STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00433087 and IN00434508 Complaint IN00433087- Federal/state deficiencies related to the allegations are cited at 689; Complaint IN00434508- Federal/state deficiencies related to the allegations are cited at F689. Survey dates: May 13 & 14, 2024. Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF: 9 SNF/NF: 108 Residential: 9 Total: 126 Census Payor Type: Medicare: 12 Medicaid: 82 Other: 23 Total: 117 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 20, 2024.	F 0000	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 citedduring the Complaint Survey conducted May 14, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 6, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure adequate	F 0689	F689 What corrective action will be	06/06/2024

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

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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	supervision was provided to Resident C, an aggressive resident, to protect Resident B, a cognitively impaired resident, from being pushed to the floor for 1 of 3 residents reviewed for accidents. This deficient practice resulted in Resident B falling and requiring hospitalization for surgical repair of a right femur fracture. (Resident B, Resident C) Finding includes: On 5/13/24 at 9:33 a.m., during interview, Resident B indicated a man got mad, pushed, and threw her, reached down, and grabbed her hair. Resident B indicated it happened in [name of city]. On 5/13/24 at 10:01 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur, anxiety disorder, vascular dementia, unspecified severity, without behavioral disturbance. A Quarterly MDS (Minimum Data Set) assessment dated 3/12/24, indicated Resident B's cognition was moderately impaired, ROM (range of motion) no impairment upper or lower, bed mobility independent, 1 (one) person assist, transfer independent set up help only, toilet independent set up, sit to lying supervision or touching assistance, sit to stand supervision or touching assistance, walk 10 feet supervision or touching assistance, mobility device, walker. The 5/14/24 MDS was still in progress. A care plan for surgical wound to right hip, dated 5/9/24, included, but was not limited to interventions of, treatments as ordered, notify provider of worsening or s/sx (signs and symptoms) of infection.		accomplished for those residents found to have been affected by the deficient practice: Resident C was discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Any Resident with on the same unit had the potential to be affected. Resident C was discharged from the facility. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policy titled “Clinically at Risk Program Guidelines” and the policy titled “Unmanageable Residents” were reviewed by the IDT and determined to be appropriate. Review of all aggressive behaviors for the past 30 days to identify residents at risk for aggression will be completed. IDT will meet to review these behaviors and update care plans as needed. Staff education was provided on the above policies, behavior monitoring and interventions, including the appropriate level of supervision, as well as new care plan updates added. Documentation will be reviewed during the AM clinical meeting to identify any new or worsening aggression.	

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	A care plan for risk for emotional and/or physical distress r/t (related to) history of sexual assault, dated 9/12/23, included, but was not limited to interventions of, allow me to express my concerns, fears, feelings, and expectations. Progress notes included, but were not limited to: 4/21/24 at 11:33 p.m., "Called to room by CNA, resident was sitting on floor in front of bathroom door, resident stated that resident in [Resident C room] came in her room and attacked her, resident was then checked for injuries, resident had large raised area noted to the top of her head and stated that her right hip was hurting, notified NP (nurse practitioner) with findings, received order to transfer resident to [name of hospital] for eval, resident was transferred via [name of ambulance service], DON, RP (representative), and NP notified. " A state reportable incident form was reviewed and indicated on 4/21/24 at 11:35 p.m., Resident C made contact with Resident B causing her to fall to the floor sustaining a reddened area to her head. An orthopedic surgery discharge summary with a discharge date of 4/24/24, included, but was not limited to: ..."Closed fracture of neck of right femur, initial encounter ..." ..."Open treatment of right displaced femoral neck fracture with right hip hemiarthroplasty." ... A progress note dated 5/8/24 at 3:51 p.m., indicated: "Resident came to facility around 1400 (2:00 p.m.) via wheelchair, accompanied by driver. Escorted to room and oriented to room with instructions on how to use call lights and bed controls. VS (vital signs) checked and recorded.		Residents identified as appropriate for the “Clinically at Risk Program” will be added to the program. 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: An audit will be completed weekly for six months on the “Clinically at Risk Program” list to ensure that residents identified during the clinical meeting were added as appropriate and reviewed. The results of the audit will be reviewed during the QAPI meeting and the process will be changed if unable to maintain 100% compliance for at least one quarter. By what date the systemic changes for each deficiency will be completed: June 6, 2024	

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	Assessed operative site with 7-8 stitches draining scant amount of yellowish fluids. No distress noted." Current Physician orders for May 2024 included but were not limited to: OT (occupational therapy) 5x/week for 8 weeks. Tx will consist of self-care training, therapeutic exercises, neuromuscular re-education, therapeutic activities, and group activities, order date 5/10/24. A follow up to the state reportable dated 4/21/24, added on 5/13/24, indicated: "Let this serve as follow up to incident # 439. [Resident C] entered [Resident B] room while she was sleeping. She got up and "confronted" the resident. [Resident C] pushed [Resident B] down resulting in hitting her head and a fractured hip. Residents separated and diversional activities provided for [Resident C]. [Resident B] was sent to ER for evaluation of injury. [Resident C] became increasingly agitated and was sent to ER for evaluation. No change in mood or behavior for [Resident B's] roommate and no signs of psychosocial distress with other residents." On 5/13/24 at 12:50 p.m., Resident C's clinical record was reviewed. Diagnoses included but were not limited to Alzheimer's disease with early onset, unspecified dementia, moderate, with agitation. An Admission MDS (Minimum Data Set) assessment dated 4/11/24, indicated Resident C's cognition was severely impaired, physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): behavior of this type occurred 1 to 3 days during the			

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	assessment period. Care plans were included but were not limited to: Resident refuses care/is non- compliant with care r/t: adjustment to nursing home, dementia, dated initiated 4/9/24. The resident is/has potential to be physically aggressive as evidenced striking out/hitting, getting angry, and being aggressive with staff and other r/t dementia, He gets agitated when staff try to provide care, tends to be more aggressive with male staff, date initiated 4/22/24. A psych progress note dated 4/8/24 included but was not limited to: "Chief Complaint/Reason for this Visit Follow up for dementia. HPI Relating to this Visit Patient seen for follow up for previous reports of agitation and adjustment to facility. Staff states patient is often combative with staff when trying to provide care. He does slightly better with female staff than male staff. He is quiet and does not say much according to staff. He is calm on assessment playing balloon ball during a group activity and says he is doing "ok." Current Risk Factors - Danger to self or others Patient is NOT currently a danger to self/others. Aggression: Physical, Verbal during care. Progress notes included, but were not limited to: 4/13/24 at 3:20 p.m., "Resident noted with the room coming behind a CNA in the resident's room while CNA was straightened up the bed and grabbed ahold of CNA's ponytail pulling back on her head and notified this writer. Resident was also throwing things around the room as well."			

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	4/21/24 at 4:40 a.m., Behavior note: " Resident has frequent episodes of anger and frustration. Verbally threatens to hit staff trying to assist him, often refuses care with ADL's (activities of daily living). Resident was able to be redirected this morning and did assist in changing clothes." 4/21/24 10:37 p.m., Incident note: " Called to Unit by CNA, noticed resident very angry and attempting to attack resident B, received order to transfer resident to ER for eval and treatment." 4/21/24 at 11:25 p.m., Behavior note: " Called to room by CNA, noted resident in violent, agitated state, resident was reported to have walked into room [Resident B] and attacked occupant of that bed, resident also attacked staff and myself included, resident 1 was separated from resident 2 to ensure safety, received order to transfer resident to [name of hospital] for Psychiatric eval, carried out order as noted, resident transferred via [name of ambulance service]" The record lacked documentation of any previous outbursts towards other residents. On 5/14/24 at 11:10 p.m., LPN 1 indicated Resident C had not been observed with aggressive behaviors towards another resident before the night of 4/21/24, only staff. On 5/14/24 at 1:06 p.m., the Administrator indicated written statements were not done by the involved staff, she had handwritten notes of the statements that were taken by phone by herself and the Assistant Director of Nursing. On 5/14/24 at 1:30 p.m., the handwritten statements were reviewed and included the following:			

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	"4/21/23(sic) Sunday 2332 (11:32 p.m.) [RN1]. RN charge called and reported that [Resident C] attacked [Resident B]. He went in room; staff heard her yelling and ran to room. Found her on floor by the bathroom. She stated he came in her room & He pushed her down. She had open area to top of head and c/o hip pain. Staff was able to get him out of room, but he continued to try to come back in door. 2 staff stayed at out on unit to watch and try to redirect him. While nurses attended to her. Another staff called 911 to transport. Staff informed to immediately notify [Administrator] and both families." "Phone call [RN 1] 4/21 around Midnight (11:45pm) [Resident C] went in [Resident B's] room. Clarified which [resident name]. She said he pushed her down and is now very agitated and aggressive with staff. Asked if other residents were around- she said no. Roommate asleep. Asked if [Resident B] was ok- she reported that she has a red spot/bleeding Where she hit her head. Stated they were sending her out. She said staff was with [Resident B] & she came to help. Asked if [Resident C] was still agitated. She said yes- He kept trying to hit staff who were nearby. Reported that [staff name] had blood on his scrubs. (From [Resident B] laceration) Discussed 911 for [Resident C] as well. [RN1] called back (11:57 pm) when 911 arrived. Police wanted to know the "end goal" with [Resident C]. Notified them we wanted evaluation for inpatient psych due to escalated behaviors. [RN1] passed message. Police had no further questions. [RN1] said no other residents were up or around & police were handling [Resident C]. EMS taking [Resident B]. Reported no staff injuries."			

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	On 5/14/24 at 11:28 a.m., the Administrator provided the current policy for unmanageable residents with a revision date of April 2010. The policy included but was not limited to: Each resident will be provided with a safe place of residence... This citation relates to Complaint IN00433087 and IN00434508. 3.1-45(a)(1)			