STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Sullivan	325 W Northwood Dr Sullivan, IN 47882

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on observation, interview, and record review, the facility failed to ensure accurate staffing sheets were posted daily for 3 of 5 days during the recertification survey. Finding includes: During an observation, on 4/15/24 at 12:40 p.m., the staffing sheet posted on the wall across from the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. During an observation, on 4/16/24 at 11:08 a.m., the staffing sheet posted on the wall across form the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. During an interview, on 4/17/24 at 8:48 a.m., the Director of Nursing (DON) indicated she was not aware the staffing sheet posted was not completed accurately. She indicated the night shift nurse was responsible for making sure the sheet was posted and was completed accurately. The staffing sheet was to be posted at midnight every night shift. The total number of hours and the actual hours worked by staff should be on the sheet. The DON indicated she would have to address the issue at the next in-service meeting. During an observation, on 4/19/24 at 9:00 a.m., the staffing sheet posted on the wall across from the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. On 4/17/24 at 10:50 a.m., the DON provided a document, with a revised date of August 2022, titled, Posting Direct Care Daily Staffing Numbers, and indicated it was the policy currently being used by the facility. The policy indicated, .1. At the beginning of each shift, the number of licensed nurses . and the number of unlicensed nursing personnel . directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed [NAME] non licensed nursing staff working for the posted shift

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 35317 Based on observation, record review, and interview, the facility failed to ensure proper administration of inhaled medication during the medication administration pass for 1 of 3 residents observed, resulting in a medication error rate of 6.67% (Resident 6). Finding includes: During a medication administration observation, on 4/17/24 at 9:01 a.m., Licensed Practical Nurse (LPN) 7 was administering an Advair (medication used to prevent asthma symptoms) inhaler (small handheld devices that allows you to breath medicine through your mouth, directly to your lungs) to Resident 6. Resident 6 then handed the inhaler back to the nurse and the nurse immediately gave the resident a Spiriva (medication used to prevent bronchospasms) inhaler to use. The resident did not rinse and spit after the use of the first inhaler nor did she wait in between administering the two inhaled medications. Resident 6's record was reviewed on 4/17/24 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, emphysema (a condition that causes shortness of breath), unspecified asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe). A physician order, dated 3/8/24, indicated Advair Diskus inhalation powder breath 100-50mcg (micrograms) one puff inhale orally two times related to emphysema. A physician order, dated 2/28/24, indicated Spiriva Handihaler inhalation capsule 18mcg inhale orally one time a day for emphysema. A care plan, dated 6/13/23, indicated the resident is at risk for impaired gas exchange related to asthma and emphysema. Interventions included, but were not limited to, administer medication as ordered and monitor for signs and symptoms of respiratory distress and repot to medical doctor. During an interview, on 4/18/24 at 9:04 a.m., LPN 10 indicated the resident should rinse and spit after use of inhaled medications and should wait several minutes in between administrating multiple inhalers to the same resident. During an interview, on 4/18/24 at 9:24 a.m., Registered Nurse (RN) 9 indicated she would wait several minutes in between administering inhaled medications to the same resident. The RN indicated the resident should rinse and spit after use of inhaled medications to prevent thrush (a fungal infection typically on the skin or mucous membranes). During an interview, on 4/18/24 at 11:51 a.m., the [NAME] President of Clinical Operations, indicated with a steroid inhaler the nurse should have had the resident swish and spit after use per manufacturer guidelines. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 11:20 a.m., the [NAME] President of Clinical Operations provided an undated document, titled, Oral and Nasal Inhalation Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .7. If more than one inhalation is ordered, wait one minute then repeat steps one to six for each inhalation ordered On 4/18/24 at 11:40 a.m., the [NAME] President of Clinical Operations provided a document, dated April 2008, titled, Adviar Diskus and indicated it was the policy currently being used by the facility. The policy indicated, .After each dose, rinse your mouth with water and spit the water out. Do not Swallow 3.1-48(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35317 Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of properly for 1 of 1 medication storage room reviewed for medication storage. Finding includes: On 4/18/24 at 10:31 a.m., the medication storage room contained an opened multi-use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution and had an open date of 2/27/24. On 4/18/24 at 10:33 a.m , the medication storage room contained an opened multi-use vial of flu vaccine solution and had an open date of 11/2/23. During an interview, on 4/18/24 at 10:35 a.m., Registered Nurse (RN) 9 indicated she was not aware of the facility policy for how long the medication was good for once it was opened but did believe they needed to be discarded. During an interview, on 4/18/24 at 10:51 a.m., the Administrator indicated the medication vials were expired. During an interview, on 4/18/24 at 11:20 a.m., [NAME] President of Clinical Operations indicated both the medications should have been discarded and were expired. On 4/18/24 at 11:20 a.m., the [NAME] President of Clinical Operations provided as a current facility policy, titled, Medication with Shortened Expiration Dates, dated 2/11/21. The policy indicated, .Aplisol discard vials 30 days after initial use .Flu Vaccine discard 28 days after initial use 3.1-25(j)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34525 Based on observation, record review, and interview, the facility failed to ensure refrigerator temperature logs were maintained for 5 of 15 days in April and freezer temperature logs were maintained for 2 of 15 days in April. Findings include: During the initial kitchen tour, on 4/15/24 at 10:10 a.m., with the housekeeping supervisor, the temperature logs for the walk-in refrigerator and walk-in freezer were observed to have not been completed. At the same time, the housekeeping supervisor indicated she was filling in as the cook for that day. The regular cook, had the day off. The walk-in refrigerator temperature log, was observed sitting on a shelf in the dry storage area. The log lacked documentation of the refrigerator's temperatures for 4/1/24, 4/11/24, 4/12/24, 4/13/24, and 4/14/24. At the same time, the housekeeping supervisor documented the temperature of the walk-in refrigerator for the date of the initial tour, on the log. The walk-in freezer temperature log, was observed posted on the door of the walk-in freezer. The temperature log lacked documentation of the freezer's temperatures for 4/13/24 and 4/14/24. At the same time, the housekeeping supervisor documented the temperature of the walk-in freezer for the date of the initial tour, on the log. During an interview, on 4/15/24 at 10:15 a.m., the housekeeping supervisor indicated she was not sure why the temperature logs had not been completed, or why the refrigerator log was not hanging on the door as it usually was. During an interview, on 4/15/24 at 10:17 a.m., dietary aide 17 indicated he was not aware that the logs had not being completed or why the refrigerator log was not hanging on the door. His understanding was that the temperatures should be checked and documented every day. On 4/16/24 at 11:00 a.m., the dietary manager provided a document, dated 1/2023, titled, Kitchen Operations: Food Storage, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .11. Refrigeration: .b. Thermometers should be checked utilizing an internal thermometer at least two times each day .12. Frozen Foods: a. Temperatures for the freezer should .be checked at least two times daily 3.1-21(i)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34525 Based on record review and interview, the facility failed to ensure the documentation of wound treatments being completed for 1 of 2 residents reviewed for pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) (Resident 25). Findings include: Resident 25's record was reviewed on 4/17/24 at 11:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose is too high), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). An admission Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 3/21/24, indicated the resident had severe cognitive deficit and was at risk for development of pressure ulcers. A care plan, dated 3/30/24, indicated the resident was at risk for impaired skin integrity related to incontinence of bowel and bladder (the inability to control the flow of urine from the bladder or the escape of stool from the rectum), weakness, impaired mobility, and need for assistance with activities of daily living (ADLs-activities related to personal care). A physician's order, dated 3/13/24, indicated weekly skin assessment, every day shift, every Wednesday morning for monitoring. The March 2024 treatment administration record (TAR) lacked documentation of an assessment having been completed on 3/27/24. A physician's order, dated 3/13/24, indicated float heels while in bed. Every shift for monitoring. The March TAR lacked documentation of the order being completed as written on 3/27/24. The April 2024 TAR lacked documentation of the order being completed as written on 4/4/24. A physician's order, dated 3/13/24, indicated offer/assist to turn/reposition resident. Every 2 hours for skin breakdown prevention. The March TAR lacked documentation of the order being completed as written on 3/27/24, at 8:00 a.m., 10:00 a.m., 12:00 p.m., and 4:00 p.m. The April 2024 TAR lacked documentation of the order being completed as written on 4/4/24, at 8:00 a.m., 10:00 a.m., 12:00 p.m., and 4:00 p.m. A wound and skin progress note, dated 3/26/24 at 9:09 a.m., indicated the resident had a deep tissue injury (DTI-purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) noted to her left buttocks. Treatment orders were provided, at that time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 3/26/24, indicated wound assessment to the left buttocks. Every day and night shift for wound care. The March TAR lacked documentation of the order being completed as written on the day shift of 3/27/24. The April 2024 TAR lacked documentation of the order being completed as written on the day shift of 4/4/24. A physician's order, dated 3/26/24, indicated apply triad paste (treatment that allows natural moisture spreads evenly across the wound surface, maximizing contact and creating a moist environment) to bilateral (both sides) buttocks every day and night shift for wound care. The March TAR lacked documentation of the order being completed as written on the day shift of 3/27/24. A physician's order, dated 3/28/24, indicated may use low air loss mattress (designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown). Check functioning every day and night shift. The April 2024 TAR lacked documentation of the order being completed as written on the day shift of 4/4/24. A wound and skin progress note, dated 4/2/24 at 8:29 a.m., indicated the area to the resident's left buttocks had been restaged to a stage 3 pressure ulcer (full thickness tissue loss where subcutaneous [beneath, or under, all the layers of the skin] fat may be visible). New treatment order to cleanse with wound cleanser, apply hydrogen (dressings that provide a mechanical barrier and moist wound environment), and cover with border foam. During an interview, on 4/17/24 at 3:15 p.m., the Director of Nursing (DON) indicated the TAR should always be signed off when the treatment was completed. Without a signature, there was no way to ensure the treatment was completed as ordered. On 4/17/24 at 3:07 p.m., the DON provided a document, dated 2020, titled, Medication Administration and General Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, . Procedure: .11. The resident's .administration record is initialed by the person administering the medication . Or if utilizing and Electronic Medical Record, the initials of the nurse are electronically stamped into the record 3.1-50(a)(1)