STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404604 and IN00404993. Complaint IN00404604- Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00404993- No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: March 27 and 28, 2023. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 96 Total: 96 Census Payor Type: Medicare: 1 Medicaid: 88 Other: 7 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 5, 2023.	F 0000	PLAN OF CORRECTION FOR ENVIVE OF Indianapolis F000 INITIAL COMMENTS Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey IN00404604 completed on March 27 & 28, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
shelley	miller	04/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was transferred in according to the resident's plan of care for transfers for 1 of 3 residents reviewed for accidents (Resident B), the facility failed to ensure neurological checks and post fall assessments were completed after a resident was hit by a dietary cart for 1 of 3 residents reviewed for accidents (Resident C), and the facility also failed to complete fall assessments with correct documentation for 1 of 3 residents reviewed for accidents (Resident D). Findings include: 1. On 3/27/23 at 10:00 a.m., the medical record was reviewed for Resident B. The diagnoses included but was not limited to hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side and diabetes. a). A Nurse Practitioner (NP) note, dated 3/13/23 at 2:20 p.m., indicated, "Per nursing request for left knee pain/ankle. HPI [history]: Resident is being seen today per nursing request for c/o pain to the left knee/ankle. No facial grimacing noted during palpation of the bilateral right and left lower extremities. Patient reports that she twisted her leg when, "they were moving me." Nursing reports that patient reported pain of the left knee and ankle yesterday. Patient asked if she could have some pain medication but denies being in pain	F 0689	**F689 – Free of Accident Hazards/Supervision/Devices SS=D** ***Based on interview and record review, the facility failed to ensure a resident was transferred in according to the resident's plan of care for transfers for 1 of 3 residents reviewed for accidents (Resident B), the facility failed to ensure neurological checks and post fall assessments were completed after a resident was hit by a dietary cart for 1 of 3 residents reviewed for accidents (Resident C), and the facility also failed to complete fall assessments with correct documentation for 1 of 3 residents reviewed for accidents (Resident D)."*** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B no longer resides in the facility. · Resident D no longer resides in the facility. · Resident C no longer resides	04/21/2023

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	during examination. Patient does not seem to be in any acute distress during this visit. Will order an x-ray of the left knee/ankle." An NP note, dated 3/14/23 at 1:23 p.m., indicated, "Follow-up to diagnostics: 3/14/2023. KNEE AP OR LAT 1- 2V, LEFT Results: There is a fracture involving left DISTAL LATERAL FEMUR with no displacement. The joint shows no dislocation. There is associated joint effusion. Conclusion: Acute left knee fracture as described above. ANKLE AP and LAT 2V, LEFT Results: There is joint space narrowing, osteophytes, and osteopenia. There is no fracture or dislocation. The soft tissues are unremarkable. Conclusion: osteoarthritis of the left ankle. Due to the type of fracture (distal lateral femur) and the residents low calcium/vitamin D level it is believed that the knee buckled due to hypocalcemia and osteopenia. Order given to send the resident to ER for treatment of the fracture and upon return to facility a DEXA scan will be completed for possible osteoporosis." On 3/14/23 at 4:54 p.m., an IDT [interdisciplinary] team note indicated, "After interviews/investigation [sic] it appears res [resident] left knee buckled during transfer, res fell and landed on bilateral knees. x-ray was obtained and results noted left knee fracture [sic]. Res sent to ER [emergency room] for furhter [sic] eval/tx. All parties notified. Careplan will be reviewed/updatd [sic] upon res return." An event/incident note indicated witnessed fall 3/12/23 at 1:08 p.m., the writer was notified on 3/13/23 that the resident was complaining of pain to the left knee related to a transfer. Resident stated she bumped her knee on the wheelchair during transfer on Sunday. Injury type: fracture.		in the facility. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents who require assistance with transfers have the potential to be affected by this alleged deficient practice. 100% audit will be completed to ensure resident transfer assistance is care planned appropriately and placed on Kardex, · Any resident that falls has the potential to be affected by this alleged deficient practice. All Falls since 3/28/23 will be audited to ensure post fall assessments and neurological assessments have been completed per policy. · Any resident being assessed for falls has the potential to be affected by this alleged deficient practice. All fall assessments since 3/28/2023 have been audited to ensure correct documentation has been completed per policy. **3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?** · All clinical staff will be in-serviced on:	

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	The family member (name), Physician, and Director of Nursing were notified. A care plan dated 11/4/22 indicated, "At risk for falls/injury due to: weakness, need for assistance with transfers. The goal, with a target date of 5/1/23 indicated, "Resident will not sustain serious injury through the review date. A care plan dated 11/4/22 indicated, "The resident has an ADL [activities of daily living] self-care performance deficient r/t [related to] hemiplegia, COPD [chronic obstructive pulmonary disease], polyneuropathy, dysphagia, osteoarthritis, neuralgia and weakness." The goal, with a target date of 5/1/23, indicated, "Resident will remain clean and well groomed through stay. The resident will maintain current level of function through the review date. The interventions included, but were not limited to, " ...Bed Mobility: provide extensive assistance x 2 staff. Transfer: Transfer the resident requires mechanical lift with 2 staff assistance for transfers ...." The most recent quarterly Minimum Data Set (MDS) assessment, dated 2/24/23, indicated in section G, Functional Status, Resident B required an extensive assist of 2 person or more (+) physical assist for bed mobility and transfers, and was total dependence of 2 person + physical assist for toilet use. b). On 2/7/23 at 7:20 p.m., an event/incident note indicated, writer was informed Resident B had slipped to the floor during transfer. No injuries observed at time of incident. The DON and Physician were notified. The ADL self-care performance care plan intervention was updated on 2/8/23, and indicated, "Staff education provided."		o "Resident transfers" o "Fall Program Guidelines" **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** · DNS/designee will conduct random audits on 5 residents requiring transfer assistance weekly x4 weeks, then biweekly x8 weeks then monthly times x3 months to ensure resident transfers are completed per care plan. · DNS/designee will review all falls in Clinical Meeting Mon – Fri x6 months and ongoing to ensure all fall assessments, post fall assessments and neurological assessments are completed and accurate per policy. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion: 4/21/2023**	

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A Fall Risk Assessment, dated 02/7/23 at 7:31 p.m., indicated Resident B had "no history of falls in the past 3 months."

c). A local hospital Emergency Room (ER) Report, dated 12/22/22, indicated Resident B presented to the ER after a mechanical fall. The resident lived at an ECF (nursing home) and was reportedly being turned by ECF caregivers when she accidentally rolled off her bed. Patient indicated she hit her head. Complained of headache, neck pain, chest pain, left elbow and abdominal pain since the fall. The diagnosis was trauma from fall with an abrasion and hematoma to left orbit (eye area). X-ray reports were negative for any fractures. The resident was discharged back to the facility on 12/23/22.

There were no nurse progress notes in related to this hospital visit or the incident. Additional records were requested but not provided.

d). On 11/7/23 at 9:30 p.m., an event/incident note indicated, Resident B was receiving care from the Certified Nursing Assistant (CNA) when she rolled out of bed to the floor. The writer helped the CNA complete the care to the resident. No injuries observed at the time of the incident. The family member, DON and Physician were notified.

A Fall Risk Assessment, dated 11/7/23 at 9:30 p.m., indicated Resident B had "no history of falls in the past 3 months."

On 3/28/23 at 10:45 a.m., during an interview, the Vice President of Clinical Operations indicated the resident sometimes wanted transferred without the lift. She did not know how the resident was being transferred when she became injured. It

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	should have said in the event documentation and/or IDT notes. She was not aware of a fall from the bed in December. 2. On 3/27/23 at 11:30 a.m., Resident D's medical record was reviewed. The diagnoses included, but were not limited to, hypertensive heart disease with heart failure, anxiety and depression. On 3/20/23 at 8:30 a.m., a Nurses' Note indicated "witnessed fall in hallway by dining room. Activity director seen Res collid [sic] with food cart and fell onto right hip and right arm." A Nurses' Note, dated 3/20/23 at 8:35 a.m., indicated DON and MD made aware of fall. Res in charge of self On 3/20/23 at 10:00 a.m., a Nurses' Note indicated, "Res at this [sic] states that when he fell onto floor he also hit the back of his head and is now having nausea and HA [headache]. MD called. Still having pain 4 on scale 1-10 to right hip and right arm and back of head. new order to sent to ER to eval. Res is not on blood thinners. DON made aware. 911 called. when ambulance here res at that time stated thr [sic] food cart bumped the back of his head then he fell. called MD back. Res stated he did not want to go to the hospital. MD and DON aware. Res in charge of self." An Interdisciplinary Team (IDT) note dated 3/21/2023 at 9:30 a.m., indicated "Review of fall on 3/20/2023. Pt [patient] was ambulating in hallway when he collided with meal service cart. Pt fell and back of head made contact with the ground. Pt was immediately assessed by Nursing staff and 911 was contacted. Pt refused EMS evaluation. Staff member pushing cart has been educated and care plan is up to date."			

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	On 3/20/23 at 5:13 p.m., a NP progress note indicated,"...Clinical Narrative: [Name of Resident D] is being seen today for a F/U [follow-up] to fall without injury. Reports, "the food cart hit the back of my head. I did not fall. When the Ambulance came I told them that and I told the nurse." Reports hitting head. AROM [active range of motion] to all extremities. Neuro checks WNL [with in normal limits] . Reports pain to his right arm and knee but states that he has had that for a while. Denies any bruising, laceration, skin tears, or swelling. Patient does not appear to be in acute distress during this visit...Vitals: 99/77 [blood pressure]...." Neuro checks and any additional assessment documentation related to the incident/fall was requested and not received. On 3/27/23 at 2:15 p.m., the VPCO indicated the resident refused care when the ambulance arrived. No further evaluation, neuro checks were done in the facility. 3. On 3/28/23 at 11:00 a.m., the medical record was reviewed for Resident C. The diagnoses included but were not limited to epilepsy (seizure disorder) and diabetes. An IDT note, dated 3/17/23 at 10:24 a.m., indicated the IDT met to discuss Resident C's fall on 3/17/23. Resident C was trying to open door while on motor scooter. Intervention was for OT (Occupational Therapy) to screen for safety awareness on scooter. The NP and DON were made aware. Care plan and assessments were updated. A review of Resident C's Fall Risk Assessment,			

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	dated 3/21/23, indicated "No falls in the past 3 months." On 3/28/23 at 12:13 p.m., the VPCO provided a current policy, dated 12/2022, titled "Fall Program Guidelines.". This policy indicated "...The resident will be assessed for fall risk upon admission and quarterly. Interventions will be implemented if resident is determined to be at risk. Should a fall occur, the nurse shall complete an assessment of the resident and circumstances surrounding the fall, incident. The Interdisciplinary Team (IDT) should determine root cause and evaluate to ensure appropriate interventions are implemented. The attending physician or medical director, in the absence of the attending physician, and the responsible party should be notified. The resident care plan should be revised to reflect any new change in interventions. Effectiveness of interventions will be monitored through the Clinically at-risk program." On 3/28/23 at 12:13 p.m., the VPCO provided a current policy, dated 8/2022, titled "Mechanical Lift Policy." This policy indicated, "A mechanical lift enables nursing personnel to lift a resident to and from bed as safely and as easy as possible. A mechanical lift is to be utilized for residents who are too heavy to be moved by one person, or who are disabled to the point of inability to assist with transfers. Two (2) personnel members must be present when a mechanical lift is utilized. The number of nursing personnel required to lift a resident is dependent upon the specific resident's plan of care and instructions from the nurse along with the manufacturer guidelines...." This Federal tag relates to Complaint IN00404604. 3.1-45(a)(2)			

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