STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		A. BUILD B. WING					
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D PROVIDER'S PLAN OF CORR CFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF AG DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
Bldg. 00	Licensure Survey. Survey dates: Octol Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type Medicare: 6 Medicaid: 17 Other: 4 Total: 27 These deficiencies: accordance with 41 Quality review com	reflect State Findings cited in 0 IAC 16.2-3.1.	F 0000	Preparation and/or executive plan of correction deconstitute admission or by the provider of the trest alleged or conclust forth in the Statement of Deficiencies. The Plant Correction is prepared a executed solely because required by the provision Federal and State law. Correction is submitted to the allegation of nonceited during the Annual conducted October 8-1. Please accept this Plant Correction as the provider respectfully received with paper compute considered in estable the provider is in substate compliance.	oes not agreement uth of the sions set of of and/or se it is ons of The Plan of to respond compliance Survey 1, 2024. of der's ompliance 24. The quests desk oliance to ishing that		
F 0580 SS=D Bldg. 00	Based on interview failed to notify the representative when	and record review, the facility physician and resident a residents left the facility of 3 residents reviewed for	F 0580	This Plan of Correction center's credible allegat compliance. Preparation and/or exect this plan of correction do constitute admission or by the provider of the tree.	tion of cution of oes not agreement	11/11/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Int. Administrator

(X6) DATE 11/01/2024

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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April Haggerty

11/13/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/11/2024 155520 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 909 NORTH FIRST AVE **ENVIVE OF RIVER CITY EVANSVILLE, IN 47710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. On 10/9/24 at 2:12 P.M., Resident 22's guardian alleged or conclusions set forth in indicated staff should contact her every time the the statement of deficiencies. The resident left the facility. On 10/4/24 she let the plan of correction is prepared facility know that it was ok for the resident to and/or executed solely because it leave on Mondays, Wednesdays, and Fridays is required by the provisions of and did not need to be contacted on those days. federal and state law. On 10/9/24 at 9:12 A.M., Resident 22's clinical 1.) What corrective action(s) will record was reviewed. Diagnoses included, but be accomplished for those were not limited to, schizophrenia and stimulant residents found to have been dependence. Resident 22 was admitted to the affected by the deficient practice? facility on 9/13/24. 1) Resident # 22 no longer resides at the facility: therefore, no The most current Admission Minimum Data Set further corrective action could be (MDS) Assessment, dated 9/20/24, indicated taken for this resident. Resident 22 had no cognitive impairment and was 2) Resident # 75's Leave of independent in all Activities of Daily Living Absence (LOA) order was updated (ADLs). on October 9, 2024, to read "Resident may go out on A Letters of Temporary Guardianship document, therapeutic leave with dated 8/29/24, indicated Resident 22 was assigned medications." a court-appointed guardian. 2.) How other residents having the An Admission Elopement Risk Assessment, dated potential to be affected by the 9/13/24, indicated Resident 22 was at low risk for same deficient practice will be elopement. identified and what corrective action(s) be taken? On 10/9/24 at 11:30 A.M., an elopement binder Residents with orders for LOA was observed on the 300 hall nurses station desk. with supervision have the potential The binder indicated Resident 22 was at risk for to be affected by the cited elopement. The binder included, but was not practice. AN audit of physician limited to, Resident 22's picture, name, date of orders has been conducted to birth, room number, physician name, and identify those residents who emergency contact name. The emergency contact require supervised LOA's. The listed was the court-appointed guardian. care plans of those residents identified will be reviewed and A physician order, dated 10/1/24, indicated that revised, as necessary. the resident had a state guardian and was not permitted to go outside and smoke or leave the 3.) What measures will be put into

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facility unless approved by the guardian.

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place and what systemic changes

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLE	ETED
		155520	B. W	ING		10/11/2	2024
		1	<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ORTH FIRST AVE		
	OF RIVER CITY				SVILLE, IN 47710		
CINVIVE	OF RIVER CITT			EVANS			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
					will be made to ensure that the	е	
		ing care plan, dated 9/18/24,			deficient practice does not rec	cur?	
	included an interve	ntion to ensure the resident's			Licensed nursing staff and		
	safety.				Social Services Director (SSD))	
					have been re-educated relativ		
		lacked a care plan related to the			Notification of Changes, include	ding	
	court-appointed gua	ardian or elopement risk.			and not limited to, notifying		
					physicians and resident		
	•	onsibility For Leave Of			representatives when resident		
	, ,	cument indicated the resident			who require supervision leave	the	
	signed herself out of	of the facility on the following			facility independently.		
	dates:						
	9/18/24 at 11:33 A.				4.) How the corrective action(s	s)	
	9/18/24 at (illegible				will be monitored?		
	9/18/24 at 5:10 P.M				Director of Nursing Services		
	9/18/24 at 7:00 P.M		(DNS), Social Services Director				
	9/19/24 at 3:50 P.M		(SSD), or designee will review			/	
	9/19/24 at 6:10 P.M				LOA logs 5 days a week for 1		
	10/3/24 at 1:30 P.M	1 .			month and 3 days a week for		
					months to identify any LOA's t		
		s note, dated 10/7/24 at 6:26			required resident representative		
		resident left the facility			and/or physician notification, a		
	independently and	returned "weak".			to ensure notifications have be		
					made, and that documentation		
		lacked documentation that the			relative to LOAs is complete a		
		vsician was notified that			accurate. Any identified conce		
		herself out of the facility on			will promptly be addressed wit		
	9/18/24, 9/19/24, 10	0/3/24, and 10/7/24.			the responsible individual(s).	The	
	0 10/0/24	0.001			results of these audits will be		
		0 P.M., the Director of Nursing			reviewed in Quality Assurance		
		at the former administrator had			Monthly x6 months or until an		
		te the resident outside to smoke			average of 90% compliance o		
		plaining. The facility was			greater is achieved x3 consec		
	_	ardian since she was admitted.			months. The QA Committee w		
		r was entered on 10/1/24 to			identify any trends or patterns		
	make staff aware the resident was not to leave				make recommendations to rev	vise	
	without guardian approval and to safeguard the				the plan of correction as		
	resident from leaving at night on her own. It was				indicated.		
		ys, Wednesdays, or Fridays,					
	but the DON was not sure when that was		1		5. Completion date: Novembe	r 11,	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520	1 1	JILDING	INSTRUCTION 00	(X3) DATE COMPL 10/11/	ETED
	PROVIDER OR SUPPLIEF			909 NO	ADDRESS, CITY, STATE, ZIP COD RTH FIRST AVE VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE
IAG	changed. The Social supposed to docume DON was unable to related to the change On 10/9/24 at 2:50 9/13/24 to 9/30/24, the facility under ar 9/30/24 and 10/4/30 mind many times alleave the facility. Ot to let Resident 22 g Mondays, Wednesd P.M. to 2:30 P.M. with the SSD when indicated the reside the SSD was not do At that time, she inducated in the clinic P.M. The SSD was documentation from guardian before 10/On 10/10/24 at 1:40 the guardian and ph when the resident leformer administrate out to smoke with s guardian. All notific physician should be note. 2. On 10/09/24 at 7 record was reviewe were not limited to, assistance with perswasting.	I Service Director (SSD) was ent that information, but the find any documentation e of LOA approval. P.M., SSD indicated that from Resident 22 was not to leave by circumstances. Between to, the guardian changed her bout when the resident could in 10/4/24, the guardian agreed to out on independent LOA on lays, and Fridays from 1:30. The resident was to check in she left and came back. She in thad been doing that, but cumenting those occurrences. Hicated a social service ling the conversations with dmission to current had been all record on 10/9/24 at 1:24 unable to provide in conversations with the		IAU	2024		DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	NG		10/11/	/2024
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			RTH FIRST AVE		
ENI\/I\/E	OF RIVER CITY				VILLE, IN 47710		
	OF RIVER OFF			LVAINO	· · · · · · · · · · · · · · · · · · ·		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	,	t) Assessment, dated 10/6/24,					
		esident was cognitively intact					
	_	on staff for transfer, dressing,					
	hygiene, and mobil	ity.					
	-	ncluded, but were not limited					
	to:	CA1 > 24					
		eave of Absence) with					
	responsible party P.	RN (as needed), dated 9/29/24.					
	A Dalanca Of Dage	onsibility For Leave Of					
		indicated the resident signed					
		acility on the following dates:					
	10/3/24 at 12:47 P.I	•					
	10/8/24 at 1:00 P.M						
		ained five signatures that did					
		r time and were illegible.					
	not specify a date of	time and were megiote.					
	The clinical record	lacked documentation that the					
		ied when the resident left					
		without a responsible party.					
	masponaona, ana	winien a respensiere parsy.					
	Interview on 10/10/	/24 at 1:36 P.M., the DON					
		g) indicated the order needed					
	· ·	ndicate the resident could go					
	LOA on his own.	e					
	On 10/9/24 at 11:55	5 A.M., the DON provided a					
	current Guidelines	for LOA policy, dated 6/2023,					
		gn-out log should be available					
	for the resident or r	esponsible party to sign out					
		npus for a leave of absence".					
	-						
	On 10/9/24 at 3:55	P.M., the DON provided a					
	_	and Elopement policy, dated					
	8/2022, that indicat	ed "A list of residents at risk					
	for elopement is ma	aintained in a binder with					
	corresponding pictor	ares When the resident					
	returns to the facilit	ty, the Director of Nursing					
	Services or Charge	Nurse willcontact the					
							I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B		A. BU	2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/11/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΤE	(X5) COMPLETION DATE	
	conditions of the relegal representative On 10/10/24 at 9:13 current Adult Guard	3 A.M., the DON provided a dianship in Indiana: The Basics						
	limited by the court	2018, that indicated "unless , a guardian is responsible for ising the protected person's						
	provided a current (Condition or Status indicated "The nurs physician or physic	O A.M., the Administrator Change in a Resident's policy, dated 8/2024, that e will notify the resident's ian on call when there has without proper medical						
F 0635 SS=D Bldg. 00	3.1-5(a)(3) 483.20(a) Admission Physicic	ian Orders for Immediate						
5. 35	Based on observation review, the facility orders upon admiss inserted central cathemanagement of their enhanced barrier proviewed for infection of the infectio	on, interview, and record failed to ensure a resident had ion for their PICC (peripherally neter), wound care, ir wound vac, and an order for ecautions for 1 of 1 resident on control. (Resident 225) O A.M., Registered Nurse (RN) 9 ring vancomycin 750 50 milliliters (mL) to administer sign on the door indicated the nanced barrier precautions of donn a gown prior to caring	F 06	35	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreer by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed set because it is required by the provisions of federal and state.	t ment he et ction olely law.	11/11/2024	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		155520	B. W	ING		10/11/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			ORTH FIRST AVE		
FN\/I\/F	OF RIVER CITY				VILLE, IN 47710		
				LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		N 9 flushed the first lumen on			be accomplished for those		
		C line with 10 mL of saline and			residents found to have been		
		cond lumen on the PICC line			affected by the deficient pract		
	with 8 mL of saline. RN 9 hooked the vancomycin				RN # 9 was re-educated at	the	
		d set the medication to run at			time of survey relative to		
		ate. At that time, a wound vac			Enhanced Barrier Precautions	3	
	was observed on th	e resident's coccyx.			(EBP).	_	
	0 10/0/04 / 1.53	D. K. D. 11 (2051) 11 1 1			Necessary physician orders		
		P.M., Resident 225's clinical			Resident # 225 pertaining to t		
		ed. Resident 225 was admitted			PICC line and precautions we		
		0/5/24. Diagnoses included, but			obtained at the time of the sur	vey.	
		, osteomyelitis (infection in the			2) Have athern residents having	4la a	
	bone).				2.) How other residents having	-	
	Current physician	arders included but were not			potential to be affected by the		
	limited to:	orders included, but were not			same deficient practice will be	•	
		ntravenous solution (antibiotic),			identified and what corrective		
		sly two times a day for			action(s) be taken? All newly admitted residents		
	_	elated to osteomyelitis, dated			have the potential to be affect		
	10/7/24.	clated to osteomyemis, dated			by the cited practice. Thus, th		
	* *	h (lab work that is checked to			plan of correct applies to all	13	
		ancomycin in blood stream),			residents newly admitted to the	e	
	CBC (complete blo	-			facility.		
		etabolic panel), one time only			lacinty.		
		s) antibiotics for 1 day, dated			3.) What measures will be put	into	
	10/8/24.	•			place and what systemic char		
	Assess IV site ever	ry shift for signs and symptoms			will be made to ensure that the	•	
		tration every shift, dated			deficient practice does not rec		
	10/6/24.				Licensed nurses have recei		
					re-education relative to Admis	sion	
	The clinical record	lacked orders for saline flushes			Physician Orders for Immedia	te	
	through Resident's	PICC line, order for PICC line,			Care, including but not limited		
	wound vac orders a	and wound care, and enhanced			ensuring all necessary physic	ian	
	_	or transmission-based			orders are present (e.g., wour	nd	
	precautions related	to Resident's wound and PICC			care, IV care, infection control	l ,	
	line.				etc).		
	Current care plans for Resident 225 included, but				4.) How the corrective action(s)	
	were not limited to				will be monitored?		
	I have a venous access device specify: picc,				DNS, or designee, will be		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	ING		10/11/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			RTH FIRST AVE		
FNVIVE	OF RIVER CITY				VILLE, IN 47710		
	- TAVER OFF						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		IV related to antibiotics, date			responsible for auditing the ch	arts	
	initiated 10/5/2024				of all new admissions the day		
		elling or increased pain during			following the admission for 1		
	1 -	nd notify provider, date			month to ensure all necessary		
	initiated 10/5/2024				physician orders are present.		
	10/5/2024.	ndicated, date initiated			Thereafter, the DNS, or design		
		ate Initiated 10/5/2024.			will be responsible for auditing	ıne	
	· · · · · · · · · · · · · · · · · · ·				charts of all new admissions	_	
		signs and symptoms of ation, infiltration, increased			within 3 days of admission for		
	pain, date initiated				months to ensure all necessar	-	
	l -	red, date initiated 10/5/2024.			physician orders are present.	Ally	
		intravenous) medications for:			promptly addressed with the		
		rellulitis (skin infection), date			responsible individual(s).		
	initiated 10/5/2024						
	10,0,2021	•			The results of these audits will	be	
	An admission skille	ed nursing note, dated 10/6/24,			reviewed in Quality Assurance		
		dent 225 had a power injection			Meetings monthly x 6 months		
		est and wounds on the left			until an average of 90%		
	_	luteal fold, coccyx, and left toe.			compliance or greater is achie	ved	
	Initial wound meas	-			x3 consecutive months. The C		
	Left gluteal fold 6	cm (centimeters) x 2 cm x 0.2 cm			Committee will identify any tre	nds	
	Right gluteal fold 3	3 cm x 1.5 cm x 0.2 cm			or patterns and make		
	Coccyx wound vac	in place			recommendations to revise the	Э	
	Left toe 1.2 cm x 0	.1 cm x 0.1 cm.			plan of correction as indicated		
		41 P.M., the Director of Nursing			5.) Completion Date: Novemb	er	
		r PICC, enhanced barrier			11, 2024		
	1 ^	ound care should have been					
		ion. She indicated a resident					
		nould have basic orders related					
		cluding saline flushes, infection					
		vering the lumens of the PICC,					
	and wounds should	have treatment orders.					
	A Disserting of the						
	1	es policy, provided by					
		on 10/11/24 at 10:01 A.M.,					
		esident is admitted, orders for					
		ion, physician assistant, purse					
	provided by physic	ian, physician assistant, nurse	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/11/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	112	DATE
F 0641	practitioner, or clin 3.1-30(a) 483.20(g)	ical nurse specialist".					
SS=D		aamanta					
	Accuracy of Asse	ssments					
Bldg. 00	failed to ensure acc (MDS) assessments with Post Traumati intravenous access of 1 residents reviewe Resident 10, Resident	32 P.M., Resident 21's clinical ed. Resident 21 was admitted on on admission included, but , osteomyelitis, Post Traumatic	F 06	541	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions storth in the statement of deficiencies. The plan of correction is prepared and/or executed store because it is required by the provisions of federal and states.	of ot ement the eet ection solely	11/11/2024
	,	TSD), and borderline			What corrective action(s) was a second or		
	Set) Assessment, da Resident 21 was co PTSD, and did not	narterly MDS (Minimum Data ated 9/25/24, indicated ognitively intact, did not have have IV (intravenous) access.			accomplished for those reside found to have been affected be deficient practice? 1.) Resident #21 had Modification of the Quarterly I and Modification of the State Optional-Other completed on	by the	
	-	, dated 9/19/24, indicated			10/10/24 to ensure accuracy	of	
		IV Medications related to			the assessments.		
	osteomyelitis of rig	tht foot, Date Initiated: 9/19/24.			2.) Resident #10 had Modification of the Quarterly I	MDS	
	During an interview	v on 10/10/24 at 12:41 P.M., the			and Modification of the State		
	Director of Nursing	g (DON) indicated the MDS			Optional-Other completed on		
	Assessment should	have indicated Resident 21			10/10/24 to ensure accuracy	of	
	did have a diagnosi	s of PTSD and did have IV			the assessments.		
	access at the time o	of the MDS Assessment on			3.) Resident #2 had Modific	ation	
	9/25/24.				of the Quarterly MDS and		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024			
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	•		
ENVIVE	OF RIVER CITY		EVANSVILLE, IN 47710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	2 0 10/0/24 + 0.3	07 A M. D. 11 . 101 . 11 . 1		Modification of the State			
		37 A.M., Resident 10's clinical d. Resident 10 was admitted on		Optional-Other completed or	· · · · · · · · · · · · · · · · · · ·		
		included, but were not limited		10/14/24 to ensure accuracy	OT		
	1	cle weakness and abnormality		the assessments.			
	of gait and mobility	-		2. How other residents havin	ing the		
	or gait and moonity	•		potential to be affected by th	-		
	The most recent Ou	arterly MDS (Minimum Data		same deficient practice will b			
		ated 9/27/24, indicated		identified and what corrective			
		gnitively intact. Resident 10		action(s) be taken?			
	required substantial	assistance (staff perform		All residents who have PTS	SD, IV		
	more than half of th	e work) for toileting, bathing,		access, and who have susta	ined		
and transfers. The MDS Assessment indicated no			falls have the potential to be				
	falls since the prior	MDS Assessment on 6/27/24.		affected. An audit has been			
				conducted to identify residen			
	_	al summary, dated 7/20/2024 at		with these conditions. This p	lan of		
		ed Resident 10 experienced an		correction applies to those			
		sulting in a large hematoma on		residents identified. The MD	S' of		
		l, and was transported to the		these residents have been			
	hospital.			reviewed to ensure accuracy			
	Duning on interview	on 10/10/24 at 12:41 D.M. the		modifications completed and			
	_	on 10/10/24 at 12:41 P.M., the (DON) indicated the MDS		submitted, as necessary.			
		have indicated Resident 10		3. What measures will be pu	t into		
		etween the previous and most		place and what systemic cha			
	recent MDS Assess			will be made to ensure that t	~		
		22 P.M., Resident 2's clinical		deficient practice does not re			
		d. Diagnoses included, but					
		repeated falls, hemiplegia and		The MDS Coordinator has	been		
	hemiparesis followi	ng cerebral infarction affecting		re-educated relative to Accur	racy of		
		ide, and symptoms and signs		Assessments, including but i	not		
	involving cognitive	functions and awareness.		limited to, ensuring diagnose	es,		
				IVs, and falls are codded			
		uarterly MDS (Minimum Data		accurately on the MDS.			
		ated 9/13/24, indicated					
		lly cognitively impaired,		4. How the corrective action((s) will		
		stance of staff (staff does less		be monitored?			
	, ,	ene and dressing, and had no		DNO 4	:.		
	lalis since the prior	assessment on 6/14/24.		DNS, or designee, will aud			
				completed MDS's 3 times pe	er		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155520	B. W	ING		10/11/	/2024
				_			
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
					PRTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Physician's orders i	ncluded, but were not limited			week for 1 month, then f2 time	es	
	to:				per week for 1 month, and we	ekly	
	Bilateral side rails t	to promote bed mobility every			thereafter for 4 months, to ens	-	
	shift, dated 4/8/24.				residents' diagnoses, IV's, and		
	1	BAT (Weight Bearing as			falls are accurately coded. An		
	Tolerated), dated 4/				identified concerns will be	,	
	,,,				promptly addressed with the N	/IDS	
	The current falls ca	re plan indicated that Resident			Coordinator.		
		ls/injury due to impaired					
		y of falls, dated 4/8/24.			The results of these audits will	l be	
		ded, but were not limited to:			reviewed in Quality Assurance		
		assist with transfer and ADL			Meeting monthly x 6 months of		
	_	Living), footwear to prevent			until an average of 90%		
		pate and meet the resident's		compliance or greater is achieved			
	needs.	•			x 3 consecutive months. The (
					Committee will identify any tre		
	A nursing progress	note, dated 7/19/24 at 1:24			or patterns and make		
		resident had an unwitnessed			recommendations to revise the	e	
	fall without injury i				plan of correction as indicated		
	During an interview	v on 10/10/24 at 3:41 P.M., the			5. Completion Date: Novembe	r 11,	
	DON (Director of N	Nursing) indicated the resident			2024		
	was not coded for f	alls on the Quarterly MDS					
	Assessment dated 9	0/13/24 and should have been.					
	On 10/11/24 at 8:30	0 A.M., Regional Support					
	provided a policy ti	itled Resident Assessment,					
	dated 8/24, that ind	icated "Assessments are					
	completed by the st	aff members who have the					
	skills and qualificat	tions to assess relevant care					
	areas and who are k	knowledgeable about the					
	resident's strengths	and areas of decline.					
	Information in the l	MDS assessment will					
	consistently reflect	information in the progress					
	notes, plan of care,	and resident					
	observations/interv	iews".					
F 0655	483.21(a)(1)-(3)						
SS=D	Baseline Care Pla	an					
Bldg. 00							

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	TOF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	, ,	JILDING	00	COMPL	
		155520	B. WING			10/11/	
						14, 11,	
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE		
ENVIVE	OF RIVER CITY				SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE
	Based on observation	on, interview, and record	F 00	655	This Plan of Correction is the		11/11/2024
		failed to ensure a resident had			center's credible allegation of		
		related to their wounds and			compliance.		
	_	t for 1 of 1 residents reviewed					
	for infection control	l. (Resident 225)			Preparation and/or execution	of	
					this plan of correction does no		
	Finding includes:				constitute admission or agree		
					by the provider of the truth of	the	
	On 10/9/24 at 11:40	A.M., a wound vac was			facts alleged or conclusions s	et	
	observed on Reside	nt 225's coccyx.			forth in the statement of		
					deficiencies. The plan of corre	ection	
	On 10/9/24 at 1:53	P.M., Resident 225's clinical			is prepared and/or executed s	solely	
	record was reviewe	d. Resident 225 was admitted			because it is required by the		
	to the facility on 10	/5/24. Diagnoses included, but			provisions of federal and state	e law.	
	were not limited to,	osteomyelitis (infection in the					
	bone).				1.) What corrective action(s)	vill	
					be accomplished for those		
		ed nursing note, dated 10/6/24,			residents found to have been		
		ent 225 had a power injection			affected by the deficient pract		
	_	est and wounds on the left			Resident #225s care plan w		
		luteal fold, coccyx, and left toe.			updated to reflect the wound		
	Initial wound measu				wound treatment on 10/12/24		
	-	em (centimeters) x 2 cm x 0.2 cm					
		cm x 1.5 cm x 0.2 cm			2.) How other residents havin	_	
	Coccyx wound vac	•			potential to be affected by the		
	Left toe 1.2 cm x 0.	1 CHI & U.1 CHI.			same deficient practice will be	;	
	The clinical record	lacked baseline care plans for 4			identified and what corrective		
		5's documented wounds, as			action(s) be taken?		
		t with a wound vac the			All newly admitted residents		
	resident had in plac				have the potential to be affect		
	1551aciii naa iii piac	- ·			by the cited practice. Thus, th		
	On 10/10/24 at 12·4	11 P.M., the Director of Nursing			plan of correction applies to a		
		were updated immediately			residents newly admitted to the		
	and as needed.				facility.		
	On 10/11/24 at 8:30	A.M., the Administrator			3.) What measures will be put	tinto	

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provided a Care Plane, Comprehensive

Person-Centered policy, dated 8/2024, that

indicated "The comprehensive, person-centered

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place and what systemic changes

deficient practice does not recur?

will be made to ensure that the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/11/2024	
	PROVIDER OR SUPPLIER OF RIVER CITY		STREET 909 N EVAN		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	care plandescribe furnished to attain o	es the services that are to be or maintain the resident's physical, mental, and		Licensed nurses responsible completion of the Baseline C Plans have been re-educated relative to ensuring all pertineresident conditions are addresson the Baseline Care Plan. 4.) How the correction action will be monitored? DNS, or designee, will be responsible for auditing the confollowing the admission for 1 month, then within 48 hours of all new admission for 5 months to enall pertinent resident conditionare addressed on the Baselin Care Plan. Any identified confollowing the admission for 5 months to enall pertinent resident conditionare addressed on the Baselin Care Plan. Any identified confollowill be promptly addressed with the responsible individual(s). The results of these audits we reviewed in Quality Assurance Meeting monthly x 6 months until an average of 90% compliance or greater is achifus a consecutive months. The Committee will identify any troop patterns and make recommendations to revise the plan of correction as indicate 5. Completion Date: November 2024	le for are dident essed (s) charts of essure ens encerns or eved QA ends ends ene d.
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155520	B. W	ING		10/11/	/2024
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					ORTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
Bldg. 00							
	Based on record review and interview, the facility failed to ensure care plans were revised for 2 of 3		F 00	657	This Plan of Correction is the		11/11/2024
					center's credible allegations of	f	
	residents reviewed for accidents. Care plans were				compliance.		
	not revised after falls, substance misuse, and						
	determination of elopement risk. (Resident 2,				Preparation and/or execution	of	
	Resident 22)				this plan of correction does no		
					constitute admission or agree		
	Findings include:				by the provider of the truth of t		
					facts alleged or conclusions se		
	1. On 10/9/24 at 12:	:22 P.M., Resident 2's clinical			forth in the statement of		
	record was reviewe	d. Diagnoses included, but			deficiencies. The plan of corre	ection	
	were not limited to, repeated falls, hemiplegia and				is prepared and/or executed s	olely	
	hemiparesis following cerebral infarction affecting				because it is required by the	•	
	left non dominant side, and symptoms and signs				provisions of federal and state	;	
	involving cognitive	functions and awareness.			law.		
	The most current Q	uarterly Minimum Data Set			1. What corrective actions(s) v	vill	
	(MDS) Assessment	, dated 9/13/24, indicated			be accomplished for those		
	Resident 2 was mile	dly cognitively impaired,			residents found to have been		
	required partial assi	stance of staff (staff does less			affected by the deficient practi	ce?	
	than half) with hygi	ene and dressing, and had no			1.) Resident # 2's fall prever	ntion	
	fall since the prior a	assessment.			care plan was reviewed and		
					revised on 10/10/24.		
	Physician's orders in	ncluded, but were not limited			2.) Resident # 22 no longer		
	to:				resides at the facility: therefore	e, no	
	Bilateral side rails t	o promote bed mobility every			further corrective action could	be	
	shift, dated 4/8/24.				taken for this resident.		
	Activity Level: WB	SAT (Weight Bearing as					
	Tolerated), dated 4/	8/24.			2. How other residents having	the	
					potential to be affected by the		
	The current falls can	re plan indicated that Resident			same deficient practice will be		
	2 was at risk for fall	ls/injury due to impaired			identified and what corrective		
	mobility and history	y of falls, dated 4/8/24.			action(s) be taken?		
	Interventions include	led, but were not limited to:			Residents who have sustain	ed	
	Anticipate and mee	t the resident's needs, initiated			falls in the last 60 days, who a	ire	
	on 4/8/24				at risk for elopement, and who)	
	Set up craft station	in room, initiated on 6/14/24.			have substance abuse concer	ns	
					have the potential to be affected	ed	
	An incident note, da	ated 6/29/24 at 1:00 P.M.,			by this cited practice. Audits h	ave	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	ING _		10/11/	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			RTH FIRST AVE		
FNVIVE	OF RIVER CITY				VILLE, IN 47710		
					,		•
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	 	TAG	DEFICIENCY)		DATE
		2 had an unwitnessed fall. The			been conducted to identify the		
	care plan was not updated with a new				residents who fit these catego	ries,	
	intervention.				their care plans have been		
					reviewed and revised, as		
	A nursing note, dated 7/19/24 at 1:24 P.M.,				necessary, to ensure interven	tions	
		2 had an unwitnessed fall. The			are current and appropriate.		
	care plan was not updated with a new						
	intervention.				3. What measures will be put		
		10/00/01			place and what systemic chan	-	
	_	ed 9/22/24 at 4:32 P.M.,			will be made to ensure that the		
		2 had an unwitnessed fall. The			deficient practice does not rec	ur?	
	care plan was not updated with a new						
	intervention.				Licensed nursing staff, MDS	5	
		10/10/01 - 0.05 7.5 1			Coordination and the		
	_	v on 10/10/24 at 2:25 P.M., the			Interdsciplinary Team (IDT) ha		
		g (DON) indicated that the care			received re-education relative		
	1 ~	updated after each fall.			Care Plan Timing and Revisio	n,	
		12 A.M., Resident 22's clinical			including but not limited to		
		d. Diagnoses included, but			implementing and/or updating		
		schizophrenia and stimulant			resident's care plan to ensure	fall	
	dependence.				prevention interventions are		
	771	1 · · · · · · · · · · · · · · · · · · ·			current, elopement risk is		
		dmission Minimum Data Set			addressed, and substance ab	use	
		, dated 9/20/24, indicated			is appropriately addressed.		
		cognitive impairment, had no			4) [[_\	
	· ·	independent in all Activities			4.) How the corrective action(s	S)	
	of Daily Living (Al	LDS).			will be monitored?		
	A gurrant history of	f substance abuse			DNS or decigned will be		
	A current history of	s) care plan, dated 9/14/24,			DNS, or designee, will be	ro	
	included the follow				responsible for auditing the ca		
		ation of feelings, fears, and	1		plans of 3 residents daily for 2	•	
	anxiety.	ation of feelings, fears, and			weeks to ensure all pertinent resident conditions are addres	read	
	Labs as ordered.						
	Medications as orde	ered			Thereafter, the DNS, or design		
		icy on substance abuse with			will be responsible for auditing		
		e party and ensure they			care plans of at least 3 resider	IIIO	
		e party and ensure they nences of not following facility	1		per week for 5 1/2 months to ensure all pertinent resident		
	policy.	ichees of not following facility			•	,	
	Therapy evaluation	as needed			conditions are addressed. Any	1	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155520	B. W	'ING		10/11/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			RTH FIRST AVE		
ENVIVE	OF RIVER CITY				VILLE, IN 47710		
					_, · · · •	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	KEGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	A Social Samilage -	rogress note, dated 9/27/24 at			promptly addressed with the		
	-	_			responsible individual(s).		
	11:39 A.M., indicated a Certified Nursing Aide (CNA) notified the Social Service Director (SSD) and Director of Nursing (DON) that Resident 22				The results of these audits wil	l bo	
					reviewed in Quality Assurance		
		t were seen crushing a white			Meeting monthly x6 months or		
		y. The white substance was			until an average of 90%	•	
		resident's deodorant			compliance or greater is achie	eved	
		orcement was called. An officer			x3 consecutive months. The C		
		upon arrival and it tested			Committee will identify any tre		
		nphetamine. Resident 22			or patterns and make		
	-	ne drug but would not say how			recommendations to revise the	е	
	long she had the drugs in her possession or				plan of correction as indicated	l.	
	where she got them						
					5. Completion date: Novembe	r 11,	
	_	not updated following the			2024		
		imphetamines or law					
	enforcement on 9/2	7/24.					
		A.M., an elopement binder					
		e 300 hall nurses station desk.					
		d Resident 22 was at risk for					
	-	der included Resident 22's					
	_	of birth, room number, d emergency contact name.					
	physician name, and	d emergency contact name.					
	The clinical record	lacked a care plan related to					
	Resident 22's eloper	-					
	1105140111 22 5 010pc						
	On 10/9/24 at 11:50	A.M., the Director of Nursing					
		at all residents in the					
		nould also have a care plan.					
	•	*					
	On 10/10/24 at 9:04	A.M., the DON indicated the					
	care plan was not up	pdated following the incident					
	with the methamph	etamine and law enforcement					
	on 9/27/24.						
		5 A.M., the Regional Support					
	indicated there was	no substance abuse policy.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024	
	PROVIDER OR SUPPLIER		909 NO	ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
IAU	That policy was reting September and was was not updated to a current Wandering 8/2022, that indicate developed and indivare at risk of elopem wandering, elopemoresident's care plan interventions to main the constant of the person-Centered point of the person-Centered point of the person and care plans are rether residents and the change".	red the first week of not replaced. The care plan	TAG		DATE
F 0658 SS=E Bldg. 00	Standards Based on interview failed to ensure insu with professional st reviewed for insulir late and by unqualif Resident 1, Residen Findings include: 1. On 10/9/24 at 10 record was reviewed	Meet Professional and record review, the facility thin was given in accordance andards for 5 of 5 residents a. Residents were given insulin fied staff. (Resident 18, t 17, Resident 11, Resident 8) 06 A.M., Resident 18's clinical d. Diagnoses included, but type 2 diabetes mellitus.	F 0658	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreen by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of correctis prepared and/or executed so	nent ne t ction

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155520	B. W	ING		10/11/2024	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	_
NAME OF I	PROVIDER OR SUPPLIEF	8			ORTH FIRST AVE		
ENVIVE	OF RIVER CITY				SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG			
					because it is required by the	DATE	
	The most current Q	uarterly Minimum Data Set			provision of federal and state	law.	
	(MDS) Assessment, dated 7/22/24, indicated				Providence of the deviation and a state		
	Resident 18 had no cognitive impairment and				1. What corrective action(s) w	ill be	
	received insulin.				accomplished for those reside		
					found to have been affected b		
	Physician orders in	cluded, but were not limited to:			deficient practice?		
	Humalog (insulin lispro - a short-acting insulin)				"===		
	KwikPen Subcutaneous Solution Pen-injector 100				1., 2., 3., 4., & 5. Resident #	's	
) - Inject as per sliding scale: if 0			18, 1, 17, 11. & 8 had no nega		
	· ·	-180 = 2 units; $181 - 240 = 4$			outcome related to the cited		
	units; 241 - 300 = 6	units; $301 - 350 = 8$ units; $351 -$			practice. Qualified Medication		
400 = 10 units; 401 - 600 = 12 units					Aide (QMA) #21 and RN # 21		
subcutaneously before meals and at bedtime for				addressed at the time of surve	еу		
	type 2 diabetes mel	litus, dated 7/11/24			relative to ensuring proper		
					documentation of medications	S	
	The September 202	4 Medication Administration					
	Record (MAR) indi	cated that Resident 18 received			2. How other residents having	the	
	8 units of insulin lis	spro on 9/23/24 at 7:30 A.M. by			potential to be affected by the		
	Qualified Medication	on Aide (QMA) 2.			same deficient practice will be	;	
					identified and what corrective		
		P.M., employee files were			action(s) be taken?		
	-	license did not include insulin					
	administration certi	fication.			All residents receiving insuli		
					have the potential to be affect		
		52 P.M., the Director of Nursing			by the cited practice. An audit		
		MAs were not allowed to			been conducted to identify the		
	administer insulin.				residents' receiving insulin, th		
	2 0 10/10/21	ND14 D 11 . 44 . 41 . 1			plan of correction applies to the	nose	
		3 P.M., Resident 1's clinical			residents identified.		
		d. Diagnoses included, but			0.34%	. ,	
	were not limited to,	type 2 diabetes mellitus.			3. What measures will be put		
	The mark at 100	ionificant Charter Mini			place and what systemic char	-	
		ignificant Change Minimum			will be made to ensure that th		
		sessment, dated 8/13/24,			deficient practice does not rec	cur?	
		1 had severe cognitive			Licensed with the staff of		
	impairment and rec	civea msum.			Licensed nursing staff and QMA's have been re-educated	.	
	Dhygiaian andan- :	aludad but ware not limited to			•		
	1 -	cluded, but were not limited to:			relative to Services Provided		
	Lantus SoloStar (in	sulin glargine - a long-acting			Professional Standards, inclu	aing	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	ING		10/11/	2024
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
	OF DIVED OITY				RTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	insulin) Subcutaneous Solution Pen-injector 100				but not limited to, respective		
	unit/mL (milliliters) - Inject 17 units subcutaneously at 8:00 A.M. and 8:00 P.M. for type 2 diabetes mellitus, dated 7/16/24				scopes of practice and timely		
					administration and documenta	tion	
					of insulin administration.		
		,					
	The September 202	4 Medication Administration			4. How the corrective action(s) will	
	Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 1 the 8:00 A.M. dose of insulin				be monitored?	,	
					2011.01.11.01.02.1		
	glargine on 9/23/24				DNS, or designee, will be		
	88				responsible to complete		
	On 10/9/24 at 2:41	P.M., the nursing schedule for			medication observation pass		
	9/22/24 through 9/28/24 was reviewed. The				audits at least 5 times a week	for	
	schedule indicated there were no nurses working				1 month, then 3 times a week		
	at the facility on 9/23/24 from 6:00 A.M. to 9:40				f1 month, then 2 times a week		
	A.M. Registered Nurse (RN) 21 began their shift				4 months, at varied times, to	. 101	
	at 9:40 A.M.	arse (1417) 21 began then shirt			ensure insulin is being		
	at 7.40 / 1.1VI.				administered timely and by		
	3 On 10/10/24 at 3	:27 P.M., Resident 17's clinical			qualified staff. Any identified		
		d. Diagnoses included, but			concerns will be promptly		
		type 2 diabetes mellitus.			addressed with the responsible	_	
	were not innited to,	type 2 diabetes memtas.			individual(s).		
	The most current ()	uarterly Minimum Data Set			ilidividual(s).		
		t, dated 9/23/24, indicated			The results of these audits will	ho	
	1 1	cognitive impairment and			reviewed in Quality Assurance		
	received insulin.	cognitive impairment and			Meeting monthly x6 months or		
	received msum.				until an average of 90%		
	Physician orders in	cluded, but were not limited to:			compliance or greater is achie	ved	
		gine - a long-acting insulin)			x3 consecutive months. The C		
		tion 100 unit/mL (milliliters) -					
		eutaneously at 8:00 A.M. for			Committee will identify any tre	ııus	
		-			or patterns and make	_	
	type 2 diabetes mel	mus, dated //11/24			recommendations to revise the		
	The Contember 202	4 Medication Administration			plan of correction as indicated	•	
	^	icated Registered Nurse (RN)			E Completion Date: November	. 11	
	` ′	` , ,			5. Completion Date: Novembe	11,	
		7 the 8:00 A.M. dose of insulin			2024		
	glargine on 9/23/24	·.					
	0:: 10/0/24 + 2.41	D.M. dhammina . 1 . 1 . 1 . 6					
		P.M., the nursing schedule for					
	_	28/24 was reviewed. The					
	schedule indicated	there were no nurses working					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 10/11/	ETED
	PROVIDER OR SUPPLIER OF RIVER CITY			909 NO	DDRESS, CITY, STATE, ZIP COD RTH FIRST AVE VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	,	23/24 from 6:00 A.M. to 9:40 urse (RN) 21 began their shift					
	record was reviewe	:29 P.M., Resident 11's clinical d. Diagnoses included, but type 2 diabetes mellitus.					
	(MDS) Assessment	uarterly Minimum Data Set , dated 9/12/24, indicated ld cognitive impairment and					
	Insulin Glargine (a 100 unit/mL (millil subcutaneously at 8 diabetes for type 2 Admelog SoloStar insulin) Subcutaneounit/mL - Inject as units; 181 - 240 = 4 350 = 8 units; 351 -	cluded, but were not limited to: long-acting insulin) Solution iters) - Inject 16 units 1:00 A.M. and 8:00 P.M. for diabetes mellitus, dated 2/1/24 (insulin lispro - a short-acting bus Solution Pen-injector 100 per sliding scale: if 141 - 180 = 2 1: units; 241 - 300 = 6 units; 301 - 1: 400 = 10 units; above 400 12 by with meals for type 2 ated 9/13/24					
	Record (MAR) indi	4 Medication Administration licated Registered Nurse (RN) 1 the 8:00 A.M. dose of insulin a lispro on 9/23/24.					
	9/22/24 through 9/2 schedule indicated at the facility on 9/2	P.M., the nursing schedule for 28/24 was reviewed. The there were no nurses working 23/24 from 6:00 A.M. to 9:40 turse (RN) 21 began their shift					
		:33 P.M., Resident 8's clinical d. Diagnoses included, but					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024	
	ROVIDER OR SUPPLIEF	2	909 NO	ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	were not limited to, The most current Si Data Set (MDS) As indicated Resident is and received insulin Physician orders in Insulin Glargine (a 100 unit/mL - Inject 8:00 A.M. for type 7/19/24 The September 202 Record (MAR) indi 21 gave Resident 8 glargine on 9/23/24 On 10/9/24 at 2:41 9/22/24 through 9/2 schedule indicated is at the facility on 9/2 A.M. Registered No at 9:40 A.M. On 10/10/24 at 1:40 (DON) indicated sh a little before 6:00 A (Certified Nurse Ai provide documentate facility on 9/23/24 indicated that she coinsulin that morning given to residents is shift at 9:40 A.M. A QMA 2 did not give documented in erro	type 2 diabetes mellitus. ignificant Change Minimum issessment, dated 9/3/24, 8 had no cognitive impairment h. cluded, but were not limited to: long-acting insulin) Solution t 15 units subcutaneously at 2 diabetes mellitus, dated 4 Medication Administration icated Registered Nurse (RN) the 8:00 A.M. dose of insulin h. P.M., the nursing schedule for 28/24 was reviewed. The there were no nurses working 23/24 from 6:00 A.M. to 9:40 turse (RN) 21 began their shift D.P.M., the Director of Nursing the was at the facility on 9/23/24 A.M. but worked as a CNA de) that morning. She could not tion that placed her in the from 6:00 A.M. to 9:40 A.M. She ould not remember if she gave g, and the insulin was probably are after RN 21 arrived for her At that time, she indicated that	IAU		DATE
	On 10/8/24 at 11:30	A.M., the Administrator			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024
	PROVIDER OR SUPPLIER OF RIVER CITY	R	909 N	ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	General Guidelines indicated "Medicatione hour of the schemeal orders are adnordered The resid person administering				
	provided a current of policy, dated 8/202	6 A.M., the Regional Support Charting and Documentation 4, that indicated the medical record will			
	provided a current s Competent Nursing indicated "Licensed	6 P.M., the Regional Support Staffing, Sufficient and policy, dated 8/2024, that I nursesare available 24 (7) days a week to provide care services".			
	provided a current of Aide Scope of Prace QMA shall not docorecord any medicate another person or not following tasks shall provided tasks shall provided tasks shall provided to the provided tasks shall provided tasks s	-			
	3.1-35(g)(1)				
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Sta	ffing Information			
	review, the facility	on, interview, and record failed to post accurate actual censed and unlicensed nursing	F 0732	This Plan of Correction is the center's credible allegation of compliance.	11/11/2021

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155520	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/11/2024
	PROVIDER OR SUPPLIEI	₹	909 N	ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE (X5) COMPLETION DATE
	daily for 3 of 4 day period. Finding includes: During an observat posted nurse staffir was observed on the entrance. The sheet to, the following in Census, total numb total hours of each (RN), Licensed Pra Certified Nurse Aid. The sheet indicated evening shift, and result the actual hours of The sheet indicated the evening shift, be hours that the staff On 10/10/24 at 10:: (DON) provided a sheets for dates 10/	er of staff for each shift and shift for Registered Nurses ctical Nurses (LPN), and de (CNA). I that staff worked day shift, night shift, but did not indicate those shifts. I CNA worked 4 hours during ut did not specify the actual		Preparation and/or execute this plan of correction doe constitute admission or age by the provider of the truth facts alleged or conclusion forth in the statement of deficiencies. The plan of deficiencies is prepared and/or execute because it is required by the provisions of federal and selaw. 1. What corrective action(seaccomplished for those refound to have been affected deficient practice? No residents were negate affected by the cited practice All revised Nursing Staff Sheet was provided to DN time of survey for future uses. 2. How other residents has potential to be affected by same deficient practice with identified and what corrections.	s not greement n of the ns set correction ed solely he state s) will be sidents ed by the tively ice. ring Data IS at the se. ving the the II be
	indicated the facilit and was unable to t worked by looking sheet.	00 A.M., the Administrator y did not have an evening shift ell the actual hours staff at the posted nurse staffing		action(s) be taken? All residents of the facilit the potential to be affected therefore, this plan of corrapplies to all residents cur residing in the facility.	d; ection
	provided a current Staffing Numbers p indicated "The info shall includethe a	6 P.M., the Regional Support Posting Direct Care Daily policy, dated 8/2024, that rmation recorded on the form ctual time worked during that ory and type of nursing staff".		3. What measures will be place and what systemic of will be made to ensure the deficient practice does not	changes at the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/11/2024	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE (OF RIVER CITY			ORTH FIRST AVE SVILLE, IN 47710	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DNS and Nursing Schedule have been re-educated relative Posted Nursing Staffing Information, including but not limited to, ensuring that Posted Nursing Staffing sheets are accurate including hours work for licensed and unlicensed nursing staff directly responsifor resident care. 4. How the corrective action(store be monitored? DNS, or designee, will audit Posted Nursing Staffing sheet days a week for 1 month, the days per month for 5 months ensure that Posted Nurse States sheets are accurate including hours worked for licensed and unlicensed nursing staff direct responsible for resident care, identified concerns will prompt be addressed with the responsindividual(s). The results of these audits with reviewed in Quality Assurance Meeting monthly x6 months of until an average of 90% compliance or greater is achieved and with the responsible will identify any treatment or patterns and make recommendations to revise the recommendations to revise the staff of the second process	r /e to ed
				plan of correction as indicated Completion Date: November 2024	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 10/11/2024				
		155520	B. W.			10/11/	2024
	PROVIDER OR SUPPLIER OF RIVER CITY		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0745 SS=D Bldg. 00	Based on interview failed to ensure soci meet a resident's me for 1 of 1 residents disturbances. (Resident 21 appears he had a history of 1 Disorder) but had neservices since admission of 10/8/24 at 2:32 record was reviewed 8/9/24. Diagnoses of were not limited to, Disorder. The most recent Question Set) Assessment, darkeident 21 was conjude and the form of the control of the c	on 10/8/24 at 11:38 A.M., ed to be anxious and indicated PTSD (Post Traumatic Stress ot met with mental health	F 0"	745	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of corrections is prepared and/or executed of because it is required by the provisions of federal and states. 1. What corrective action(s) we accomplished for those reside found to have been affected be deficient practice? Resident #21 was referred the psychological services on 10/10/23 and is currently waited to be seen. Several attempts been made for the resident to seen; however, resident frequences on LOAs and is not in the facility when psychological services are present.	ot ment the et ection colely e law. ill be ents by the or ing have be ently e rvice	11/11/2024
	to:				potential to be affected by the		
		Coping due to 31 years in			same deficient practice will be)	
		prison, PTSD diagnosis and d while detained all those			identified and what corrective		
	I incluences witnesse	a wille actained all those	1		action(s) be taken?		Ī

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
155520		B. WI	B. WING			10/11/2024	
	PROVIDER OR SUPPLIED	R	•	909 NC	ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	years, Date Initiate	d: 8/15/24					
	Collaborate care w	ith medical providers and psych			All residents with psycholog	ical	
	services, Date Initia	ated: 8/15/24			concerns/psychiatric diagnose	es	
					have the potential to be affect	ed	
		nission Screening and Resident			by the cited practice. An audit		
	· · · · · · · · · · · · · · · · · · ·	screening was completed for			been conducted to identify the	ose	
	_	admission. The screening			residents; this plan of correcti	on	
		l health diagnosis was known			applies to all those identified.		
	or suspected.						
					3. What measures will be put		
		t 21 completed a form that			place and what systemic char	•	
		like to receive mental health			will be made to ensure that th		
	services while in the facility.				deficient practice does not rec	cur?	
	On 8/15/24 a form titled PHQ-9 Questionnaire (an				SSD has been re-educated		
	assessment that me	asures the severity of		relative to Provision of Medically			
	depression), contain	ning answers given by		Related Social Services, including			
	Resident 21, was co	ompleted by the Social Service			but not limited to, ensuring so	cial	
	Director (SSD). Th	e total score indicated Resident			services are provided to meet		
	21 experienced mil	d depression.			resident's mental and		
					psychosocial needs.		
	_	v on 10/9/24 at 10:20 A.M., the					
		nospital completed the PASRR			4. How the corrective action(s	s) will	
	_	ly prior to admission to the			be monitored?		
	-	essment should have been					
		omitted correctly on admission			Executive Director (ED) or		
		SSD indicated when a resident			designee, will audit the charts		
	_	s on the PHQ-9 Questionnaire			all new admissions 3 times pe		
	_	ession, mental health services			week for 1 month, then 2 time		
		ndicated Resident 21 should			per week for 1 month, then 1		
		tal health services but the			weekly for 4 months to ensure		
		ompany that was contracted			appropriate referrals have been	en	
		could not bill Resident 21's			sent, including necessary		
		acility would have to pay for			psychological services, with the	ne	
	uie services. No oth	ner providers were contacted.			same documented.		
	On 10/11/24 at 8:30	0 A.M., the Regional Support			The results of these audits	will	
	provided a docume	nt titled Position Description			be reviewed in Quality Assura	nce	
	Social Services Dir	rector that indicated "The Social			Meeting monthly x6 months. t		
	Services Director p	rovides medically-related social			QA Committee will identify an		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024	
	PROVIDER OR SUPPLIER		909 N	T ADDRESS, CITY, STATE, ZIP COD IORTH FIRST AVE ISVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
	practicable physical well-being of each of functions: Assesses needs and develops Collaborates with of consultants, commu	maintain the highest , mental, and psychosocial resident. Essential position each resident's psychosocial a plan for providing care. ther departments, physicians, unity agencies, and institutions ity of services and resolve ".		trends or patterns and make recommendations to revise to plan of correction as indicated 5. Completion Date: Novem 11, 2024	the ed.
F 0758 SS=D Bldg. 00	Use Based on interview failed to ensure resi unnecessary medica reviewed for unnece resident's as needed ordered for greater Finding includes: On 10/9/24 at 10:06 record was reviewe were not limited to, The most current Q (MDS) Assessment Resident 18 had no received an antianx Physician orders inc diazepam (an antiar (mg) - Give 0.5 tabl needed for anxiety, date.	and record review, the facility dents were free from ations for 1 of 5 residents ressary medications. A antianxiety medication was than 14 days. (Resident 18) A.M., Resident 18's clinical d. Diagnoses included, but generalized anxiety disorder. The property of the pro	F 0758	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does a constitute admission or agree by the provider of the truth of facts alleged or conclusions forth in the statement of deficiencies. The plan of corris prepared and/or executed because it is required by the provisions of federal and state. 1. What corrective action(s) accomplished for those reside found to have been affected deficient practice? Resident #18's PRN anti-ant medication was discontinued 10/10/24 with a routine order obtained from the physician.	of not ement of the set rection solely ente law. will be dents by the exiety don r

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
155520		B. WING		10/11/2024		
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	₹		ORTH FIRST AVE		
FNVIVE	OF RIVER CITY			SVILLE, IN 47710		
				T	1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		/9/24 indicated Resident 18		2. How other residents having		
		(PRN) antianxiety medication		potential to be affected by the		
	on the following da	ites:		same deficient practice will be	;	
	8/28/24			identified and what corrective		
	8/29/24			action(s) be taken?		
	8/30/24					
	9/2/24			Any resident with a PRN ord		
	9/3/24 9/4/24			for psychotropic medication ha		
	9/4/24			the potential to be affected by		
	9/10/24			cited practice. An audit has be		
	9/10/24			conducted to ensure any PRN		
	9/11/24			psychotropic medications have		
	9/17/24		review/stop dates no greater than			
	9/18/24			14 days post-order date, unless continued necessity was identified		
	9/23/24			- with an extension ordered.	illeu	
	9/24/24			- with an extension ordered.		
	9/25/24			3. What measures will be put	into	
	9/26/24			place and what systemic changes		
	10/1/24			will be made to ensure that the		
	10/2/24					
	10/7/24			deficient practice does not rec		
	10/9/24			Nursing staff and SSD have b	een	
				re-educated relative to Free fr		
	On 10/10/24 at 10:	20 A.M., the Director of Nursing		Unnecessary Psychotropic		
	(DON) indicated th	at PRN antianxiety medications		Meds/PRN Use, including but	not	
	should have a stop	date of 14 days. The	limited to ensuring a review of			
	medication needed	to be reviewed by the		no more than 14 days after the		
	physician every 14	days to evaluate for		initial order date is specified -		
	continuance.			unless an extension is ordered	d.	
	On 10/11/24 at 8:30 A.M., the Administrator			4. How the corrective action(s) will	
	provided a current Psychotropic Medication Use			be monitored?		
		4, that indicated "PRN orders				
		edications are limited to 14		DNS, or Designee, and IDT		
	days".			review daily, on scheduled da	ys of	
				work, during clinical meeting,		
	3.1-48(a)(2)			ongoing, new physician orders	s for	
				psychotropic medications to		

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ensure re-evaluation/stop dates

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155520		(X2) MULTIPLE (A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/11/2024	
NAME OF P	PROVIDER OR SUPPLIER		909 N	ADDRESS, CITY, STATE, ZIP COD ORTH FIRST AVE	
ENVIVE	OF RIVER CITY		EVAN	SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0761 SS=D Bldg. 00	review, the facility were labeled, opened dated, and medicating for 1 of 2 medication cart) Finding includes: On 10/9/24 at 7:40 observed in the 100 an oblong maroon of a small round white two dropper bottles label two open bottles of	and Biologicals on, interview and record failed to ensure medications d-multi-dose containers were on carts were free of loose pills in carts observed. (100 hall med A.M., the following were hall med cart: olored pill	F 0761	are specified. Any identified concerns will be addressed withe responsible individual(s). The results of these audits be reviewed in Quality Assurd Meeting monthly x6 months of until an average of 90% compliance or greater is achit x3 consecutive months. The Committee will identify any trong patterns and make recommendations to revise the plan of correction as indicate. Completion Date: November 2024 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of federal and state 1. What corrective action(s) waccomplished for those reside found to have been affected.	will ance or deved QA ends he d. 11, 11/11/2024 f 11/11/2

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Event ID:

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Facility ID: 000437

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If continuation sheet Page 29 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/11/2024				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY			STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION (X5) LID BE ROPRIATE COMPLETION DATE			
	(DON) indicated the as Miralax, did not written on them. A Medication Labe provided by the Ad A.M., indicated "m stored in the package dispensing systems multi-dose vials the accessed are dated	O P.M., the Director of Nursing at multi-dose medications such need to have the date opened ling and Storage policy, ministrator on 10/11/24 at 8:30 edications and biologicals are ging, containers or other in which they are received at have been opened or and discarded within 28 days turer specifies a shorter or open vial".		deficient practice? The loose pills, the unlab dropper bottles of medicate the open bottles of undat multi-dose medications were moved from the 100-has medication cart at the time survey. The multi-dose medications were reorded the pharmacy. NO reside negativity affected by the practice. 2. How other residents has potential to be affected by same deficient practice widentified and what correspond to the practice of the facility. All residents of the facility orders for medications; the facility. 3. What measures will be place and what systemic will be made to ensure the deficient practice does not be more deficient practice does not be more deficient practice does not be more deficient practice does not be medication carts routinely, medications are correctly labeled with residents.	ation, and ed vere all ne of red from ents were ocited aving the y the vill be ctive lity have nerefore, plies to iding in put into changes nat the ot recur? MAS elative to iologicals, o, emoved see			

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/11/2024	
	ROVIDER OR SUPPLIE DF RIVER CITY	R	909 NC	ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE SVILLE, IN 47710	
	OF RIVER CITY SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	909 NC	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) identifying information, and multi-dose medications are labeled with the open date. 4. How the corrective action(s) be monitored? DNS, or designee, will be responsible daily, on schedule days of work, for 1 month to at 1 medication cart and 1 medication room 1 time week! 4 months to ensure there are a loose pills, medications are correctly labeled with resident identifying information, and all multi-dose medications are labeled with the open date. An identified concerns will be promptly addressed with the responsible individual(s). The results of these audits we be reviewed in Quality Assura Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The C committee will identify any tre or patterns and make recommendations to revise the) will ed udit tion inth, y for ino vill ince feved DA inds e
				plan of correction as indicated 5. Completion Date: Novembe 2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520			A. BUILDING <u>00</u> COM			COMPL	TE SURVEY MPLETED 111/2024	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY		!	STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIE		PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE	
F 0805 SS=D Bldg. 00	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 805 483.60(d)(3) Food in Form to Meet Individual Needs		F 080		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of corrections is prepared and/or executed subcause it is required by the provisions of federal and state law. 1. What corrective action(s) with accomplished for those reside found to have been affected by deficient practice?	of t ment the et ection olely ill be nts	11/11/2024	
					Dietary Cook #4 was re-educated at the time of survive relative to proper preparation of pureed foods. NO residents with negatively affected by the cited practice. 2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?	of ere d the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/11/2024 155520 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 909 NORTH FIRST AVE **ENVIVE OF RIVER CITY EVANSVILLE, IN 47710** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 15 slices of ham All residents who have 1/2 cup (four fluid ounces) apple juice mechanically altered diets, one tablespoon of food thickener including pureed diets, have the potential to be affected. An audit Dietary Cook 4 emptied the contents of the puree has been conducted to identify food into a food canister, wrapped the top with those residents; this plan of plastic wrap, and transferred the canister to the correction applies to identified temperature holding area. residents. During an interview on 10/10/24 at 11:15 A.M., the 3. What measures will be put into Administrator indicated the puree conversions place and what systemic changes were incorrect. will be made to ensure that the deficient practice does not recur? On 10/11/24 at 9:02 A.M., Regional Support provided a document titled Food Preparation and Dietary employees have been Service, revised 11/22, that indicated "Food and re-educated relative to Food in nutrition services employees prepare, distribute, Form to Meet Individual Needs. and serve food in a manner that complies with including but not limited to, correct safe food handling practices. Food preparation preparation of mechanically means the series of operational processes altered diets, including pureed involved in preparing foods for serving such as:.. diets. pureeing". 4. How the corrective action(s) will 3.1-21(a)(3)be monitored? Dietary Manager, or designee, will be responsible to visually observe preparation of mechanically altered foods daily to ensure meals are prepared properly, on scheduled days of work, for 2 weeks, then 3 times weekly for 2 weeks, then 2 times weekly for 5 months. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/11/2024	
NAME OF P	ROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE				
ENVIVE	OF RIVER CITY			EVANS	/ILLE, IN 47710		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
					Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Q Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated 5. Completion Date: November 2024	ved NA nds	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483. Resident Records	70(i)(1)-(5) - Identifiable Information					
	failed to ensure doc accurate for 2 of 3 r elopement and 1 of Documentation requalsence (LOA) was neurological checks ordered after a fall. Resident 2) Findings include: 1. On 10/9/24 at 9:1 record was reviewe were not limited to, dependence. Reside facility on 9/13/24. The most current A (MDS) Assessment Resident 22 had no	Resident 22, Resident 21, 12 A.M., Resident 22's clinical d. Diagnoses included, but schizophrenia and stimulant ent 22 was admitted to the	F 084	72	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed subscause it is required by the provisions of federal and state. 1. What corrective action(s) with accomplished for those reside found to have been affected by deficient practice? 1.) Resident #22 no longer resides at the facility; therefore further corrective action could taken for this resident.	t ment he et ction olely law. Il be nts y the	11/11/2024

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155520	B. W	<u> </u>		10/11/	/2024	
				·				
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD			
					PRTH FIRST AVE			
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	A Letters of Tempo	orary Guardianship document,			2.) Resident#21's physician			
	dated 8/29/24, indic	cated Resident 22 was assigned			order for LOA was obtained or	า		
	a court-appointed g	uardian.			10/09/24, "Resident may go o	n		
					therapeutic leave with			
	An Admission Elop	ement Risk Assessment, dated			medications." Resident #21 do	oes		
	9/13/24, indicated I	Resident 22 was at low risk for			frequently go on LOA, if reside	ent is		
	elopement.				going to be out of the facility w	hen		
					medications are due, resident	will		
	On 10/9/24 at 11:30	0 A.M., an elopement binder			request the medications be tal	ken		
	was observed on th	e 300 hall nurses station desk.			with him. Typically, the resider	nt is		
	The binder indicate	ed Resident 22 was at risk for			not out of the facility at medica	ation		
	elopement. The bin	der included, but was not			administration times, thus,			
	limited to, Resident	t 22's picture, name, date of		medications are not required		o be		
	birth, room number	, physician name, and		sent with the resident, and no				
	emergency contact	name. The emergency contact			documentation of medications			
	listed was the court	-appointed guardian.			sent is necessary.			
					3.) Resident #2 did have mis	ssing		
		dated 10/1/24, indicated that		entries on the neurological		ecks		
		tate guardian and was not			referenced on the 2567, howe	ver,		
		side and smoke or leave the			most of the checks were			
	facility unless appre	oved by the guardian.			completed with no neurologic			
					changes identified. Resident #	2		
		oonsibility For Leave Of			did not have any negative			
	` ′	cument indicated the resident		outcomes as a result of the cite		ed		
	l ~	of the facility on the following			practice.			
	dates:							
	9/17/24 at 12:20 P.				2. How other residents having	the		
	9/18/24 at 11:33 A.				potential to be affected by the			
	9/18/24 at 1:45 P.M				same deficient practice will be			
	9/18/24 at (illegible				identified and what corrective			
	9/18/24 at 5:10 P.M				action(s) be taken?			
	9/18/24 at 7:00 P.M				,			
	9/19/24 at 3:50 P.M				Residents with orders for LC)A		
	9/19/24 at 6:10 P.M				with supervision and/or with			
	9/22/24 at (illegible				medications have the potentia			
	10/3/24 at 1:30 P.M	1.			be affected by the cited praction			
		1. 110/5/64			An audit of physician orders h			
		s note, dated 10/7/24 at 6:26			been conducted to identify the			
		resident left the facility			residents who require supervis			
	independently and	returned "weak".			LOAs, or who require medicat	ions		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00			COMPLETED	
		155520	B. WING 10/11/202			/2024		
		l		STDEET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ORTH FIRST AVE			
ENI\/I\/E	OF RIVER CITY				SVILLE, IN 47710			
LINVIVE	OI MIVEN OITI		_	LVANS	, v ILLE, IIN 4// IU			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					to be sent when on LOA. The	care		
		lacked documentation			plan of those residents identifi			
	_	resident left with, expected			will be reviewed and revised,	as		
		ructions provided, and a list of			necessary.			
	medications sent.							
					Residents who have sustain	ied		
		P.M., Social Services Director			falls have the potential to be	_		
	` ′	e resident was to check in with			affected by the cited practice.	An		
		left and came back. She			audit has been conducted to			
		ent had been doing that, but			identify residents who have			
	the SSD was not do	ocumenting those occurrences.			sustained falls in the last 60 d	•		
					those residents who have had			
		O P.M., the Director of Nursing			requiring neurologic checks to			
		at documentation regarding the			completed (e.g. unwitnessed,			
		went LOA could not be found.	resident hit their head) have had a					
		32 P.M., Resident 21's clinical		baseline neurologic check (Envive				
		d. Resident 21 was admitted on		Neurologic Check User Defined				
	_	on admission included, but			Assessment - UDA) complete			
		, osteomyelitis, Post Traumatic			ensure no negative outcome.	NO		
		SD), and Borderline			concerns were identified.			
	Personality Disorde	er.						
	TEI	A LANDS AS A DA		3. What measures will be put into				
		narterly MDS (Minimum Data			place and what systemic char	-		
	· ·	ated 9/25/24, indicated			will be made to ensure that the			
		gnitively intact and was			deficient practice does not rec	cur?		
	independent for eat	ing, toileting, and transfers.			licensed mussisses staff!	h = = 10		
	On 10/0/24 at 11:54	5 A.M., the Leave of Absence			Licensed nursing staff have			
					re-educated relative to Reside			
		reviewed. Resident 21 signed			Records - Identifiable Informa	uon,		
	10/6 12:50	following days and times:			including but not limited to,			
	10/6 12:30				ensuring that accurate and			
	10/6 2:32				complete documentation is	o the		
	10/7 4:05				present for residents who leav			
	10/7 4:03				facility on LOAs, and accurate	anu		
	10/8 9:31				complete documentation of			
	10/8 2:10				neurological checks, when			
	10/20.43				necessary.			
	The leave of about	ce form and clinical record,			4 How the corrective estimate	\ \will		
		notes and assessments, lacked			4. How the corrective action(s be monitored?) WIII		
I	I meruding progress	notes and assessments, lacked	1		pe monitoreu:		I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	NG		10/11/	/2024
				CED FIELD	ADDRESS OF A STATE OF COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP COD		
END (1) (E	05 DIV (5D 0)TV				ORTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documentation indi	cating if medications were sent					
	with Resident 21 du	aring each leave of absence,			DNS, SSD, or designee, will		
	date and time the re	sident arrived back to the			review LOA logs 5 days a wee	k for	
	facility, and signatu	re of facility representative for			1 month and 3 days a week fo	r 5	
	each leave of absen	ce.			months to identify any LOAs th	nat	
					require resident representative	•	
	On 10/9/24 at 3:55 P.M., the facility elopement				and/or physician notification, a	ınd	
	binder was reviewed. Resident 21 was observed				to ensure notifications have be	een	
	in the binder along with an identifying photo.				made, and that documentation	1	
					relative to LOAs is complete a	nd	
	The clinical record lacked an order related to				accurate. Any identified conce	rns	
	approval of physician for independent leave of				will promptly be addressed wit	h	
	absence.				the responsible individual(s).		
	3. On 10/9/24 at 12	:22 P.M., Resident 2's clinical					
	record was reviewe	d. Diagnoses included, but			DNS, or designee, will comp	lete	
	were not limited to,	repeated falls, hemiplegia and			an audit of the neurological		
	hemiparesis follow	ing cerebral infarction affecting	checks of all residents requiring				
	left non dominant s	ide, and symptoms and signs			them, daily, on scheduled days	s of	
	involving cognitive	functions and awareness			work for 1 month to validate th	at	
					all neurological checks have b	een	
	· ·	rly Minimum Data Set (MDS)			completed, and documented.		
		9/13/24, indicated Resident 2			Thereafter, DNS, or designee,	will	
		vely impaired, required partial			complete audits of the		
		staff does less than half) with			neurological checks of residen		
		ng, and had no falls since the			requiring them 3 times per wee		
	prior assessment.				for 2 months and then 2 times		
					week for 3 months. Any identif	fied	
	Physician's orders i	ncluded, but were not limited			concerns will be promptly		
	to:				addressed with the responsible	е	
		o promote bed mobility every			individual(s).		
	shift, dated 4/8/24.						
	Activity Level: WBAT (Weight Bearing as				The results of the audits will		
	Tolerated), dated 4/8/24.				reviewed by Quality Assurance		
					Meeting monthly x6 months or	•	
	The current falls care plan indicated that Resident				until an average of 90%		
	2 was at risk for falls/injury due to impaired				compliance or greater is achie		
	mobility and history of falls, dated 4/8/24.				x3 consecutive months. The C		
		led, but were not limited to:			Committee will identify any tre	nds	
	_	assist with transfer and ADL			or patterns and make		
	(Activities of Daily	Living)			recommendations to revise the	Э	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	ING		10/11/2024	
				CTREET	ADDRESS STEW STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
EINVIVE	OF RIVER CITY			EVAINS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Footwear to preven	t slipping			plan of correction as indicated		
	Anticipate and mee	t the resident's needs.					
					5. Completion Date: Novembe	r 11,	
	On 10/9/24 at 2:15	P.M., the Administrator			2024		
	provided copies of	the neurological check list for					
	Resident 2 as follows:						
	Fall 1						
	On 9/23/24 at 10:00 A.M., the fourth 4-hour neuro						
	check was partially	-					
	On 9/23/23 at 2:00	P.M., the fifth 4-hour neuro					
	check was left blank.						
	On 9/23/23 at 4:00 P.M., the sixth 4-hour neuro						
	check was left blan	k.					
	Fall 2						
		P.M., the second 15-minute					
	check was left blan						
		P.M., the third 15-minute check					
	was left blank.						
	0 10/10/04 . 0 40						
		3 A.M., the Director of Nursing					
	` ′	at when there was an					
		euro checks were completed					
		out completely. If there was e checks could not be done at					
		it should be completed late.					
	ale selleduled lime,	n should be completed late.					
	On 10/9/24 at 11:54	5 A.M., the DON provided a					
		for LOA policy, dated 6/2023,					
		sing documentation should					
		d time the resident left, who					
		cted time of return, instructions					
		cations sent (type and number					
	of doses)".	carrons som (type and number					
	31 4000) .						
	On 10/10/24 at 4:06	6 P.M., the Regional Support					
		Charting and Documentation					
	policy, dated 8/202	_					
		the medical record will be					
		onated or speculative),					
	I system of the opini						1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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i '		(X2) M	î î		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155520	B. W	ING		10/11/	/2024
	PROVIDER OR SUPPLIER			909 NO	ADDRESS, CITY, STATE, ZIP COD IRTH FIRST AVE VILLE, IN 47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	'-	DATE
F 0880 SS=D Bldg. 00	provided a current provided a current provided a current provided a current provided in the residual procedure". 3.1-50(a)(1) 3.1-50(a)(2) 483.80(a)(1)(2)(4) Infection Prevention Based on observation review, the facility provided provided procedure Based on observation review, the facility provided	(e)(f) on & Control on, interview, and record failed to ensure a resident with injection central catheter) and as provided enhanced barrier for 1 of 1 resident reviewed for Resident 225) A.M., Registered Nurse (RN) 9 ring vancomycin 750 50 milliliters (mL) to administer sign on the door indicated the anced barrier precautions t donn a gown prior to caring 9 flushed the first lumen on C line with 10 mL of saline and ond lumen on the PICC line RN 9 hooked the vancomycin d set the medication to run at tet. At that time, a wound vac	F 03	880	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions soforth in the statement of deficiencies. The plan of correctis prepared and/or executed subsection because it is required by the provisions of federal and states. 1. What corrective action(s) we accomplished for those reside found to have been affected by deficient practice? RN#9 was re-educated at the time of survey related to Enhald Barrier Precautions (EBP).	ot ment the et ection olely e law. ill be ents y the	11/11/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLETED	
		155520	B. W	ING		10/11/2024	
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH FIRST AVE		
	OF RIVER CITY				SVILLE, IN 47710		
EINVIVE	OF RIVER CITY			EVAINS	SVILLE, IN 477 IO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	record was reviewe	d. Diagnoses included, but			Necessary physician orders	for	
	were not limited to,	osteomyelitis (infection in the			Resident # 225 pertaining to t	he	
	bone).				PICC line and precautions we	re	
					obtained at the time of the sur	vey.	
		ed nursing note, dated 10/6/24,					
	indicated that Resident 225 had a power injection				2. How other residents having		
	catheter in right chest and wounds on the left				potential to be affected by the		
		luteal fold, coccyx, and left toe.			same deficient practice will be	;	
	Initial wound meas				identified and what corrective		
	_	cm (centimeters) x 2 cm x 0.2 cm			action(s) be taken?		
	~ ~	cm x 1.5 cm x 0.2 cm					
	Coccyx wound vac in place				Residents who meet the crit		
	Left toe 1.2 cm x 0.	.1 cm x 0.1 cm.			for placement in EBP have the		
					potential to be affected by the		
		lacked orders for enhanced			cited practice. An audit has be	een	
	_	or transmission-based			conducted to identify these		
	_	to Resident 225's wound and			residents with physician order		
	PICC line.				obtained and care plans upda	ted,	
		C D 11 (225) 1 1 1 1 1			as necessary.		
	_	for Resident 225 included, but				. ,	
	were not limited to:				3. What measures will be put		
		ess device specify: picc,			place and what systemic char	-	
	initiated 10/5/2024.	IV related to antibiotics, date			will be made to ensure that the		
					deficient practice does not rec	cur?	
		Illing or increased pain during and notify provider, date			All stoff evaluation Distant	2010	
	initiated 10/5/2024.				All staff, excluding Dietary, been re-educated relative to	lave	
		dicated, date initiated			Infection Control and Preventi	on	
	10/5/2024.	dicated, date initiated			including but not limited to, cri		
		te Initiated 10/5/2024.			for placing a resident EBP, an		
		signs and symptoms of			ensuring all necessary	lu	
		tion, infiltration, increased			components are in place such	1.26	
	· ·				physician orders and care pla		
	pain, date initiated 10/5/2024. Treatments as ordered, date initiated 10/5/2024.				etc.	110,	
		intravenous) medications for:					
		ellulitis (skin infection), date			Licensed nursed have recei	ved	
	initiated 10/5/2024.	, , , , , , , , , , , , , , , , , , , ,			re-education relative to Infecti		
					Control and Prevention includ		
	On 10/10/24 at 12:4	41 P.M., the Director of Nursing			but not limited to, ensuring all	=	
		lld wear personal protective			necessary physician orders a		
	I	paradian protective			1	~	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/11/2024	
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF RIVER CITY			NORTH FIRST AVE NSVILLE, IN 47710	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
		oviding care to resident.		present (e.g., wound care, IV infection control, etc.)	√ care,
	by Regional Suppor	er Precautions policy, provided et on 10/11/24 at 10:01 A.M., d barrier precautions are used ention and control		4. How the corrective action be monitored?	(s) will
	resistance organism	ce the spread of multi drug s to residents. EBPs employ		The IP nurse/DNS/designe complete random visual rour	
		glove used during high e activities examples of		daily, on scheduled days of	
		nt care activities are device		for 1 month, then 3 times pe week for 1 month, then 2 tim	
	care or use (central			per week for 4 months to en	
	2.1.10(1)			staff are practicing appropria	ate
	3.1-18(b)			Infection Control Practices, including but not limited to,	
				identified residents are in EE	3P
				with all the necessary	
				components in place. Any	
				identified concerns will be	
				promptly addressed with the	
				responsible individual(s).	
				DNS, or designee, will be	
				responsible for auditing the	
				of all residents with PICC lin	
				other intravenous lines daily	·
				scheduled days of work, for	
				month to ensure all necessa physician orders are present	-
				Thereafter, the DNS, or desi	
				will be responsible for auditing	-
				charts of all residents with P	-
				lines or other intravenous lin	-
				times per week for 1 month,	
				2 times per week for 4 month	
				ensure all necessary physici	
				orders are present. Any ider concerns will be promptly	iuiled
				addressed with the responsi	hle
				individual(s).	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155520		B. WING			10/11/2024	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
F 0882 SS=D Bldg. 00	Based on interview failed to ensure desired preventionist (IP). It dedicate at least part 1 staff members reventioning include: On 10/8/24 at 12:10 (DON) indicated ship the infection preventing facility. She independent on the facility. She independent on the infection prevention on 10/9/24 at 1:49 is was reviewed. The indicated 11/14/21. On 10/11/24 at 8:50	and record review, the facility gnation of a certified Infection The IP did not currently time to the role of IP for 1 of iewed for IP. P.M., the Director of Nursing e was currently responsible for tion and control program in icated she worked full time as able to dedicate about 8 hours ection control program. P.M., the DON's employee file DON had an IP certification A.M. the Administrator and ated "Job Description:	F 08	382	The results of these audits will reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated 5. Completion Date: November 11,2024 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed set because it is required by the provisions of federal and state 1. What corrective action(s) with accomplished for those reside found to have been affected by deficient practice? No residents were negatively the provisions were negatively deficient practice?	oved DA nds e control of the et control of the e	11/11/2024	

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155520	A. BUILDING B. WING	00	COMPLETED 10/11/2024			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Infection Prevention The job description assistance to the Din needed". On 10/9/24 at 11:30 provided a current I Control Program (II indicated "The com- member of the clinic IPCP program to pe	nist Nurse" job description. indicated " the IP provides rector of Nursing when O A.M., the Administrator infection Prevention and PCP), dated 8/2022, that munity shall designate a cal team to monitor the campus rform surveillance to identify, and prevent the spread of		affected by the cited practice. 2. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have potential to be affected; therefore, this plan of corrective applies to all residents curren residing in the facility. 3. What measures will be put place and what systemic char willbe made to ensure that the deficient practice does not recommended to the preventionist (IP) Qualifications/Role, including not limited to, ensuring the designation of a certified Infection Preventionist. 4. How the corrective action(see monitored? DNS, or designee, will be responsible daily, on scheduled days of work for 1 month, the times per week for 5 months, ensure that an IP is in place a dedicating at least part-time to role of IP. Any identified concommitted with the responsible individual(s).	ave on tity into nges ecur? on but etion but etion o the erns			

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Event ID:

J7X011

Facility ID: 000437

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155520	B. Wl	ING		10/11/	2024
	PROVIDER OR SUPPLIER			909 NO	ADDRESS, CITY, STATE, ZIP COD PRTH FIRST AVE VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 9999					The results of these audits we be reviewed in Quality Assura Meeting Monthly x6 months or until an average of 90% compliance or greater is achie x3 consecutive months. The Committee will identify any treor patterns and make recommendations to revise the plan of correction as indicated 5. Completion date: November 11,2024	ved NA nds	
Bldg. 00	management of the as a departmental su of nursing or food s same hours. The resadministrator shall ithe following: (1) Immediately infittelephone, followed twenty-four (24) ho that directly threater of the resident or re This state rule was a Based on interview	or is responsible for the overall facility but shall not function apervisor, for example, director ervice supervisor, during the sponsibilities of the include, but are not limited to, forming the division by by written notice within the welfare, safety, or health sidents not met as evidenced by: and record review, the facility	F 99	999	The Plan of Corrective is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions seforth in the statement of deficiencies. The plan of correctis prepared and/or executed subsection because it is required by the provisions of federal and state. 1. What corrective action(s) we accomplished for those reside found to have been affected by deficient practice?	t ment he et ction olely law. Il be nts	11/11/2024
	failed to report a res	sident was found with an illegal			#1Administration and		

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Event ID:

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Facility ID: 000437

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(Y2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	l í	ULTIPLE CO UILDING	00	COMPLETED	
AND PLAN	OF CORRECTION	155520	B. W		<u></u>	10/11/2024	
		100020	D. W	_		10/11/2024	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ORTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		liana Department of Health			Management		
		residents reviewed for					
	_	ation. (Resident 22, Resident			1.) Resident #22 no longer		
	18)				residents at the facility; therefo	ore,	
	Findings include:				no further corrective action cou	uld	
					be taken for this resident.		
					2.) Resident #18 did not inge		
		12 A.M., Resident 22's clinical			any of the substance, therefore		
		d. The most current Admission			there was nothing to report, an		
		(MDS) Assessment, dated			there was no negative effect to	this	
	9/20/24, indicated the resident had no cognitive				resident.		
	impairment.				#2Personnel		
	A Social Services r	progress note, dated 9/27/24 at			"ZI GIGGIIIGI		
		ted a Certified Nursing Aide			1.) All employee files have be	een	
		Social Service Director (SSD)			audited with references obtained		
	1 '	rsing (DON) that Resident 22			and placed in the files, as		
		at were seen crushing a white			necessary.		
		y. The white substance was			,		
		e resident's deodorant			#3 Personnel		
	container. Law enfo	orcement was called. An officer			1., 2., &3). All employee files	s	
	tested the substance	e upon arrival and it tested			have been audited with job		
		nphetamine (meth). Resident 22			descriptions, orientation to the		
	admitted to using th	ne drug but would not say how			facility, job specific orientations		
		ugs in her possession or			and orientation to resident righ		
	where she got them	ı.			obtained and placed in the files		
					as necessary.		
	2. On 10/9/24 at 10	:06 A.M., Resident 18's clinical					
		d. The most current Quarterly			#4 Personnel		
	MDS Assessment,	dated 7/22/24, indicated			1.) All employee files have be	een	
	Resident 18 had no	cognitive impairment.			audited with physical		
					examinations and TB		
	_	rogress note, dated 9/27/24 at			screens/annual TB risk		
	4:44 P.M., indicated the SSD and DON asked				assessments obtained and pla	ced	
		her resident was in her room			in files, as necessary.		
		ining something. Resident 18					
		th and Resident 22 ingested it,			#5 Personnel		
	but she did not take	e any.			1.) All employee files have be		
					audited with dementia-specific		
	A review of Facility	y Reported Incidents for			training conducted and		

J7X011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building <u>00</u>			COMPLETED	
		155520	B. W	ING		10/11/2	2024	
				CTREET	ADDRESS CITY STATE ZIR COD			
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD DRTH FIRST AVE			
ENI\/I\/E	OF RIVER CITY				SVILLE, IN 47710			
CINVIVE	OF KIVER CITT			EVAINS	SVILLE, IN 477 IO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	September lacked a	report of the police being			documentation of the same pla	aced		
	called to the facility	for residents with			in the files, as necessary.			
	methamphetamine.							
					2. How other residents having	the		
	On 10/10/24 at 9:04	A.M., the DON indicated she			potential to be affected by the			
	was told by a corpo	rate employee that finding			same deficient practice will be			
	illegal substances in the facility and calling law				identified and what corrective			
	enforcement was not a reportable offense. She				action(s) be taken?			
	indicated she would	I not speak to whether or not						
	finding meth in the building was an unusual				All residents of the facility ha	ive		
	occurrence or not. The facility did not do an				the potential to be affected;			
	investigation into the	ne incident, and neither			therefore, this plan of correction	n		
	resident was drug tested because Resident 22				applies to all residents current			
	admitted to using the drug and Resident 18 was				residing in the facility.			
	headed to dialysis a	nd it would be flushed out						
	anyway.				All incidents that have occur	red		
					within the last 60 days will be			
	On 10/10/24 at 4:06	P.M., the Regional Support			reviewed and if any incidents i	neet		
	provided a current I	Unusual Occurrence Reporting			the guidelines for incident			
	policy, dated 8/2024	4, that indicated "Our facility			reporting and have not been			
	will report the follo	wing events to appropriate			reported to IDOH, they will be			
	agencies:other oc	ccurrences that interfere with			reported.			
	facility operations a	and affect the welfare, safety,						
	or health of residen	ts, employees or visitors.			3. What measures will be put i	n		
	Unusual occurrence	es shall be reported via			place and what systemic chan	ges		
	telephone to approp	riate agencies as required by			will be made to ensure that the	•		
	current law and/or r	regulations within twenty-four			deficient practice does not rec	ur?		
	(24) hours of such i	ncident or as otherwise						
	required by federal	and state regulations".			ED, DNS, and all necessary			
					facility staff have been re-educ	cated		
	#2.				relative to Administration and			
	3.1-14 PERSONNE	EL			Management, and Personnel			
					requirements, including but no	t l		
	(a) Each facility sha	all have specific procedures			limited to, Indiana Reportable			
	written and implem	ented for the screening of			Unusual Occurrence Guideline	es		
	prospective employees. Specific inquiries shall be				and Reporting; pre-employme	nt		
	made for prospective employees. The facility shall				requirements: references, phy			
		licy that considers references			examinations and TB screening			
		s in accordance with IC			and education requirements (-		
	16-28-13-3.				orientation to the facility	•		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155520	B. W	ING		10/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			ORTH FIRST AVE		
ENVIVE	OF RIVER CITY				SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					job-specific orientation, and		
		not met as evidenced by:			dementia-specific training.		
		and record review, the facility					
	_	spective employees by			4. How the corrective action(s	s) will	
		references for 3 of 6 staff			be monitored?		
	employed less than one year reviewed. (DON,						
	Dietary Manager, MDS Coordinator)				The ED/Designee will review		
					occurrences with the IDT, dai	•	
	Finding includes:				scheduled days of work, ongo	_	
					to determine if considered an		
	On 10/9/24 at 1:49 P.M., employee files were				unusual occurrence and will		
	reviewed. Employee files for the Director of				submit reportable unusual		
	Nursing (DON), Dietary Manager, and Minimum				occurrences via the Gateway	,	
	Data Set (MDS) Co				when necessary.		
	documentation of r	eference checks.					
					The ED/Designee will perfo		
		8 A.M., the Regional Support			audit of incidents that occur ir		
		check documentation for the			facility to ensure that incident	s are	
	I	ager, and MDS Coordinator			reported to the IDOH in		
	was unable to be for	ound.			accordance with facility policy		
					the Indiana Long-Term Care		
		8 A.M., the Regional Support			and Incident Reporting Policy		
	_	: Pre-Employment Reference			Audits will be performed week	dy for	
		ed 5/4/2024, that indicated		1 month, then bi-weekly for 1			
		references must be obtained on			month, then monthly x 4 mon	ths.	
		considered for employment.					
		the most recent employers must			ED, or designee, will condu		
		loyment, position held, and			audit of at least 5 employee fi		
		ge rate, if provided. Whenever			weekly for 2 months, and ther		
	*	job duties and performances			employee files bi-weekly for 4		
		fied. When there is no prior			months to ensure all required		
	employment, attempts should be made to obtain				pre-employment requirements		
		nools, churches, or personal			all required education/oriental		
	associations. The Human Resources designee will				is completed and placed in the	е	
	conduct employer i	reierences".			files.		
	#3.				Any identified concerns will	be	
	3.1-14 PERSONNI	EL			promptly addressed with the		
					responsible individual(s).		
	(g) Each facility sh	all maintain current and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155520	B. W	ING		10/11/2024	
				CED FEET A	DDDEGG CUTY CTATE JID COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
	OF DIVED O'TY				RTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	rc	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	accurate personnel	records for all employees. The			The results of these audits w	/ill	
	personnel records for	or all employees shall include			be reviewed in Quality Assura		
	the following:				Meeting monthly x6 months or		
	_	acility and job description.			until an average of 90%		
	1 1	of orientation to the facility			compliance or greater is achie	ved	
	and to the specific j				x3 consecutive months. The Q		
		edgement of orientation to			Committee will identify any tre		
	residents' rights.	6 			or patterns and make		
	1191101				recommendations to revise the	2	
	This state rule was	not met as evidenced by:			plan of correction as indicated		
	This state rule was not met as evidenced by: Based on interview and record review, the facility				plan or correction as indicated	•	
	failed to maintain personnel records with				5. Completion Date: November	or.	
	documentation of job description, general				11, 2024	21	
		cific orientation, and			11, 2021		
		ents' rights for 6 of 10					
		eviewed. (LPN 15, RN 7, DON,					
		MDS Coordinator, QMA 2)					
	Dictary Wanager, W	indication, QWA 2)					
	Findings include:						
	i mamga meraac.						
	1 On 10/9/24 at 1:4	49 P.M., employee files were					
		loyee file for Qualified					
	_	QMA) 2 lacked a job					
	description.	21417 1) 2 lacked a job					
	description.						
	On 10/11/24 at 9:08	3 A.M., the Regional Support					
		cription could not be found in					
	QMA 2's employee	-					
	QWIA 2 s employee	Tille.					
	On 10/11/24 at 0:46	6 A.M., the Regional Support					
		facility's policy for a job					
	description to be Ke	ept in an employee's file.					
	2 On 10/0/24 -4.1	10 D.M. ampleyes files					
		49 P.M., employee files were					
		e files for Registered Nurse					
	(RN) 7, the Director of Nursing (DON), Dietary Manager, and Minimum Data Set (MDS)						
		documentation of orientation					
	to the facility and jo	ob specific orientation.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 10/11.						
NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY			909 NC	STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLE	ETION		
	indicated general ar could not be found orientation could no Dietary Manager, a	3 A.M., the Regional Support and job specific orientation for RN 7, and job specific of the found for the DON, and MDS Coordinator.						
	reviewed. The empl	loyee file for Licensed Practical ked documentation of						
		3 A.M., the Regional Support n to residents' rights could not 5.						
	provided a current of Hired Employees, T 8/2024, that indicate an in-depth review of procedures. A check reviewed. A written participant's oriental records include the initials, subject matinformation deemed Records of orientatifile upon completio On 10/11/24 at 8:30	o P.M., the Regional Support Drientation Program for Newly Transfers, Volunteers, dated ed "Our orientation program is of our facility's policies and klist is used to record materials a record is maintained of each tion program. Orientation date reviewed, participant's ter reviewed, and other d necessary or appropriate. In on are filed in the personnel of the orientation program". O A.M., the Administrator on-Service Training policy,						
	dated 8/2024, that is	n-service Training policy, ndicated "Required training ollowing:resident rights and						
	#4. 3.1-14 PERSONNE	EL .						
		ination shall be required for facility within one (1) month						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		A. BU	X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMP. B. WING 10/11		ETED		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY			STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	include a tuberculim method (5 TU PPD having documentation department-approve intradermal tuberculim method (5 TU PPD having documentation department-approve intradermal tuberculim series of including the process of the following: (1) At the time of empthereafter, employe facilities shall be somethereafter, employe facilities shall be somethereafter, employe facilities shall be somethereafter to the process of the following the preceding baseline tuberculim two-step method. If second test should be seen to the following with tuberculosis. This state rule was a Based on interview failed to ensure emprior to employment tuberculosis (TB) are perform a TB risk a staff employed less of 4 staff employed reviewed. (DON, Quentle for the following trades of the following	at. The examination shall askin test, using the Mantoux by, administered by persons on of training from a sed course of instruction in lin skin testing, reading, and previously positive reaction. The result shall be recorded duration with the date given, shom administered. The must be read prior to the prock. The facility must assure mployment, or within one (1) loyment, and at least annually ses and nonpaid personnel of reened for tuberculosis. For who have not had a previously months, the skin testing should employ the other first step is negative, a see performed one (1) to three first step. The frequency of the frequency of epend on the risk of infection mot met as evidenced by: and record review, the facility ployees had a physical exam at, screen employees for the time of employment, and ssessment annually for 4 of 6 than one year reviewed and 4 greater than one year MA 2, Dietary Manager, RN 7, pok 4, LPN 15, LPN 14)					

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Event ID:

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Facility ID: 000437

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155520		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/11/2024					
NAME OF PROVIDER OR SUPPLIER ENVIVE OF RIVER CITY			STREET ADDRESS, CITY, STATE, ZIP COD 909 NORTH FIRST AVE EVANSVILLE, IN 47710				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE COMPLETION		
PREFIX TAG	REGULATORY OF 1. On 10/9/24 at 1:4 reviewed. Employe Nursing (DON) and (QMA) 2 lacked do exam had been perfeto employment. On 10/11/24 at 9:08 indicated he could rephysical exam had been perfeto employment for the On 10/11/24 at 9:46 indicated that it was to have a physical exam had been perfeto employment for the On 10/11/24 at 9:46 indicated that it was to have a physical exam had been perfeto employee. 2. On 10/9/24 at 1:4 reviewed. Employee Nursing (DON), Di Nurse (RN) 7 lackee one month prior to be been been been been been been been	A LSC IDENTIFYING INFORMATION 19 P.M., employee files were the files for the Director of I Qualified Medication Aide cumentation that a physical formed within one month prior 3 A.M., the Regional Support that find documentation that a the peen performed prior to DON and QMA 2. 3 A.M., the Regional Support to the facility's policy for staff that the facility's policy for staff that peen performed prior to The performed prior to The policy for staff that the facility's policy for staff that the performed prior to The perf	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
		culin skin test (TST) or elease assay (IGRA) and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00 CC		COMPLI	COMPLETED	
155520		B. WING 10/11/2024			2024		
				CTREET	DDBECC CITY CTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
5NV (V / 5 O 5 D N / 5 D O 1 T) /					RTH FIRST AVE		
ENVIVE	OF RIVER CITY			EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	symptom screening	prior to beginning					
	employment The	decision to perform serial (e.g.					
	annual) testing after	r baseline is based on					
	individual risk facto	ors of exposure both at work					
	and outside of work						
	#5.						
	3.1-14 PERSONNE	EL					
		e required inservice hours in					
		who have regular contact with					
		a minimum of six (6) hours of					
		raining within six (6) months of					
		or within thirty (30) days for					
	personnel assigned to the Alzheimer's and						
	_	re unit, and three (3) hours					
	annually thereafter to meet the needs or						
	preferences, or both, of cognitively impaired						
	residents and to gain understanding of the current						
	standards of care fo	r residents with dementia.					
		not met as evidenced by:					
		and record review, the facility					
	_	cumentation of staff					
	completing a minimum of six hours of						
		raining within six months of					
	initial employment for 2 of 6 staff employed less						
		wed and three hours of					
		raining annually for 4 of 4 staff					
		nan 1 year reviewed. (LPN 16,					
	Dietary Cook 4, LP	N 15, QMA 2, RN 9, LPN 14)					
	Fig. 41						
	Finding includes:						
	On 10/0/24 of 1-40	P.M., employee files were					
		e files for Licensed Practical					
	1 ,	letary Cook 4, LPN 15, Qualified					
		(MA) 2, Registered Nurse (RN)					
		ed documentation of					
	dementia-specific to	annig.				l	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
155520		155520	B. WING		10/11/2024		
			STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				ORTH FIRST AVE			
ENVIVE OF RIVER CITY			EVANSVILLE, IN 47710				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE		
	3/26/14. Dietary Cook 4 star facility on 9/19/12. LPN 15 started emp 9/18/23. QMA 2 started emp 4/9/24. RN 9 started emplo 10/24/23.	oloyment with the facility on ted employment with the oloyment with the facility on oloyment with the facility on yment with the facility on oloyment with the facility on oloyment with the facility on					
	On 10/9/24 at 2:55 P.M., the Regional Support provided a Course Completion History for all staff. At that time, he indicated that they were aware staff were behind on completing inservices.						
	Dietary Cook 4 lacl LPN 15 lacked 1 de QMA 2 lacked 6 de RN 9 lacked 6 dem	ementia inservice hours. ked 3 dementia inservice hours. ementia inservice hour. ementia inservice hours. entia inservice hours. ementia inservice hours.					
	provided a current l policy, revised 8/20 training topics inclu	O A.M., the Administrator In-Service Training, All Staff 124, that indicated "Required ade the followingdementia sident abuse prevention".					

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