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	10/22/2024

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 Complaints IN00445466, IN00444830, and IN00442866. Complaint IN00445466: Federal and State deficiencies related to the allegations are cited at F559 and F609. Complaint IN00444830: No deficiencies related to the allegations are cited. Complaint IN00442866: Federal and State deficiencies related to the allegations are cited at F689. Survey dates: October 21 & 22, 2024 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census bed type: SNF: 1 SNF/NF: 110 Residential: 9 Total: 120 Census payor type: Medicare: 4 Medicaid: 90 Other: 17 Total: 111 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 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 October 22, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 20, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Trevino	Executive Director	11/15/2024

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 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change Based on observation, interview, and record review, the facility failed to ensure a resident received a written notice prior to a room change for 1 of 4 residents reviewed for resident rights. A resident was moved from the locked dementia unit to a different hall off the unit without prior or documented notification. (Resident B) Finding includes: During an observation on 10/21/24 at 9:00 A.M., Resident B was observed to have a room on the 500 hall. During record review on 10/21/24 at 10:30 A.M., Resident B's diagnoses included, but was not limited to, dementia with mood disturbance and agitation, anxiety, and major depressive disorder. Resident B's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/8/24, indicated the resident had no cognitive impairment, and resided on the Pavilion (Memory) Unit in room 713 in bed 2. Resident B's physician orders included, but were not limited to, resident may reside on locked secured memory unit (dated 6/7/24). Resident B's progress notes included, but were not limited to, a noted dated 10/16/24 at 11:47 A.M., indicated that resident moved to room 549-2 that date. All personal belongings and medications moved to new unit. Monitoring in place. Encourage acclimation to new apartment and unit.	F 0559	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident B changed rooms in the past. Unable to correct a missed prior notification of a room change that occurred in the past. **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 a room change has the potential to be affected. Notification will be provided and documented for any room change. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff in all departments have been educated that they are not to change resident rooms without prior notification of the Resident's responsible party and that social services should be directing all moves in the absence of an emergency. Anticipated room changes will be discussed in the clinical meeting with IDT. **How the corrective action will be monitored to ensure the deficient practice will not**	11/20/2024

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	During an interview on 10/21/24 at 1:35 P.M., Resident B indicated that he did not receive notification prior to the recent room change, and that he preferred his old room better. During an interview on 10/22/24 at 10:10 A.M., SS4 (Social Service 4) indicated that residents should be notified in writing prior to a room change using an intra-facility room change form. The documentation should be scanned into the resident's record. SS4 indicated that she was not working the day Resident B was transferred and was unaware if the resident was notified in writing prior to the room change. On 10/22/24 at 2:30 P.M., the Facility Administrator provided a facility policy titled, Transfer, Room to Room, dated 08/2024. The policy included, "The purpose of this procedure is to provide guidelines for safely transferring residents from one room to another when such transfer has been approved in accordance with facility policies... Steps in the Procedure... 8. Inform the resident that you are going to move him or her to his or her new room..." This citation relates to complaint IN00445466. 3.1-3(v)(2)		**recur, i.e., what quality assurance program will be put into place:** An audit form was created to determine if notification was completed and documented prior to a room change. This audit will be completed by the ED or designee on all room changes weekly for six months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** November 20, 2024	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to ensure staff immediately reported alleged resident to resident abuse to the Facility Administrator and the facility failed to include known relevant information for 1 of 1 allegations of abuse reviewed. Following documented alleged resident to resident abuse, the facility failed to	F 0609	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The report was updated for the allegation involving Resident B and	11/20/2024

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	report the allegation to the State Agency for 7 days. The reported incident did not contain all residents involved nor did it contain a detailed description of the incident. (Resident B, Resident K) Finding includes: During a review of State reportable incidents on 10/21/24 at 10:05 A.M., an incident report indicated that there was an allegation of inappropriate contact made by Resident B and an "unidentified resident." The incident date and time was reported to be 10/15/24 at 9:01 A.M.. During a review of the facility's investigation of the incident on 10/21/24 at 2:35 P.M., an undated, untimed, typed document indicated that on 10/15/24 an investigation was initiated based on an allegation that Resident B had touched the breast of a female resident. CNA 8 reported to staff that Resident B had grabbed the breast of Resident K. CNA 7 indicated that she was outside the dining room when she heard Resident K yell out, "I'm being molested." CNA 7 then observed Resident B standing behind Resident K. During record review on 10/21/24 at 10:30 A.M., Resident B's diagnoses included, but was not limited to, dementia with mood disturbance and agitation, and sexual dysfunction, and high risk heterosexual behavior. Resident B's most recent quarterly Minimum Data Set (MDS) assessment, dated 10/8/24, indicated the resident had no cognitive impairment and displayed behaviors directed towards others during 1-3 days during the 7 day observation period.		Resident K to include all residents involved and a detailed description of the alleged incident. **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 involved in an abuse allegation has the potential to be affected. Alleged abuse allegations will be reported to the administrator timely. Any reported incidents will include all residents involved and a detailed description of the incident in the final reporting. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff in all departments have been educated to report abuse to the administrator immediately. Administrator and Department Managers reviewed and were reeducated on reporting guidelines. **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:** IDT will review and audit any reportable abuse allegations	

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	Resident B's care plan included, but was not limited to, resident has sexual inappropriate behaviors. A psychiatry visit note, dated 10/8/24, indicated, "Staff request for provider visit due to concerns about increased inappropriate sexual behaviors. Staff reports patient has made inappropriate sexual behaviors to female staff, grabbed another female resident's breast, and tried getting a female staff member into his bed..." During an interview on 10/21/24 at 2:54 P.M., SS4 indicated that a staff member had notified her of an incident that included Resident B had inappropriately touched Resident K. SS4 felt the incident could be interpreted as sexual abuse and notified the Facility Administrator of the allegation. During an interview on 10/22/24 at 1:50 P.M., SS4 indicated that the psychiatry visit note dated 10/8/24, was referencing the same incident between Resident B and Resident K that was reported on 10/15/24.. SS4 indicated that a staff member had came to her on 10/15/24 to ensure that the incident was being looked into, however, that was the first time SS4 had heard of the incident. SS4 then notified the the Facility Administrator. During an interview on 10/21/24 at 9:09 A.M., LPN 12 indicated if perceived abuse was observed, staff should intervene and ensure resident safety, and immediately report the abuse to the Facility Administrator and Director of Nursing (DON). On 10/22/24 at 8:50 A.M., the Facility Administrator supplied a facility policy titled Resident Abuse, Neglect, and Exploitation		during the clinical meetings at least 3 times per week for six months. Reports will be audited to ensure timely reporting, all residents involved are included, and the final report includes a detailed description of the incident. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** November 20, 2024	

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	Procedural Guidelines, dated 09/2022. The policy included, "[Facility Name] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect... d. Identification... ii. Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal... iv. Immediately notify the Executive Director... ii. The Executive Director is responsible for: 1. Notification to the State Department of Health and other agencies..." This citation relates to complaint IN00445466. 3.1-28(c)			
F 0689 SS=D 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 each resident received adequate supervision and assistance devices to prevent falls for 1 of 3 residents reviewed for falls. A resident's fall interventions were not in place. (Resident K) Finding includes: On 10/21/24 at 10:11 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with psychotic disturbance, and repeated falls. Resident K's most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/21/24, indicated the resident's cognition was severely impaired, resident required extensive assist of 2 staff for bed mobility, transfers, toileting, and requried supervision with set up for eating. Resident K had 2 falls since the last assessment,	F 0689	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The fall intervention is in place for Resident K. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents at risk of falls have the potential to be affected. All residents with a fall in the last 30 days were reviewed to determine their fall interventions and confirm that they are in place. **What measures will be put into place and what systemic**	11/20/2024

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	one with injury. Resident K's physician's orders included, but were not limited to, the following: Fall mat at bedside while in bed every shift (ordered 8/1/24). Non-skid mat in front of toilet every shift (ordered 8/1/24). Motion sensor while in bed. Check functioning and placement every shift (ordered 8/20/24). Resident K's care plans included, but were not limited to, resident at risk for falls, included, but were not limited to, the following interventions: Non-skid mat in front of toilet (initiated 8/1/24). Fall mat at bedside while in bed (initiated 8/1/24). Encourage toileting upon rising (initiated 8/20/24). Motion sensor while in bed (initiated 8/20/24). Staff education on functioning of motion sensor (initiated 8/26/24). Toilet and dress every morning at 6:00 A.M. (initiated 9/13/24). Resident K's nurse's progress notes form 8/1/24 through 10/21/24 included the following 4 falls: Fall 1 On 8/1/24 at 2:48 A.M., Nurses Note: "Resident found on the floor mat beside her bed. Asked resident what she was trying to do and resident stated "I don't know" then resident proceeded to state she needed to use the restroom..." On 8/1/24 at 9:28 A.M., Interdisciplinary Team (IDT) Note: "...new intervention in place for fall matt [sic] by bedside while resident is in bed for increased safety." Fall 2 On 8/20/24 at 10:02 A.M., IDT Note: ...resident was attempting to self transfer to bathroom. Head to toe assessment completed, skin tear to R [right] elbow observed, and first aid applied. Wound		**changes will be made to ensure that the deficient practice does not recur:** Staff in all departments were educated on the necessity of maintaining fall interventions. IDT reviewed all residents with a fall in the last 30 days to determine which fall interventions were needed and confirmed placement. Any required fall prevention devices have been placed on the chart as an order to have device placement and functioning confirmed every shift. All new falls will be reviewed by the IDT in AM clinical meetings 5 times per week and a determination will be made about which interventions should be in place. IDT will confirm placement and the presence of an order to check placement and functioning every shift. **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 by the DNS or designee to ensure fall interventions are in place and on the chart for documentation on Five residents twice a week for four weeks, then on 5 residents per week for two months, then on five residents every other week for 3 months. Results of the audit will be	

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	nurse to follow skin tear. Care plan reviewed and updated to include offer and encourage toileting upon rising..." Fall 3 On 8/24/24 at 7:00 A.M., an initial fall note indicated Resident K was found on fall mat next to bed during shift change and the suspected root cause of the fall was that Resident K was previously a night shift get up. The get up list was removed from the unit and her bed alarm was in the off position. On 8/26/24 at 8:57 A.M., IDT Note: "...Resident fell from bed in early morning and was noted sitting on the fall mat next to bed. Staff educated on the proper on and off function of the motion sensor alarm which family provided and being used per family request and preference... " Fall 4 On 9/13/24 at 9:53 A.M., Nurses Note: "Resident slide [sic] to the floor at approx. [approximately] 0600 [6:00 A.M.] this morning... Resident transferred from floor per nursing staff and assisted to personal w/c [wheelchair] and then to dining room area for increased supervision per staff. New intervention in place to assist resident for toileting et dress assist at 0600 [6:00 A.M.] for further prevention of falls and safety." Resident K's Medication Administration Record (MAR), dated 10/22/24, indicated Licensed Practical Nurse (LPN) 24 documented she checked to verify the following interventions were in place: Motion sensor while in bed-check functioning and placement every shift. Resident K's Treatment Administration Record (TAR) for 10/22/24 indicated LPN 24 documented she checked to verify the following interventions were in place: Non-skid mat in front of toilet every shift.		reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** November 20, 2024	

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	Fall mat at bedside while in bed every shift. On 10/21/24 at 1:41 P.M., Resident K was observed in the Pavilion Unit (locked dementia unit) dining room across from the nurse's station sitting in a wheelchair with her eyes closed. There were no staff members present at the time. On 10/22/24 at 1:33 P.M., a non-skid mat was not observed in front of the toilet in Resident K's room. During an interview on 10/22/24 at 1:37 P.M., LPN 24 indicated she was not aware of Resident K having falls and was not sure what interventions were in place at that time. During an interview on 10/22/24 at 1:42 P.M., Qualified Medication Aide (QMA) 43 indicated during day shift Resident K was always in her wheelchair and not in her bed so they could watch her closer, and she was unsure if there should be a non-skid mat in front of the toilet. She was not sure when or who was supposed to check the bed alarm to see if it was on or working because Resident K wasn't in bed during her day shifts. At that time, she indicated the working shifts were 6:30 A.M. to 7:00 P.M. and 6:30 P.M. to 7:00 A.M. During an interview on 10/22/24 at 2:20 P.M., the Facility Administrator indicated they did not have a policy, but staff should follow physician's orders and the resident's plan of care. On 10/22/24 at 2:45 P.M., a Falls and Fall Risk Managing Policy, dated 08/2024, was provided by the Administrator. The policy indicated "...the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling... will implement a			

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	resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls... Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy... " This citation relates to complaint IN00442866. 3.1-45(a)			