STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00440606. Complaint IN00440606 - Federal/State deficiency related to the allegations is cited at F610. Survey dates: August 12 and 13, 2024 Facility number: 000022 Provider number: 155061 AIM number: 100274510 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 1 Medicaid: 35 Total: 36 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 14, 2024.	F 0000	**Plan of Correction FOR Envive of Lawrenceburg** **F610 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 conducted August 12-13 , 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 21, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith McKee	Executive Director	08/28/2024

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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	§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate a resident's allegation of abuse for 1 of 1 abuse allegations reviewed. (Resident B) Findings include: During an interview on 08/13/24 at 10:14 A.M., the SSD (Social Services Director) indicated Resident B made some allegations of physical abuse during a meeting on 08/08/24. The SSD followed up with the resident for 72 hours related to the allegations and the resident did not repeat the allegations or have any other concerns. She did not interview any other residents about abuse. When she brought the allegation to the Administrator, he took over the investigation. The incident was reported to the State Department of Health by the Administrator on 08/08/24 at 3:28 P.M. The brief description of the incident indicated the resident told a social worker she had been locked in her closet and locked in her room and that someone choked her at night. The resident stated she had a bruise above her eye. The resident was assessed and had no bruising above her eye or on her throat. The resident had a	F 0610	**F610 – Investigate/Prevent/Correct Alleged Violation** *"Facility failed to thoroughly investigate a resident's allegation of abuse for 1 of 1 abuse allegations reviewed. (Resident B)".* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Resident B has extensive history of hallucination, false allegations and delusions, which are care planned and managed as appropriate. The investigation was launched to determine validity of allegation versus hallucination, false allegations and/or delusions. Once determined to be a delusion, investigation was no longer needed.	08/21/2024

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	cupboard for clothing that did not lock and there were no locks on the residents' room doors. The resident's Psychiatric Health Care Provider was notified of the resident's increased hallucinations and would look at adjusting the resident's medications at their next visit. The resident's clinical record was reviewed on 08/12/24 at 7:26 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/30/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, alcohol abuse with alcohol-induced psychotic disorder with hallucination, anxiety, depression, and seizure disorder. The resident resided on the third floor of the facility. During an interview on 08/13/24 at 10:43 A.M., the Administrator indicated the SSD came to him with the resident's allegations. He typed up the reportable and sent it to the State. They looked at the complaint. The resident had no closets to lock her in, and no locks on her doors. The resident reported being choked, but the resident was assessed and had no injuries. Normally, they would interview the other residents that resided on the same floor the resident lived on, but they were all too confused and non-interviewable. The DON (Director of Nursing) may have assessed the non-interviewable residents for signs or symptoms of abuse. During an interview on 08/13/24 at 11:52 A.M., the DON indicated she completed a head-to-toe assessment of Resident B, with no findings. She assessed the other residents that resided on the third floor on the side of the hall that Resident B lived on. There were some residents that were interviewable that lived on the third floor. She did not ask any of the interviewable residents about		**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.** - Like residents with hallucinations, and/or delusions have the potential to be affected by the alleged deficient practice. Resident was assessed with no such allegations. Residents unable to communicate were assessed with no further findings. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Each allegation of abuse will be reviewed in the morning meeting and discussed among the IDT team to determine role and responsibilities for investigative process". If allegations are made over weekends and holidays, the ED will assign roles and responsibilities to those present within the facility to complete timely and report findings. - Education and training were provided to DHS and ADHS on 8/9/24 by the clinical support consultant. Education provided: Accidents/Incidents/Investigation Policy	

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	abuse. She thought the SSD was interviewing residents. Several residents could have been interviewed; she did physical assessments on residents that were not interviewable. A document signed by the DON on 08/09/24 at 2:00 P.M., indicated the names and room numbers of the seven residents that were assessed and found to have no bruising or skin discoloration. A Bed Board for 08/09/24 indicated twenty residents resided on the third floor at the time the allegation of abuse was made. Seven of those residents (Residents B, E, F, G, H, J, and K) were assessed for bruises and skin discoloration. The other thirteen residents (Residents L, M, N, O, P, Q, R, S, T, V, W, X, and Z) that lived on the third floor were not assessed for signs or symptoms of abuse. Of the thirteen residents not assessed, six of them (Residents L, M, S, V, W, and X) were determined to be cognitively intact and interviewable based on their most recent MDS assessments. The current facility policy, titled "Accidents/Incidents/Investigation", with an effective date of 10/2022, was provided by the Administrator on 08/13/24 at 1:25 P.M. The policy indicated, "...All accidents or incidents involving residents...shall be investigated...The following data, as applicable, shall be included...Other pertinent data as necessary or required..." This citation relates to Complaint IN00440606. 3.1-28(d)		**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?** The Accidents/Incidents/Investigation Policy will continue to be followed and reviewed in clinical care meeting to ensure any resident with allegations will be followed up properly for investigation procedure. The results of each allegation will be reviewed by the IDT team to determine validity and accuracy as quickly as the investigation is complete. A determination for the next steps will be determined following this review. IDT team will monitoring continued compliance of the Accidents/Incidents/Investigation Policy for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	