STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Huntington	850 Ash St Huntington, IN 46750

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48384 Based on record review and interview, the facility failed to provide notice of transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 2 residents reviewed for hospitalization . (Resident 21) Findings include: Resident 21's clinical record was reviewed on 1/23/25 at 10:17 a.m. Diagnoses included, but were not limited to, Type 1 diabetes mellitus, bipolar disorder, anoxic brain damage, and end stage renal disease. On 3/25/24, Resident 21 was showing signs and symptoms of diabetic ketoacidosis. The resident was lethargic and nauseated. His blood glucose level was checked and resulted in a reading of HI. He was transferred to the emergency room for evaluation and treatment. The clinical record lacked an Ombudsman notification for a transfer/discharge on this date. On 5/18/24, the resident refused to go to dialysis, refused all medications, and had a blood glucose reading of HI. The nurse practitioner gave an order for the resident to be transferred to the emergency room . He was then transferred to another acute care facility to receive dialysis. On 10/8/24, the resident complained of a headache. His blood pressure was 226/127 (normal blood pressure ranges from 110/70 to 120/80). He was sent to the emergency room and transferred from there to another acute care facility where he was treated for hypertension, hyperglycemia (high blood glucose), and hyperkalemia (high potassium). On 12/8/24, the resident was anxious, restless, and refused to take his medications. He was sent to the emergency room for evaluation and treatment. He was admitted to the acute care facility. During a review of monthly Ombudsman notifications, provided by the Social Services Director (SSD) on 1/23/25 at 12:30 p.m., the records lacked notification of Resident 21's transfers for the following months: March 2024, May 2024, October 2024, and December 2024. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/23/25 at 2:22 p.m., the Social Services Director indicated a report was run monthly, which included transfers and discharges. She would provide these reports to the Ombudsman on a monthly basis, via email. If a resident had been put on a bed-hold status, the electronic health record would not notify her of a resident's hospitalization . It was her understanding that the Ombudsman should only be notified if the resident had been discharged and their return was not anticipated. During an interview, on 1/23/25 at 2:58 p.m., the Administrator indicated the facility did not have a policy addressing notification of the Ombudsman. 3.1-12(a)(6)(A)(iv)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48384 Based on interview and record review, the facility failed to review and revise care plan interventions for dialysis and pressure injury management for 2 of 13 residents reviewed for care plans. (Residents 21 and 27) Findings include: Resident 21's clinical record was reviewed on 1/23/25 at 10:17 a.m. Diagnoses included hypertension, type 1 diabetes mellitus, anoxic brain damage, and end stage renal disease. A physician order, dated 10/18/24 at 9:00 a.m., indicated a pre-dialysis assessment was to be completed every Monday, Wednesday, and Friday. A physician order, dated 10/18/24 at 3:30 p.m., indicated a post-dialysis assessment was to be completed every Monday, Wednesday, and Friday. A current care plan, initiated 3/7/24, indicated the resident had renal insufficiency related to end stage renal disease. The resident required hemodialysis. An intervention, initiated on 10/6/22 and revised on 3/7/24, indicated the resident was to go for scheduled dialysis appointments. He received dialysis Tuesday, Thursday, and Saturday. During an interview, on 1/23/25 at 9:15 a.m., LPN 5 indicated the dialysis days and times should be in the resident's orders and on the medication administration record (MAR). The electronic record system prompted nurses to perform the pre-assessments and post-assessments on dialysis days. During an interview, on 1/23/25 at 9:29 a.m., RN 4 indicated there was a bar at the top of the resident's care profile which indicated dialysis was Monday, Wednesday, and Friday between 9:30 a.m. and 3:15 p.m. 49411 2. Resident 27's clinical record was reviewed on 1/21/25 at 9:28 a.m. Diagnoses included alcoholic cirrhosis of liver with ascites (a chronic liver disease caused by excessive alcohol consumption, leading to scarring and damage to the liver), muscle weakness, dysphagia (swallowing difficulties), essential hypertension (high blood pressure), alcoholic polyneuropathy (nerve damage caused by chronic alcohol abuse), and pressure ulcer of left buttock, unstageable. A nursing progress note, dated 9/22/24 at 10:36 a.m., indicated the CNA notified the writer that Resident 27 had a purplish area to his left buttock, which was not open at that time. The area was cleansed, and a comfort dressing was applied. Resident 27 denied any pain or discomfort. The physician, DON, and the residents representative were notified of the area. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 9/24/24 at 10:52 a.m., indicated Resident 27 continued with worsening overall decline in his condition. He had increased confusion, difficulty staying awake and alert, increased edema and increased abdominal distention. The Nurse Practitioner (NP) was notified, and the resident was sent to the emergency room (ER) by EMS for evaluation and treatment. A nursing progress note, dated 10/5/24 at 4:10 p.m., indicated Resident 27 returned from the hospital accompanied by hospital staff. Resident 27 was alert and oriented and had a pressure injury to his left buttock and multiple areas of bruising to his upper extremities. The resident denied any pain or discomfort. Resident 27's care plan was not updated to include the presence of a pressure injury, nor a goal for healing and interventions for management of the injury. A skin Assessment document, dated 10/15/24 at 3:06 a.m., indicated Resident 27 had skin discolorations or impairments on his skin and was not a new area of discoloration or impaired skin integrity. The wound location was on Resident 27's left buttock, which was an open area. Treatment continued as ordered and the wound NP assessed the area weekly. A quarterly Minimum Data Set (MDS) assessment, dated 10/12/24, indicated Resident 27 had one unstageable (cannot be accurately staged due to the presence of a thick layer of dead tissue (eschar) or slough that obscures the underlying wound bed) pressure ulcer due to coverage of the wound bed by slough and/or eschar. Resident 27 required substantial/ maximal assist by staff members for toileting hygiene, upper body dressing, personal hygiene, rolling to the left and right, sit to lying, lying to sitting, chair/bed to chair transfer, toilet transfer and tub/shower transfer. He had no impairment to his upper and lower extremities. Resident 27's clinical record continued to lack a care plan for the management of the unstageable pressure injury to his left buttock. A current care plan focus, initiated and revised on 1/17/25, indicated Resident 27 had an unstageable pressure ulcer/injury to his left buttock. He was at risk for complications related to wound healing and at risk for developing another pressure ulcer. Interventions included the following: Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document the status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician. Encourage and assist resident to change position frequently. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Pressure reducing mattress to bed. Pressure relieving cushion to wheelchair/chair. Supplements as ordered to promote healing. During an interview, on 1/21/25 at 2:42 p.m., the DON indicated Resident 27 admitted from the hospital on 10/5/24 with a pressure injury on his left buttock. His interventions included a low air loss mattress, turn and reposition every two hours as tolerated, and pressure reducing cushions to his wheelchair. During an interview, on 1/21/25 at 2:49 p.m., Social Services indicated care plans were updated quarterly, and she tried to keep them updated continuously. She ran orders every morning, anything new with any resdient would show up on the orders. Resident 27's care plan should have been updated when he returned from the hospital. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Care Plans, Comprehensive Person-Centered, provided by the Administrator on 1/22/25 at 11:59 a.m., indicated the following: .12. The interdisciplinary team reviews and updated the care plan: When there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment 3.1-35(e)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49411 Based on interview and record review, the facility failed to ensure an anti-hypotensive medication was ordered and administered according to indication for use for 1 of 8 residents reviewed for medication administration. (Resident 21) Findings include: Resident 21's clinical record was reviewed on 1/23/25 at 10:17 a.m. Diagnoses included anoxic brain damage (lack of oxygen to the brain) not elsewhere classified, type 1 diabetes mellitus, end stage renal disease (kidney failure), dependence on renal dialysis, bipolar disorder, and hypertension (high blood pressure). Current medications included midodrine (medication used to increase blood pressure) 2.5 milligram (mg), take one tablet three times a day every Tuesday, Thursday, Saturday, and Sunday for hypotension, hold if systolic (top number) blood pressure was greater than 120 millimeter of mercury (mmHg) and midodrine 5 mg, take one tablet three times a day every Monday, Wednesday, and Friday; hold if systolic blood pressure was less than 120 mmHg. A December 2024 MAR indicated Midodrine 2.5 mg was administered as follows: On 12/14/24 at 7:30 a.m., when his systolic blood pressure was 126 mmHg. During an interview, on 1/23/25 at 9:51 a.m., the DON indicated the order for Midodrine 5 mg give one tablet by mouth three times a day every Monday, Wednesday, and Friday for hypotension and to hold if systolic blood pressure was less than 120 mmHg was written incorrectly. The order should state to hold the medication if systolic blood pressure was greater than 120 mmHg. Whichever nurse worked alongside the nurse who placed the medication order, that staff member would double check to make sure the order was put in the computer correctly. Staff were not administering the medication correctly as the order was written to hold the medication if Resident 21's systolic blood pressure was below 120 mmHg. During an interview, on 1/23/25 at 11:00 a.m., the Nurse Practitioner (NP) 6 indicated the order for Midodrine 5 mg give one tablet by mouth three times a day every Monday, Wednesday, and Friday for hypotension and to hold if systolic blood pressure is less than 120 mmHg was written incorrectly. The medication should have been held if the residents systolic blood pressure was greater than 120 mmHg not less than 120 mmHg. Almost all verbal orders were sent to him electronically to be reviewed and signed. It was an error on his part as well. With the midodrine being at a low dose, it would increase Resident 21's blood pressure both systolic and diastolic by 10-20 points each. 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 49411 Based on interview and record review, the facility failed to obtain blood pressure readings before administering an anti-hypotensive medication per physician order for 1 of 8 residents reviewed for medication administration. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 1/21/25 at 9:28 a.m. Diagnoses included alcoholic cirrhosis of liver with ascites (a chronic liver disease caused by excessive alcohol consumption, leading to scarring and damage to the liver), muscle weakness, dysphagia (swallowing difficulties), essential hypertension (high blood pressure), alcoholic polyneuropathy (nerve damage caused by chronic alcohol abuse). Current medications included midodrine 10 mg, take one tablet by mouth two times a day for decreased blood pressure; hold if blood pressure was greater than 120/80 mmHg. A December 2024 Medication Administration Record (MAR) indicated midodrine 10 mg was given on 12/28/24 at 9:00 a.m., when Resident 27's blood pressure was outside the parameters for the medication. His blood pressure was documented at 148/89. A January 2025 MAR indicated midodrine 10 mg was held when Resident 27's blood pressure was not documented in the MAR, under the vital signs tab, or in the progress note as follows: On 1/3/25 at 9:00 p.m. On 1/7/25 at 9:00 p.m. On 1/9/25 at 9:00 p.m. On 1/12/25 at 9:00 p.m. On 1/16/25 at 9:00 p.m. On 1/17/25 at 9:00 p.m. During an interview, on 1/22/25 at 1:15 p.m., QMA 3 indicated an X marked on the MAR indicated the medication was not given. Staff would document vitals on the MAR when giving the medication, under the vitals tab, or in the progress note. During an interview, on 1/22/25 at 1:20 p.m., RN 4 indicated if a resident's vital signs were outside the parameters, they would be documented on the MAR. During an interview, on 1/22/25 at 1:30 p.m., LPN 5 indicated vital signs would be documented under the progress note tab in the MAR. Vital signs could also be documented under the vitals tab or progress notes. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/22/25 at 1:32 p.m., the DON indicated staff were checking off that the parameters for the medication were checked but not necessarily meaning that the medication was administered. A current policy, titled Administering Medications, provided by the DON, on 1/23/25 at 12:40 p.m., indicated the following: .4. Medications are administered in accordance with prescriber orders, including any required time frame 3.1-48(a)(3)

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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. 48384 Based on observation, interview, and record review, the facility failed to ensure residents did not receive antipsychotic medication without indication related to targeted behavior expressions and mental health diagnoses for 1 of 6 residents reviewed for unnecessary medications. (Resident 28) Findings include: Resident 28's clinical record was reviewed on 1/22/25 at 10:15 a.m. Diagnoses included bipolar disorder, mild intellectual disabilities, paranoid personality disorder, delusional disorder, and major depressive disorder, recurrent, severe, without psychotic features. Resident 28's quarterly Minimum Data Set (MDS) assessments, dated 2/23/24, 4/17/24, and 6/24/24, indicated in section I (medical diagnoses), the resident did not have a psychotic disorder: An annual MDS assessment, dated 9/24/24, indicated the resident did have a psychotic disorder, categorized as other than schizophrenia. A quarterly MDS assessment, dated 12/23/24, indicated the resident did have a psychotic disorder (other than schizophrenia). A care plan, initiated on 10/20/22, indicated the resident used antipsychotic medication(s) related to paranoid personality disorder. Interventions included administration of psychotropic medications as ordered by physician, and consider dosage reduction when clinically appropriate, A care plan, initiated 10/23/24, indicated the resident exhibited signs and symptoms of depression, such as being tearful, withdrawn from activities, agitation, and restlessness. Interventions included administering medications as ordered and to monitor and document side effects and effectiveness of medications. Discuss with the resident her fears and issues regarding health or other subjects. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. A care plan, revised on 11/19/24, indicated the resident used an anti-anxiety medication for restlessness and agitation. Interventions included administering anti-anxiety medications as ordered, and monitor for side effects and effectiveness every shift. Monitor the resident for safety. Anti-anxiety medication are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia. There was an increased risk of falls, broken hips, and legs. Monitor/document/report, as needed, any adverse reactions to anti-anxiety therapy such as drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, etc . Unexpected side effects included mania, hostility, rage, aggressive or impulsive behavior, and hallucinations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, revised 4/2/24, indicated the resident demonstrated cognitive impairment, in particular, with her short term memory. She had a diagnosis of mild intellectual impairment. The goal was she would remain oriented to her name and her personal surroundings daily. Interventions included administering medications as ordered, monitor and document side effects and effectiveness, ask yes and/or no question in order to determine her needs, cue, reorient, and supervise as needed, engage the resident in simple, structured activities that avoid overly demanding tasks, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. A current 4/2/24 care plan indicated the resident demonstrated cognitive impairment and as an adverse result, her communication ability was impaired. The goal was for the resident to continue to verbally express her basic needs daily. Interventions included anticipating and meeting her needs, allow her adequate time to respond, repeat as necessary, and not to rush her during conversations. Encourage the resident to continue stating thoughts even if she was having difficulty expressing herself. Monitor and document nonverbal indicators of discomfort or distress. A current 4/2/24 care plan also indicated the resident suffered with bipolar disorder and as an adverse result, she had increased potential for mood decline. Interventions included administering anti-depressant medication as prescribed, assist the resident, family, and caregivers to identify strengths, positive coping skills, and to reinforce these. Encourage the resident to express her feelings, provide behavioral health consults as needed, and monitor/record/report to the medical director any acute feelings of sadness, loss of pleasure, loss of interest in activities, feelings of worthlessness or guilt, and any changes in sleep patterns. Observe for signs and symptoms of mania or hypomania, racing thoughts, euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, and marked changes in need for sleep, agitation or hyperactivity. A current 4/2/24 care plan indicated the resident heard voices tell her she was going to have to move back to a group home. She did not want to go back. The voices also told her they were going to move in with her at her apartment and she did not want them to. She wanted to stay here (the facility). Interventions included a behavior monitoring program, medication reviews as indicated, and to assure her the hallucination was not real and that she was safe. Engage in activities and assist to an area with less stimulation. Current physician orders included the following: Lorazepam (a benzodiazepine used to treat anxiety) 1 mg one time a day for anxiety, dated 1/3/25 at 9:00 a.m., Paliperidone (antipsychotic) oral tablet, extended release, 1.5 mg one time a day every Monday, related to bipolar disorder and paranoid personality disorder, dated 11/25/24 at 9:00 a.m., Paliperidone tablet, extended release, 3 mg one time a day every Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday, related to bipolar disorder and paranoid personality disorder, dated 11/22/24 at 9:00 a.m., Sertraline HCL (antidepressant) oral tablet, 50 mg, 1 tablet by mouth one time a day related to other specified depressive episodes. Give with 25 mg tablet for total dose of 75 mg daily, dated 4/10/24 at 9:00 a.m., and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sertraline HCL oral tablet 25 mg, 1 tablet by mouth one time a day to be given with 50 mg tablet for a total dose of 75 mg daily, dated 4/10/24 at 9:00 a.m. A behavior note, dated 9/24/24 at 4:39 p.m., indicated the resident was interviewed to complete a PHQ-9 depression assessment. After the interview was completed, the resident became tearful, saying she could hear voices of people who were not there. She could not determine what they were saying, but she could hear voices. The floor nurse was notified. A social services progress note, dated 12/20/24 at 11:25, indicated the resident became tearful, afraid she was going to be discharged or moved to another facility. After receiving reassurance from the social service director (SSD), she did calm down. The SSD indicated the resident was very childlike in her mannerisms and seemed to be intellectually challenged. She also seemed to have some cognitive deficits that hindered her emotionally. A progress note, dated 12/21/24 at 8:07 a.m., indicated the resident was tearful. She thought the facility had given away her room and she had nowhere to go. She was reassured that her room had not been taken. She continued to be tearful and chose to lay down for a nap. A progress note, dated 12/27/24 at 12:27 p.m., indicated the resident was making rude comments in the dining room. Her overall mood seemed different. She was fearful that she was going to have to move. The resident's distress required redirection several times during the noon meal. A progress note, dated 1/1/25 at 12:41 p.m., indicated the resident was tearful, sad, and bawling, stating the staff was going to kick her out and she would have nowhere to go. A progress note, dated 1/2/25 at 11:01 A.M., indicated the resident had failed the gradual dose reduction of the anti-anxiety medication lorazepam 1 mg, and was to resume the medication once daily for anxiety. A review of pharmacy medication regimen reviews, on 1/22/25 at 1:46 p.m., indicated the following: A progress note, dated 10/17/24 at 11:53, indicated a gradual dose reduction (GDR) meeting was held. Lorazepam was reviewed for a GDR attempt. The interdisciplinary team (IDT) determined to change the lorazepam 1 mg daily to as needed (PRN) for 14 days, then review. It was clinically contraindicated to reduce the antipsychotic paliperidone or the antidepressant sertraline while attempting to reduce the lorazepam at that time. A progress note, dated 10/17/24, at which time the lorazepam dose had been changed to as needed, indicated no changes were made to sertraline or paliperidone because reducing more than one psychotropic could cause undo distress that could negatively impact the resident's function and well-being. A progress note, dated 10/31/24 at 8:56 a.m., indicated the lorazepam was due for review. It had been on hold for 14 days with no use. The IDT team decided to discontinue the lorazepam order at that time, related to non-use. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 11/21/24 at 11:45 a.m., indicated a GDR meeting was held that morning. The IDT team discussed medications and determined to attempt a GDR of the antipsychotic paliperidone. The plan was to decrease the Monday dose to 1.5 mg and continue the Tuesday through Sunday dose at 3 mg. Further review of progress notes indicated no behaviors, including hallucinations or delusions, for the following time periods: 6/20/24 - 7/20/24 - No behaviors. 7/21/24 - 8/20/24 - No behaviors. 8/21/24 - 9/20/24 - No behaviors. During an interview with the MDS Coordinator, on 1/22/25 at 1:58 p.m., she indicated the psychiatric nurse practitioner had added the diagnosis of delusional disorder to the resident's chart on 9/19/24. During an interview with RN 4, on 1/23/25 at 1:02 p.m., she indicated the resident's ability to understand conversations often waxed and waned. The resident could become tearful and easily upset. She could be difficult to redirect, it took time to get her to calm down. She could become tearful at any given time, sometimes during meals. During an interview with LPN 5, on 1/23/25 at 1:07 p.m., she indicated the resident could understand if asked specific questions. The resident was more of an observer. Her tearfulness was random and not prompted by anything in particular. She could be difficult to redirect. She could take a piece of a conversation and direct it towards herself (mistakenly), causing her distress. Many times, the resident's response seemed more like an anxiety response. During an interview with CNA 8, on 1/23/25 at 2:06 p.m., she indicated Resident 28 could understand when speaking with her. She would sometimes cry or say ouch when being touched, even gently. The resident could be calmed down. CNA 8 never observed the resident to be inconsolable. Conversations with Resident 28 were not like conversing with an adult. She required reassurance and responded well when the staff spent time with her or gave her a hug. A facility policy, revised 8/2024, provided by the administrator on 1/22/25 at 12:30 p.m., and titled Antipsychotic Medication Use, indicated the following: Policy Statement - Residents will not receive medications that are not clinically indicated to treat a specific condition. 1) Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2) The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others .4) The attending physician and facility staff will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions 3.1-48(a)(6)