

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2024
NAME OF PROVIDER OR SUPPLIER  Envive of Anderson		STREET ADDRESS, CITY, STATE, ZIP CODE  1821 Lindberg Rd Anderson, IN 46012	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>32663</p> <p>Based on record review and interview, the facility failed to ensure medications were received from pharmacy in accordance with policy to ensure the safe handling of narcotics.</p> <p>Findings include:</p> <p>Review of a facility reportable, dated 11/25/24, indicated on 11/24/24, LPN 1 received medications from the pharmacy and did not secure a pill card of tramadol (opiod analgesic) immediately or properly. This deficient practice resulted in the 30 pill card becoming missing.</p> <p>Review of a written statement by LPN 1, provided by the facility, indicated on 11/24/24 at approximately 8:30 p.m., medications from the pharmacy were delivered to the facility. LPN 1 placed the 30 pill card of Tramadol (opiod analgesic) in the nurses' station, unsupervised. After checking the number of medications against the medications on the list, LPN 1 became distracted and placed the card of tramadol on the back of the desk in the nurses' station. As he continued with task throughout the shift, LPN 1 failed to realize the Tramadol had not been properly secured in the locked narcotic drawer of the medication cart. LPN 1 did not realize the medication were not present until the morning medication administration pass.</p> <p>LPN 1 was not available for interview during the survey.</p> <p>During an interview on 12/3/24 at 7:46 a.m., LPN 2 indicated medications from the pharmacy were checked and the nurse signed off receipt. If there were narcotics for another medication cart, the medications should be locked up in a cart until they could be delivered to the proper cart. Medications should never be left unsupervised.</p> <p>During an interview on 12/3/24 at 9:30 a.m., the DON indicated LPN 1 had received a medication delivery from the pharmacy. LPN 1 reported he had gotten distracted before he could put away the medications and left a card of tramadol at the nurses station. The card contained 30 pills. When LPN 1 returned to the nurses station, the medications were gone. The DON indicated medications should never be left at the nurses station. If something were to happen and he was unable to put all of the medications away, he should have locked them in the bottom of the medication cart.</p> <p>A current undated policy titled Controlled Medication-Ordering &amp; Receipt was provided by the DON on 12/3/24 at 9:30 a.m. The policy indicated the following:</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Medications listed in Schedule II, are stored under double lock in a locked cabinet or safe designed for that purpose, separated from all other medications. Alternatively, in a unit dose system, Scheduled III, IV, and V medications may be kept with other medications in the cart. In some States all controls must be secured in the lock box located in the medication cart if so, the State regulation will supersede.</p> <p>7. The medication nurse on duty maintains possession of a key to controlled medications. The Director of Nursing keeps back-up keys to all medication storage areas, including those for controlled medications.</p> <p>This citation relates to Complaint IN00447984.</p> <p>3.1-25(n)</p>