STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155480	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Brookville	11049 State Road 101 Brookville, IN 47012

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30344 Based on observation, interview, and record review, the facility failed to ensure treatments were completed and documented on night shift and a resident had a fall intervention in place for 5 of 5 residents reviewed for unnecessary medications and 1 of 2 residents reviewed for falls. (Residents C, G, 7, 9, 24, and 36) Findings include: 1. a) The clinical record 7 was reviewed on 2/25/25 at 12:47 p.m. His diagnoses included, but were not limited to, Parkinson's disease. The 1/12/25 Accident & Incident Report and Investigation indicated Resident 7 had a fall from his wheelchair at the nurse's station on 1/12/25 at 6:51 p.m. He attempted to stand up. A CNA (Certified Nurse Aide) ran to try and catch him but was unable to reach him in time. He fell , striking his head on a bedside table. He suffered a laceration to the top of his head, a laceration to his top lip, and was sent to the emergency room . The 1/12/25 emergency department notes indicated he had a large laceration to his scalp that was repaired with a total of nineteen staples and a smaller laceration to his upper lip that was repaired with four stitches. The 1/13/25 at risk for falls care plan indicated an intervention was hipsters/padded undergarments to be worn when up, initiated 1/13/25. An observation of Resident 7 was made on 2/27/25 at 2:34 p.m. He was sitting in his wheelchair in front of the nurse's station. An interview was conducted with the DON (Director of Nursing) and CNA 5 on 2/27/25 at 2:34 p.m. The DON indicated she didn't know Resident 7 was supposed to wear hipsters when up. The DON inquired with the ADON (Assistant Director of Nursing) via telephone, and indicated the ADON didn't know anything about it either. CNA 5 indicated he wasn't currently wearing hipsters and didn't wear anything like that. The Assessing Falls and Their Causes policy was provided by the DON on 2/27/25 at 3:10 p.m. It indicated, Review the resident's care plan to assess for any special needs of the resident . Assemble the equipment and supplies as needed. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. b) The clinical record for Resident 7 was reviewed on 2/25/25 at 12:47 p.m. His diagnoses included, but were not limited to, Parkinson's disease, heart disease, and hypertension. The 1/29/25 care plan indicated Resident 7 had impaired skin integrity related to decreased mobility, fragile skin, and incontinence. The 2/10/25 anticoagulant medication care plan indicated he had the potential for hemorrhage due to his use of Eliquis. The goal was for him to have no signs or symptoms of hemorrhage through the next review. An intervention was to monitor for signs and symptoms of adverse reactions. The physician's order for Resident 7 indicated to monitor for signs and symptoms of bruising and bleeding, and to notify medical provider with complications, every shift starting 1/1/25; to apply house barrier cream to peri-area and buttocks every shift, starting 1/1/25; and to float heels while in bed every shift, starting 1/1/25. The February 2025 TAR (treatment administration record) indicated the signs and symptoms of bruising and bleeding were not monitored every night shift the entire month; the house barrier cream was not applied to his peri-area and buttocks every night shift the entire month; and his heels were not floated while in bed the entire month. 2. The clinical record for Resident 9 was reviewed on 2/27/25 at 11:14 a.m. Her diagnoses included, but were not limited to, peripheral vascular disease and chronic obstructive pulmonary disease (COPD). The 1/22/25 COPD care plan indicated the goal was for her to have optimal breathing patterns daily with an intervention for the head of her bed to be elevated to her preference. The 1/22/25 care plan indicated she had the potential for skin breakdown related to incontinence and assistance required for bed mobility. The physician's orders for Resident 9 indicated to apply moisture barrier to bilateral buttocks at bedtime for prevention, starting 12/30/24; apply skin prep to bilateral heels at bedtime, starting 12/30/24; apply house barrier cream to peri-area and buttocks every shift, starting 12/30/24; encourage her to keep her feet elevated on a pillow while in bed and check every shift, starting 12/30/24; apply skin repair cream to chest/back/stomach every shift, starting 12/30/24; monitor for signs and symptoms of bruising and bleeding, and to notify medical provider with complications; and to elevate the head of her bed to her preference to alleviate/avoid shortness of breath while lying flat every shift, starting 1/22/25. The February 2025 TAR indicated the moisture barrier to bilateral buttocks at bedtime was not applied every night shift the entire month; the skin prep to bilateral heels was not applied at bedtime the entire month; the house barrier cream to peri-area and buttocks was not applied every night shift the entire month; she was not encouraged to keep her feet elevated on a pillow while in bed every night shift the entire month; the skin repair cream to her chest/back/stomach was not applied every night shift the entire month; she was not monitored for signs and symptoms of bruising and bleeding every night shift the entire month; and the head of her bed was not elevated to her preference every night shift the entire month. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45291 3. The clinical record for Resident 36 was reviewed on 2/26/2025 at 11:30 a.m. The medical diagnosis included Parkinson's disease. A Quarterly Minimum Data Set assessment, dated 11/27/2024, indicated Resident 36 was cognitively intact and did not have skin alterations. A care plan, revised 12/2/2024, indicated Resident 36 was at risk for developing skin alterations. A physician order, dated 12/31/2024, indicated to utilize barrier cream to peri-area and buttocks. Review of the February 2025 TAR for Resident 36 indicated the night shift administrations for barrier cream were not recorded as completed. 4. The clinical record for Resident C was reviewed on 2/25/2025 at 11:38 a.m. The medical diagnoses included chronic kidney disease, extended spectrum beta-lactamase (ESBL) resistance, and urinary tract infections. A Quarterly Minimum Data Set assessment, dated 12/23/2024, indicated Resident C was cognitively intact, utilized an indwelling urinary catheter, and received isolation due to infectious disease. A care plan, revised 10/23/2024, indicated Resident C utilized an indwelling urinary catheter for management of obstructive uropathy. Interventions included providing catheter care every shift. A physician order for Resident C, dated 12/30/2024, indicated to apply skin prep to heels at bedtime for prevention. A physician order, dated 12/31/2024, indicated Resident C to have barrier cream to peri-area and buttocks. A physician order, dated 12/31/2024, indicated to assess Resident C's indwelling urinary device every day and night shift. A physician order, dated 12/31/2024, indicated to complete catheter care every shift for Resident C. A physician order, dated 12/31/2024, indicated to ensure Resident C's head of bed was elevated as tolerated every day and night shift. A physician order for Resident C, dated 12/31/2024, indicated to record the amount of output every shift and report to medical doctor if output was less than 240 milliliters (ml). Review of the February 2025 TAR for Resident C indicated the night shift administrations for barrier cream, catheter care and associated orders as aforementioned, and skin prep were not documented as completed. 50436 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. The clinical record for Resident 24 was reviewed on 2/26/25 at 9:54 a.m. The diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, and overactive bladder. Physician's orders, dated 12/29/24, indicated Resident 24 had orders for catheter care every shift, to monitor catheter output every shift, and verify catheter was anchored every shift. The TAR was provided by the Chief Nursing Officer (CNO) on 2/27/25 at 2:15 p.m. The TAR indicated no catheter care, catheter output, or verification of catheter being anchored was documented for night shift from 2/1/25 to 2/25/25. 6. The clinical record for Resident G was reviewed on 2/26/25 at 10:02 a.m. The diagnoses included, but were not limited to, dementia and peripheral vascular disease. Physician's orders, dated 12/30/24, indicated Resident G had orders to document keeping the head of the bed elevated to alleviate/avoid shortness of breath while lying flat every shift, to monitor oxygen saturations every shift, and to apply oxygen at or up to two liters per minute, to maintain saturation levels greater than 90%. The TAR was provided by the CNO on 2/26/25 at 12:45 p.m. The TAR indicated Resident G had no documentation on night shift, from 2/1/25 to 2/25/25, for keeping the head of the bed elevated or monitoring oxygen levels. Resident G had physician orders, dated 12/30/24, to apply house barrier cream to peri-area and buttocks every shift. During review of the TAR for February 2025, no documentation for application of barrier cream was documented for night shift from 2/1/25 to 2/25/25. A physician's order, dated 2/10/25, indicated Resident G had orders for bacitracin ointment (topical) to RLE (right lower extremity) two times daily and hydrocortisone external cream 1% to be applied to BLE (bilateral lower extremities) two times a day. The February 2025 TAR indicated there was no documentation of these treatments during night shift from 2/10/25 to 2/25/25. During an interview with the Director of Nursing (DON) on 2/26/25 at 12:05 p.m., they indicated the computer system should flag if nurses were not charting what they were supposed to be charting and checking off. They did not know why there was no documentation recorded for treatments on night shift. The treatments are not popping up on the nightly scheduled medication pass on the medication administration record (MAR). The DON indicated it was found the night shift nurses did not have access to the TAR when they transitioned from one electronic health record (EHR) computer system to a different EHR computer system on 1/1/25. During an interview with the CNO on 2/26/25 at 1:52 p.m., they indicated the night shift nurses did not have the availability to see the night shift TAR due to a security issue. He wasn't sure if they were doing it. The nurses can see the MAR, but not the TAR. It was on the label, and he would expect a competent nurse to look at the label and order to know to administer it. The CNO indicated they did not know it was an issue until today, 2/26/25, when it was discovered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Qualified Medication Aide (QMA) 3 on 02/26/25 at 04:45 p.m., they indicated treatments were not scheduled at night and she had access to the TAR, but nothing triggered at night. QMA 3 indicated if any treatments were due, they trigger on the TAR to let the nurse know something needed to be done. During an interview with QMA 4 on 02/27/25 at 09:51 a.m., she indicated she did not have any treatments ordered right now at nighttime. QMA 4 indicated nothing had been triggering on the TAR for administration. During an interview with the CNO on 02/27/25 at 11:13 a.m., they indicated, It's our expectation that physician's orders are followed, it's a standard of care. A Prevention of Pressure Injuries policy was provided by the CNO on 2/26/25 at 3:40 p.m. It indicated, .7. Use a barrier product to protect skin from moisture .20. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice . A Catheter Care, Urinary policy was provided by the CNO on 2/27/25 at 2:17 p.m. It indicated the following, . Documentation: The following information should be recorded in the resident's medical record . 57. The date and time that catheter care was given., 58. The name and title of the individual(s) giving the catheter care . A Medication Therapy policy was provided by the CNO on 2/26/25 at 3:40 p.m. The policy indicated the following, .2. All decisions related to medications shall include appropriate elements of the care process, such as: a. adequately detailed assessment; b. review of causes of symptoms . A Pulse Oximetry (Assessing Oxygen Saturation) policy was provided by the DON on 2/27/25 at 10:00 a.m. The policy indicated the following, .8. Assess the resident for the following signs and symptoms of impaired oxygen saturation: a. altered respirations, c. cyanotic appearance, d. restlessness, irritability, e. confusion . Documentation: The SaO2 flow sheet should be placed in the medical record. In addition, the following information should be recorded in the resident's medical record: 30. the date and time that the procedure was performed, 32. the assessment data gathered prior to the procedure, 34. any unusual findings, 36. the signature and title of the person performing the procedure . An Administering Medications policy was provided by the DON on 2/26/25 at 1:15 p.m. The policy indicated the following, .4. Medications are administered in accordance with prescriber orders, including any required time frame .24. Topical medications used in treatments are recorded on the resident's treatment record (TAR) . 3.1-37(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 30344 Based on interview and record review, the facility failed to monitor and document target behaviors for 5 of 5 residents reviewed for unnecessary medications. (Residents C, G, 7, 9, and 36) Findings include: 1. The clinical record for Resident 7 was reviewed on 2/25/25 at 12:47 p.m. His diagnoses included, but were not limited to, depression and insomnia. The 1/29/25 care plan indicated he used an antidepressant medication related to depression. An intervention was to administer the medication as ordered by the physician and monitor/document side effects and effectiveness every shift. The 2/11/25 care plan indicated he had a diagnosis of insomnia. The physician's orders indicated to administer one 50 milligrams (mg) tablet of sertraline daily, effective 1/9/25, for depression and one 5 mg tablet of melatonin at bedtime, starting 1/8/25, for insomnia/sleeplessness. They indicated to monitor for the following behaviors related to depression, starting 1/1/25: tearfulness, withdrawn, agitation, excessive crying, or social isolation, and at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behaviors, and how he responded to redirection; and related to insomnia, starting 1/1/25, at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behavior, and how he responded to redirection. The February 2025 TAR (treatment administration record) indicated the above behaviors related to Resident 7's depression and insomnia were not monitored and documented for frequency, intensity, and response to redirection on night shift the entire month. 2. The clinical record for Resident 9 was reviewed on 2/27/25 at 11:14 a.m. Her diagnoses included, but were not limited to, depression, anxiety, mood disturbance, pseudobulbar effect, and dementia. The 1/22/25 care plan indicated she required the use of anticonvulsant medication related to mood disturbance. The 1/22/25 care plan indicated she had a diagnosis of depression and, at times, may display triggers such as being short tempered, easily annoyed, trouble concentrating, and poor appetite. An intervention was to monitor/document for side effects and effectiveness. The 1/22/25 care plan indicated she used anti-anxiety medication related to anxiety and impulse disorder. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders indicated to administer one 0.5 mg tablet of alprazolam daily, effective 1/18/25, for anxiety; four 125 mg capsules of Depakote sprinkles every day, starting 2/10/25 and three 125 mg capsules of Depakote sprinkles every day, starting 2/10/25; and one 12.5 mg tablet of sertraline, starting 12/30/24, for depression. They indicated to monitor for psychosis, delusions, and hallucinations, starting 1/3/25, and at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behavior, and how she responded to redirection; the following behaviors related to depression, starting 1/3/25: tearfulness, withdrawn, agitation, excessive crying, or social isolation, and at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behaviors, and how she responded to redirection; and the following behaviors related to anxiety, starting 1/3/25: self reported nervousness, restlessness, sleeplessness, etc., and at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behavior, and how she responded to redirection. The February 2025 TAR indicated that the above behaviors were not monitored and documented for frequency, intensity, and response to redirection on night shift the entire month. 45291 3. The clinical record for Resident 36 was reviewed on 2/26/2025 at 11:30 a.m. The medical diagnoses included Parkinson's disease, anxiety disorder, and depression. A Quarterly Minimum Data Set assessment, dated 11/27/2024, indicated Resident 36 was cognitively intact. A psychotropic medication care plan, dated 11/18/2024, indicated Resident 36 utilized antidepressant medication. Interventions were listed as monitoring for adverse side effects and for behavior. A psychotropic medication care plan, dated 11/18/2024, indicated Resident 36 utilized antianxiety medication. Interventions were listed as monitoring for adverse side effects and for behavior. A physician order, dated 12/31/2024, indicated to monitor Resident 36 for target behaviors of depression every shift. A physician order, dated 12/31/2024, indicated to monitor Resident 36 for target behaviors of anxiety every shift. Review of the February 2025 TAR for Resident 36 indicated the night shift administrations for monitoring for target behaviors of psychotropic medications was not marked as completed. 4. The clinical record for Resident C was reviewed on 2/25/2025 at 11:38 a.m. The medical diagnoses included depression and anxiety disorder. A Quarterly Minimum Data Set assessment, dated 12/23/2024, indicated Resident C was cognitively intact. A psychotropic care plan, revised 12/10/2024, indicated Resident C utilized antidepressant medication. Interventions were listed as monitoring for adverse side effects and for behavior. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A psychotropic care plan, dated revised 12/10/2024, indicated Resident C utilized antianxiety medication. Interventions were listed as monitoring for adverse side effects and for behavior. A physician order, dated 12/31/2024, indicated to monitor Resident C for target behaviors of depression every shift. A physician order, dated 12/31/2024, indicated to monitor Resident C for target behaviors of anxiety every shift. Review of the February 2025 TAR for Resident C indicated the night shift administrations for monitoring for target behaviors of psychotropic medications were not indicated as completed. 50436 5. The clinical record for Resident G was reviewed on 2/26/25 at 10:02 a.m. The diagnoses included, but were not limited to, dementia and peripheral vascular disease. Physician orders for Resident G, dated 12/30/24, indicated Resident G was ordered divalproex sodium for mood and behaviors. A physician's order, dated 12/31/24, indicated Resident G was ordered sertraline for depression and aripiprazole for depression. Behavior monitoring every shift was indicated in the physician's orders for all three of these medications. They indicated to monitor for the following behaviors related to depression, starting 12/30/24: tearfulness, withdrawn, agitation, excessive crying, or social isolation, and at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behaviors, and how he responded to redirection; and related to psychosis, delusions and hallucinations starting 1/3/25, at the end of each shift, mark the frequency of how often the behavior occurred, the intensity of the behavior, and how he responded to redirection. The TAR was reviewed on 2/26/25 at 11:30 a.m. The TAR indicated no monitoring of behaviors were being done on night shift from 2/1/25 to 2/25/25. During an interview with the Director of Nursing (DON) on 2/26/25 at 12:05 p.m., they indicated the computer system should flag if nurses were not charting what they were supposed to be charting and checking off. They did not know why there was no documentation recorded for treatments on night shift. The treatments were not popping up on the nightly scheduled medication pass on the Medication Administration Record (MAR). The DON indicated it was discovered the night shift nurses did not have access to the TAR when they transitioned from one electronic health record (EHR) computer system to another EHR computer system on 1/1/25. During an interview with the Chief Nursing Officer (CNO) on 2/26/25 at 1:52 p.m., they indicated the night shift nurses did not have the ability to see the night shift TAR due to a security issue. He wasn't sure if they were doing it. The nurses can see the MAR, but not the TAR. It was on the label, and he would expect a competent nurse to look at the label and order to know to administer it. The CNO indicated they did not know it was an issue until today, 2/26/25, when it was discovered. During an interview with the CNO on 2/27/25 at 11:13 a.m., they indicated, It's our expectation that physician's orders are followed, it's a standard of care. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavioral Assessment, intervention and Monitoring policy was provided by the CNO on 2/27/25 at 2:15 p. m. The policy indicated, .6. The nursing staff will identify, document, and inform the physician about specific details regarding changes in the individual's mental status, behavior, and cognition, including . i. onset, duration, intensity, and frequency of behavioral symptoms . 3.1-37(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 30344 Based on interview and record review, the facility failed to monitor for side effects of psychotropic medications, as ordered, for 5 of 5 residents reviewed for unnecessary medications. (Residents C, G, 7, 9, and 36) Findings include: 1. The clinical record for Resident 7 was reviewed on 2/25/25 at 12:47 p.m. His diagnoses included, but were not limited to, depression. The 1/29/25 care plan indicated he used an antidepressant medication related to depression. An intervention was to administer the medication as ordered by the physician and monitor/document side effects and effectiveness every shift. The physician's orders indicated to administer one 50 milligrams (mg) tablet of sertraline daily, starting 1/9/25, for depression. They indicated to monitor for side effects of psychotropic medications every shift, starting 1/1/25. The February 2025 TAR (treatment administration record) indicated he was not monitored for side effects of psychotropic medications on night shift the entire month. 2. The clinical record for Resident 9 was reviewed on 2/27/25 at 11:14 a.m. Her diagnoses included, but were not limited to, depression, anxiety, mood disturbance, pseudobulbar effect, and dementia. The 1/22/25 care plan indicated she had a diagnosis of depression and at times, may display triggers such as being short tempered, easily annoyed, trouble concentrating, and poor appetite. An intervention was to monitor/document for side effects and effectiveness. The 1/22/25 care plan indicated she used anti-anxiety medication related to anxiety and impulse disorder. The goal was for her to be free from adverse reactions related to anti-anxiety therapy through the review date. The physician's orders indicated to administer one 0.5 mg tablet of alprazolam daily, effective 1/18/25, for anxiety, and one 12.5 mg tablet of sertraline, starting 12/30/24, for depression. They indicated to monitor for side effects of psychotropic medications every shift, starting 12/30/24. The February 2025 TAR indicated she was not monitored for side effects of psychotropic medications on night shift the entire month. 45291 3. The clinical record for Resident 36 was reviewed on 2/26/2025 at 11:30 a.m. The medical diagnoses included Parkinson's disease, anxiety disorder, and depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Minimum Data Set assessment, dated 11/27/2024, indicated Resident 36 was cognitively intact. A psychotropic medication care plan, dated 11/18/2024, indicated Resident 36 utilized antidepressant medication. Interventions were listed as monitoring for adverse side effects and for behaviors. A psychotropic medication care plan, dated 11/18/2024, indicated Resident 36 utilized antianxiety medication. Interventions were listed as monitoring for adverse side effects and for behavior. A physician order, dated 12/31/2024, indicated Resident 36 to receive antianxiety medication daily. A physician order, dated 1/23/2025, indicated Resident 36 received an antidepressant medication daily. Review of the February 2025 TAR for Resident 36 indicated the night shift administrations for monitoring side effects of psychotropic medications was not documented as completed. 4. The clinical record for Resident C was reviewed on 2/25/2025 at 11:38 a.m. The medical diagnoses included depression and anxiety disorder. A Quarterly Minimum Data Set assessment, dated 12/23/2024, indicated Resident C was cognitively intact. A psychotropic care plan, revised 12/10/2024, indicated Resident C utilized antidepressant medication. Interventions were listed as monitoring for adverse side effects and for behavior. A psychotropic care plan, revised 12/10/2024, indicated Resident C utilized antianxiety medication. Interventions were listed as monitoring for adverse side effects and for behavior. A physician order, dated 12/31/2024, indicated for Resident C to receive an antidepressant medication daily. A physician order, dated 12/31/2024, indicated for Resident C to receive an antianxiety medication daily. Review of the February 2025 TAR for Resident C indicated the night shift administrations for monitoring side effects of psychotropic medications was not documented as completed. 50436 5. The clinical record for Resident G was reviewed on 2/26/25 at 10:02 a.m. The diagnoses included, but were not limited to, dementia and peripheral vascular disease. Physician orders for Resident G, dated 12/30/24, indicated Resident G was ordered divalproex sodium. A physician's order, dated 12/31/24, indicated Resident G was ordered sertraline and aripiprazole. Psychotropic side effect monitoring every shift was indicated in the physician's orders for all three of these medications. (continued on next page)

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Envive of Brookville	11049 State Road 101 Brookville, IN 47012

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The TAR was reviewed on 2/26/25 at 11:30 a.m. The TAR indicated no monitoring of side effects for psychotropic medications were being done on night shift from 2/1/25 to 2/25/25. During an interview with the Director of Nursing (DON) on 2/26/25 at 12:05 p.m., they indicated the computer system should flag if nurses were not charting what they are supposed to be charting and checking off. They did not know why there was no documentation recorded for treatments on night shift. The treatments are not popping up on the nightly scheduled medication pass on the Medication Administration Record (MAR). The DON indicated it was found the night shift nurses did not have access to the TAR when they transitioned from one electronic health record (EHR) computer system to another EHR computer system on 1/1/25. During an interview with the Chief Nursing Officer (CNO) on 2/26/25 at 1:52 p.m., they indicated the night shift nurses did not have the ability to see the night shift TAR due to a security issue. He wasn't sure if they were doing it. The nurses can see the MAR, but not the TAR. It was on the label, and he would expect a competent nurse to look at the label and order to know to administer it. The CNO indicated they did not know it was an issue until today, 2/26/25, when it was discovered. A Psychotropic Medication Use policy was provided by the CNO on 2/27/25 at 2:15 p.m. It indicated, .2. Drugs in the following categories are considered psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics .13. Residents receiving psychotropic medications are monitored for adverse consequences, including: j. anticholinergic effects- flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation; k. cardiovascular effects- irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension; l. metabolic effects- increased cholesterol and triglycerides, poorly controlled or unstable blood sugar, weight gain; m. neurologic effects- agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and n. psychosocial effects- inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate . 3.1-48(b)(1) 3.1-48(b)(2)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45291 Based on interviews, observations, and record reviews, the facility failed to provide a diet that was palatable and attractive to 9 of 9 residents reviewed. (Residents G, H, J, 1, 14, 30, 35, 36, and 37) Findings include: 1. The clinical record for Resident 36 was reviewed on 2/26/2025 at 11:30 a.m. The medical diagnoses included Parkinson's disease. A Quarterly Minimum Data Set (MDS) assessment, dated 11/27/2024, indicated Resident 36 was cognitively intact and had no significant weight changes. A physician order, dated 12/30/2024, indicated Resident 36 received a regular diet. During an interview on 2/25/2025 at 12:35 p.m., Resident 36 indicated the food was terrible. The food was often too mushy to eat, has poor to no taste, and she goes without eating because of the quality of the food, or will just eat peanut butter and jelly sandwiches. She stated, Last night they gave us pea soup over mashed potatoes with Jello. It was so bad that I couldn't even eat it, so I just had candy that my [family] brings in. There was some yellow stuff on the side. I think it was supposed to be a vegetable, but I couldn't make out what it was. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. During an observation on 2/25/2025 at 12:55 p.m., Resident 36 was served a tray with what she described as an egg omelet, a piece of bread, and mashed broccoli, with some kind of pastry. Resident 36 attempted one bite of the eggs, broccoli, and roll before she indicated she could not eat the food provided because the eggs tasted awful, the broccoli was just mush, and the dessert was too dry. Resident 36 then ate part of her roll and then retrieved ice cream from her freezer to eat. 30344 2. An interview was conducted with Resident 14 on 2/25/25 at 11:25 a.m. They indicated the facility food was not good. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident 14 on 2/25/25 at 2:02 p.m. He indicated the above lunch meal was not good at all. He didn't eat the diced potatoes, because he didn't like them, and didn't eat the roll, because he didn't want it. 3. An interview was conducted with Resident 30 on 2/25/25 at 11:54 a.m. She indicated the facility food was horrible. Dinner last night was terrible, and she couldn't eat it. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. An interview was conducted with Resident 30 on 2/25/25 at 1:56 p.m. She indicated, in regards to the frittata, I don't know what that egg thing was. There was no taste at all, and she wasn't sure if there was broccoli or spinach in it. Every meal is bad. She didn't eat all of any of the above lunch meal. The potatoes were bland, but most stuff was. There was no spice or much flavor. The broccoli was dull with no flavor, no nothing, like they poured it in a pan and served it. She stated, I'm just hoping they can do better. How can it be so hard to fix a halfway decent meal. 4. An interview was conducted with Resident 37 on 2/24/25 at 1:23 p.m. He indicated some of the facility food was not fit to eat and poor quality. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. An interview was conducted with Resident 37 on 2/25/25 at 1:54 p.m. He indicated, in regard to the above lunch meal, the potatoes were not flavorful, and the frittata was bland and of different texture. 5. An interview was conducted with Resident J on 2/25/25 at 11:35 a.m. She indicated the facility food taste and quality was horrendous and inedible. It practically turns my stomach and I'm not a picky eater. The facility did not cook the food correctly and needed cooking lessons. Either they didn't know or didn't care. It had been this way for over a year. They discussed it in resident council, but nothing was ever done about it. It's very frustrating. She went to bed hungry many times, because the food was so bad, and she would eat pretty much anything. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. 50436 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The clinical record for Resident 1 was reviewed on 2/26/25 at 10:29 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic pain syndrome. During an interview with Resident 1 on 2/25/25 at 10:03 a.m., Resident 1 indicated the food had no taste, and was barely warm. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. During an interview on 2/25/25 at 12:47 p.m., Resident 1 indicated lunch was just plain lousy. It had no taste and he only took a few bites of it. Resident 1 indicated he would not eat it again, and also indicated he says that about every meal he received. A Quarterly MDS assessment, dated 1/2/25, indicated Resident 1 was cognitively intact. A physician's order, dated 1/1/25, indicated Resident 1 was ordered a regular diet, chopped meats texture, regular/thin consistency for mechanical soft. 7. The clinical record was reviewed for Resident G on 2/26/25 at 10:02 a.m. The diagnoses included, but were not limited to, dementia and chronic kidney disease. A Quarterly Minimum Data Set assessment, dated 2/18/25, indicated Resident G was cognitively intact. During an interview on 2/25/25 at 10:27 a.m., Resident G indicated he refused dinner the night before. He indicated the food had no taste. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. During an interview with Resident G on 2/25/25 at 12:49 p.m., he indicated his lunch had no taste or flavor. Resident G indicated he did not eat much because the taste was so bad. A physician's order, dated 12/30/24, indicated Resident G was ordered a regular diet, mechanical soft texture, regular/thin consistency. 8. The clinical record for Resident H was reviewed on 2/26/25 at 9:54 a.m. The diagnoses included, but were not limited to, Parkinson's disease and diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 1/9/25, indicated Resident H was cognitively intact. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident H on 2/25/25 at 11:44 a.m., he indicated the food was terrible. Resident H indicated the food did not have much taste and was very bland. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. During an interview with Resident H on 2/25/25 at 12:52 p.m., he indicated lunch tasted horrible, it had no taste, and was a bunch of mush. During an interview with Resident H on 2/26/25 at 12:51 p.m., he indicated lunch was not good and he did not know what he was eating. Resident H indicated the food was mushy and he had to request a replacement meal. A physician's order, dated 12/29/24, indicated Resident 24 was ordered a no added salt diet. 9. The clinical record for Resident 35 was reviewed on 2/26/25 at 10:09 a.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia and anorexia. An Annual Minimum Data Set assessment, dated 12/22/24, indicated Resident 35 was severely cognitively impaired. During an interview with Resident 35's husband, also her roommate, on 2/25/25 at 10:03 a.m., they indicated the food had no taste, was bland, and was barely warm when it arrived to them. A test tray of the facility lunch meal was provided by the Clinical Support on 2/25/25 at 12:10 p.m. It included a frittata, diced potatoes, broccoli, and a roll. Three out of four of the foods were yellow in color and did not appear appetizing. The frittata had a bland taste with an unappealing texture. The diced potatoes were bland tasting and lacked any flavor. The broccoli was overcooked, mushy, and bland tasting. The roll was soggy on the bottom from the broccoli juices. During an interview with Resident 35's husband on 2/25/25 at 12:47 p.m., he indicated Resident 35 had barely touched her food. He indicated the food tasted lousy today. During an interview with the Dietary Manager (DM) on 2/26/25 at 3:19 p.m., she indicated she had residents' voice concerns that they do not care for the food. The DM indicated the menu changed, on 1/1/25, and she thinks that was part of the concerns. The DM also indicated she has noticed a request for a lot more alternative foods since changing the menu. A General Food Preparation and Handling policy provided by the Chief Nursing Officer, on 2/26/25 at 3:40 p. m., indicated, .13. All food will be prepared by methods that preserve nutritive value, flavor, and appearance. Food will be attractively served at the appropriate temperature and in a form to meet the individual needs of the resident . This citation relates to Complaint IN00440035. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-21(a)(1) 3.1-21(a)(2)

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 50436 Based on observation, interview, and record review, the facility failed to ensure proper eating utensils were provided to 1 of 1 resident reviewed for assistive devices. (Resident 29) Findings include: During an observation on 2/25/25 at 12:44 p.m., Resident 29 was laying back in bed eating lunch. He had a curved spoon, regular fork, and regular dinner plate on his lunch tray. A carton of milk with a straw in it and a plastic cup with no handle that contained lemonade with a straw were also on the tray. The clinical record for Resident 29 was reviewed on 2/25/25 at 11:33 a.m. The diagnoses included, but were not limited to, flaccid hemiplegia (paralysis and loss of muscle tone on one side of the body) affecting left non-dominant side and dysphagia (difficulty swallowing). A Quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated Resident 29 was mildly cognitively impaired. The MDS indicated he received a mechanically altered diet, requiring a change in texture of food or liquids (e.g., pureed food, thickened liquids). A physician's order, dated 12/30/24, indicated Resident 29 was to have a plate guard with all meals as necessary, independence cup with handle and fluid control lid with every meal, and right-hand adaptive spoon and fork with meals. A therapy special instruction order, dated 12/30/24, indicated Resident 29 was to have scoop bowls and curved utensils on tray at all times. During an observation of Resident 29 on 2/26/25 at 12:47 p.m., he was laying back in bed with his lunch tray in front of him. A regular dinner plate, an adaptive spoon, regular fork, carton of milk with a straw in it, and a cup with no handle of lemonade and straw in it were noted on the lunch tray. During an interview with Licensed Practical Nurse 2 on 2/26/25 at 12:49 p.m., they indicated Resident 29 was to have a plate guard and specialized cup with a handle on every tray. During an interview with the Dietary Manager (DM) on 2/26/25 at 3:19 p.m., they indicated the kitchen was missing a lot of specialized utensils, because they kept coming up missing, and she needed to order more. She indicated only specialized spoons were available in the kitchen. The DM indicated dietary receives the nursing order for any specialized utensils needed for a resident and that information was printed on the resident's tray card, so dietary staff know each resident's special needs. The DM indicated she did not know why Resident 29 was not receiving a plate guard on his meal trays. An activities of daily living care plan provided by the Director of Nursing (DON), on 2/27/25 at 10:00 a.m., indicated Resident 29 was to be provided with adaptive equipment, if necessary. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Assistance with Meals policy was provided by the DON on 2/27/25 at 10:33 a.m. It indicated, .Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided by residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 2. Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils . 3.1-21(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45291 Based on interview and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP) for a resident with an indwelling medical device for 1 of 2 residents reviewed for catheters (Resident C). Findings include: The clinical record for Resident C was reviewed on 2/25/2025 at 11:38 a.m. The medical diagnoses included chronic kidney disease, extended spectrum beta-lactamase (ESBL) resistance, and urinary tract infections. A Quarterly Minimum Data Set assessment, dated 12/23/2024, indicated Resident C was cognitively intact, utilized an indwelling urinary catheter, and received isolation due to infectious disease. A care plan, revised 10/23/2024, indicated Resident C utilized an indwelling urinary catheter for management of obstructive uropathy. Interventions included providing catheter care every shift. A physician order, dated 12/31/2024, indicated Resident C had an indwelling catheter. During an interview with Resident C on 2/25/2025 at 11:20 a.m., she indicated staff do not utilize gowns with her when they assist with her catheter care. During a confidential interview conducted during the survey, Confidential Interviewee 1 indicated they did not know who was on transmission-based precautions, including EBP. They stated they use standard precautions for all residents and only utilize gloves when providing care for Resident C, including providing care for Resident C's indwelling medical device. During a confidential interview conducted during the survey, Confidential Interviewee 2 indicated they were not aware Resident C was on EBP. They stated Resident C does not have an EBP bin in the room, so they did not utilize EBP with Resident C when providing care, which included bed baths and catheter care. During an observation with Confidential Interviewee 2, Resident C's room had an EBP container, containing only a box of gloves, in the entry way of the room. The bin was covered in clean linen and spare pillows and a confidential interviewee stated, Oh, I never even know that was there. I thought it was just storage for [Resident C]. A policy entitled, Enhanced Barrier Precautions, was provided by the Assistant Director of Nursing on 2/26/2025 at 2:05 p.m. The policy indicated that EBP should be utilized to prevent the spread of multi-drug-resistant organisms (MDROs). EBP was to be used during high-contact resident care activities, including dressing, bathing, and device care such as care for a urinary catheter. EBP should have been used for residents with indwelling medical devices, including urinary catheters, and that signage should have been posted .in the door or wall outside the resident room . This citation relates to Complaint IN00440035. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-18(b)(2)