| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155468 | A. Building<br>B. Wing | 09/29/2025 |

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

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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on record review and interview, the facility failed to ensure a resident's representative was notified with new medication orders for 1 of 3 residents reviewed for notifications (Resident B). Findings include: Resident B's record was reviewed on 9/29/25 at 10:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease (a progressive and fatal brain disorder that causes memory loss, confusion, and other cognitive decline), cognitive communication deficit, and major depressive disorder recurrent and severe with psychotic symptoms (a severe form of depression characterized by persistent low mood, loss of interest, and other symptoms, accompanied by delusions and/or hallucinations). A quarterly Minimum Data Set (MDS) assessment, dated 8/27/25, indicated the resident had a severe cognitive impairment. A physician's order, dated 4/25/25 and discontinued on 6/23/25, indicated Risperdal (antipsychotic medication) 0.25 milligrams (mg) by mouth twice daily for major depressive disorder, recurrent and severe, with psychotic symptoms. A progress note, dated 6/23/25, indicated the resident continued to exit seek and wanted to go home. The resident stated her family was picking her up. When the resident was redirected, she stated if she was not able to go home, she would kill herself. The Social Services Director (SSD) called the psychiatric provider and received an order from the Nurse Practitioner (NP) to increase Risperdal to 0.5 mg twice daily. The progress note lacked documentation the resident's representative was notified of the new order. A physician's order, dated 6/24/25, indicated Risperdal 0.5 mg by mouth twice daily for major depressive disorder, recurrent and severe, with psychotic symptoms. A progress note, dated 7/4/25, indicated a new order was received for vitamin D3 25 micrograms (mcg), one tablet once daily. The next shift was to notify the resident's family. Progress notes lacked documentation the resident's representative was notified of the new Vitamin D3 order. A physician's order, dated 7/4/25, indicated vitamin D3 25 mcg by mouth daily. During an interview, on 9/29/25 at 9:50 a.m., Resident B's family member indicated there had been issues at times with the facility not communicating information with them regarding changes with the resident. During an interview, on 9/29/25 at 2:40 p.m., the Director of Nursing (DON) indicated she reviewed the 24-hour report documentation, and the resident's medical record, and she was unable to find documentation the resident's representative was notified of the Risperdal and Vitamin D3 orders. The facility should have notified the resident's representative of new medication orders, but she was not sure how long they had to complete the notifications. On 9/29/25 at 3:16 p.m., the DON provided a document titled, Health, Medical Condition and Treatment Options, Informing Residents of, last revised in August 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Statement: Every resident is informed of his or her total health status, medical condition and options for treatment and/or care. Policy Interpretation and Implementation: 1. Each resident is informed of his/her total health status and medical condition, including.treatment recommendations.in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also<br><br>(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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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | informed. 2. The resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the resident's.g. psychosocial status.i. type of care or treatment recommended.4. Information about the resident's health status is presented at times.when a change of treatment is proposed. This citation relates to Intake 1841129.<br>3.1-5(a)(2)3.1-5(a)(3) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure documentation was completed in the resident's electronic health record related to falls that occurred at the facility, and they failed to ensure interventions were implemented for 2 of 3 residents reviewed for accidents (Residents C and B). Findings include: 1. Resident C's record was reviewed on 9/29/25 at 10:45 a.m. The profile indicated the resident diagnoses included, but were not limited to, unspecified dementia moderate with mood disturbance (a medical diagnosis with moderate level of dementia whose cause is unknown, accompanied by symptoms of mood disturbance like depression, apathy[lack of interest], of loss of pleasure), type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin), and paroxysmal atrial fibrillation (a type of heart rhythm disorder where the heart's upper chambers beat irregularly and rapidly for a short period).<br><br>The facility census indicated Resident C admitted to the facility on [DATE].<br><br>An admission Minimum Data Set (MDS) assessment, dated 6/24/25, indicated Resident C had severe cognitive impairment and required maximum assistance with toileting and bathing.<br><br>A care plan, dated 6/17/25, indicated the resident was at risk for falls/injury due to impaired ADL (activities of daily living) function, incontinence of bowel/bladder, difficulty walking, and impaired condition related to dementia.<br><br>Review of fall log, dated 6/10/25 through 9/22/25, indicated Resident C had a fall on 7/3/25 at 3:00 a.m. that was un-witnessed, the medical record lacked documentation of the fall occurring until 7/7/25 at 9:51 a.m. when an Interdisciplinary team (IDT) note was placed in the record. The record lacked documentation of a fall assessment, skin assessment, pain assessment, or progress note being completed on the resident related to the unwitnessed fall that occurred on 7/3/25 at 3:00 a.m.<br><br>Review of progress note, dated 7/3/25 at 10:37 p.m., indicated Resident C had an unwitnessed fall at 9:30 p.m. The record lacked documentation of a fall assessment, skin assessment, pain assessment, or detailed progress notes of how or where the fall occurred. An IDT note was placed in the chart on 7/7/25 at 10:20 a.m. regarding the fall that occurred on 7/3/25 at 9:30 p.m.<br><br>Review of fall log, indicated Resident C had a fall on 7/9/25 at 11:55 a.m., that was witnessed, the medical record lacked documentation of a fall until 7/10/25 at 12:28 a.m. The record lacked an IDT note related to the fall that occurred on 7/9/25 at 11:55 a.m. The record lacked documentation of any new interventions being added to the care plan due to the fall.<br><br>Review of progress note, dated 7/11/25 at 7:15 p.m., indicated the resident had an unwitnessed fall, the medical record lacked documentation that the family was notified at the time of the fall.<br><br>During an interview, on 9/29/25 at 11:26 a.m., Licensed Practical Nurse (LPN) 3 indicated that staff should complete a fall assessment, skin assessment, pain assessment, fall risk management assessment, and progress note whenever they had a fall that occurred in the facility. She indicated the IDT team would meet the next day or if over the weekend on Monday to discuss the falls and place new interventions in the care plans.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 9/29/25 at 11:40 a.m., the Director of Nursing (DON) indicated staff should make sure to assess the resident, complete a fall risk management assessment, progress note, and fall assessment. Staff should also notify the DON, doctor, and family of all falls immediately.<br><br>During an interview, on 9/29/25 at 1:56 p. the DON indicated she was not aware that the fall risk management assessment was not a part of the medical record. It was an internal document and not available for everyone to see. She was also not aware that if a resident fell more than once in a 24-hour period the computer system would not trigger staff to complete all of the fall assessments. She would need to investigate it and figure out how to fix it.<br><br>2. Resident B's record was reviewed on 9/29/25 at 10:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease (a progressive and fatal brain disorder that causes memory loss, confusion, and other cognitive decline) unspecified and cognitive communication deficit.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 8/27/25, indicated the resident had a severe cognitive impairment and had one fall, with no injury, since the prior assessment.<br><br>A care plan, last revised on 8/28/24, indicated the resident was at risk for falls and injury due to potential side effects from medications and diagnosis of Alzheimer's dementia.<br><br>An incident log indicated the resident had an unwitnessed fall on 6/13/25.<br><br>A change in condition evaluation included in the resident's assessments, dated 6/13/25, indicated the resident fell and included vital signs. The evaluation did not include a description of the circumstances of the fall or an intervention to prevent further falls.<br><br>Progress notes, dated 6/13/25, lacked documentation of the resident's fall.<br><br>A progress note, dated 6/14/25, indicated the facility attempted to contact the resident's son to notify him of the fall, but he did not answer. The note lacked documentation of information regarding the fall, an assessment, or an intervention put in place to prevent further falls.<br><br>Progress notes, dated 6/15/25 and 6/16/25, lacked documentation of the resident's fall, an assessment, or an intervention put in place to prevent further falls.<br><br>An interdisciplinary team (IDT) progress note, dated 6/17/25, indicated the IDT reviewed the resident for an unplanned change of plane that occurred on 6/13/25. The staff observed the resident on her knees in the hallway. The Certified Nurse Aide (CNA) alerted the nurse, and the nurse assessed the resident. The resident stated she stumbled when walking down the hallway. The resident's shoes were noted to be too big, and the resident was to be taken to get a pair of shoes that fit.<br><br>During an interview, on 9/29/25 at 11:40 a.m., the Director of Nursing (DON) indicated when a resident fell the staff should have immediately assessed the resident and provided necessary assistance. If the intervention was an easy thing they might have implemented something at the time, however if it was more complicated, they would have waited until the IDT review. The IDT reviewed falls on the next business day. They documented fall information progress notes in the risk management portion of the chart. She was not aware that risk management was not visible in the resident's electronic health record.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 9/29/25 at 1:53 p.m., the DON provided an incident report from the risk management, dated 9/13/25. The bottom of the report indicated, Privileged and confidential-not part of the medical record. The report indicated the resident was found on the floor on her knees. There was an abrasion to the right knee. The report lacked documentation an intervention was put in place at the time of the fall. At the same time, the DON indicated they were not aware the risk management incident reports were not part of the resident's medical record. The DON indicated there was no further documentation of the resident's fall, on 6/13/25, in the resident's medical record.<br><br>On 9/29/25 at 2:00 p.m., the DON provided a document titled, Falls-Clinical Protocol, last revised in August 2024. The policy indicated, .Assessment and Recognition.2. In addition, the nurse shall assess and document/report the following: a. Vital signs; b. Recent injury, especially forehead or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; g. Freqeuncy and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy; and j. All active diagnoses.5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.Cause Identification: 1. For an individual who has fallen the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall.Treatment/Management: 4. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.<br><br>This citation relates to the Intake 1841129<br><br>3.1-45(a)(2) |