STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155690	A. BUILDING 00 B. WING	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	1821 LINDBERG RD ANDERSON, IN 46012

(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 Complaints IN00425213, IN00425817, IN00430011, and IN00430437. Complaint IN00425213 - No deficiencies related to the allegations are cited. Complaint IN00425817 - No deficiencies related to the allegations are cited. Complaint IN00430011 - Federal/state deficiencies related to the allegations are cited at F610. Complaint IN00430437 - No deficiencies related to the allegations are cited. Survey dates: March 14 & 15, 2024 Facility number: 000027 Provider number: 155690 AIM number: 100266180 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 1 Medicaid: 41 Other: 6 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 22, 2024.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Koontz RN	DNS	04/02/2024

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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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. §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 report an allegation of abuse to the State Agency in the required timeframe, and failed to complete a thorough investigation of the allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 3/14/24 at 3:21 p.m. Diagnoses included history of a stroke, left side hemiplegia, bipolar disorder, anxiety disorder and depression. An admission Minimum Data Set (MDS) assessment, dated 2/9/24, indicated the resident had moderate cognitive impairment. The resident had no hallucinations or delusions, rejection of care, and had no physical or verbal behaviors.	F 0610	/p> 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 March 15, 2024. Please accept this Plan of	04/05/2024

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	Review of a facility self reportable, dated 3/6/24, indicated on 3/1/24, Resident D alleged a staff member had physical contact with his face. The resident had called the police. The nurse who assessed the resident noted no marks on their face and no evidence of physical contact of any kind. A pain assessment was performed. A follow up report was submitted on 3/12/24 and indicated that due to the resident's inability to provide consistent statements the allegation was determined to be unsubstantiated. The clinical record lacked a progress note regarding the incident on 3/1/24 or a pain assessment. Review of an undated witness statement completed by LPN 3 and included in the facility's investigation documents, indicated the Administrator was called to notify him of the resident's statement that the resident had been struck on his face by a staff member. During an interview on 3/15/24 at 10:07 a.m., the Administrator indicated staff had contacted him the evening of 3/1/24, but had said nothing about the resident's allegation of being struck. He was unaware the outcome of the facility's investigation, which was started on 3/6/24. During an interview on 3/15/24 at 12:50 p.m., QMA 2 indicated she heard LPN 3 talking with the Administrator regarding the resident's allegation that he had been struck in the face. During an interview on 3/14/24 at 3:21 p.m., Resident D indicated, following a smoke break, he had the cigarette tackle box on his lap and was returning it to the nurse's station after being asked		Correction as the provider's credible allegation of compliance as of April 05, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. p paraid="1410128559" paraeid="{50fcb5e5-b405-4e6d-bc6d-d51c176fda68}{122}" >Tag # - F610 Investigate/Prevent Correct Alleged Violation "Facility failed to report an allegation of abuse to the State Agency in the required timeframe, and failed to complete a thorough investigation of the allegation of abuse for 1 of 3 Residents reviewed for abuse (Resident D) 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Resident D's allegation was thoroughly investigated and was found to be unsubstantiated. 2: How other residents having the potential to be affected by the	

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	to by a staff member. Another staff member accused him of taking it. He became upset and began to cuss. Another staff member came up behind him and hit him on the right side of his face from behind his wheelchair. He had waited for the Administrator to come and talk with him, but on 3/5/24, he went to the Social Services Director and the Administrator to ask about the incident. The Administrator indicated he had not seen anything on the surveillance cameras. During an interview on 3/15/24 at 8:45 a.m., the Administrator indicated he was unsure how to access the information on the surveillance cameras and did not have the password to access stored footage. During an interview on 3/15/24 at 9:36 a.m., the DON indicated the allegation of abuse report had not been completed until 3/6/24 because she had not been aware of any incident taking place. She had taken a verbal confirmation from the nursing staff that all assessments had been completed the evening of the incident on 3/1/24, but had failed to check the electronic health record for the information. She had not reviewed the staff written statements prior to submitting the report to the State Agency. During an interview on 3/15/24 at 1:18 p.m., the Corporate Nurse Consultant indicated the facility was unable to access the stored footage on the surveillance cameras at this time. A current facility policy, dated 9/2022, titled, "Resident Abuse, Neglect and Exploitation Procedural Guidelines," provided by the DON on 3/15/24 at 9:36 a.m., indicated the following: "...Purpose: Envive Healthcare (EHC) has developed and implemented processes, which		same deficient practice will be identified and what corrective action will be taken. - All residents had the potential to be affected by the alleged deficient practice. No other Residents were found to be affected. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All Staff was educated on abuse policy and procedure and the ISDH reporting guidelines. - DNS was educated on thorough investigation practices. p paraid="1091449053" paraeid="{85de4ee8-22cd-493c-81c9-6b4797a2126f}{88}" >4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Executive Director/Designee will review Guardian Angel Room Round interviews and Grievances 5 days a week for 4 weeks, then 3	

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	strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedures:...4....f. Investigation i. The Executive Director is accountable for investigation and reporting. ...iv. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations v. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause. vi. Providing complete & thorough documentation of the investigation...." This citation relates to Complaint IN00430011. 3.1-28(d)		times weekly x 4 weeks then weekly x 4 months. ·Executive Director/Designee will interview 5 random staff members on abuse policy and procedure weekly for 6 months. ·Results of these audits will be reviewed by 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 POC as needed for sustaining substantial compliance for no less than months. 5. Date of completion: 04/05/2024	