication to treat symptoms of anxiety disorder was initiated on 7/10/24 and revised on 7/10/24. The goals included the resident will show decreased number of episodes of anxiety though the next review date of 12/5/24 (initiated 7/10/24 and revised 8/29/24). The interventions included the following: Administer antianxiety medications as ordered by the physician. Monitor for side effects and effectiveness every shift (initiated 7/10/24). A medication administration record for August		by the alleged deficient practice. • All residents with PRN psychotropic medication orders were audited by the DNS for appropriate interventions. No concerns identified at this time. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The DNS was educated by clinical support consultant on the Psychotropic Medication Use policy with concentration on, but not limited to, non-pharmacological approaches to minimize the need for medication. - Education and training was provided to clinical staff by DNS, including: o Psychotropic Medication Use 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? (Ongoing compliance in QAPI) - DNS/designee will complete daily monitoring through the clinical care meeting and PRN Psychotropic Medication monitoring tool to ensure that any resident with behavior symptoms is getting non-pharmacological interventions for proper monitoring procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks	

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	155699	A. BUILDING 00 B. WING	11/08/2024

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	2024 indicated the resident was given lorazepam 0.5 mg on 8/5/24 at 5:04 p.m. and 11:05 p.m., 8/7/24 at 11:24 a.m., and 8/12/24 at 9:03 p.m. 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 8/7/24 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 8/7/24.		and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DNS/designee will be responsible for the PRN Psychotropic Medication monitoring compliance of the line list procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive 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 substantial compliance for no less than 6 months.	

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	A nurses note, dated 8/12/24 at 9:03 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 8/12/24 indicated no resident behaviors were observed and no interventions attempted. A medication administration record for September 2024 indicated the resident was given lorazepam 0.5 mg on 9/11/24 at 1:56 p.m. and 10:18 p.m., 9/14/24 at 10:57 p.m., 9/17/24 at 9:09 p.m., 9/18/24 at 6:12 a.m., 9/20/24 at 10:32 p.m., 9/21/24 at 7:11 p.m., and 9/28/24 at 1:57 a.m. A Nurse's Note, dated 9/11/24 at 1:56 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. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/11/24. A Nurse's Note, date 9/14/24 at 10:57 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 9/14/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 9/17/24 at 9:09 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record			

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	lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/17/24. A nurses note, dated 9/18/24 at 6:12 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 9/18/24. A Nurse's Note, dated 9/20/24 at 10:32 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. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/20/24. A nurses note, dated 9/21/24 at 7:11 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. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/21/24. A Nurse's Note, dated 9/28/24 at 1:57 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record			

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	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. 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. 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. During an observation on 11/7/24 at 8:30 a.m., the			

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	resident was lying in bed in with her eyes closed. Resident 28's clinical record was reviewed on 11/7/24 at 9:27 a.m. Diagnoses included anxiety disorder and congestive heart failure. Physician's orders included lorazepam 0.5 mg every 6 hours PRN for anxiety/agitation (started 7/30/24), lorazepam 0.5 mg two times a day (started 11/4/24), and hydroxyzine pamoate (used for anxiety) 25 mg twice a day (started 2/15/24 and discontinued 11/4/24). A significant change MDS assessment, dated 8/9/24, indicated the resident was moderately cognitively impaired. She required partial/moderate assistance with toileting hygiene, showering and bathing, upper body dressing, and moving from sitting to lying and lying to sitting. She was dependent on the staff for transfers. A care plan with a focus on the resident's restlessness, nervousness, and other anxiety symptoms due to anxiety disorder was initiated on 1/8/24 and revised on 8/28/24. The interventions included the following: Encourage the resident to participate in activities of choice (initiated 1/15/24 and revised 8/28/24). Give meds as ordered (initiated 1/8/24 and revised 1/15/24). A medication administration record for October 2024 indicated the resident was given lorazepam 0.5 mg on 10/4/24 at 3:54 p.m. A Nurse's Note, dated 10/4/24 at 3:54 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.			

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	No behaviors or interventions were marked on the behavior monitoring and interventions report on 10/4/24. During an interview, on 11/8/24 at 10:10 a.m., Licensed Practical Nurse (LPN) 7 indicated prior to giving any PRN medications, interventions should be attempted. The nurse should always put in a progress note of the behavior and the interventions. During an interview, on 11/8/24 at 10:24 a.m., Registered Nurse (RN) 8 indicated before giving PRN medications, the order should be checked, the expiration date should be checked, check what interventions are appropriate and do those, and document the behavior and interventions. During an interview, on 11/8/24 at 3:48 p.m., the Director of Nursing (DON) indicated interventions should be attempted prior to giving PRN psychoactive medications. She was unable to supply documentation of interventions attempted prior to the administration of the PRN medications for the residents. A current facility policy, dated 8/2024, provided by the DON on 11/8/24 at 4:43 p.m., titled "Psychotropic Medication Use," indicated the following: " ...Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible ...." 3.1-48(a)(4)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview, and record review, the facility failed to utilize infection prevention and control procedures during insulin administration for 2 of 4 residents reviewed for medication administration. (Residents 16 and 7) Findings include: 1. During a random medication administration observation on 11/6/24 at 10:56 a.m., RN 5 removed Resident 16's insulin aspart Flexpen 100 units/milliliter(mL) from the compartment in the top drawer of the medication cart where the insulin pens for the residents on the 200 unit were stored. She removed the unsealed pen cap, did not cleanse the rubber stopper of the multi-dose pen, and attached the pen needle to the insulin pen. The pen was primed and dialed to 11 units for scheduled and sliding scale insulin. The skin was cleansed with an alcohol pad, and the insulin was administered subcutaneously in the resident's right lower abdomen. Resident 16's clinical record was reviewed on 11/8/24 at 12:35 p.m. Diagnoses included, type 2 diabetes mellitus with diabetic neuropathy. Current physician's orders, dated 5/8/24, included insulin aspart injection solution 100 units/mL - inject 7 units subcutaneously with meals and insulin aspart injection solution 100 units/mL - inject as per sliding scale subcutaneously with meals. 2. During a random medication administration observation on 11/6/24 at 11:20 a.m., RN 5 removed Resident 7's Humalog KwikPen (insulin) solution pen-injector 100 units/mL from the compartment in the top drawer of the medication cart where the insulin pens for the residents on	F 0880	Tag F880 – Infection Prevention & Control "Facility failed to utilize infection prevention and control procedures during insulin administration for 2 of 4 residents reviewed for medication administration." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Correct alleged deficient practice) • 2 residents were affected by the alleged deficient practice. • Nurse that was administering those medications was immediately educated on cleaning rubber stoppers on insulin pens. 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. (How to protect like residents). - All residents that require insulin have the potential to be affected by the alleged deficient practice. • All current inhouse residents were audited for appropriate insulin pen administration and manufacturer guidelines for cleaning before administration. No further action needed at this time. 3: What measures will be put into place or what systemic changes	12/18/2024

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	the 200 unit were stored. She removed the unsealed pen cap, did not cleanse the rubber stopper of the multi-dose pen, and attached the pen needle to the insulin pen. The pen was primed and dialed to a total of 7 units for scheduled and sliding scale insulin. The skin was cleansed with an alcohol pad, and the insulin was administered subcutaneously in the resident's left upper arm. Resident 7's clinical record was reviewed on 11/8/24 at 12:49 p.m. Diagnoses included, type 2 diabetes mellitus with other circulatory complications. A current physician's order, dated 11/27/23, included Humalog injection solution 100 units/mL - inject 5 units subcutaneously with meals. A current physician's order, dated 12/13/23, included Humalog KwikPen solution pen-injector 100 units/mL - inject as per sliding scale subcutaneously before meals and at bedtime. During an interview on 11/6/24 at 11:30 a.m., RN 5 indicated she should have cleansed the rubber stoppers for the insulin pen injectors prior to attachment of the needles during the medication administration observations, because they were pierced multiple times since they were opened for administration of the medication. This should have been done for infection prevention. During an interview on 11/7/24 at 3:04 p.m., the Vice President of Clinical Operations indicated the insulin pens should have been cleansed prior to attachment of the needle according to the manufacturers' guidelines. A current document, last revised on 2/2023, titled		will be made to ensure that the deficient practice does not recur? (Actions taken, education, training, to prevent it from happening again). DNS/SSD • The DNS was educated on Flex pen use and procedure with concentration on, but not limited to, cleansing rubber cap before putting on the needle. - Education and training were provided to the clinical staff by the DNS. Education provided: o Insulin pen manufacturer instructions 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? (Ongoing compliance in QAPI) - Infection Preventionist/DNS/designee will complete daily monitoring through observation and insulin pen monitoring tool to ensure that any resident with an insulin pen administration is being observed for proper practicing procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - Infection Preventionist/DNS/designee will be responsible for the Insulin pen monitoring compliance for 6	

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	"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...." A current document, last revised on 7/2023, titled "INSTRUCTIONS FOR USE HUMALOG... KwikPen... injection, for subcutaneous use 3 mL single-patient-use pen (100 units per mL)," provided by the Administrator on 11/7/24 at 3:03 p.m., indicated the following: "...Preparing your Pen... Step 1: ...Pull the Pen Cap straight off... Wipe the Rubber Seal with an alcohol swab...." A current document, titled "Insulin Pens," last reviewed 2/24/24 and retrieved on 11/12/24 from the Cleveland Clinic website: https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections. The guidance included the following: "Step-by-step instructions for preparing your insulin pen include: 1. Wash your hands. 2. Remove the cap of the insulin pen... 4. Wipe the rubber stopper with an alcohol wipe. 5. Attach a new pen needle to the insulin pen...." 3.1-18(a)		months. The results of these audits will be reviewed by the QA committee overseen by the Executive 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 substantial compliance for no less than 6 months.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons	F 9999	Tag F9999 – Final Observations "Facility failed to accurately document the administration and results of mandatory tuberculin skin tests performed on 4 of 5 new employee files reviewed.."	12/18/2024

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	having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration and results of mandatory tuberculin skin tests (TST) performed on 4 of 5 new employee files reviewed. (Certified Nurse Aide (CNA) 3, CNA 6, Registered Nurse (RN) 5, and Social Services Director (SSD)) Findings include: Employee records, provided by the Administrator on 11/6/24 at 11:04 a.m., were reviewed on 11/6/24 at 3:34 p.m. An employee tuberculosis (tb) form for CNA 3 indicated a first step tb test was performed on 4/3/24 and read on 4/5/24. A second step tb test was performed on 4/17/24 and read on 4/19/24. The tests administered did not include the times administered or read. An employee tb form for CNA 6 indicated a first step tb test was performed on 1/29/24 and read on 1/31/24. A second step tb test was performed on 2/14/24 and read on 2/16/24. The tests administered did not include the times administered or read.		1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Correct alleged deficient practice) • 0 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. (How to protect like residents). - All residents have the potential to be affected by the alleged deficient practice. • All current inhouse staff was addressed by the BOM for TB test documentation. All staff appropriate for TB documentation was updated as appropriate. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? (Actions taken, education, training, to prevent it from happening again). SSD/DNS • The DNS was educated on the Tuberculosis screening – Administration and Interpretation of Tuberculin Skin Test policy including proper documentation. - Education and training were provided to clinical staff by the DNS. Education provided:	

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	An employee tb form for the SSD indicated a first step tb test was performed on 3/11/24 and read on 3/14/24. A second step tb test was performed on 4/5/24 and read on 4/8/24. The tests administered did not include the times administered or read. An employee tb form for RN 5 indicated a first step tb test was performed on 7/10/24 at 11 a.m. and read on 7/12/24. A second step tb test was performed on 7/24/24 and read on 7/26/24. The test administered on 7/24/24 did not include the time administered. The tests did not include the times read. During an interview, on 11/8/24 at 10:10 a.m., LPN 7 indicated when a tb test is given and read, the time, date, expiration date, lot number, company, where given, the size of the wheal and who gave it should be documented. The time must be documented as it must be read within 72 hours. During an interview, on 11/8/24 at 10:24 a.m., RN 8 indicated when a tb test is given and read, the expiration date, the size of the wheal, who gave/read the test, the date, and the time must be documented. During an interview, on 11/8/24 at 1:19 p.m., the DON indicated tb test should have the time and date documented when given and read as they are to be read within 48 to 72 hours of administration. A current facility policy, dated 8/2024, provided by the Administrator on 11/8/24 at 2:09 p.m., titled "Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Test (TST)," indicated the following: " ...Document the following information in the resident or employee medical record: f. Date and time the TST was given ...h. Date and time the TST results were		o Tuberculosis screening – Administration and Interpretation of Tuberculin Skin Test 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? (Ongoing compliance in QAPI) - DNS/designee will complete monitoring during the hiring process for proper TB testing procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DNS/designee will be responsible for TB Test, monitoring compliance of the line list procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive 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 substantial compliance for no less than 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 00 B. WING	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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	interpreted ...."			