STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey date: February 5, 6, 7, 8, and 9, 2024. Facility number: 000022 Provider number: 155061 AIM number: 100274510 Census Bed Type: SNF: 1 SNF/NF: 48 Total: 49 Census Payor Type: Medicare: 10 Medicaid: 36 Other: 3 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 15, 2024.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF LAWRENCEBURG INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted February 20,2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 22, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary Preece	Executive Director	02/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide a homelike setting for 7 of 14 residents using the shower	F 0584	Tag #F584 - Safe/Clean/Comfortable/Homelike Environment	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rooms on the 100 Hall related to loose wires hanging from the walls. Findings include: On 02/07/24 at 10:11 A.M., Shower Room 1 on the 100 Hall was observed. Four black electrical wires were running from a hole in the wall near the ceiling, behind the entrance door, down to the floor with the ends of the wires bundled and wound back and forth laying on the floor. The ends of the wires were wrapped with blue paper-like tape. The bundle was approximately 12 inches by 4 inches and the full length of the bundle was laying flat against the floor. During an observation and interview on 02/08/24 at 12:12 P.M., Shower Room 2 on the 100 Hall had four black electrical wires hanging from a hole in the wall near the ceiling above the entrance door. The wires were draped over a second door in the shower room that led to the toilet area and hung down the door to about two feet from the floor. The ends of the wires were wrapped in blue paper-like tape. CNA (Certified Nurse Aide) 7 indicated the shower rooms had been remodeled and the wires in both shower rooms had been this way since October of 2023. The residents currently used both shower rooms. During an interview on 02/08/24 at 12:29 P.M., Resident 33 indicated she had used both shower rooms recently. During an interview and observation on 02/08/24 at 12:35 P.M., the Maintenance Director indicated the wires were from the old call light system and were to be used for the future call light system. The wires were currently "dead". The shower rooms had been remodeled since September of		"Facility failed to provide a homelike setting for 7 of 14 residents using the shower rooms on the 100 Hall related to lose wires hanging from the walls." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - 7 residents located on the first floor were affected by the alleged deficient practice. - Loose wires were tested and found inactive/dead to electricity and were properly taped and capped placed into the wall and hole sealed. 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. - First floor residents have the potential to be affected by the alleged deficient practice. First floor residents were audited on 2/15/24 to ensure no complaints remained after shower rooms were repaired for a safe environment. - Residents on first floor were updated on call light system and potential completion of remodeling. 3: What measures will be put into place or what systemic changes will be made to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2023, and the wires had been hanging there since that time. He verified the wire ends were wrapped in painter's tape, not electrical tape. Shower Rooms 1 and 2 were observed on 02/08/24 at 3:19 P.M. The wires had been cut off at the wall and capped with red and yellow wire caps. During an interview on 02/08/24 at 3:20 P.M., the Administrator indicated he had the Maintenance Director test the wires, cut the wires off, cap them, and put fire caulk around the wires. He did not know why the Maintenance Director decided to cut the wires off today. During an interview on 02/09/24 at 11:00 A.M., the Maintenance Director indicated it was an executive decision after he had spoken with the Administrator to cut the wires. They had verified there was no power going to them, it was a dead system. He was told by the contractors to leave them for the new system they would be installing. The original quote for the call light system, dated 10/11/23, was provided by the Vice President of Clinical Services on 02/09/24 at 2:29 P.M. He indicated the contract was just for the first floor of the building and the remodel should be finished by the middle of the first quarter of the year 2024. The quote did not list a specific date the call system was to be completed. The current facility Admission Agreement provided at the Entrance Conference indicated, "...The resident has a right to a safe, clean, comfortable and homelike environment..." 3.1-19(f)(5)		deficient practice does not recur? - All Staff were educated in a homelike environment and TELS system to ensure that mechanical/maintenance repairs reported timely to ensure proper environment. Education provided: o Envive Policy for Homelike Environment o TELS how to create a work order 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e.; what quality assurance program will be put into place? - ED/Maintenance Director/designee will complete daily monitoring through the Facility to ensure that homelike environment maintained/repairs completed accurately/timely for 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. - The Maintenance Director will be responsible for monitoring TELS system 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			months. 5. Date of completion: 03/22/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure care plans were in place for residents related to a risk for skin impairments, resident's oral health status; and a care plan/physician's order related to the adequate assessment, and ongoing monitoring for the use of a seat belt and body positioning device for 3 of 14 residents reviewed for care plans. (Residents 14, 25, and 2) Findings include: 1. On 02/07/24 at 3:25 P.M., Resident 14 was observed to have an open area on his right buttock. The Wound Nurse indicated the area was newly identified and a dressing was placed on the wound daily. The clinical record for Resident 14 was reviewed on 02/07/24 at 3:41 P.M. An Annual MDS (Minimum Data Set) assessment, dated 12/11/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited, coronary artery disease, hypertension, chronic obstructive pulmonary disease, arthritis,	F 0656	Tag #656 - Development Comprehensive Care Plan “Facility failed to ensure care plans were in place for residents related to a risk for skin impairments, resident's oral health status; and a care plan/physician's order related to the adequate assessment, and ongoing monitoring for the use of a seat belt and body positioning device for 3 of 14 residents reviewed for care plans. (Residents 14, 25, and 2) 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - 3 Residents were affected by the alleged deficient practice. Complete care plan audit was completed for affected residents and updated as appropriate on	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and depression. The resident was at risk for skin break down and required assistance with transfers. The resident's complete Care Plan was provided by the DON (Director of Nursing) on 02/09/24 at 11:40 A.M. and lacked a care plan related to the resident's at risk for skin break down status. During an interview on 02/09/24 at 1:50 P.M., the DON indicated the resident previously had a care plan related to his risk for skin break down. The care plan was discontinued. She was unsure why the resident no longer had an at risk for skin break down care plan. 2. Resident 25 was observed on 02/06/24 at 11:18 A.M. The resident was missing several teeth. The resident indicated she was missing teeth and had some cavities she wanted worked on. She wanted to see the dentist. She told a staff member, but she was not sure who it was. She had been in the facility since July of 2023. The resident's clinical record was reviewed on 02/08/24 at 2:29 P.M. An Admission MDS assessment, dated 07/12/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, diabetes, heart failure, and renal disease. The assessment indicated the resident had obvious or likely cavities or broken natural teeth. The Care Area Assessment Summary section of the assessment indicated that the "Dental Care" care area triggered and should be addressed in the resident's care plan. The resident's complete Care Plan was provided by the DON on 02/09/24 at 11:40 A.M. and lacked a care plan related to the resident's oral status.		2/15/2024. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice.100% audit and corrective update on all residents' care plan was completed by 2/22/2024. Residents with potential for pressure/oral health and ongoing needs were care planned for preventive measures. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - All Staff were educated on the comprehensive care policy and preventive pressure reducing modalities. - Education and training were provided to staff on 2/15/24 by the DNS (Director of Nursing Services). Education provided: o Comprehensive Care Policy o Baseline Functional Abilities Assessment 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e.; what quality assurance program will be put into place? - DNS/designee will complete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 02/09/24 at 1:50 P.M., the DON indicated the resident did sign up for ancillary services that included dental services upon admission. There were some issues with the resident's insurance. The resident was on the list to see the dentist at the end of this month. She was not sure why the resident did not have a care plan for her oral status. 3. On 02/07/24 at 10:03 A.M., Resident 3 was observed in her room sitting upright in her wheelchair. A body positioning device was attached to the back of the resident's wheelchair with straps on each side of the resident's seat. The device went over the resident's shoulders and buckled on each side of the resident's trunk. A seat belt was also in place and buckled across the resident's midsection at the hips. During an interview on 02/07/24 at 10:18 A.M., RN 3 indicated the resident had a seat belt and a harness type positioning device. She wasn't sure if the resident had an order for the devices. Nursing staff did not document monitoring of the devices that she was aware of. The resident's record was reviewed on 02/07/24 at 11:00 A.M. An Annual MDS (Minimum Data Set) assessment, dated 12/19/23, indicated the resident's memory was impaired. The diagnoses included, but were not limited to, seizure disorder, severe intellectual disabilities, and diabetes. The resident's lower extremities were impaired. The resident required substantial/maximal assistance for eating and upper body dressing and was totally dependent on staff for assistance with all other ADLs (Activities of Daily Living). The resident's record lacked a physician's order for the positioning device or seat belt; a care plan for the assessment for use of the devices, and		daily monitoring through the clinical care meeting to ensure that any resident with preventive measures for pressure oral health and ongoing needs are added to the care plan 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/MDS/designee will be responsible for comprehensive care plan monitoring and compliance of the care plan 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. 5. Date of completion: 03/22/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation of ongoing monitoring of the use of the devices. During an interview on 02/07/24 at 10:27 A.M., the DON (Director of Nursing) indicated the resident did have a seat belt and positioning device. There should be a physician's order for the seat belt and positioning device and orders to monitor the resident when the devices were being used. The current facility policy, titled "Comprehensive Care Plan Guideline", with a revision date of 08/2022, was provided by the Vice President of Clinical Services on 02/09/24 at 2:31 P.M. The policy indicated, "...To ensure appropriateness of services and communication that will meet the resident's needs...in accordance with state and federal regulations...Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident..." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow physician's orders for insulin administration (Resident 22) and and follow manufacturer's guidelines related to insulin pen usage (Resident 24) for 2 of 6	F 0684	Tag # 684- Quality of Care “Facility failed to follow physician's orders for insulin administration (Resident 22) and follow manufacturer's guidelines related	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents observed for Quality of Care. Findings include: 1. The clinical record for Resident 22 was reviewed on 02/06/24 at 3:20 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/22/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, dementia, hypertension, diabetes, anxiety, and depression. A physician's order, dated of 09/18/23 through 02/02/24, indicated the resident was to receive Insulin Glargine Solution 100 units per ml (milliliter). The staff were to inject 30 units subcutaneously one time a day for diabetes, hold if blood sugar was less than 120 mg/dl (milligrams per deciliter). The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for December 2023, January and February 2024, indicated the resident had received the insulin medication when the blood sugar was less than 120 mg/dl for the following dates: - On 12/02/23 the resident's blood sugar was 104. - On 12/08/23 the resident's blood sugar was 104. - On 12/17/23 the resident's blood sugar was 112. - On 12/18/23 the resident's blood sugar was 114. - On 12/19/23 the resident's blood sugar was 82. - On 12/20/23 the resident's blood sugar was 95. - On 12/22/23 the resident's blood sugar was 92 - On 12/23/23 the resident's blood sugar was 95. - On 12/24/23 the resident's blood sugar was 101. - On 12/25/23 the resident's blood sugar was 78. - On 12/26/23 the resident's blood sugar was 89. - On 01/01/24 the resident's blood sugar was 108.		to insulin pen usage (Resident 24) for 2 of 6 residents observed for Quality of Care. 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. Residents 24 and Resident 22 had medication administration assessments completed by DNS and adjustments made as appropriate. 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. - 13 Residents have the potential to be affected by the alleged deficient practice. Current inhouse residents on insulin were audited on 2/15/24 by the DNS. No current inhouse residents require corrective action related to insulin administration. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - Nursing staff required to deliver insulin administration were educated on use of insulin pen administration and medication orders policy and procedure with concentration on, but not limited	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- On 01/02/24 the resident's blood sugar was 91. - On 01/03/24 the resident's blood sugar was 113. - On 01/08/24 the resident's blood sugar was 93. - On 01/13/24 the resident's blood sugar was 112. - On 01/14/24 the resident's blood sugar was 96. - On 01/16/24 the resident's blood sugar was 102. - On 01/17/24 the resident's blood sugar was 118. - On 01/18/24 the resident's blood sugar was 83. - On 01/20/24 the resident's blood sugar was 86. - On 01/21/24 the resident's blood sugar was 77. - On 01/22/24 the resident's blood sugar was 107. - On 01/23/24 the resident's blood sugar was 99. - On 01/29/24 the resident's blood sugar was 119. - On 02/01/24 the resident's blood sugar was 85. - On 02/02/24 the resident's blood sugar was 79. On 02/08/24 at 10:57 A.M., RN 3 indicated if a resident had a routine insulin medication, she would use the blood sugar reading that was taken earlier that morning. If there were hold parameters for the medication the physician's orders should have been followed. The current facility policy titled "Medication Administration and General Guidelines" was provided by the Director of Nursing on 02/08/24 at 12:44 P.M. The policy indicated "...Medications are administered in accordance with written orders of the attending physician..." 2. Medication administration was observed on 02/08/24 at 8:42 A.M., with RN 5 as she prepared insulin pens for Resident 24. The RN gathered a Lispro insulin pen and a Lantus insulin pen from a plastic bag and indicated the resident was to receive 17 units of Lispro (a short-acting insulin) with meals and 40 units of Lantus (a long acting insulin). The resident's blood glucose level had been 178. The nurse applied needles to both pens, not wiping off the rubber seal with an alcohol wipe, turned the dial at the end of the pens to the		to, priming insulin pen and orders to hold insulin and notify MD if out of parameter. - Education and training were provided to nursing staff on 02/15/24 by the DNS. Education provided: o Medication orders policy o Manufacturer guideline on insulin pen administration 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? - DNS/designee will complete daily monitoring through the clinical care meeting to ensure that any resident with insulin orders is being followed properly and according to physician direction. Monitoring procedure will occur 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 Insulin Administration/Physician orders as related to insulin administration monitoring compliance 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appropriate dose, used hand sanitizer, entered the resident's room, cleaned the resident's abdomen with an alcohol wipe, donned gloves, verified the resident's name, administered the two insulins, holding the pens in place for a few seconds following administration, and exited the room. During an interview following the administration of the insulin, the RN indicated when preparing an insulin pen for use, she would wipe off the insulin pen tip with an alcohol wipe, apply the needle, turn the pen to the required dose, and administer the insulin. After conferring with QMA (Qualified Medication Aide) 6, the RN indicated you should prime the insulin pen before use. The clinical record for Resident 24 was reviewed on 02/08/24 at 9:45 A.M. A Quarterly MDS assessment, dated 01/18/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes and renal insufficiency. The Lantus insulin package insert was provided by the Vice President of Clinical Services on 02/08/24 at 3:05 P.M. The record indicated, "...HOW TO USE YOUR LANTUS...PEN...Wipe the pen tip (rubber seal) with an alcohol swab...Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on...after you have attached the needle, take off the outer needle cap and save it...Remove the inner needle cap and throw it away... PERFORM A SAFETY TEST...Dial a test dose of 2 units...Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose...Press the injection button all the way in and check to see that insulin comes out of the needle..."		to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/22/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Lispro insulin package insert was provided by the Vice President of Clinical Services on 02/09/24 at 3:32 P.M. The record indicated, "...INSTRUCTIONS FOR USE...Pull the Pen Cap straight off...Wipe the Rubber Seal with an alcohol swab...push the capped Needle straight onto the Pen...Pull off the Outer Needle Shield...Pull off the Inner Needle Shield...Prime before each injection...Priming you Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly...If you do not prime before each injection, you may get too much or too little insulin...To prime your Pen, turn the Dose Knob to select 2 units...Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top...Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window...You should see insulin at the tip of the Needle..." The current "Medication Administration and General Guidelines" policy, 2020 Edition, was provided by the Vice President of Clinical Services on 02/09/24 at 3:32 P.M. The policy indicated, "...Medications are administered...using good nursing principles and practices..." 3.1-37(b)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	preferences. Based on observation, interview, and record review, the facility failed to adequately monitor a dialysis access site for 1 of 2 residents that received dialysis treatments. (Resident 25) Findings include: On 02/07/24 at 10:16 A.M., Resident 25 was observed in her room in her wheelchair. A dressing was observed on her right chest. The resident indicated she received dialysis treatments through the access site in her chest. She had surgery recently to place a fistula (a surgically created vascular access used for dialysis treatments) in her left arm. The fistula was not ready to be used yet, so they still used the chest access. During an interview on 02/08/24 at 12:06 P.M., RN 3 indicated the resident had a permacath access site in her chest and a fistula in her arm. Nursing staff assessed the fistula site and documented the assessment in the resident's EHR (Electronic Health Record) every shift. If a resident had a permacath, the site should be assessed to ensure the dressing was clean, dry, and intact. You would also look for signs of infection or bleeding. She did assess the permacath site, but she did not document the assessment. The resident's clinical record was reviewed on 02/08/24 03:01 P.M. A Quarterly MDS (Minimum Data Set) Assessment, dated 01/15/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, diabetes, heart failure, and renal disease. The resident received dialysis treatments. The resident's current physician's orders were	F 0698	Tag # 698- Dialysis Facility failed to adequately monitor a dialysis access site for 1 of 2 residents that received dialysis treatments. (Resident 25) 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - 1 resident was affected by the alleged deficient practice. Dialysis access site assessed by DNS and corrected on 2/15/24. 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. - 2 residents have the potential to be affected by the alleged deficient practice. - Dialysis residents were audited on 2/15/24 by the DNS for dialysis site monitoring interventions. No residents required corrective action of dialysis site monitoring. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - Nursing staff were educated on the Dialysis monitoring policy and procedure with concentration on, but not limited to, site monitoring and adverse reactions. - Education and training were	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed and lacked an order to assess the resident's permacath access site. The resident's record lacked documentation the access site was assessed with any regularity. During an interview on 02/09/24 at 1:50 P.M., the DON (Director of Nursing) indicated the resident should have had an order to assess the dialysis access site and the assessment should have been documented. The current facility policy, titled "Dialysis Monitoring", with a revision date of 11/2022, was provided by the DON on 02/05/24. The policy indicated, "...If the resident has a catheter for dialysis the nurse will assess the catheter site for any signs of drainage and condition of the dressing to the site every shift...Documentation...3. Assessment of dialysis catheter site for any signs of drainage and condition of the dressing to the site..." 3.1-37(a)		provided to nursing staff on 2/15/24 by the DNS. Education provided: o Dialysis Monitoring Guidelines o Notification of Physician with adverse reactions. o Bruit/Thrill monitoring/ Permacath/Fistula 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e.; what quality assurance program will be put into place? - DHS/designee will complete daily monitoring through the clinical care meeting and PCC to ensure that any resident receiving Dialysis has appropriate physician orders for proper access site monitoring 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. - DHS/designee will be responsible for the Dialysis monitoring compliance 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
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			5. Date of completion: 03/22/2024	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the facility failed to transcribe orders on admission for 1 of 5 residents reviewed for pharmacy services. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 02/07/24 at 10:11 A.M. An Admission MDS (Minimum Data Set) assessment, dated 01/18/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, seizure disorder, depression, and paranoid personality disorder. A Hospital Discharge Summary, dated 01/09/24, included, but were not limited to, the following discharge medication orders: - Zyprexa/Olanzapine (an antipsychotic medication) 5 mg (milligrams) daily, and - Baclofen/Lioresal (a muscle relaxant) 5 mg, three times daily. The January and February 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the following medications: - Olanzapine 20 mg, daily from 01/09/24 through 01/23/24, - Olanzapine 15 mg, daily from 01/24/24 through 02/07/24, and - Midodrine (a hypotension medication) 5 mg, three time a day from 01/09/24 through 02/08/24.	F 0755	Tag # 755- Pharmacy Services/Procedures/Pharmacist Records “Facility failed to transcribe orders on admission for 1 of 5 residents reviewed for pharmacy services. (Resident 16). 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - 1 resident was affected by the alleged deficient practice. - Resident 16 immediately had medication orders audited by DNS and adjustments made as appropriate on 2/15/2024. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. - Current inhouse residents were audited on 2/22/24 by the DNS for Medication transcription errors. No residents qualified for immediate interventions. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - Nursing staff were educated on Physician orders policy and procedures and medication orders	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The residents clinical record lacked that an order was transcribed for the Baclofen since admission on 01/09/24. During an interview on 02/08/24 at 2:08 P.M., LPN (Licensed Practical Nurse) 4 indicated when the resident was admitted she had transcribed the Zyprexa order wrong. The resident's order should have been 5 mg daily and not 20 mg daily. The resident should have never had an order for midodrine, and the resident should have been started on baclofen upon admission. The current, undated, facility policy titled, "Medication Orders" was provided by the Vice President of Clinical Services on 02/08/24 at 3:57 P.M. The policy indicated, "...Written transfer orders (sent with a resident by a hospital or other health care facility)...Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician. Unless the order is unclear or incomplete, or the date signed is different from the date of admission. If the order is unsigned or signed by another prescriber or the date is other than the date of admission, the receiving nurse verifies the order with the current attending physician before the medications are administered. The nurse documents verification on the admission order record by entering the time, date, and signature..." 3.1-37(a) 3.1-48(a)(1)		with concentration on, but not limited to, transcription and verification by two nurses. - Education and training were provided to nursing staff on 2/15/24 by the DNS. Education provided: o Medication Orders o Physician Orders Policy and Procedure 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e.; what quality assurance program will be put into place? - DHS/designee will complete daily monitoring through the clinical care meeting and admission audit tool to ensure that residents with medication orders upon admission are double checked for proper transcription 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. - DHS/designee will be responsible for the medication order/transcription 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/22/2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications appropriately for 2 of 3 medications rooms (Units 2 and 3) and 2 of 3 medication carts reviewed. (Units 2 and 1)	F 0761	Tag #761 - Label/Store Drugs and Biologicals “Facility failed to store medications appropriately for 2 of	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. On 02/08/24 at 12:10 P.M., a medication room located behind the unlocked nurse's station on Unit 2 was observed. RN 5 opened the door to the medication room without unlocking it. The room contained medical supplies and a large gray tote that was overflowing with residents' medications. The medications varied from pills to IV (intravenous) medications and the RN indicated the medications were waiting to be returned to the pharmacy. IV antibiotic medications for Resident 26 were laying on an open shelf. The RN indicated the nurses, CNA's (Certified Nurse Aides), and QMA's (Qualified Medication Aides) had access to the medication room. The medication storage room should have been locked. During an observation on 02/08/24 at 12:20 P.M., RN 5 went down the hallway to assist a resident and was out of view of the medication room. The medication room remained unlocked. 2. During an observation on 02/08/24 at 12:27 P.M., a medication room located behind the unlocked nurse's station on Unit 3 was unlocked with no staff present. Resident 195 walked down the hallway past the nurse's station. At 12:28 P.M., RN 3 came and entered the medication room. The room contained medical supplies. A gray tote contained two bottles of MiraLAX with no resident name or label and an inhaler with no resident name or label. The refrigerator contained an undated ¾ full bottle of tuberculin serum. RN 3 indicated the serum was good for 30 days after it was opened. 3. During an observation on 02/08/24 at 12:22 P.M., a medication cart on Unit 2 contained a		3 medications rooms (Units 2 and 3) and 2 of 3 medication carts reviewed. (Units 2 and 1). 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - No residents were affected by the alleged deficient practice. - Units 2/3 immediately had medication room and carts audited by DNS and statements provided accordingly on 2/15/2024. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. - Current inhouse residents were audited on 2/22/24 by the DNS for expired medications. No residents required corrective action 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 - Nursing staff were educated on the expired medications and medications with shortened expiration dates and medication storage in the facility with concentration on, but not limited to, monitoring to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Lantus insulin pen for Resident 6, that was half full with no open date. RN 5 indicated the insulin should have had an open date. 4. During an observation on 02/08/24 at 12:59 P.M., a medication cart on Unit 1 was observed with RN 9. The cart contained a vial of Novolin R (an insulin medication) for Resident 32. The vial was ¾ full and had an open date of 01/03/24. The DON (Director of Nursing) indicated the medication was good for 28 days after opening. During an interview on 02/08/24 at 1:54 P.M., the DON indicated the tuberculin serum should have had an open date and the medication storage rooms should have been locked. The current, undated, package insert titled, "Tubersol", was provided by the ADON (Assistant Director of Nursing) on 02/08/24 at 3:05 P.M. The policy indicated, "...A vial of TUBERSOL which has been entered and in use for 30 days should be discarded..." The Lantus insulin package insert was provided by the Vice President of Clinical Services on 02/08/24 at 3:05 P.M. The record indicated, "...Once you take your SoloStar [Lantus] out of cool storage, for use or as a spare, you can use it for up to 28 days..." The current, undated, facility policy titled, "Medication Storage in the Facility", was provided by the ADON on 02/08/24 at 3:05 P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The supply is accessible only to license nursing personnel, pharmacy personnel, or staff members		medication rooms are locked and dates on opened medications are present. - Education and training were provided to All nursing staff on 2/15/24 by the DNS. Education provided: o Medication Storage in the facility o Expired Medications and Medications with shortened expiration dates 4: How will the corrective action be monitored to ensure the deficient practice will not recur i.e.; what quality assurance program will be put into place? - DNS/designee will complete daily monitoring through the clinical care meeting and audit monitoring tool to ensure that any resident with expired medications is discarded or unit medication rooms will be locked while not in use by appropriate personnel. Monitoring procedures will be 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. - DHS/designee will be responsible for the Med rooms locked and Expired medication audit monitoring compliance 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lawfully authorized to administer medications...Only licensed nurses, the Consultant Pharmacist, and those lawfully authorized to administer medications (e.g., medication aides) are allowed unsupervised access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access..." The current, undated, facility policy titled, "Expired Medications and Medications with Shortened Expiration Dates", was provided by the ADON on 02/08/24 at 3:05 P.M. The policy indicated, "...Ensure that all medications in the facility are rotated and/or reviewed on a consistent basis to prevent having expired medications in the facility...In the event that a medication has a [shortened] expiration date once opened the medication (open-dated) will be labeled with the date opened and the initials of the nurse..." 3.1-25(j) 3.1-25(o) 3.1-25(q)		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. 5. Date of completion: 03/22/2024	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on interview and record review, the facility failed to ensure a complete and accurate facility assessment based on the resident population and identification of resources needed to provide the necessary care and services required for their residents for 1 of 1 assessment reviewed. Finding includes: On 02/05/24 at 11:00 A.M., the Administrator provided a facility assessment form dated 12/27/23. The form was incomplete related to the care areas and population of residents in the facility and the number of residents in each care area. The form lacked resources needed during emergencies. The form lacked training topics and competencies specific to the facility. The form lacked physical environment and building/plant needs. On 02/09/24 at 2:17 P.M., the Administrator indicated he and the Director of Nursing started working on the facility assessment in November 2023. He acknowledged the facility assessment was incomplete and didn't show an accurate picture of the facility. The current facility policy, titled "Facility assessment Policy", with a revision date of 06/2022, was provided by the Administrator on	F 0838	Tag #838 - Facility Assessment “Facility failed to ensure a complete and accurate facility assessment based on the resident population and identification of resources needed to provide the necessary care and services required for their residents for 1 of 1 assessment reviewed. 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - No residents were affected by the alleged deficient practice. - Facility assessment was immediately audited and corrected by ED (Executive Director) and on 2/15/2024. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - All residents have the potential to be affected by the alleged deficient practice. - Current in-house residents were	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	02/09/24 at 2:55 P.M. The policy indicated, "...The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies..."		audited on 2/22/24 by the ED/DNS for necessary care resources. No residents required corrective measures 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? - Staff were educated in the Facility Assessment with concentration on, but not limited to, how resources are allocated based on facility assessment. - Education and training were provided to DHS and ADHS on 10/5/21 by the clinical support consultant. Education provided: o Medicaid/Medicare 483.70 Facility Assessment 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place - ED/designee will complete daily monitoring through the clinical care Facility Assessment audit monitoring tool to ensure that the Facility Assessment is accurate representation of residents 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. - ED/designee will be responsible for the Facility Assessment Audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitoring compliance 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. 5. Date of completion: 03/22/2024	