STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 00 B. WING	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(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 dates: December 11, 12, 13, 14, and 15, 2022 Facility number:000546 Provider number:155473 AIM number:100267370 Census Bed Type: SNF/NF:36 Total:36 Census Payor Type: Medicare:7 Medicaid:25 Other:4 Total:36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 16, 2022	F 0000	PLAN OF CORRECTION FOR ENVIVE OF BERNE F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey completed on December 11, 12, 13, 14 and 15, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of December 29, 2022. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record	F 0641	**F641 – Accuracy of Assessments**	12/29/2022

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

Shelley Miller | Chief Nursing Officer | 12/29/2022

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

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	review, the facility failed to ensure smoking assessments were completed for 1 of 2 residents reviewed. (Resident 10) Findings included: During an observation on 12/12/22 at 9:34 AM, Resident 10 was observed smoking with other residents in the designated smoking area outside the facility. Resident 10 was wearing a protective apron and staff was assisting with smoking materials. During an observation on 12/12/22 at 1:36 PM, Resident 10 was observed smoking with other residents in the designated smoking area outside the facility. Resident 10 was wearing a protective apron and staff was assisting with smoking materials. During an observation on 12/14/22 at 9:49 AM, Resident 10 was observed smoking with other residents in the designated smoking area outside the facility. Resident 10 was wearing a protective apron and staff was assisting with smoking materials. Resident 10's record was reviewed on 12/12/22 at 11:38 AM. Diagnoses included major depressive disorder, recurrent, severe with psychotic symptoms, cognitive social or emotional deficit following cerebral infarction, other cerebral infarction due to occlusion or stenosis of small artery, polyneuropathy in diseases classified elsewhere, anxiety disorder, unspecified. A Minimum Data Set (MDS) assessment, dated 10/18/22, indicated Resident 10 had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).		**SS=D** *"The facility failed to ensure smoking assessments were completed for 1 of 2 residents reviewed. (Resident 10)"* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 10 had smoking assessment completed and documented. **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 who smoke have the potential to be affected by this alleged deficient practice. · All residents who smoke were audited to ensure they have smoking assessments completed and documented. All assessments are in place. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in-serviced on:	

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	A facility nursing admission/readmission evaluation, dated 3/25/22, indicated, under the smoking evaluation, Resident 10 did not smoke. A physician progress note, dated 4/14/22, indicated Resident 10 was a current daily smoker. Resident 10 had smoked 1 pack of cigarettes per day for 46 years. A supervised smoking policy/contract, dated 4/11/22, was signed by Resident 10. The policy/contract included rules to be followed by the resident who wished to smoke, the designated smoking times, the facility's right to implement a behavioral contract, monitor, document all smoking related behaviors and the facility's rights when a resident violated the smoking policy. The policy/contract did not include an assessment of a resident that wished to smoke. A supervised smoking policy/contract, dated 10/22/22, was signed by Resident 10. The policy/contract included rules to be followed by the resident who wished to smoke, the designated smoking times, the facility's right to implement a behavioral contract, monitor, document all smoking related behaviors and the facility's rights when a resident violated the smoking policy. The smoking policy/contract did not include an assessment of a resident that wished to smoke. An independent activity tracking log for Resident 10, dated November 2022, was provided by the Director of Nursing on 12/13/22 at 11:07 AM. The log indicated Resident 10 smoked on November 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 21, 22, 23, 25, 26, 28, 29, and 30. An independent activity tracking log for Resident		o "Smoking Policy", including completion and documentation of smoking assessments. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will audit all newly admitted residents daily Monday thru Friday for 6 months and ongoing to ensure newly admitted residents who smoke have a smoking assessment completed and documented. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 12/29/2022	

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	10, dated December 2022, was provided by the Director of Nursing on 12/13/22 at 11:07 AM. The log indicated Resident 10 smoked on December 1, 2, 3, 5, 6, 7, 8, 9, 10, and 12. A care plan, initiated on 12/13/22, indicated Resident 10's desire to use tobacco products. The goals indicated Resident 10 would adhere to the facility's smoking policy and would not have any injuries related to smoking through the next review. The interventions indicated the facility was to complete smoking assessments as indicated. No care plan was in place for smoking prior to 12/13/22. No smoking assessments were in Resident 10's record. In an interview on 12/12/22 at 12:06 PM, RN 2 indicated an admission assessment, completed by a nurse, included a smoking assessment. RN 2 indicated social services might, also, do an assessment. In an interview on 12/12/22 at 1:50 PM, the Social Service Director (SSD) indicated an initial smoking assessment was to be done by nursing and quarterly assessments were to be done by the SSD. In an interview on 12/13/22 at 9:37 AM, the Director of Nursing (DON) indicated a resident's smoking status was assessed by a nurse in the admission/readmission assessment. If the response indicated the resident was a smoker, additional questions would populate to be answered. The DON indicated quarterly smoking assessments were to be done by the SSD. The DON indicated a resident's desire to smoke did not require a physician's order but "absolutely			

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	needed to be care planned." In an interview on 12/13/22 10:11AM, the Regional Director indicated a care plan should be completed if a resident desired to smoke. The Regional Director indicated when a resident signed the facility smoking policy/contract, it indicated the resident was assessed for smoking. No resident assessment questions were found within the facility smoking policy/contract. A current policy, titled Smoking Policy, dated 12/2022, indicated under Procedure: " ...3. Assessments of residents a. Each resident who smokes must have a smoking assessment completed upon admission, quarterly and with significant change in condition by Social Services or designee. b. Smoking assessment will determine the amount of supervision required for each resident. Supervision requirements will be care planned and communicated to staff monitoring smoking ...."			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.			

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	(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, and interview, the facility failed to ensure the daily report of nursing staff directly responsible for resident care was accurately posted. 36 residents currently resided in the facility. Findings included: In an observation on 12/11/2022 at 11:28 AM, the daily staffing post located on the wall next to the nurse's station was composed of single sheet, dated 11/22/2022. In an observation on 12/11/2022 at 12:30 PM, the daily staffing post continued to show the date of 11/22/2022.	F 0732	**F732 – Posted Nurse Staffing Information** **SS=C** *"The facility failed to ensure the daily report of nursing staff directly responsible for resident care was accurately posted. 36 residents currently resided in the facility."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The daily report of nursing staff directly responsible for	12/29/2022

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	In an observation on 12/11/2022 at 1:05 PM, the same daily staffing post continued to show the date of 11/22/2022. Floor staff walked past the daily staff post without acknowledgement. An interview with the Director of Nursing at 1:07 PM, indicated there was a floor nurse in charge of changing the staff post, this staff member worked during the week, and the post should be changed every day. An interview with RN 2 on 12/12/2022 at 12:05 PM, indicated she had not been told she was in charge of changing the daily staff post. The posting was usually done on 3rd shift since it was easier to change because the day would begin on their shift, she did not know it was her responsibility. A policy, Nurse staffing posting policy and procedure, dated 8/2022. Was provided by the Director of Nursing on 12/12/2022 at 11:57 AM. The policy indicated ..." Posting of information will be completed by the designated person in each facility ...Data requirements, Facility name, current date, total number of actual hours worked in the categories of Registered Nurses, Licenses Practical nurses, Qualified Medication Aides, and Certified Nurses Aides and Resident Census ...."		resident care was posted. · No residents were affected by this alleged deficient practice. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have potential to be affected by this alleged deficient practice. · DNS/designee will post the daily report of nursing staff directly responsible for resident care seven days a week. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · DNS will be in-serviced on: “Nursing Staffing Posting 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?** · ED/designee will audit the daily report of nursing staff directly responsible for resident care three times a week x 4 weeks, then twice a week x 8/ weeks, then weekly x 3 months to ensure the	

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			daily report of nursing staff directly responsible for resident care is posted seven days a week. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. . **5. Date of completion:** 12/29/2022	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the			

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	reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review the facility failed to ensure a medication prescribed had an appropriate diagnosis for 1 of 5 residents reviewed. (Resident 134). Findings include: In an interview on 12/12/22 at 9:26AM, Resident 134 indicated she took medications but was unsure for what purpose. Resident 134's record review began on 12/12/22 at 2:18PM, indicated Resident 134 had the following diagnoses: displaced fracture of right clavicle, pneumonia, chronic lung disease, recurrent and persistent hematuria, hyperglycemia, A fib, acute and chronic respiratory failure, major depressive disorder recurrent, anxiety disorder, coronary artery bypass, and burn of 2nd degree to thigh. Resident 134's diagnoses list did not include a history of migraines or a seizure disorder. An admission MDS (minimum data set) assessment section I (active diagnosis), completed on 12/1/22 indicated diagnoses were: fracture, A fib, pneumonia, anxiety disorder, depression, chronic lung disease, respiratory failure, recurrent hematuria, hyperglycemia, burn, and atherosclerosis. The MDS did not indicate a diagnosis of seizure or migraine. Resident 134's current care plan did not indicate a problem area of seizures or migraines. Resident 134 had an order for Topiramate Tab 200mg to be given by mouth twice a day for seizures started on 11/23/22. Resident 134's medication administration record (MAR) dated	F 0757	**F757 – Drug Regimen is Free from Unnecessary Drugs** **SS=D** *"The facility failed to ensure a medication prescribed had an appropriate diagnosis for 1 of 5 residents reviewed. (Resident 134)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 134's diagnosis for medication was corrected. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by this alleged deficient practice. · 100 % audit was completed on all active resident medications to ensure the appropriate diagnoses were in place for each medication. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?**	12/29/2022

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	December 2022 indicated the medication was documented as given twice a day on December 1st through December 11th. In an interview on 12/13/22 at 8:29AM, the DON indicated Resident 134 was taking Topiramate for migraines. The DON indicated the diagnosis was entered incorrectly in system. The DON indicated for admissions a nurse was to put the orders in and a second nurse then was to verify the physician orders were correct. The DON indicated there was no diagnosis of migraine or treatment plan for migraines in Resident 134's record. On 12/13/22 at 2:40PM the current facility policy was reviewed. A policy titled, "Physician Services/Orders" effective 09/30/2022, provided by DON 12/13/22 at 2:30PM, indicated ....3. The physician will perform pertinent, timely medical assessments, prescribe an appropriate medical regimen .... 3.1-48(a)(4)		· All licensed clinical staff will be in-serviced on: “Physician Services/Orders” **4.How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/Designee will complete random audits on 3 residents with new medication orders three times a week x4 weeks, then twice a week x8 weeks, then weekly x3 months to ensure active medications have appropriate diagnoses for each medication. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved **5 Date of completion:** 12/29/2022	
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.			

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	§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, interview, and record review the facility failed to ensure insulin was dated when opened for 3 residents, in 1 of 2 medication storage carts observed. (Resident 14, Resident 12, and Resident 1). Findings include: During an observation, on 12/13/22 at 8:02AM with QMA 3, 3 insulin pens and a bottle of insulin without an open date were observed. In an interview with QMA 3, she indicated all meds should be labeled with an open date when they are first opened. QMA 3 indicated insulin is considered opened when it is taken from the refrigerator and put into the cart. QMA 3 was unable to determine when the 4 containers of insulin were put into the cart. In an interview, on 12/13/22 at 9:06AM the DON	F 0761	**F761 – Label/Store Drugs and Biologicals** **SS=D** *"The facility failed to ensure insulin was dated when opened for 3 residents, in 1 of 2 medication storage carts observed. (Resident 14, Resident 12, and Resident 1)."* **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 14, 12 and 11's insulins were discarded and new vials opened and dated. **2. How other residents having the potential to be**	12/29/2022

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	indicated all medications should be labeled with a pharmacy label and should have an open date. 1) Resident 14's record review began on 12/13/22 at 9:22AM. The record indicated diagnoses included type 2 diabetes mellitus with diabetic neuropathy. Resident 14 had a physician's order for Lantus SoloStar solution pen injector, (an insulin) give 55 units twice daily. In the 400 hall med cart Resident 14's insulin pen was observed with approximately 160units remaining and no open date was found. Resident 14's medication administration record dated December 2022 indicated documentation insulin utilizing the pen was given twice a day from December 1st through December 12th. 2) Resident 12's record review began on 12/12/22 at 10:54AM. The record indicated diagnoses included type 2 diabetes without complications. Resident 12 had physician orders for Insulin Degludec solution injection 20units daily and Insulin Lispro solution per sliding scale. In the 400 hall cart Resident 12's Degludec insulin pen was observed without an open date and with approximately 20 units remaining. Resident 12's lispro (insulin) was observed in cart without an open date. Resident 12's medication administration record for December 2022 indicated documentation insulin Lispro was administered: December 1st at 8:00PM December 3 at 11:30am and 8PM December 4 at 11:30AM, 4:30PM, and 8PM		**affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents on insulin have the potential to be affected by this alleged deficient practice. · All medication carts were inspected to ensure all opened insulins were dated. All opened insulins are dated. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All licensed clinical staff will be in serviced on the following o "Medication Receipt, Labeling and Destruction Policy and Procedure" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/Designee will inspect/audit two medication carts twice weekly x3 months then once weekly x3months to ensure all opened insulins are dated. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 00 B. WING	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF BERNE	1065 PARKWAY ST BERNE, IN 46711

(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
	December 5 at 4:30PM December 6 at 8PM December 7 at 4:30PM and 8PM December 8 at 4:30PM December 9 at 4:30PM December 10 at 11:30AM December 12 at 4:30PM and 8PM Resident 12's medication administration record for December 2022, indicated documentation of administration of Degludec 20units daily in am for December 1st-14th. 3) Resident 1's record review began on 12/13/22 at 9:30AM. The record indicated diagnoses included type 2 diabetes mellitus without complications. Resident 1 had a physician's order for Insulin Lispro per sliding scale. In the 400-hall med cart Resident 1's insulin was observed without an no open date. Resident 1's medication administration record for December 2022 indicated documentation Resident 1 was administered Lispro at 8PM on December 1, 3, 4, 5, 6, 8, 9, 10, 11, and 12th. On 12/15/22 at 11:16AM the current facility policy was reviewed. A policy titled, "Medication Receipt, Labeling, and Destruction Policy and Procedure" effective 8/29/2022, provided by the Regional Nurse Constultant on 12/15/22 at 11:08AM, indicated ...."3. Items such as insulin, eye drops,, etc, will be dated when opened"... 3.1-25(k)(6)		results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 12/29/2022	