STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Hartford City	715 N Mill St Hartford City, IN 47348

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45122 Based on interview and record review, the facility failed to ensure pharmacy recommendations were reviewed and addressed in a timely manner for 2 of 5 residents reviewed for unnecessary medications (Resident 16 and Resident 18). Findings include: 1. Resident 16's clinical record was reviewed on 11/7/24 at 11:52 a.m. Diagnoses included aphasia following cerebral infarction, depression, disorientation, and anxiety disorder. Physician's orders included lorazepam (antianxiety) 0.5 mg (milligrams) two tablets every 4 hours as needed (PRN) for anxiety/agitation (started 10/27/24) and lorazepam 0.5 mg every 6 hours PRN anxiety/agitation (started 8/5/24 and discontinued 10/27/24). A significant change Minimum Data Set (MDS) assessment, dated 8/28/24, indicated the resident was severely cognitively impaired. A medication administration record for August 2024 indicated the resident was given lorazepam 0.5 mg on 8/5/24 at 5:04 p.m. and 11:05 p.m., 8/7/24 at 11:24 a.m., and 8/12/24 at 9:03 p.m. A medication regimen review, completed on 8/19/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 8/5/24 was a PRN order for a psychotropic drug and was limited to 14 days, except if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days. Rationale and duration of the PRN order was to be documented by the prescriber in the resident's medical record. A medication administration record for September 2024 indicated the resident was given lorazepam 0.5 mg on 9/11/24 at 1:56 p.m. and 10:18 p.m., 9/14/24 at 10:57 p.m., 9/17/24 at 9:09 p.m., 9/18/24 at 6:12 a.m., 9/20/24 at 10:32 p.m., 9/21/24 at 7:11 p.m., and 9/28/24 at 1:57 a.m. A medication administration record for October 2024 indicated the resident was given 0.5 mg lorazepam on 10/18/24 at 10:35 p.m., 10/26/24 at 7:28 p.m., and 10/27/24 at 1:46 p.m. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication regimen review, completed on 10/21/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 8/5/24 was a PRN order for a psychotropic drug and was limited to 14 days except if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days. Rationale and duration of the PRN order was to be documented by the prescriber in the resident's medical record. The nurses notes lacked documentation of physician notification and response to the 8/19/24 and 10/21/24 medication regimen reviews. A Nurse's Note, dated 10/27/24 at 3:27 p.m., indicated the PRN lorazepam order for 0.5 mg started on 8/5/24 was discontinued. A new order for lorazepam 1 mg every 4 hours PRN anxiety/agitation was started and lacked a stop date. 2. Resident 28's clinical record was reviewed on 11/7/24 at 9:27 a.m. Diagnoses included anxiety disorder and congestive heart failure. Physician's orders included lorazepam 0.5 mg every 6 hours PRN for anxiety/agitation (started 7/30/24) and lorazepam 0.5 mg two times a day (started 11/4/24). A significant change MDS assessment, dated 8/9/24, indicated the resident was moderately cognitively impaired. A medication administration record for August 2024 indicated the resident was given lorazepam 0.5 mg on 8/13/24 at 7:05 p.m. and 8/15/24 at 6:00 p.m. A medication regimen review, completed on 8/19/24, indicated lorazepam 0.5 mg give every 6 hours PRN anxiety/agitation started on 7/30/24 required a 14 day stop date or for longer duration if clinically appropriate. A medication administration record for October 2024 indicated the resident was given lorazepam 0.5 mg on 10/4/24 at 3:54 p.m. The Nurse's Notes lacked documentation of the physician notification and response of the 8/19/24 medication regimen review. During an interview, on 11/8/24 at 3:38 p.m., the DON indicated the pharmacy's medication regimen review would have been sent to the resident's physician for review. She usually kept the reviews clipped until she received a response. She had missed this review and did not have a physician response. A current facility policy, dated 2020, provided by the DON on 11/8/24 at 4:43 p.m., titled Drug Regimen Review, indicated the following: .A written report is provided to the physician within seven working days or according to facility policy, with a copy to the facility .The physician's response is documented in the Consultant Pharmacist review record or elsewhere in the resident's medical record .The physician provides a written response of the report to the facility within one month after the report is sent. A copy of the report is kept by the facility until the physicians signed response is returned 3.1-25(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45122 Based on observation, interview, and record review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of an as needed (PRN) psychoactive medication for 2 of 5 residents reviewed for unnecessary medications. (Resident 16 and Resident 28) Findings include: 1. During an observation, on 11/4/24 at 9:20 a.m., Resident 16 rested in bed with his eyes closed. On 11/6/24 at 3:59 p.m., the resident rested in bed in bed with his eyes closed and leaned right. On 11/7/24 at 12:43 p.m., the resident rested in bed with his eyes gazing at the television. Resident 16's clinical record was reviewed on 11/7/24 at 11:52 a.m. Diagnoses included aphasia following cerebral infarction, depression, disorientation, and anxiety disorder. Physician's orders included lorazepam (antianxiety) 0.5 mg (milligrams) two tablets every 4 hours PRN for anxiety/agitation (started 10/27/24), lorazepam 0.5 mg every 6 hours PRN anxiety/agitation (started 8/5/24 and discontinued 10/27/24), and duloxetine (antidepressant) delayed release 90 mg daily (started 10/22/24). A significant change Minimum Data Set (MDS) assessment, dated 8/28/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, personal hygiene, showering/bathing, upper and lower body dressing, rolling left and right, moving from sitting to lying and lying to sitting, and transfers. A care plan for the behavior of calling 911 for basic needs instead of pressing his call light was initiated 5/31/24 and revised on 9/18/24. The interventions included the following: Care givers to provide positive interaction and attention and to stop and talk to the resident when passing by him (initiated 5/31/24 and revised on 9/18/24). Discuss the resident's behavior with him and explain/reinforce why the behavior is inappropriate and/or unacceptable (initiated 5/21/24 and revised 9/18/24). Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes (initiated 5/31/24). A care plan for the use of antianxiety medication to treat symptoms of anxiety disorder was initiated on 7/10/24 and revised on 7/10/24. The goals included the resident will show decreased number of episodes of anxiety though the next review date of 12/5/24 (initiated 7/10/24 and revised 8/29/24). The interventions included the following: Administer antianxiety medications as ordered by the physician. Monitor for side effects and effectiveness every shift (initiated 7/10/24). A medication administration record for August 2024 indicated the resident was given lorazepam 0.5 mg on 8/5/24 at 5:04 p.m. and 11:05 p.m., 8/7/24 at 11:24 a.m., and 8/12/24 at 9:03 p.m. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 8/5/24 at 5:01 p.m., indicated the resident was having anxiety. The physician ordered PRN lorazepam 0.5 mg every 6 hours. A Nurse's Note, dated 8/5/24 at 5:04 p.m., indicated the resident was having a lot of anxiety/agitation and a PRN lorazepam was given. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. A Nurse's Note, dated 8/5/24 at 11:05 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/5/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 8/6/24 at 8:58 a.m., indicated the resident was sleeping soundly and would not awaken to take medications. A Nurse's Note, dated 8/7/24 at 11:24 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 8/7/24. A nurses note, dated 8/12/24 at 9:03 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 8/12/24 indicated no resident behaviors were observed and no interventions attempted. A medication administration record for September 2024 indicated the resident was given lorazepam 0.5 mg on 9/11/24 at 1:56 p.m. and 10:18 p.m., 9/14/24 at 10:57 p.m., 9/17/24 at 9:09 p.m., 9/18/24 at 6:12 a.m., 9/20/24 at 10:32 p.m., 9/21/24 at 7:11 p.m., and 9/28/24 at 1:57 a.m. A Nurse's Note, dated 9/11/24 at 1:56 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/11/24. A Nurse's Note, date 9/14/24 at 10:57 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 9/14/24 indicated no resident behaviors were observed. No interventions were marked. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 9/17/24 at 9:09 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/17/24. A nurses note, dated 9/18/24 at 6:12 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/18/24. A Nurse's Note, dated 9/20/24 at 10:32 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/20/24. A nurses note, dated 9/21/24 at 7:11 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 9/21/24. A Nurse's Note, dated 9/28/24 at 1:57 a.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 9/28/24 indicated no resident behaviors were observed. No interventions were marked. A medication administration record for October 2024 indicated the resident was given 0.5 mg lorazepam on 10/18/24 at 10:35 p.m., 10/26/24 at 7:28 p.m., and 10/27/24 at 1:46 p.m. A Nurse's Note, dated 10/18/24 at 10:35 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. The behavior monitoring and interventions report on 10/18/24 indicated no resident behaviors were observed. No interventions were marked. A Nurse's Note, dated 10/26/24 at 7:28 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior monitoring and interventions report on 10/26/24 indicated no resident behaviors were observed. No interventions were marked. 2. During an observation on 11/4/24 at 10:14 a.m., Resident 28 was sitting up in a wheelchair in her room with her eyes open. During an observation on 11/6/24 at 3:57 p.m., the resident was lying in bed with her eyes closed. During an observation on 11/7/24 at 8:30 a.m., the resident was lying in bed in with her eyes closed. Resident 28's clinical record was reviewed on 11/7/24 at 9:27 a.m. Diagnoses included anxiety disorder and congestive heart failure. Physician's orders included lorazepam 0.5 mg every 6 hours PRN for anxiety/agitation (started 7/30/24), lorazepam 0.5 mg two times a day (started 11/4/24), and hydroxyzine pamoate (used for anxiety) 25 mg twice a day (started 2/15/24 and discontinued 11/4/24). A significant change MDS assessment, dated 8/9/24, indicated the resident was moderately cognitively impaired. She required partial/moderate assistance with toileting hygiene, showering and bathing, upper body dressing, and moving from sitting to lying and lying to sitting. She was dependent on the staff for transfers. A care plan with a focus on the resident's restlessness, nervousness, and other anxiety symptoms due to anxiety disorder was initiated on 1/8/24 and revised on 8/28/24. The interventions included the following: Encourage the resident to participate in activities of choice (initiated 1/15/24 and revised 8/28/24). Give meds as ordered (initiated 1/8/24 and revised 1/15/24). A medication administration record for October 2024 indicated the resident was given lorazepam 0.5 mg on 10/4/24 at 3:54 p.m. A Nurse's Note, dated 10/4/24 at 3:54 p.m., indicated the resident was given a PRN lorazepam for anxiety/agitation. The resident's clinical record lacked interventions attempted prior to administration of the PRN medication. No behaviors or interventions were marked on the behavior monitoring and interventions report on 10/4/24. During an interview, on 11/8/24 at 10:10 a.m., Licensed Practical Nurse (LPN) 7 indicated prior to giving any PRN medications, interventions should be attempted. The nurse should always put in a progress note of the behavior and the interventions. During an interview, on 11/8/24 at 10:24 a.m., Registered Nurse (RN) 8 indicated before giving PRN medications, the order should be checked, the expiration date should be checked, check what interventions are appropriate and do those, and document the behavior and interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 11/8/24 at 3:48 p.m., the Director of Nursing (DON) indicated interventions should be attempted prior to giving PRN psychoactive medications. She was unable to supply documentation of interventions attempted prior to the administration of the PRN medications for the residents. A current facility policy, dated 8/2024, provided by the DON on 11/8/24 at 4:43 p.m., titled Psychotropic Medication Use, indicated the following: .Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible 3.1-48(a)(4)

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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. 42685 Based on observation, interview, and record review, the facility failed to utilize infection prevention and control procedures during insulin administration for 2 of 4 residents reviewed for medication administration. (Residents 16 and 7) Findings include: 1. During a random medication administration observation on 11/6/24 at 10:56 a.m., RN 5 removed Resident 16's insulin aspart Flexpen 100 units/milliliter(mL) from the compartment in the top drawer of the medication cart where the insulin pens for the residents on the 200 unit were stored. She removed the unsealed pen cap, did not cleanse the rubber stopper of the multi-dose pen, and attached the pen needle to the insulin pen. The pen was primed and dialed to 11 units for scheduled and sliding scale insulin. The skin was cleansed with an alcohol pad, and the insulin was administered subcutaneously in the resident's right lower abdomen. Resident 16's clinical record was reviewed on 11/8/24 at 12:35 p.m. Diagnoses included, type 2 diabetes mellitus with diabetic neuropathy. Current physician's orders, dated 5/8/24, included insulin aspart injection solution 100 units/mL - inject 7 units subcutaneously with meals and insulin aspart injection solution 100 units/mL - inject as per sliding scale subcutaneously with meals. 2. During a random medication administration observation on 11/6/24 at 11:20 a.m., RN 5 removed Resident 7's Humalog KwikPen (insulin) solution pen-injector 100 units/mL from the compartment in the top drawer of the medication cart where the insulin pens for the residents on the 200 unit were stored. She removed the unsealed pen cap, did not cleanse the rubber stopper of the multi-dose pen, and attached the pen needle to the insulin pen. The pen was primed and dialed to a total of 7 units for scheduled and sliding scale insulin. The skin was cleansed with an alcohol pad, and the insulin was administered subcutaneously in the resident's left upper arm. Resident 7's clinical record was reviewed on 11/8/24 at 12:49 p.m. Diagnoses included, type 2 diabetes mellitus with other circulatory complications. A current physician's order, dated 11/27/23, included Humalog injection solution 100 units/mL - inject 5 units subcutaneously with meals. A current physician's order, dated 12/13/23, included Humalog KwikPen solution pen-injector 100 units/mL - inject as per sliding scale subcutaneously before meals and at bedtime. During an interview on 11/6/24 at 11:30 a.m., RN 5 indicated she should have cleansed the rubber stoppers for the insulin pen injectors prior to attachment of the needles during the medication administration observations, because they were pierced multiple times since they were opened for administration of the medication. This should have been done for infection prevention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 3:04 p.m., the [NAME] President of Clinical Operations indicated the insulin pens should have been cleansed prior to attachment of the needle according to the manufacturers' guidelines. A current document, last revised on 2/2023, titled Insulin Aspart FlexPen INSTRUCTIONS FOR USE, provided by the Administrator on 11/7/24 at 3:03 p.m., indicated the following: .Preparing your Insulin Aspart FlexPen . A. Pull off the pen cap . Wipe the rubber stopper with an alcohol swab A current document, last revised on 7/2023, titled INSTRUCTIONS FOR USE HUMALOG . KwikPen . injection, for subcutaneous use 3 mL single-patient-use pen (100 units per mL), provided by the Administrator on 11/7/24 at 3:03 p.m., indicated the following: .Preparing your Pen . Step 1: .Pull the Pen Cap straight off . Wipe the Rubber Seal with an alcohol swab A current document, titled Insulin Pens, last reviewed 2/24/24 and retrieved on 11/12/24 from the Cleveland Clinic website: https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections. The guidance included the following: Step-by-step instructions for preparing your insulin pen include: 1. Wash your hands. 2. Remove the cap of the insulin pen . 4. Wipe the rubber stopper with an alcohol wipe. 5. Attach a new pen needle to the insulin pen 3.1-18(a)