						PRIN	TED: 02	/2//2025	
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FORM APPROVED			
ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED		
		155716	B. WING			01/27/2025			
					DDDDGG CHTV CTATE TIP COD				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD					
				601 N BOEKE RD					
ENVIVE (OF EVANSVILLE			EVANS'	VILLE, IN 47711				
(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	COMPLE	TION	
	nnor:: . monr:: on	T CO IN THE INTERIOR OF THE PARTY OF THE INTERIOR OF THE INTER		m . a	DEFICIENCY)				

NAME OF	PROVIDER OR SUPPLIER	601 N BOEKE RD EVANSVILLE, IN 47711				
ENVIVE	OF EVANSVILLE					
	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 000		BOEKE RD	(X5) COMPLETION DATE		
	Complaint IN00448/49 - Federal/State deficiencies related to the allegations are cited at F677, F689, F842, and F9999. Complaint IN00450264 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 21, 22, 23, 24, and 27, 2025 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 118 SNF: 9 Residential: 11 Total: 138 Census Payor Type: Medicare: 4		Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 26, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.			

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

(X6) DATE

TITLE

Tara Trevino **Executive Director** 02/20/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155716	B. W	B. WING 01/27/202			025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				BOEKE RD		
ENVIVE (OF EVANSVILLE			EVANS	SVILLE, IN 47711		
(X4) ID	SUMMARY 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 APPROPRIATE		TE C	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Medicaid: 93						
	Other: 30						
	Total: 127						
	These deficiencies r	reflect State Findings cited in					
	accordance with 410						
	Quality review completed on February 7, 2025.						
F 0582 483.10(g)(17)(18)(i)-(v)							
SS=D	Medicaid/Medicare	e Coverage/Liability Notice					
Bldg. 00	Raced on interview	and record review, the facility	F 0:	500	F 582		02/26/2025
		F-ABN (Skilled Nursing	F U.	382	What corrective action will b		J2/20/2023
		Beneficiary Notice) Forms were			accomplished for those		
	provided following the end of Medicare skilled				residents found to have been	n	
	services for 1 of 2 residents who discharged from				affected by the deficient	' -	
		nd remained in the facility.			practice:		
	(Resident Z)	ž			Resident Z was discharged from	om	
	,				the facility.		
	Finding includes:						
					How other residents having	the	
		A.M., the SNF (Skilled Nursing			potential to be affected by th	ie	
	• .	y Protection Notification			same deficient practice will be	эе	
		e reviewed. The form indicated			identified and what correctiv	'e	
		Medicare Part A Skilled			action will be taken:		
		/4/24. The form indicated the			Residents being cut from	.	
	-	Part A services was 1/14/25			Medicare Part A and remainin	-	
		nained in the facility. The form			the facility have the potential to	o be	
		Z did not receive a SNF-ABN			affected. A SNF ABN will be		
	`	cility-Advanced Beneficiary use she was scheduled to be			issued to any residents who a		
	,	1/15/25 following the last			being cut from Medicare Part	^	
	-	mily failed to pick up the			and remaining in the facility. What measures will be put in	110	
	•	ned in the facility. At that time,			place and what systemic		
		ndicated a SNF-ABN had not			changes will be made to		
	been issued to the re				ensure that the deficient		
					practice does not recur:		
	During an interview	on 1/21/25 at 12:41 P.M., the			IDT was educated on the proc	cess	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155716 B. WING 01/27/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 Administrator indicated Resident Z was still in the for issuing a SNF ABN. facility and would be responsible for the fees associated with room and board for her stay in the How the corrective action will facility between 1/14/25 and whenever she was be monitored to ensure the discharged. deficient practice will not recur, i.e., what quality assurance program will be put On 1/23/25 at 9:30 A.M., Resident Z's clinical record was reviewed. The census indicated into place: Resident Z was admitted on 12/4/24 with Medicare An audit will be completed by as the payer source. On 1/15/25 the payer source BOM or designee weekly for all was changed to private pay. On 1/22/25 the residents discharged from resident was discharged from the facility. Medicare Part A who are remaining in the facility to ensure On 1/27/25 at 12:31 P.M., the Administrator that the SNF ABN was issued. provided a Notice of Medicare Non-Coverage Results of the audit will be (NOMNC) policy, revised 10/1/23, that did not reviewed by QA team during QAPI address the SNF-ABN form requirements. meetings. POC may be revised or updated, based on QA review, as During an interview on 1/27/25 at 2:47 P.M., the needed to achieve, and maintain Administrator indicated that the facility did not compliance. Audits may be have a policy that addressed SNF-ABN forms and discontinued after six months with expected the facility to follow federal regulations at least two consecutive months of for form requirements and distribution. 100% compliance achieved. By what date the systemic 3.1-4(f)(2)changes for each deficiency will be completed: February 26, 2025 F 0622 483.15(c)(1)(i)(ii)(2)(i)-(iii) SS=D Transfer and Discharge Requirements Bldg. 00 Based on interview and record review, the facility F 622 F 0622 02/26/2025 failed to ensure a resident's discharge was What corrective action will be documented in the clinical record for 1 of 3 accomplished for those residents reviewed for discharge. (Resident 60) residents found to have been

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Finding includes:

On 1/23/25 at 12:24 P.M., Resident 60's clinical

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practice:

affected by the deficient

Resident 60 has been discharged

from the facility. Unable correct

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155716 B. WING 01/27/2025

		_	***************************************		
NAME OF PROVIDER OR SUPPLIER		STREET A			
FNVIVE	OF EVANSVILLE		601 N BOEKE RD EVANSVILLE, IN 47711		
	1			1 775	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION record was reviewed. Resident 60 was admitted on	TAG	past missed documentation.	DATE	
	2/24/22. Diagnoses included, but were not limited		past missed documentation.		
	to, Parkinson's Disease.		How other residents having th	e	
	100, 1 unimport of 2 is table.		potential to be affected by the	"	
	The most recent Quarterly Minimum Data Set		same deficient practice will be		
	(MDS) Assessment, dated 11/5/24, indicated		identified and what corrective		
	Resident 60 was moderately cognitively impaired,		action will be taken:		
	required substantial assistance from staff (staff		Any resident discharged from th	е	
	does more than half of the work) for toileting and		facility has the potential to be		
	transfers, and was dependent on staff for bathing.		affected.		
	A nutrition note created on 1/17/25 at 2:09 P.M.,		What measures will be put into	,	
	indicated Resident 60 was discharged with return		place and what systemic		
	not anticipated.		changes will be made to		
			ensure that the deficient		
	The clinical record, including progress notes,		practice does not recur:		
	assessments, and documents, lacked information		IDT educated on the need to		
	regarding planning of a discharge, documents		complete documentation for		
	sent during discharge, where Resident 60 was		discharge planning. Nursing sta	aff	
	discharged to, or when discharge occurred.		educated on the need to		
	During an interview on 1/23/25 at 2:58 P.M., the		document discharges in the clinical record. Discharges will	ho	
	Admissions Director indicated Resident 60 left the		reviewed in clinical meetings fiv		
	facility on 1/16/25 after a planned discharge and		times per week to ensure that the		
	went to another long term care facility, but was		proper documentation of discha		
	unable to find any documentation of discharge		planning is completed.		
	planning.				
			How the corrective action will		
	On 1/23/25 at 2:35 P.M., the Administrator		be monitored to ensure the		
	provided a document titled Summary of Episode		deficient practice will not		
	Note, created on 1/17/25, and indicated nursing		recur, i.e., what quality		
	staff should make a progress note when a resident leaves the facility stating when they left, where		assurance program will be put		
	they went, and what was sent with the resident.		into place: An audit will be completed by		
	diey went, and what was sent with the resident.		DNS or designee on all discharge	res er	
	On 1/27/25 at 12:31 P.M., the Administrator		weekly to determine if the prope	·	
	provided a policy titled Discharge Summary and		documentation was completed.	"	
	Plan, dated 8/2024, that indicated "When a		Results of the audit will be		
				I	
	resident's discharge is anticipated, a discharge		reviewed by QA team during QA	API I	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155716	A. BUILDING 00 B. WING		00	COMPLETED 01/27/2025	
		1557 10	D. W.			01/2//	2020
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BOEKE RD		
ENVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711				
(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
F 0645 SS=D	assist the resident with discharge. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. A member of the interdisciplinary team reviews the final post-discharge plan with the resident and family at least 24 hours before discharge takes place. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post-discharge plan, and the discharge summary." 3.1-12(a)(6)(A) 3.1-12(a)(6)(B) 483.20(k)(1)-(3) PASARR Screening for MD & ID			TAG	updated, based on QA review needed to achieve, and maint compliance. Audits may be discontinued after six months at least two consecutive mont 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025.	ain with	DATE
Bldg. 00	failed to ensure soci meet a resident's me for 1 of 1 residents in Screening and Resid (Resident 61) Finding includes: On 1/22/25 at 2:14 in record was reviewed were not limited to, alcohol use disorder seizures, anxiety, depsychiatric disorder the facility on 1/20/2. The most recent Qu (MDS) Assessment, resident was cognitic	arterly Minimum Data Set , dated 12/20/24, indicated the ively intact, required nobility tasks, and received	F 00	545	F 645 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: A new Level 1 PASRR has be completed for resident 61. How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents with newly identified mental illness after the completed initial PASRR will have an updated level 1 completed pricadmission. Current residents be audited to determine if level accurately reflects their currendiagnosis and an updated PASR	the e e e e e e e e e e e e e e e e e e	02/26/2025

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155716	B. WING		01/27/2025	
		1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R				
FN\/I\/F	OF EVANSVILLE		601 N BOEKE RD EVANSVILLE, IN 47711			
LINVIVE	UI LVANSVILLE		EVANS	, v I L L L , II N + / /		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	d anticonvulsants during the		will be completed if needed.		
	7-day look back per	riod.				
				What measures will be put in	nto	
		cluded, but were not limited to:		place and what systemic		
		psychotic medication) oral		changes will be made to		
		s (mg) - 1 tablet at bedtime,		ensure that the deficient		
	dated 11/21/23.			practice does not recur:		
				IDT will be educated on the		
	· ·	iety medication) oral tablet 2 mg		PASRR process and regulation	I	
	- 1 tablet by mouth twice daily, dated 6/3/24.			Newly added diagnosis will be)	
	W III (reviewed in the daily clinical		
	Wellbutrin XL (an antidepressant) oral tablet			meeting to determine if an upo	dated	
	Extended Release 24 Hour - give 150 mg by mouth			PASRR may be required.		
	one time a day, date	ea 1/21/24.				
	41.::	disample at a trade at the control of		How the corrective action wi	"	
	· ·	given to alcoholics to prevent		be monitored to ensure the		
	_	alopathy) HCl oral tablet - give		deficient practice will not		
	100 mg by mouth o	one time a day, dated 1/21/24.		recur, i.e., what quality	4	
	Target behavioras	sychosis, delusions,		assurance program will be p	ul	
		be monitored and charted on at		into place: An audit will be completed by		
	the end of each shift			social services weekly on 10		
	and chu di cacii silli	ii, aatou 10/13/27.		residents for three months, the	en	
	Observe closely for	r significant side effects from		on 5 residents per week for th		
	-	cation use such as sedation,		months to determine if an upd		
		outh, constipation, blurred		PASRR may be required.		
	_	emors/facial/tongue		Results of the audit will be		
	· ·	t gain, edema, postural		reviewed by QA team during (DAPI	
	_	ing, loss of appetite, urinary		meetings. POC may be revise		
		ovider if observed and		updated, based on QA review		
		ess notes, dated 10/13/24.		needed to achieve, and maint		
	l seement in progre			compliance. Audits may be	a	
	May utilize (name o	of mental health facility) for		discontinued after six months	with	
	counseling services			at least two consecutive mont		
		,		100% compliance achieved.		
	Target behaviors: d	lepression- tearfulness,		By what date the systemic		
		on, excessive crying, or social		changes for each deficiency		
	_	onitored and documented at the		will be completed:		
	end of each shift, d			February 26, 2025		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155716	B. WING		01/27/2025	
	PROVIDER OR SUPPLIER	· :	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DDOVIDEDIC DI AN 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 APPROPR		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	nxiety- self-reported				
		ssness, sleeplessness, etc. To				
	be monitored and documented at the end of each shift, dated 6/24/24. Resident may reside on secured memory care unit, dated 6/6/24.					
	Antianxiety medica	tion- monitor for drowsiness,				
	slurred speech, dizz					
	aggressive/impulse behavior. Monitor and					
	document at the end of each shift, dated 6/4/24.					
	Current care plans included, but were not limited					
	to:					
		secured memory care unit. s of dementia, Wernicke's				
		cohol induced persisting				
		and other signs involving				
		and other signs involving				
	-	ing and wanting to leave to go				
	home. Date Initiate					
		or ineffective coping due to				
		loved one (sister and spouse).				
		24. Interventions included:				
	rsych services as no	eeded. Date Initiated: 2/1/24.				
	On 1/23/25 at 9:00	A.M., the Administrator				
		a PASARR completed for				
		1 2023, 8 months prior to the				
	resident's admission	n to the facility.				
	D	1/07/05 + 0.50 + 3.5 - 1				
	_	on 1/27/25 at 9:52 A.M., the				
		ated that Resident 61's				
	diagnoses were updated after the previous PASARR was completed and the Admissions					
		re reviewed the PASARR on				
		sure it was current and				
	undated.	one is was carroin and				

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155716				O1/27/2025	
		1007 10	<i>D.</i> 11			01/21/2020	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BOEKE RD		
ENVIVE (OF EVANSVILLE				SVILLE, IN 47711		
(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 APPROPRI. DEFICIENCY)			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	DATE	
F 0655 SS=D Bldg. 00	On 1/27/25 at 12:31 provided an Admiss 8/2024, that indicate readmissions are set (MD), intellectual disorders (RD) per 1 Screening and Resid 3.1-34(a) 483.21(a)(1)-(3) Baseline Care Plate Based on interview failed to ensure the of a baseline care plate hours of admission equipment, tracheos Precautions (EBP) frespiratory care. (Reference of the control of the co	P.M., the Administrator sions Criteria policy, dated ed "All new admissions and reened for mental disorders lisorders (ID), or related the Medicaid Pre-Admission dent Review process". In and record review, the facility development and completion lan within forty-eight (48) for use of respiratory stomy, and Enhanced Barrier for 1 of 1 residents reviewed for	F 00		F 655 What corrective action will b accomplished for those residents found to have beer affected by the deficient practice: Unable to complete the misse 48-hour baseline care plan in past. Resident 277 has a person-centered comprehensicare plan in place.	02/26/2025 e n d the	
	on 1/13/25. Diagnos	d. Resident 277 was admitted ses included, but were not respiratory failure with hypoxia			How other residents having a potential to be affected by the same deficient practice will be a same deficient practice.	ie	
	The Admission Mir Assessment was in a Current physician o limited to, the follow Change oxygen tube (PRN), one time a december of	rders included, but were not wing: ing monthly and as needed lay every four weeks on			identified and what corrective action will be taken: New admissions have the potential to be affected by a missed 48 baseline care plan. New admissions will have a baseline care plan completed.	ential -hour ne	
	soiled or compromi	(O2) use and as needed for sed, dated 1/15/25.			What measures will be put in place and what systemic changes will be made to	ito	

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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 COMPLETED 00 B. WING 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 Change humidifier/bubbler monthly and as ensure that the deficient needed (PRN), as needed for empty/compromised practice does not recur: and change one time a day every four weeks on Nursing and IDT educated on the Sunday for routine oxygen, dated 1/15/25. requirements for the completion of a baseline care plan. All new Resident requires the use of Enhanced Barrier admissions will be reviewed five Precautions (EBP) related to the medical device times per week in the daily clinical (Tracheostomy & Peg Tube) to reduce the risk of meeting to determine if the transmission of Multiple Drug-Resistant baseline care plan has been Organisms (MDROs) every shift for Isolation completed and ensure Precautions. Use Personal Protective Equipment completion. (PPE) precautions when providing prolonged direct resident care, dated 1/14/25. How the corrective action will be monitored to ensure the The clinical record lacked a base line care plan for deficient practice will not the tracheostomy, oxygen use, and EBP protocol. recur, i.e., what quality assurance program will be put During an interview on 1/23/25 at 11:35 A.M., the into place: Assistant Director of Nursing (ADON) indicated An audit will be completed by that a baseline care plan was based on the initial DNS or designee weekly on all assessment that the admitting nurse completed. new admissions to determine if The initial assessment included, but was not the baseline care plan has been limited to, physical assessment of the resident and completed. oxygen use with a baseline care plan initiated Results of the audit will be within 48 hours of admission. reviewed by QA team during QAPI meetings. POC may be revised or On 1/27/25 at 12:31 P.M., the Administrator updated, based on QA review, as provided a current Care Plans, Baseline policy, needed to achieve, and maintain revised 8/2024, that indicated "A baseline care compliance. Audits may be plan to meet the resident's immediate health and discontinued after six months with safety needs is developed within forty-eight (48) at least two consecutive months of hours of admission. The baseline care plan 100% compliance achieved. includes instructions to provide effective. By what date the systemic person-center care for the resident to meet changes for each deficiency professional standards of practice and must will be completed: include the minimum healthcare information to February 26, 2025 properly care for the resident...". 3.1-30(a)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155716	B. WI	NG	01/27/	/2025	
	PROVIDER OR SUPPLIER OF EVANSVILLE	.	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF COR			(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
F 0657	()()()						
SS=D	Care Plan Timing and Revision						
Bldg. 00	Based on record refailed to ensure care fall for 1 of 6 reside (Resident 8) Finding includes: On 1/21/25 at 3:19 record was reviewed were not limited to, stenosis lumbosacra physical disability. The most current Q (MDS) Assessment resident was mildly substantial to maximalf) with dressing, assistance of staff (transferring, and haprior assessment. Current physician climited to: 1/4 side rails for meand night shift to aimorbid (severe) obed. A current falls care that Resident 8 was	view and interview, the facility e plans were updated after a ents reviewed for falls. P.M., Resident 8's clinical d. Diagnoses included, but a chronic pain syndrome, spinal al region, and age-related Puarterly Minimum Data Set and the region of the cognitively impaired, required mal help (staff does more than required partial to moderate staff does less than half) with a done fall with injury since the corders included, but were not obbility positioning every day de with bed mobility related to esity, dated 11/20/20. Plan, dated 12/12/17, indicated at risk for falls related to	F 06	557	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Falls care plan for resident 8 is been reviewed and is current. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents with falls have the potential to be affected. Reside with a fall in the past 30 days have falls care plans reviewed updated if indicated. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing and IDT were educate the requirement to update the plan interventions and docume following each fall. All falls will reviewed in clinical meetings fallings per week to ensure that	nas the e e ents will I and tto ed on care ent Il be ive	02/26/2025
	_	ts of medications (cardiac, cal etc.). Interventions			times per week to ensure that documentation is in place and		
		not limited to, the following:			interventions are updated on t		
	· ·	labs, and orthostatic blood			care plan.		
	Pain management,	initiated 12/2/24. afe environment with even			How the corrective action wi	II	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLETE			ETED
		155716	B. W	ING		01/27/	2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t .			BOEKE RD		
FNVIVE	OF EVANSVILLE				SVILLE, IN 47711		
					· · · · · · · · · · · · · · · · · · ·		
(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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		lls and/or clutter; adequate,			deficient practice will not		
	1	orking and reachable call light,			recur, i.e., what quality		
	_	ion at night; Side rails as			assurance program will be p	ut	
		on walls, personal items within			into place:		
	reach initiated on 12	2/17/17 and revised on 8/2/23.			An audit will be completed by		
					DNS or designee on all falls		
		Team (IDT) note, dated			weekly to ensure that		
		I., indicated that Resident 8 had			documentation is in place and		
	an unwitnessed fall with injury on 11/27/24 at 9:45				interventions are added to the	care	
	P.M. The intervention for that fall was to provide				plans.		
	an environmental assessment.				Results of the audit will be		
					reviewed by QA team during (
		lacked documentation to			meetings. POC may be revise		
	indicate the new intervention was added to the				updated, based on QA review		
	plan of care.				needed to achieve, and maint	ain	
					compliance. Audits may be		
	_	on 1/23/25 at 3:15 P.M., the			discontinued after six months		
		ated there should be a new			at least two consecutive mont	ns of	
		ach fall and the care plan was			100% compliance achieved.		
	_	new intervention after the			By what date the systemic		
	resident fell on 11/2	27/24.			changes for each deficiency will be completed:		
		P.M., the Administrator			February 26, 2025		
	1 ~	Comprehensive Care plans					
	policy, revised 8/20						
	_	sessments are utilized in					
		centered care plansa					
	significant change i	_					
		esident's status that will not					
		self without intervention by					
	staff".						
	3.1-35(d)(2)						
F 0658	483.21(b)(3)(i)						
SS=D	Services Provided	l Meet Professional					
Bldg. 00	Standards						
		on, record review, and	F 0	658	F 658		02/26/2025
		ty failed to ensure physician			What corrective action will b	е	
	orders were followe	ed for 2 of 5 residents reviewed			accomplished for those		

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPI	LETED
		155716	B. WING	B. WING		01/27	/2025
				_			
NAME OF	PROVIDER OR SUPPLIEI	8			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF	I KO VIDEK OK SOITEIEI			601 N E	BOEKE RD		
ENVIVE	OF EVANSVILLE			EVANS	VILLE, IN 47711		
(VA) ID	CURALARY	CTATEMENT OF DEPLOYENCIE		ID			(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	for nutrition. (Resid	dent 35 and Resident L)			residents found to have been	n	
					affected by the deficient		
	Findings include:				practice:		
					Resident 35 has Tubigrip orde	ers	
	1. During an observ	vation on 1/21/25 at 10:15 A.M.,			placed on the TAR and on Ta		
	I -	r extremities were swollen.			for the CNAs. Tubigrips have		
		ed she was supposed to wear			applied per order.	===	
		ngs to reduce edema but staff			Resident L has been weighed		
	had not put them or				Transfer E has been weighted	•	
	nad not put them of	ii ioi iici.			How other residents having	tho	
	On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on				_		
					potential to be affected by the		
					same deficient practice will		
	10/8/24. Diagnoses included, but were not limited				identified and what corrective	e e	
	to, renal failure and	diabetes mellitus.			action will be taken:		
					Other residents with orders fo		
		arterly Minimum Data Set			Tubigrip have the potential to		
		t, dated 1/16/25, indicated			affected. All orders for Tubigr	-	
		gnitively intact and required			have been placed on the TAR	and	
	substantial assistan	ce from staff (staff does more			on Tasks for the CNAs.		
	than half of the wor	rk) for toileting, bathing, and			Residents are wearing Tubigr	ip per	
	transfers.				orders.		
					Residents with orders for weig	ghts	
	Current physician of	orders included, but were not			have the potential to be affect	ed.	
	limited to:				All residents' orders for weigh		
	Patient to wear stoo	ckings on bilateral lower			have been verified for correct		
	extremities (Tubigr	rips size G) for edema reduction			frequency, and all weights ha	ve	
	1	Nursing to assist patient in			been obtained per orders or		
	_	on stockings in the AM			refusals documented.		
	_ ^	at HS (bedtime); Start date					
	11/21/24.	ar 112 (coarmie), zame ame			What measures will be put in	nto	
					place and what systemic		
	2 On 1/21/25 at 12	:34 P.M., Resident L's clinical			changes will be made to		
		ed. Diagnoses included, but			ensure that the deficient		
	were not limited to						
	were not infinted to	, uemenua.			practice does not recur:		
	The meet	1Minimum D (S (Nursing staff educated on the		
		nnual Minimum Data Set			necessity to follow doctor's or		
		t, dated 12/23/24, indicated			and document the completion	ot or	
		derately cognitively impaired			refusal of orders. Nursing		1
	and required substa	intial assistance from staff			educated on the importance o	of	1

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(staff does more than half of the work) for

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If continuation sheet

obtaining accurate weights when

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02/27/2025 PRINTED:

DEPARTMEN CENTERS FO	FORM APPROVED OMB NO. 0938-039					
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/27/2025	
	PROVIDER OR SUPPLIEF	3	601 N	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF toileting, bathing, a Physician orders inc Obtain weight one of three days; Start day The clinical record, vitals, and medicati administration reco weight recorded sin During an interview Director of Nursing ordered on 1/14/25 blank in the order a During an interview Administrator indic written policy for for	cluded, but were not limited to: time only for monitoring for te: 1/14/25 including progress notes, on and treatment rds, lacked documentation of a	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (ACAPT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) ordered. IDT will review all new orders times per week in the clinical meeting to ensure they are p appropriately on the TAR or needed and to determine if a new orders for weights were received. How the corrective action we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be into place: An audit will be completed by DNS or designee on 10 resid per week to monitor for the completion of weights or the documentation of refusals. A audit will be completed by DN designee on five residents with orders for Tubigrip per week determine if they were applied order, or if refused, that documentation was completed Results of the audit will be reviewed by QA team during meetings. POC may be revisually assurance. Audits may be discontinued after six months at least two consecutive mon 100% compliance achieved.	s five laced Task if iny vill put y dents An NS or ith to ed per ed. QAPI sed or w, as itain s with	(X5) COMPLETION DATE
				By what date the systemic changes for each deficiency	y	

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will be completed: February 26, 2025

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· ′		X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETE	
		155716	B. WI	NG		01/27/202	:5
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ENVIVE (OF EVANSVILLE				BOEKE RD VILLE, IN 47711		
(X4) ID	SUMMARY	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 APPROPRIATE		MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provide	d for Dependent Residents					
	Based on observation, record review, and interview, the facility failed to ensure assistance at meals or assistance with bathing was provided for 7 of 8 residents reviewed for Activities of Daily		F 06	77	F677		2/26/2025
					What corrective action will b	e	
					accomplished for those		
					residents found to have been	n	
		. (Resident L, Resident S,			affected by the deficient		
		nt U, Resident R, Resident N,			practice:		
	and Resident T)				Assistance with meals was		
					provided for resident L and me		
	Findings include:				consumption was documented		
					Residents S, G, U, R, and N v		
	_	ous observation on 1/16/25			given showers. Resident T is	s no	
		P.M., a kitchen staff member			longer in the facility.		
		ering trays to the dining room.					
	-	from the cart and placed them			How other residents having		
	_	Resident L was observed			potential to be affected by the		
	-	facing the dining area. Staff			same deficient practice will l		
		ents at the dining tables, then			identified and what correctiv	e	
	_	sidents were done eating. At			action will be taken:		
		nt L called out to staff for help			Residents requiring assistance		
		At 12:47 P.M., staff transferred			with dining or showers have th	ne	
		ne recliner into a wheelchair			potential to be affected.		
		the dining table where			Residents have been assisted	I	
	Resident L ate alone	e.			dining and meal consumption	I	
	0 1/01/07 10 5	IDM D. 11 - T. P. 1			documented, and residents ha	ave	
		P.M., Resident L's clinical			received showers.		
		d. Diagnoses included, but			What measures will be put in	nto	
	were not limited to,	dementia.			place and what systemic		
	Th	1Minimum D. (C)			changes will be made to		
		nual Minimum Data Set			ensure that the deficient		
		, dated 12/23/24, indicated			practice does not recur:		
		derately cognitively impaired			Nursing staff were educated o		
	_	ntial assistance from staff			importance of providing shows		
	`	in half of the work) for			per preference or documentin	~	
	toileting, bathing, a	na mobility.			refusals of care. Nursing staff		
	Marilina 1 C D	ident Terre and decree 4			were educated on the importa	nce	
		ident L was not documented			of assisting with dining and		
	for lunch or dinner	on 1/16/24.			documenting meal consumption	on.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155716	B. W	NG		01/27/	2025
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
= N / N / E /	05 5) (44) (0) (1) 1 5				BOEKE RD		
ENVIVE	OF EVANSVILLE			EVANS	VILLE, IN 47711		
(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)	16	DATE
					IDT audited shower tasks in P	ос	
	2. During an intervi	ew on 1/21/25 at 10:54 A.M.,			to ensure that shower tasks		
	_	d showers were not being			match resident preferences.		
	given according to t	_			IDT will review POC charting f	ive	
	8	1			days a week in clinical meeting		
	On 1/22/25 at 9:15	A.M., Resident S's clinical			documentation of showers and	-	
		d. Diagnoses included, but			meal consumption.	-	
		chronic ulcers and congestive					
	heart failure.	omenie wieers with congestive			How the corrective action will	ıı .	
	110011 10110101				be monitored to ensure the		
	The most recent Ou	arterly Minimum Data Set			deficient practice will not		
	,	, dated 1/9/25, indicated			recur, i.e., what quality		
		substantial assistance (staff			assurance program will be p	ut	
	•	of the work) from staff for			into place:	ut	
	bathing.	of the work) from start for			DNS or Designee will monitor		
	outning.				meal service attendance five		
	The Point of Care (POC) (a Certified Nurse Aide			meals per week for 4 weeks, the	hon	
	· ·	em) Tasks for showering		three meals per week for 4 weeks,			
	-	ng/showers were to be given			then one weekly for 16 weeks		
		ursday dayshift, before			ensure that residents requiring		
		l or partial bed bath on			assistance are served at the s		
	non-shower days.	or partial oca oath on			time as the other residents in t		
	non-snower days.				area.	i i C	
	Resident S's clinica	l record lacked showers			DNS or Designee will audit 10		
		owing preferred days in			residents per week for the		
	December 2024 and	9.1			completion of showers as		
	12/2/24	. variant y 2025.			assigned and completion of		
	12/12/24				documentation.		
	1/13/25				Results of the audit will be		
	1/20/25				reviewed by QA team during 0	λΔΡΙ	
	1/20/23				meetings. POC may be revise		
	On 12/19/24 at 12:0	03 P.M. and 1/9/25 at 5:51 P.M.,			updated, based on QA review,		
		re documented but did not			needed to achieve, and mainta		
		Ference of time of day offered.			compliance. Audits may be	an I	
	Tonow resident pier	erence of time of day offered.			discontinued after six months	with	
	3 On 1/22/25 at 1.5	55 P.M., Resident G's clinical			at least two consecutive month		
		d. Diagnoses included, but			100% compliance achieved.	is UI	
	were not limited to,	_			By what date the systemic		
	were not ininied to,	dementia.			changes for each deficiency		
	The most recent Ou	arterly Minimum Data Set			will be completed:		
	The most recent Qu	arterry winning Data Set			will be completed.		

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/27/2025	
	PROVIDER OR SUPPLIE	R		601 N E	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
	Resident G was se required substantia than half of the wo The Point of Care documentation sys indicated that Bath Tuesday and Frida Resident G's clinic provided on the fo December 2024 and 1/3/25 1/10/25 1/10/25 1/10/25 1/21/25 4. On 1/21/25 at 2: she did not received were not limited to The most current C (MDS) Assessment Resident U was co supervision of staff	al record lacked showers llowing preferred days in d January 2025: 04 P.M., Resident U indicated showers twice a week. P.M., Resident U's clinical ed. Diagnoses included, but			February 26, 2025			

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night time.

A preferences care plan, dated 6/20/23, indicated the resident preferred showers every other day at

The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident U received showers on Wednesdays and Saturdays on night shift. Resident U did not receive or refuse a shower on

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STATEMEN			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155716	B. WING		01/27/2025
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	-
		-		BOEKE RD	
ENVIVE	OF EVANSVILLE		EVANS	SVILLE, IN 47711 	<u>-</u>
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
	2025:	in December 2024 and January			
	12/4/24				
	12/7/24				
	12/14/24				
	12/25/24				
	1/11/25				
	1/11/23				
	5. On 1/21/25 at 2:0	04 P.M., Resident R indicated he			
	did not receive show				
		P.M., Resident R's clinical			
		d. Diagnoses included, but			
	were not limited to,	pulmonary fibrosis.			
		gnificant Change Minimum			
		sessment, dated 1/11/25,			
		R was cognitively intact,			
		to maximal assistance of staff			
	1	nn half) for bathing, and had no			
	l •	ring the 7-day look back			
	period.				
	A choices care plan	, revised 1/4/24, indicated the			
	•	howers on Tuesdays and			
	Fridays during the o				
		POC) (a Certified Nurse Aide			
	1	em) Tasks for showering			
		R received showers on			
	· ·	ys before bed. Resident R did			
		e a shower on the following			
	1 .	2024 and January 2025:			
	12/6/24				
	12/13/24				
	12/17/24				
	12/20/24				
	12/27/24				
	12/31/24				
	1/3/25				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155716		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/27/2025		
NAME OF P	PROVIDER OR SUPPLIER	· {		ADDRESS, CITY, STATE, ZIP COD	-	
ENVIVE	OF EVANSVILLE			BOEKE RD SVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1/7/25					
	1/10/25 1/14/25					
	1/17/25					
	1/1//25					
	6. On 1/21/25 at 2:0	04 P.M., Resident N indicated				
	she did not receive	showers twice a week.				
		P.M., Resident N's clinical				
		d. Diagnoses included, but				
	were not limited to,	chronic pain syndrome.				
	The most current Quarterly Minimum Data Set					
		, dated 12/19/24, indicated				
		gnitively intact, required				
	_	nal assistance of staff (staff				
		f) for bathing, and had no				
	rejection of care du	ring the 7-day look back				
	period.					
	An Activities of Da	ily Living (ADL) care plan,				
		ated the resident required				
		of one with bathing due to				
	chronic pain.	C				
	The Doint of Come	POC) (a Certified Nurse Aide				
		em) Tasks for showering				
		N received showers on				
		ys on day shift. Resident N				
	-	efuse a shower on the				
		December 2024 and January				
	2025:	,				
	12/6/24					
	12/13/24					
	12/20/24					
	12/23/24					
	1/6/25					
		interview, it was indicated				
		not been getting his showers				
	and smelled like he	hadn't showered and was				

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		r /		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	
		155716	B. WING			01/27/	2025
	PROVIDER OR SUPPLIER	· :	60	1 N B	DDRESS, CITY, STATE, ZIP COD OEKE RD VILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	. [DROVIDEDIS DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TA	.G	DEFICIENCY)		DATE
	"living on the street	s". Staff had indicated they					
		nt T's teeth because he was					
	•	sh his own teeth even though					
	Resident T was righ						
	had been broken an						
	On 1/21/25 at 1.20	P.M., Resident T's clinical					
		d. Diagnoses included, but					
		Alzheimer's disease with late					
	·	stal end of femur, fracture of					
		ateau fracture (right side).					
	inoura, una tionar pre	ateur fracture (fight side).					
	The most recent Sig	gnificant Change Minimum					
		sessment, dated 7/29/24,					
	indicated Resident	T had mild to moderate					
	cognitive impairme	nt, exhibited behaviors that					
	included other beha	viors not directed towards					
	anyone that had wo	rsened since the previous					
	assessment, and req	uired substantial to maximal					
	assistance (staff doe	es more than half) with oral					
	hygiene and shower	ring.					
	A assumant A stissis	of Doily Living (ALD)					
		s of Daily Living (ALD) care					
	interventions:	, included the following					
		es extensive assist by one staff					
	with bathing/showe						
		independent but occasionally					
		ive assist by one staff for					
	personal hygiene an						
	1 2 2 8.0 41						
	The Point of Care (POC) (a Certified Nurse Aide					
	documentation syste	em) Tasks for showering					
		T received showers on					
		ys. Resident T did not receive					
		on the following days in June					
	and July 2024:						
	6/11/24						
	7/12/24						
	7/19/24						

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

Event ID:

KT8011

Facility ID: 000439

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		a. Building <u>00</u>			COMPL	X3) DATE SURVEY COMPLETED	
		155716	B. WI	NG		01/27/	2025	
	PROVIDER OR SUPPLIER			601 N B	NDDRESS, CITY, STATE, ZIP COD BOEKE RD VILLE, IN 47711			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION]	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
F 0686 SS=D Bldg. 00	A nursing progress: P.M., indicated the Resident T to have per change his clothing in need of someone as brushing teeth, but the Poc Tasks. Shower not part of the clinic During an interview 1/27/25 at 12:31 P.M. written policy relater residents were experimentally with the policy relater residents were experimentally with the policy relater residents were experimentally to a policy to dated 8/2024, that in serve resident trays require assistance we cannot feed themsel to safety, comfort, at This citation relates 3.1-38(a)(2)(A) 3.1-38(a)(2)(D) 3.1-38(a)(3) 3.1-38(b)(1) 3.1-38(b)(2) 483.25(b)(1)(i)(ii)	note, dated 7/24/24 at 6:45 Registered Nurse (RN) noted poor oral hygiene, could not on his own, and that he was to help in doing hygiene such athing, and changing clothes. P.M., the Director of Nursing at all showers were charted in r sheets were used but were cal record. With the Administrator on M., she indicated there was no ed to the timing of showers, but cted to receive showers twice P.M., the Administrator titled Assistance with Meals, indicated "Facility staff will and will help residents who lives will be fed with attention						
	Based on interview,	, observation, and record	F 06	86	F686 What corrective action will b	e	02/26/2025	

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Event ID:

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Facility ID: 000439

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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
		155716	B. W	ING _		01/27/	2025
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BOEKE RD		
FNVIVE	OF EVANSVILLE				VILLE, IN 47711		
	C. EV/(140 VILLE			LVANO	· · · · · · · · · · · · · · · · · · ·		
(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	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		failed to promote the			accomplished for those		
		ure ulcer development through			residents found to have been	n	
	evaluation of clinic				affected by the deficient		
		interventions consistent with			practice:		
	resident needs for 1 of 2 residents reviewed for facility acquired pressure injuries. (Resident G) Finding includes:				Pressure injury risk factors		
					identified, and interventions		
					implemented, and care planne		
					Resident G. Meeting held with		
					family and physician to review	1	
		ous interview, it was indicated			current resident status and		
		ecline in mobility since			orders.		
		being left in the same position					
		time resulting in skin			How other residents having		
	breakdown.				potential to be affected by th		
					same deficient practice will l		
	_	ion on 1/23/25 at 8:57 A.M.,			identified and what correctiv	e e	
		ing in a recliner in the common			action will be taken:		
		not have a pressure reducing			Other residents at risk of pres		
	cushion for skin bre	eakdown prevention.			injury have the potential to be		
					affected. Branden assessmer		
		P.M., Resident G's clinical			completed for residents to ide	-	
		d. Resident G was admitted on			those at high risk for pressure		
	_	included, but were not limited			injury. Interventions reviewed		
	to, dementia.				implemented, and/or care plar		
					as needed for residents at hig	h	
	1	narterly Minimum Data Set			risk.		
		, dated 12/24/24, indicated			l		
		verely cognitively impaired,			What measures will be put in	nto	
		l assistance (staff do more			place and what systemic		
		rk) for bathing and transferring,			changes will be made to		
	and was at risk for	pressure ulcers.			ensure that the deficient		
	Comment of the comment	and a market of the dead of th			practice does not recur:		
		orders included, but were not			Nursing educated on the		
	limited to:	hi			importance of identifying risk	1	
	_	eushion to chair/wheelchair			factors for pressure injury and		
	every shift, Start da	tte 12/9/24.			ensuring implementation of		
	Tr	did historia in a P. N. D.			interventions as ordered. CN/		
		ded, but was not limited to:			have been educated regarding	9	
		aired skin integrity related to			ensuring the accuracy of		
	bowel and bladder	incontinence, Date Initiated:	1		documentation in their POC.		

CENTERS FOR	NTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG	00	COMPL	ETED
		155716	B. WING			01/27	/2025
					_		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					OEKE RD		
ENVIVE	OF EVANSVILLE		ΕV	'ANS	VILLE, IN 47711		
(V4) ID	CIMMADV	CTATEMENT OF DEFICIENCIE		1			(V5)
(X4) ID		STATEMENT OF DEFICIENCIE	ID	2137	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	G			DATE
	12/10/24.				Nurse managers will audit		
					pressure relieving device orde	rs to	
	The care plan did no	ot include an individualized			ensure that they are on tasks,		
	repositioning sched	ule.			orders, and care plan.		
					IDT will review any new skin		
	A progress note, da	ted 1/23/25 at 6:08 A.M.,			issues or orders in clinical		
		G had an open area on his			meetings five times a week to		
		l record lacked notification to			ensure that appropriate		
	family or physician				interventions are ordered,		
	, F-2, 2-31mi	1			implemented, and care planne	d	
	Δ progress note dat	ted 1/23/25 at 4:29 P.M.,			Family and physician notificati		
		G had open areas on bilateral			will be reviewed during the clir		
		d nurse was notified.			· ·	licai	
	buttocks. The woun	d hurse was notified.			meetings to ensure proper		
		1 . 11/22/25 4.20 P.M.			notifications have been		
		dated 1/23/25 at 4:39 P.M.,			completed.		
		G had five open wounds on his					
		ncluding two stage two			How the corrective action will	II	
	wounds (partial thic	kness skin loss).			be monitored to ensure the		
					deficient practice will not		
	_	and times were documented			recur, i.e., what quality		
	as no skin issues in	the skin observation task:			assurance program will be p	ut	
	1/21/25 12:57 P.M.				into place:		
	1/22/25 7:42 P.M.				An audit will be conducted on	10	
	1/23/25 6:16 P.M.				residents per week to ensure t	hat	
	1/24/25 8:40 A.M.				interventions are ordered,		
					implemented, documented and	b	
	On 1/27/25 at 12:31	P.M., the Administrator			care planned.		
		tled Prevention of Pressure			Results of the audit will be		
		24, that indicated " Reposition			reviewed by QA team during Q	DAPI	
	1 -	at risk of pressure injuries on			meetings. POC may be revise		
		chedule, as determined by the			updated, based on QA review,		
		re team. Evaluate, report, and			needed to achieve, and mainta		
		changes in the skin."				aii i	
	document potential	changes in the skill.			compliance. Audits may be	ما المان	
	2.1.40(.)(1)				discontinued after six months		
	3.1-40(a)(1)				at least two consecutive month	ns of	
	3.1-40(a)(3)				100% compliance achieved.		
					By what date the systemic		
					changes for each deficiency		
					will be completed:		

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February 26, 2025

If continuation sheet

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STATEME	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	COMPI	LETED	
		155716	B. W	ING		01/27	//2025	
		<u>L</u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			BOEKE RD			
ENVIVE	OF EVANSVILLE				SVILLE, IN 47711			
(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	
F 0689	483.25(d)(1)(2)							
SS=D	Free of Accident							
Bldg. 00	Hazards/Supervis	sion/Devices						
	Based on interview	and record review, the facility	F 00	589	F 689		02/26/2025	
	failed to ensure pos	st fall assessments were			What corrective action will b	e		
	completed, care pla	completed, care plans were updated, and			accomplished for those			
	interventions were	in place to prevent falls for 3 of			residents found to have bee	n		
	6 residents reviewe			affected by the deficient				
	Resident P, and Re	Resident P, and Resident G)			practice:			
				Unable to complete post fall				
	Findings include:				assessments in the past. Car	e		
					plans updated and interventio	ns in		
	1. On 1/22/25 at 8:	59 A.M., Resident W's clinical			place to prevent falls for resid	ents		
	record was reviewe	ed. Diagnoses included, but			W, P, and G.			
	were not limited to	, Alzheimer's Disease.						
					How other residents having	the		
	The most current A	Annual Minimum Data Set			potential to be affected by the	ıe		
	(MDS) Assessmen	t, dated 12/3/24, indicated			same deficient practice will	be		
	Resident W had mo	oderate cognitive impairment,			identified and what corrective	e e		
	required substantia	l to maximal assistance of staff			action will be taken:			
	(staff does more that	an half) for bed mobility,			Residents with falls have the			
	_	ng, and had no falls since the			potential to be affected. Resid	lents		
	prior assessment or	n 9/3/24.			with a fall in the past 30 days	will		
					have falls care plans reviewed	d and		
		assessment, dated 1/5/25,			updated if indicated. Unable			
	indicated Resident	W was at high risk for falls.			complete post fall assessmen	ts in		
					the past. Interventions are in			
		e plan, revised 9/12/22, indicated			place for these residents.			
		potential for falls related to						
	impaired balance.				What measures will be put in	ıto		
		(D. 11. 11. 11. 11. 11. 11. 11. 11. 11. 1			place and what systemic			
		s of Daily Living (ADL) care			changes will be made to			
	1 -	2, indicated Resident W			ensure that the deficient			
	_	of two staff for bed mobility,			practice does not recur:			
	transfers, toileting,	and bathing.			Nursing and IDT were educate			
	D1 · · · · · · ·	1111			the requirement to update the			
	,	icluded, but were not limited to:			assessments, care plan			
	_	t using hot charting progress			interventions and to complete			
	-	. Monitor vital signs every			documentation following each			
I	shift post fall for 72	2 hours to rule out any	I		IDT was educated that a follow	w up	İ	

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02/27/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 abnormal results or fluctuations every shift for note is required when the three days, dated 1/7/25 intervention involves monitoring for a specific amount of time, or if a A change in condition note, dated 1/5/25 at 6:48 resident returns from an outside P.M., indicated Resident W had a fall due to provider with new interventions. altered mental status and was sent to the All falls will be reviewed in clinical Emergency Room (ER) for evaluation and meetings five times per week to treatment. ensure that assessments are completed, documentation is in A health status note, dated 1/6/25 at 2:18 P.M., place and interventions are indicated Resident W returned from the hospital updated on the care plan. If a with a diagnosis of Urinary Tract Infection (UTI). monitoring intervention is used, Imaging done at the hospital was normal. the IDT will complete a follow-up during the scheduled clinical An Interdisciplinary Team (IDT) note, dated meeting following the completion 1/7/25 at 10:09 A.M., indicated Resident W's fall of monitoring. was reviewed and a new intervention to monitor vital signs over 72 hours for any fluctuations or How the corrective action will abnormal results post fall was added to the care be monitored to ensure the plan. deficient practice will not recur, i.e., what quality A Nurse Practitioner (NP) note, dated 1/8/25 at assurance program will be put 11:59 P.M., indicated the resident was seen due to into place: "increased pain and altered mental status An audit will be completed by following a recent fall and hospitalization, where DNS or designee on all falls she was diagnosed with a UTI and received weekly to ensure that any post fall various diagnostic tests. Her vital signs show assessments are completed. erratic blood pressure and an elevated pulse, documentation is in place and raising concerns for potential sepsis ... Continue interventions are added to the care close monitoring of vital signs, particularly blood plans, and any IDT follow-up pressure and heart rate". documentation is completed. Results of the audit will be An alert note, dated 1/13/25 at 4:04 P.M., indicated reviewed by QA team during QAPI after continued complaints of pain, the Nurse meetings. POC may be revised or Practitioner (NP) ordered a repeat x-ray that updated, based on QA review, as showed an acute fracture of the distal femur, and needed to achieve, and maintain the resident was sent to the ER for evaluation and compliance. Audits may be treatment. discontinued after six months with

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Hospital discharge papers, dated 1/13/25 at 5:55

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If continuation sheet

at least two consecutive months of

100% compliance achieved.

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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. B	JILDING	00	COMPL	LETED
		155716	B. W	ING		01/27	/2025
		<u>l</u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			BOEKE RD		
FNI\/I\/E	OF EVANSVILLE				VILLE, IN 47711		
LINVIVE.	CI LVANOVILLE			LVAINO	VILLE, IIN 77771		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		resident was being discharged			By what date the systemic		
		gnosis of fracture of distal end			changes for each deficiency		
		of fibula, and tibial plateau		will be completed:			
	fracture (right side)	fracture (right side).			February 26, 2025		
	A munain a mma am	note detect 1/12/25 at 7:22					
		note, dated 1/13/25 at 7:22					
	P.M., indicated the resident returned to the facility						
	with an illinoulize	with an immobilizer in place on her right leg.					
	The clinical record	lacked documentation that the					
		for vital signs x 72 hours" was					
	reviewed for effectiveness or that the care plan was updated after the resident returned from the						
	_	with a new diagnosis of femur					
	fracture and an imn	_					
		•					
	In an interview on 1	1/22/25 at 9:56 A.M., the					
	Director of Nursing	g (DON) indicated that the					
	terminology "hot ch	narting" was to remind the					
	nurse they had some	ething specific to chart. Vital					
	sign hot charting we	ould be documented in the					
	vital signs tab.						
		A.M., the Regional Support					
	ı ^	and vitals summary for					
		/7/24 to 1/9/24. The following					
	l	charted once per shift during					
	that time:	0/25: -14 -1:0 1/0/25 : 14					
	_	8/25 night shift, 1/9/25 night					
	shift Pulse - 1/8/25 night	shift					
	_	25 day shift and night shift					
		night shift, 1/9/25 day shift and					
	night shift	ingin sinit, 1/7/25 day sinit and					
		5 day shift and night shift,					
	1/9/25 day shift and						
	I -	- 1/8/25 day shift and night					
		ift and night shift.2. On 1/22/25					
		ent G's clinical record was					
		G was admitted on 12/9/24.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/27/2025		
	ROVIDER OR SUPPLIER		601 N I	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION	Ŋ
	dementia.	, but were not limited to,				
	(MDS) Assessment Resident G was sev required substantial	arterly Minimum Data Set, dated 12/24/24, indicated erely cognitively impaired and assistance (staff do more for bathing and transferring.				
	Resident G was a hi	ent, dated 1/15/25, indicated tigh risk for falls and had fallen e past in the past three months.				
	I am at risk for falls cognition related to initiated 12/10/24, I Assess for pain, Da call light is within r	ded, but was not limited to: /injury due to: impaired dementia, history of falls, interventions included: te Initiated: 12/13/24 each, Date Initiated: 12/13/24 e free of clutter, Date Initiated:				
	Keep personal item 12/13/24 Physical therapy to indicated, Date Initi Staff education rega to assist with restles	eval (evaluate) and treat as lated: 1/9/25 arding ambulation of resident senses, Date Initiated: 1/17/25 side, Date Initiated: 1/17/25				
	indicated Resident a recliner without ass the recliner with leg	at 6:37 A.M., an incident note attempted to get out of the istance and slid to bottom of gs on floor. Resident G was all light when needing unsafe transfers.				
	Team (IDT) note in	3 A.M., an Interdisciplinary dicated the IDT team agreed a for the fall on 12/21/24 was to to getting up.				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	A. BUIL	A. BUILDING <u>00</u>		COMPL	(3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	The care plan was r intervention for fall	not updated with the new fall one.						
	indicated IDT revie occurred on 1/8/25. his walker and fell intervention of 72 h implemented and a physical therapy to Fall 3: On 1/15/25 a found sitting on the using his hands and attempting to self-tr impaired memory a was updated with n	e 9:21 A.M., an IDT note swed a witnessed fall that Resident G was reaching for forward. An immediate nour hot charting was new order was entered for evaluate and treat. at 11:30 P.M., Resident G was a floor near his bed scooting I feet. Resident G was ransfer unassisted and had and unsteady gait. The care plan onskid mat at bedside.						
		dent G slid onto the floor. The d minor pain and was the chair.						
	notification to the p	lacked a post-fall assessment, ohysician or family, an ing the fall, and an update to fall four.						
	note indicated a nur	at 4:05 P.M., a nursing progress rse and Certified Nurse Aide transfer Resident G. Resident						
	notification to the p	lacked a post-fall assessment, obysician or family, an ing the fall, and an update to fall five.						
	Fall 6: On 1/26/25	at 10:24 P.M., a nursing progress						

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STATEMENT OF DEFICIENCIES X1) PROV AND PLAN OF CORRECTION IDENTIFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N E	ADDRESS, CITY, STATE, ZIP CO BOEKE RD VILLE, IN 47711	D		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	note indicated Residulation.	dent G slid out of bed onto the					
	notification to the p	lacked a post-fall assessment, hysician or family, an ing the fall, and an update to fall six.					
	Therapy Manager is receiving therapy b	y on 1/23/25 at 11:39 A.M., the ndicated Resident G was not ecause insurance had not and was not receiving daily					
	Administrator and I indicated they could Resident G on 1/21 unaware Resident C 1/22/25 at 2:47 P.M was reviewed. Diag	on 1/27/25 at 2:50 P.M., the Director of Nursing (DON) d not find fall assessments for /25 and 1/26/25 and were 6 had fallen either dates. 3. On I., Resident P's clinical record moses included, but were not er's Disease and a right mur fracture.					
	Data Set (MDS) As indicated the reside required substantial	ignificant Change Minimum sessment, dated 11/11/24, nt was not cognitively intact, to maximum assistance (staff t) with transfers, and had no assessment.					
		ll risk assessment, dated Resident P was at high risk for					
	indicated the reside	alls care plan, initiated 5/2/24, nt was at risk for injury from a cognition and dementia.					

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A Communication with the Family note, dated

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		TE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716			A. BUILDING B. WING			COMPLETED 01/27/2025	
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CO	D		
ENVIVE	OF EVANSVILLE		EVANS	SVILLE, IN 47711			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION	
TAG	REGULATORY OF 12/30/24 at 8:00 P.I family member was the hallway with not a Skilled Charting P.M., included vital assessment. The no regarding the resided A Nurse Practitione 11:59 P.M., indicate per staff/resident re An Interdisciplinary 12/31/24 at 9:26 A. occurred on 12/30/2 Resident P was with from her wheelchair and slid to floor. The new intervention wheelchair. The clinical record indicate Resident P after falling on 12/3 During an interview Administrator indicate A.M. until the skilled that night. During an interview Administrator indicate after the A.M. until the skilled that night.	R LSC IDENTIFYING INFORMATION M., indicated the resident's a notified of a witnessed fall in pointing. Note, dated 12/30/24 at 11:00 I signs and a skin/wound te lacked documentation ent's witnessed fall. er (NP) note, dated 12/30/24 at ed that the resident was seen quest for a fall. y Team (IDT) note, dated M., indicated the fall that 24 at 11:00 A.M. was reviewed. In the case of the care plan was updated with an to apply anti-rollbacks to the lacked documentation to was assessed immediately	TAG	CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	PROPRIATE	DATE	
	with a new interventeam would meet the	ntion after each fall. The clinical ne next day after a fall, discuss opriate intervention would be,					

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and look for an intervention that would prevent the next fall or a fall of the same nature. If the intervention was to monitor vital signs, obtain

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	labs, or review med would meet to follo determine if it were case orders were re it was determined i another new intervand placed in the placet of the place	5 P.M., the DON provided a falls and Their Causes policy, at indicated "When a resident	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	in the resident's me which the resident including vital sign Notification of the Appropriate interve falls Notify the f resident falls: The r Attending Physicia	information should be recorded dical record: The condition in was found Assessment date, is and any obvious injuries physician and family entions taken to prevent future following individuals when a resident's family; The in Report other information facility policy and professional ite".					
	provided a current policy, effective 8/2 systematic evaluati identifies several per may choose to prior underlying causes of corrected, staff will based on assessment falling".	I P.M., the Administrator Falls and Fall Risk, Managing 2024, that indicated "If a on of a resident's fall risk cossible interventions, the staff ritize interventions If cannot be readily identified or try various interventions, at of the nature or category of					
	3.1-45(a)(2)	s to Complaint Invol446/47.					
F 0695 SS=D	483.25(i) Respiratory/Trach	eostomy Care and					

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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 COMPLETED 00 B. WING 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 00 Based on observation, record review, and F 0695 F 695 02/26/2025 interview, the facility failed to ensure residents What corrective action will be received respiratory care services in accordance accomplished for those with professional standards of practice for 1 of 1 residents found to have been residents reviewed for respiratory care. The affected by the deficient facility failed to date oxygen tubing, oxygen practice: concentrator, and suction tubing, and place signs The oxygen tubing, oxygen that indicated oxygen was in use. (Resident 277) concentrators, and suction tubing for Resident 277 have been dated. Finding includes: Signs have been placed notifying that oxygen is in use for Resident On 1/21/25 at 9:17 A.M., Resident 277's oxygen 277. An emergency obturator is in tubing, suction tubing, and oxygen concentrator place in the resident's room. were observed without a label and date. There were no oxygen signs observed that indicated the How other residents having the resident received oxygen. Resident was observed potential to be affected by the to have a tracheostomy. same deficient practice will be identified and what corrective During the observation of Resident 277's action will be taken: tracheostomy care on 1/22/25 at 8:34 A.M., the Other residents with oxygen, obturator for emergency tracheostomy use was tracheostomy or suctioning have not identified in the room. the potential to be affected. All residents with oxygen tubing, On 1/22/25 at 8:53 A.M., Resident 277's oxygen oxygen concentrators or suction tubing, suction tubing, and oxygen concentrator tubing have them in place and were observed without a label and date. There dated. Any resident with a were no oxygen signs observed that indicated the tracheostomy has the obturator in resident received oxygen. place in the room for emergencies. All residents with On 1/21/25 at 11:21 A.M., Resident 277's clinical oxygen have a sign in place record was reviewed. Diagnoses included, but indicating that oxygen is in use. were not limited to, chronic respiratory failure with hypoxia and tracheostomy. What measures will be put into place and what systemic The Admission Minimum Data Set (MDS) changes will be made to Assessment was in progress. ensure that the deficient practice does not recur: Current physician orders included the following: Nursing staff have been educated Oxygen (O2) - six liters per tracheostomy mask. on dating oxygen tubing,

PRINTED: 02/27/2025 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 Titrate to keep O2 saturation greater than 92% at concentrators, and suction tubing bedtime, dated 1/15/25. and the need to maintain signs indicating that oxygen is in use. Change oxygen tubing monthly and as needed Nurses have been educated on the (PRN), one time a day every 4 weeks on Sunday need to maintain the obturator in a for oxygen use and as needed for soiled or resident's room if they have a compromised, dated 1/15/25. tracheostomy, for emergency tracheostomy insertion. Change humidifier/bubbler [sic] (container) IDT will review orders in clinical monthly and PRN for empty/compromised, and meeting five times per week and change one time a day every 4 weeks on Sunday ensure that any residents with for routine oxygen, dated 1/15/25. new respiratory care orders have all tubing dated and oxygen The clinical record lacked a base line care plan for signage in place as required. the tracheostomy and oxygen use. How the corrective action will be monitored to ensure the During an interview on 1/22/25 at 2:35 P.M., the deficient practice will not Director of Nursing (DON) indicated the oxygen recur, i.e., what quality tubing, suction tubing, and concentrator should assurance program will be put be labeled. There should be a sign on the outside into place:

of the door indicating oxygen use.

On 1/22/25 at 9:56 A.M., the DON provided a current Oxygen Administration policy, revised 8/2024, that indicated "the purpose of this procedure was to provide safe guidelines for safe oxygen administration...equipment needed...no smoking/Oxygen in use sign on the outside of the room entrance door...".

3.1-47(a)(4)3.1-47(a)(5)

3.1-47(a)(6)

DNS or designee will audit all residents with tracheostomies each week to ensure that the obturator is in place for emergency insertion. DNS or designee will audit five residents with respiratory care orders each week for the presence of dates and labels on oxygen tubing, suction tubing, or concentrators and ensure that an

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"oxygen in use" sign is present.

reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of

Results of the audit will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025		
	PROVIDER OR SUPPLIER		601 N	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711		
(X4) ID PREFIX TAG	SUMMARY (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) 100% compliance achieved. By what date the systemic	(X5) COMPLETION DATE	N
				changes for each deficiency will be completed: February 26, 2025		
F 0698 SS=D Bldg. 00	483.25(I) Dialysis					
	failed to follow phy ongoing assessment and monitoring for pre-dialysis evaluate residents reviewed (Resident 35) Finding includes: On 1/21/25 at 1:37 record was reviewed 10/8/24. Diagnoses	and record review, the facility resician orders and provide to the resident's condition complications by completing ions assessments for 1 of 1 for dialysis management. P.M., Resident 35's clinical d. Resident 35 was admitted on included, but were not limited	F 0698	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: A pre-dialysis assessment has been completed for Resident with blood pressure taken in the Right arm. Care profile updat reflect blood pressure in the right arm only.	n s 35 he ed to ight	!5
	The most recent Qu (MDS) Assessment Resident 35 was co substantial assistant than half of the wortransfers. Current physician of limited to: Do not obtain blood date 10/8/24.	peripheral vascular disease. parterly Minimum Data Set dated 1/16/25, indicated gnitively intact and required see from staff (staff does more sk) for toileting, bathing, and briders included, but were not dipressure in the left arm, Start ment to be completed prior to		How other residents having potential to be affected by the same deficient practice will lidentified and what corrective action will be taken: Other residents with dialysis he the potential to be affected. A dialysis residents have had a pre-dialysis assessment completed following resident specific instructions. Care prohave been updated for any restrictions regarding blood pressures in specific extremitions.	ne be ve nave NII	

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Start date 10/9/24

dialysis one time a day every Monday,

Wednesday, Friday for pre-dialysis assessment;

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What measures will be put into

place and what systemic

changes will be made to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716 IDENTIFICATION NUMBER 200 STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711 IDENTIFICATION NUMBER ENVIVE OF EVANSVILLE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 12/5/24 10:03 A.M. 12/11/24 9:34 A.M. IDENTIFICATION NUMBER A. BUILDING 00 STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711 ID PROVIDERS PLAN OF CORRECTION (EACH OPERITY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Nurses were educated on the need for pre and post-dialysis assessments as well as the need to follow any vital sign restrictions and to document results. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE (X4) ID PREFIX TAG Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/5/24 10:03 A.M. STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711 ID PROVIDERS PLAN OF CORRECTION FINAL ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY: PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY: Nurses were educated on the need to follow any vital sign restrictions and to document results. How the corrective action will be monitored to ensure the deficient practice will not	
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 11/5/24 10:03 A.M. ID PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION EACH COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (COMPLETIVE ACTION SHOULD BE CROSS-REFERENCED TO THE	
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Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 assessments as well as the need to follow any vital sign restrictions and to document results. The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 12/5/24 10:03 A.M. TAG ensure that the deficient practice does not recur: Nurses were educated on the need to follow any vital sign restrictions and to document results. How the corrective action will be monitored to ensure the deficient practice will not	ETION
Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 12/5/24 10:03 A.M. Practice does not recur: Nurses were educated on the need to follow any vital sign restrictions and to document results. How the corrective action will be monitored to ensure the deficient practice will not	Е
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12/4/24 2:54 P.M. 12/5/24 10:03 A.M. be monitored to ensure the deficient practice will not	
12/5/24 10:03 A.M. deficient practice will not	
12/11/24 9:34 A M	
Tecui, i.e., what quality	
1/7/25 11:20 A.M. assurance program will be put	
1/8/25 7:56 A.M. into place:	
1/15/25 11:33 A.M. DNS or designee will monitor the	
1/15/25 5:47 P.M. completion of pre and post	
1/22/25 8:00 A.M. dialysis assessments for all	
1/22/25 3:22 P.M. dialysis residents, including	
obtaining and documenting vital	
A pre-dialysis assessment on 12/31/24 contained signs, three times weekly for 8	
vitals including blood pressure, from a previous weeks and then weekly for four	
date (12/27/24). months.	
Results of the audit will be	
A pre-dialysis assessment on 1/10/25 contained reviewed by QA team during QAPI	
vitals, including blood pressure, from a previous meetings. POC may be revised or	
date (1/8/25). updated, based on QA review, as	
needed to achieve, and maintain	
A pre-dialysis assessment on 1/24/25 contained compliance. Audits may be	
vitals, including blood pressure, from a previous discontinued after six months with	
date (1/22/25). at least two consecutive months of	
100% compliance achieved.	
During an interview on 1/24/25 at 1:32 P.M., the By what date the systemic	
Director of Nursing (DON) indicated Resident 35's changes for each deficiency	
blood pressure should not be taken in the left arm. will be completed:	
February 26, 2025	
During an interview on 1/27/25 at 12:31 P.M., the	
Administrator indicated the facility did not have a	
written policy for following physician orders, but	
it was the facility's policy to follow the physician	
orders as written.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 0712 SS=D Bldg. 00	A policy related to was requested and 3.1-37(a) 483.30(c)(1)-(4) Physician Visits-FNPP Based on interview failed to ensure a rephysician since addreviewed for dialys Finding includes: During an interview Resident 35 indicated by a physician in the On 1/21/25 at 1:37 record was reviewed 10/8/24. Diagnoses to, renal failure and The most recent Quantum (MDS) Assessment Resident 35 was consubstantial assistant than half of the wortransfers. The clinical record.	assessment of dialysis patients not provided. Frequency/Timeliness/Alt and record review, the facility esident was assessed by a nission for 1 of 1 residents	F 0712	F 712 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician has evaluated the Resident 35. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential be affected. An audit was completed on all residents. An resident who was due or past of for a physician evaluation has been completed. What measures will be put integrated that the deficient	02/26/2025 he e e to y due
	assessment of Residual facility since admis	dent 35 by a physician in the		practice does not recur: IDT was educated on the requirements for physician visit and the physician was provided with the results of the audit	

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any physician assessments since admission for

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indicating who was due for an

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711	
(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)	(X5) COMPLETION DATE
	provided a policy to Physician, dated 8/ attending physician responsibilities incorresident assessmen Physician visits, fro care of residents, et	I P.M., the Administrator tled Choice of Attending 24, that indicated "The requirements and tude: participating in the is and care planning; equency of visits, emergency c., are provided in accordance a regulations and facility		evaluation. Physician will be provided with a list of new residents on scheduled weekly rounding days and a monthly of residents who are due for ongoing evaluation. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: ED or designee will audit physician visits monthly for compliance. Results of the audit will be reviewed by QA team during of meetings. POC may be revised updated, based on QA review, needed to achieve, and maintal compliance. Audits may be discontinued after six months at least two consecutive month 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	Uist UAPI ed or , as ain with
F 0804 SS=E Bldg. 00	Temp	opear, Palatable/Prefer			
	review, the facility	on, interview, and record failed to ensure meals were e temperature for 1 of 1 trays are. (North Hall)	F 0804	F 804 What corrective action will be accomplished for those residents found to have beer affected by the deficient practice: Food has been served at a	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 On 1/17/25 at 10:46 A.M., Resident 118 indicated palatable temperature for all the food tasted bad and was cold. residents. On 1/21/25 at 10:13 A.M., Resident 35 indicated How other residents having the the food temperature was never what it was potential to be affected by the supposed to be. Her hot foods were not hot and same deficient practice will be her cold foods were not cold. identified and what corrective action will be taken: On 1/21/25 at 10:53 A.M., Resident S indicated the All residents who receive food from food was cold when she got it and hot plates were the kitchen have the potential to sometimes not used to keep it warm while be affected. All residents have delivering it to residents. been served food at a palatable temperature. On 1/23/24 at 12:45 P.M. a test tray was obtained. Food temperatures from that meal were: What measures will be put into Cheeseburger 100.6 F (Fahrenheit) place and what systemic Sweet potato fries 87 F changes will be made to The food tasted lukewarm and the cheeseburger ensure that the deficient was observed to be pink in the middle of the meat. practice does not recur: Dietary staff have been educated On 1/23/24 at 12:50 P.M., the Dietary Supervisor on the need to ensure that food indicated that the burgers used were precooked. leaves the kitchen at appropriate temperatures and that the heated On 1/27/25 at 12:31 P.M., the Administrator covers are used as appropriate. provided a Food Temperatures policy, dated 2021, Nursing staff have been educated that indicated "foods sent to the units for on the need to ensure that trays distribution (such as meals, snacks, nourishments, are passed in a timely manner to oral supplements) will be transported and ensure food is served at the delivered to unit storage areas to maintain correct temperatures. temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot How the corrective action will foods". be monitored to ensure the deficient practice will not 3.1-21(a)(2) recur, i.e., what quality assurance program will be put into place: DNS or Designee will monitor

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meal service attendance during five meals per week for 4 weeks, then three meals per week for 4

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/27/2025	
	PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
				weeks, then one weekly for 16 weeks to ensure that residents requiring assistance are served the same time as the other residents in the area and that is served promptly to allow for proper temperatures. Dietary Manager or designee waudit food temps five meals perweek for 4 weeks, then three meal	d at food will er hen esure ble QAPI ed or as ain	
F 0842 SS=D Bldg. 00	Based on interview	and record review, the facility	F 0842	F 842		02/26/2025
	accurate for 1 of 3 discharge from Me	rumentation was complete and residents reviewed for dicare Part A and 1 of 6 for falls. (Resident Z and		What corrective action will be accomplished for those residents found to have been affected by the deficient		

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Resident T) Attempts to contact the family were

were not documented accurately.

not documented and details of an injury from a fall

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Residents T and Z are no longer in

practice:

the facility.

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		155716	B. W	ING		01/27/	/2025
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(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
TAG	Findings include: 1. During an intervent the Administrator is scheduled to be disfamily failed to pichad attempted to cathey had not answer they had not anyther the	iew on 1/17/25 at 9:45 A.M., ndicated Resident Z was scharged home on 1/15/25, but ik up the resident. The facility all the resident's family, but be the phone. W on 1/17/25 at 9:58 A.M., we member indicated that the facility short term for rehabilistic discharged soon. They were reall from the Social Services set a date for discharge but had be discharged but had be discharged soon. They were reall from the Social Services set a date for discharge but had be discharged but had			How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken: Any resident whose family is contacted has the potential to affected. Attempts to contact families have been document the clinical record. Residents with falls have the potential to be affected. Documentation will be complet accurately for residents with find what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nursing and IDT have been not the necessity for accurate documentation and that any attempts to contact families must be documented in the clinical record. All clinical progress notes will reviewed by the IDT in the clinical record. All clinical progress notes will reviewed by the IDT in the clinical record. How the corrective action we be monitored to ensure the deficient practice will not	the he be we be seed in the set of the set o	DATE
	·	nd a family member would pick			recur, i.e., what quality		
	her up that day.				assurance program will be p	out	
					into place:		
	A late entry social	services note, dated 1/15/25 at			An audit will be completed by	,	

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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 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 8:58 A.M., indicated the SSD left a voicemail for DNS or designee on all falls the family member asking when the resident would weekly to ensure that be picked up. documentation is in place and family notification is completed The clinical record lacked documentation to and documented. indicate the facility attempted to call the family An audit will be completed by member between 1/15/25 at 8:58 A.M. and 1/17/25 DNS or designee on 10 residents at 12:47 P.M. per week to determine if there is any missing notification of family A Social Service note, dated 1/17/25 at 12:47 P.M., documentation. indicated the SSD spoke with the family member Results of the audit will be and arrangements were made for discharge from reviewed by QA team during QAPI the facility on 1/22/25. meetings. POC may be revised or updated, based on QA review, as During an interview on 1/24/25 at 3:20 P.M., the needed to achieve, and maintain Administrator indicated the Social Services compliance. Audits may be Director was no longer employed by the facility discontinued after six months with and documentation of attempts to contact at least two consecutive months of Resident Z's family between 1/15/25 and 1/17/25 100% compliance achieved. could not be found. 2. On 1/21/25 at 1:39 P.M., By what date the systemic Resident T's clinical record was reviewed. changes for each deficiency Diagnoses included, but were not limited to, a will be completed: Alzheimer's disease with late onset, nondisplaced February 26, 2025 fracture of greater tuberosity of right humerus, and other displaced fracture of upper end of right humerus. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with toileting, showering/bathing, bed mobility, and transfers, and had two or more falls with major injury since the last assessment. An incident note, dated 7/19/24 at 10:44 A.M.,

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indicated Resident T fell in his room. The resident complained of hip and neck pain. Resident T was assessed and "had no injury, with the exception

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	arm with bruises vis The Social Service to put a sling on res to the sling the resic stable and did not e A nursing progress A.M., indicated Res	ary in his left upper and lower sible to almost all of left arm". Director (SSD) "then decided ident provided by facility due dent had currently, was not levate their left arm". note, dated 7/19/24 at 10:50 sident T had bruising and a right arm from his neck to his					
	Administrator indice arm the resident hur on 7/19/24 but it was that time, she indicated SSD to make the decision.	or on 1/27/25 at 9:52 A.M., the ated she was unsure of which rt during the fall that occurred as most likely his right arm. At ated it was not typical for the etermination to put a sling on a togress note was documented					
	provided a current (policy, effective 8/2 following informati resident medical rec changes in the care Documentation in the objective (not opinic complete, and accur	P.M., the Administrator Charting and Documentation 2024, that indicated "The on is to be documented in the cord:progress towards or plan goals and objectives the medical record will be onated or speculative), rate".					
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention						
2.29. 00		on, record review, and ty failed to ensure the proper	F 0880	F 880 What corrective action will b	02/26/2025 e		

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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 COMPLETED 00 B. WING 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 use of Enhanced Barrier Protocol (EBP), Personal accomplished for those Protective Equipment (PPE), and hand washing for residents found to have been 2 of 2 residents reviewed for wound care and 1 of affected by the deficient 1 residents reviewed for tracheostomy care. practice: (Resident 13, Resident 18, Resident 277) EBP sign has been placed for Resident 227. Findings include: Dressing changes for residents 13, and 18 were completed using 1. On 1/21/25 at 11:21 A.M., Resident 277's clinical proper PPE, EBP, and record was reviewed. Diagnoses included, but handwashing. were not limited to, chronic respiratory failure with Tracheostomy care was provided hypoxia and tracheostomy. for Resident 277 using proper PPE, EBP, and handwashing. Physician orders included, but were not limited to: How other residents having the Resident requires the use of Enhanced Barrier potential to be affected by the Precautions (EBP) related to the medical device same deficient practice will be (Tracheostomy & Peg Tube) to reduce the risk of identified and what corrective transmission of multidrug-resistant organisms action will be taken: (MDROs) every shift for Isolation Precautions. An audit will be completed to Use Personal Protective Equipment (PPE) determine which residents require precautions when providing prolonged direct EBP. Other residents requiring resident care, dated 1/14/25. EBP have the potential to be affected. Residents in EBP were On 1/22/25 at 8:34 A.M., Resident 227 was provided care with the proper use observed with a tracheostomy. There was not an of PPE and handwashing. EBP Enhanced Barrier Precaution (EBP) sign observed signs are placed for each resident in the resident's room. who is on EBP. On 1/22/25 at 8:58 A.M., Licensed Practical Nurse What measures will be put into (LPN) 23 was observed performing tracheostomy place and what systemic care for Resident 227. LPN 23 did not wear a gown changes will be made to during care. LPN 23 did not wash her hands prior ensure that the deficient to putting on gloves and opening items for a practice does not recur: sterile field. The items were placed onto the sterile Staff will be educated on field and LPN 23 removed her gloves. LPN 23 Enhanced Barrier Precautions, washed her hands for 15 seconds with soap and how to identify who requires them, water prior to putting on sterile gloves. LPN 23 and what those precautions proceeded to place a sterile suction catheter into entail. Staff will be educated on right hand while using left hand to remove handwashing for wound and speaking valve. LPN 23 then suctioned Resident tracheostomy care as well as

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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 COMPLETED 00 B. WING 01/27/2025 155716 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 N BOEKE RD **ENVIVE OF EVANSVILLE EVANSVILLE, IN 47711** (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 227 three times to clean out the tracheostomy proper use of PPE. tube. After the suctioning was complete, LPN 23 IDT will review new orders and removed the old trach dressing, removed her progress notes five times a week gloves, and did not perform hand hygiene. LPN 23 during clinical meetings to identify donned new sterile gloves, kept her right hand any residents requiring the sterile, and utilized her left hand to remove the initiation of EBP. inner cannula. LPN 23 removed the dirty gloves, How the corrective action will but did not perform hand hygiene before donning be monitored to ensure the another pair of sterile gloves to place the sterile deficient practice will not new inner cannula into the tracheostomy. LPN 23 recur, i.e., what quality placed a clean dressing under the cannula. LPN 23 assurance program will be put did not perform hand hygiene after completing the into place: care. DNS or designee will perform an audit of 10 residents per week to During an interview on 1/22/25 at 9:18 A.M., LPN determine if they should be in 23 indicated Resident 277 should be on EBP due EBP, and if the proper signage to the tracheostomy. and PPE are in place. DNS or designee will complete an During an interview on 1/22/25 at 9:36 A.M., the observation audit of 5 staff Infection Preventionist indicated gloves should performing care in EBP to monitor be changed each time when going from dirty to for the proper use of PPE and clean tasks and hands should be washed in handwashing. These observations between glove changes. will occur with a variety of staff members on different days and 2. On 1/23/25 at 2:30 P.M., Licensed Practical shifts and will include at least one Nurse (LPN) 23 and LPN 3 were observed tracheostomy care and one wound performing wound care for Resident 18. An EBP care observation. sign was present on the door indicating the Results of the audit will be precautions and the PPE necessary when reviewed by QA team during QAPI providing direct care. LPN 23 and LPN 3 did not meetings. POC may be revised or wear wear a gown while providing wound care to updated, based on QA review, as five areas on the resident's lower legs. needed to achieve, and maintain compliance. Audits may be On 1/24/25 at 3:00 P.M., Resident 18's clinical discontinued after six months with record was reviewed. Diagnoses included, but at least two consecutive months of were not limited to, peripheral vascular disease, 100% compliance achieved. varicose veins with ulcer to left leg, and varicose By what date the systemic veins with ulcer to right leg. changes for each deficiency will be completed:

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The clinical record lacked orders and a care plan

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		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155716	B. WING		01/27/2025
NAME OF F	PROVIDER OR SUPPLIEF	\		ADDRESS, CITY, STATE, ZIP COD	
ENIVIVE	OF EVANSVILLE			BOEKE RD SVILLE, IN 47711	
	T			T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE
	for Enhanced Barrio				
	3. On 1/22/25 at 10	:27 A.M., Resident 13's clinical			
		d. Diagnoses included, but			
	were not limited to,	stage three pressure ulcer.			
	The most current O	uarterly Minimum Data Set			
		, dated 12/7/24, indicated			
		oderate cognitive impairment,			
	_	taff for all Activities of Daily			
		I had two stage three pressure			
	injuries.				
	Physician orders included, but were not limited to:				
	Resident requires th	ne use of Enhanced Barrier			
		to chronic wound to reduce			
		sion of multidrug-resistant			
		s). Use personal protective recautions when providing			
		sident care, dated 11/14/24.			
		,			
		are ulcer to right posterior			
	_	n, dated 7/2/24, included an			
	intervention for enn	nanced barrier precautions.			
	A stage three pressu	are ulcer to left lateral lower			
	1 - 1	7/2/24, included an			
	intervention for enh	nanced barrier precautions.			
	A diabetic ulcer to l	left second toe care plan, dated			
		an intervention for enhanced			
	barrier precautions.				
		A.M., Licensed Practical Nurse			
		9 were observed performing a Resident 13's wounds. A sign			
		ent was on Enhanced Barrier			
	_	was observed in the room. LPN			
		ot wear a gown during the			
	dressing change pro	ocedure.			
I	l		1	i	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/27/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
F 0921	Director of Nursing wear all the proper gloves, when contains should be a sign on protocol. On 1/22/25 at 9:56 current Enhanced Brevised 8/2024, that targeted gown and gresident care activities and gloves for EBP caretracheostomy opening requiring do not the door or wall indicating the type provided". On 1/27/25 at 12:31 provided a current I Hygiene policy, revimens to prevent the Indications for hand moving from work	wound care (any skin ressing) Signs are posted outside the resident room of precautions and PPE P.M., the Administrator Handwashing and Hand ised 8/2024, that indicated ders hand hygiene the primary e spread ofinfections I hygiene include: before on a soiled body site to a clean me resident and immediately					
SS=E Bldg. 00	Safe/Functional/S	anitary/Comfortable Environ	F 0921	F 921	02/26/2025		
	review, the facility sanitary environment	failed to provide a safe and	1 0721	What corrective action will accomplished for those residents found to have been	be		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COM			ETED
		155716	B. WI	NG	01/27/2025		2025
		<u> </u>	_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			BOEKE RD		
ENVIVE	OF EVANSVILLE				SVILLE, IN 47711		
	Г		1		_,	Т	
(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)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	1 ^	debris were on the floor.			affected by the deficient		
		all, 500-hall, Pavilion Dining			practice:		
	Room)				The unattended rolling trash of		
	E' 1' ' 1 1				has been emptied. The areas		
	Findings include:				the facility where there were c		
	1 0 1/1/25 : 2 2	22 A M 1 1 111			have been cleaned. The floor		
		23 A.M., an unattended rolling			Pavilion dining room was swe	pt	
	_	in front of East Hall nurses			and mopped.		
		consistent with bowel			l	.	
	movement.				How other residents having		
	0.01/1/20	20.125.4.500.1.33.3			potential to be affected by th		
2. On 1/16/25 at 9:32 A.M., the 500-hall had a				same deficient practice will I			
strong putrid smell.					identified and what corrective	re	
					action will be taken:		
		35 A.M., the West Hall was			Residents in all areas have th	е	
		or consistent with bowel			potential to be affected.		
	movement.						
					What measures will be put in	nto	
		:37 P.M., the Pavilion dining			place and what systemic		
		rge puddle of fluid and dirty	changes will be made to				
		ng the dining room floors.			ensure that the deficient		
		00 A.M., the East Hall was noted			practice does not recur:		
	to have an odor con	sistent with urine.			Staff have been educated that		
					barrels with trash and soiled li		
		0 A.M., the East Hall was noted			may not be left unattended on		
	to have an odor con	sistent with urine.			halls, spills of liquids or food r		
					to be promptly cleaned, and the	nat	
		:41 A.M., the West Hall was			areas with odors should be		
		or consistent with bowel			addressed to ensure that		
	movement.				residents are cleaned and soi		
		4/04/07 0.40			linens and trash are removed.	.	
	_	on 1/24/25 at 9:19 A.M., the					
		ervisor indicated that			How the corrective action wi	ill	
		s a part of the housekeeping			be monitored to ensure the		
	I	g tasks. All housekeepers have			deficient practice will not		
		pplies on their cart and odors			recur, i.e., what quality		
	were taken care of a	as soon as they were noticed.			assurance program will be p	ut	
					into place:		
		P.M., the Administrator			ED or designee will round on		
	provided a current I	Homelike Environment policy.			least two areas of the facility r	ner	

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DEPARTMENT CENTERS FOF	FORM APPROVED OMB NO. 0938-039					
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD BOEKE RD		
ENVIVE	OF EVANSVILLE			SVILLE, IN 47711		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG	effective 8/2024, th and management m the characteristics of personalized, home	at indicated "The facility staff aximizes, to the extent possible, of the facility that reflect a like setting. These adepleasant, neutral scents".	TAG	day five times per week for six weeks, then three times per weeks, then weekly for weeks to identify if there are a unattended trash barrels, spills food or liquids, or odors noted are not being addressed by the staff on duty. Results of the audit will be reviewed by QA team during 0 meetings. POC may be revised updated, based on QA review, needed to achieve, and maintac compliance. Audits may be discontinued after six months at least two consecutive month 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	eek 12 ny s of that e QAPI ed or as ain	
F 9999						
Bldg. 00	management of the the administrator shot, the following:	RATION AND or is responsible for the overall facility. The responsibilities of hall include, but are not limited division within twenty-four (24)	F 9999	F9999 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1 Resident T is no longer in facility. The incident was repo for Resident W. 2 QMA 1, LPN 3, Cook 5, R. 7, Dietary 22, RN 9, and CNA	the rted	

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hours of becoming aware of an unusual

occurrence that directly threatens the welfare,

safety, or health of a resident. Notice of unusual

occurrence may be made by telephone, followed

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have completed six hours of

How other residents having the

potential to be affected by the

dementia specific training.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/27/2025	
	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY 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	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Based on interview failed to report a fa Indiana Departmen residents reviewed (Resident W and R Findings include: 1. During an interviewed to During an interviewed to the port and the port of the p	or by a written report only that electronic mail to the division four (24) hour time period. The estimated session include, but are not limited session. The estimated session include, but are not limited session include but are not limited session include session includ		same deficient practice will to identified and what corrective action will be taken: 1 Other residents with a fall with injury have the potential to affected. Any future falls with major injury will be reported potentially the guidelines. 2 Any resident has the potential to be affected. Staff in all departments will complete six hours of dementia training. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: 1 IDT reviewed the IDOH guidelines for reportable incident to ensure that all are informed and able to identify incidents requiring reporting. IDT will reall falls in clinical meetings five times per week to identify any	oe re loo be er ential oto ents lof eview e
	(MDS) Assessment Resident W had mo required substantia (staff does more that toileting, and bathin prior assessment or A change in condit P.M., indicated Resaltered mental statu	annual Minimum Data Set at, dated 12/3/24, indicated oderate cognitive impairment, I to maximal assistance of staff an half) for bed mobility, ang, and had no falls since the a 9/3/24. Sident W had a fall due to us and was sent to the (ER) for evaluation and		with injuries that require repor Nurse managers on call will not the ED of any suspected serior injuries related to falls. 2 Staff in all departments we are unable to show proof of training will complete the initial hours of dementia training at to time. They will be removed from the schedule until completion confirmed if not completed prints 02/24/25. New hires will have six hours of dementia training scheduled as part of their initial	ting. otify ous ho al six chis om is or to e the

A health status note, dated 1/6/25 at 2:18 P.M.,

orientation.

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			ETED
		155716	B. W	ING		01/27/	2025
						<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
EN (1) (E	05 5) (4 1 0) (11 1 5				BOEKE RD		
ENVIVE	OF EVANSVILLE			EVANS	VILLE, IN 47711		
(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 APPROPRI	ΔTE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	112	DATE
	indicated Resident	W returned from the hospital			How the corrective action w	ill	
	and imaging done	at the hospital was normal.			be monitored to ensure the		
					deficient practice will not		
	An alert note, dated	d 1/13/25 at 4:04 P.M., indicated			recur, i.e., what quality		
	after continued cor	nplaints of pain, the Nurse			assurance program will be p	out	
	Practitioner (NP) o	rdered a repeat x-ray that			into place:		
	showed an acute fr	acture of the distal femur, and			DNS or designee will audit all	falls	
	the resident was se	nt to the ER for evaluation and			with major injury requiring		
	treatment.				reporting to ensure that the re	eport	
					is completed.		
	Hospital discharge papers, dated 1/13/25 at 5:55				An audit will be completed by	· ED	
	P.M., indicated the resident was being discharged				or designee on 5 employee fi	les	
	with a primary diagnosis of fracture of distal end				per week to ensure completion		
	of femur, fracture of fibula, and tibial plateau				the required dementia training		
	fracture (right side)).			Results of the audit will be		
					reviewed by QA team during	QAPI	
	A nursing progress	note, dated 1/13/25 at 7:22			meetings. POC may be revis	ed or	
	P.M., indicated the	resident returned to the facility			updated, based on QA review	v, as	
	with an immobilize	er in place on her right leg.			needed to achieve, and main	tain	
					compliance. Audits may be		
	A review of Facilit	y Reported Incidents for			discontinued after six months	with	
	January 2025 lacke	ed a report of this resident's fall.			at least two consecutive mon	ths of	
					100% compliance achieved.		
	During an interview	w on 1/23/25 at 9:52 A.M., the			By what date the systemic		
		cated she did not report			changes for each deficiency	,	
		vith major injury to the State			will be completed:		
	within 24 hours of				February 26, 2025		
		39 P.M., Resident T's clinical					
		ed. Diagnoses included, but					
		, a Alzheimer's disease with late				ļ	
		d fracture of greater tuberosity					
		nd other displaced fracture of					
	upper end of right	humerus.					
		gnificant Change Minimum				ļ	
		ssessment, dated 7/29/24,					
		ent was not cognitively intact,					
		l to maximum assistance (staff					
	does more than hal	· ·					
showering/bathing, bed mobility, and transfers,							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/27 /	ETED	
	PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(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
	the last assessment.						
	Recommendation) P.M., indicated that floor in a common Resident T stated h resident's leg. Resident that the resident is shoulder. No lead to the resident was un	n Background Assessment and summary, dated 7/12/24 at 2:45 at the resident was found on the area by the nurses station. The had tripped over another dent T reported pain to his pruising or redness was noted. The hable to lift his right arm by the ler was notified and ordered an					
	A radiology report, dated 7/12/24, indicated Resident T had an impacted humerus neck fracture.						
	indicated x-ray resu Practitioner, and an	d 7/13/24 at 3:20 A.M., alts were reported to the Nurse order was received to transfer mergency Room (ER) for tment.					
	A.M., indicated Re facility from the EF	note, dated 7/13/24 at 12:58 sident T had arrived back to R with a sling on his right arm ow up with Orthopedic Surgery					
		y Reported Incidents for July rt of this resident's fall.					
	Administrator indic	ov on 1/23/24 at 10:52 A.M., the cated they could not find a cident completed for Resident injury on 7/12/24.					
	_	v on 1/27/25 at 10:11 A.M., the rated it was the policy of the					

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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. BUILDING <u>00</u> COMPL			ETED	
		155716	B. WI	NG		01/27/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			BOEKE RD		
FN\/I\/F	OF EVANSVILLE				VILLE, IN 47711		
	OI EV/IIVOVILLE			LV/IIIO	VILLE, IN 47711		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX				PREFIX	CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		_	TAG	DEFICIENCY)		DATE
		ls with major injury to the State					
	as required by the re	egulation.					
	0 1/22/25 4 12 15	EDM (LD) (CM)					
		5 P.M., the Director of Nursing					
	· / •	current Assessing Falls and					
		y, effective 8/2024, that ne following individuals when a					
		rt other information in					
	•	cility policy and professional					
	standards of practic						
	standards of practic						
	This citation relates to Complaint IN00448749.						
	State Finding #2.						
	3.1-14 PERSONNE	EL					
	(u) In addition to th	e required in-service 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					
		to the Alzheimer's and					
		are unit, and three (3) hours					
		to meet the needs or					
	· ·	n, of cognitively impaired					
		n understanding of the current					
		or residents with dementia.					
	This state rule was	not met as evidenced by:					
		and record review, the facility					
	_	ocumentation of staff					
		num of three hours of					
	_	raining annually for 4 of 5 staff					
		nan 1 year reviewed and 3 of 5					
		ess than a year. (Qualified					
		Licensed Practical Nurse 3,					
	Cook 5, Registered Certified Nurse Aid	Nurse 7, Dietary 22, RN 9, and					
	Cerunea Nurse Ala	ic 11 <i>)</i>					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/27/2025	
	PROVIDER OR SUPPLIER OF EVANSVILLE		601 N I	ADDRESS, CITY, STATE, ZIP COD BOEKE RD SVILLE, IN 47711	•
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	Finding includes:	P.M., employee files were			
	reviewed. The follo documentation of d hours for staff empl	wing employees lacked ementia-specific training of six oyed less than a year and employed greater than a year:			
	employment with th	on Aide (QMA) 1 started ne facility on 1/8/24 and had no hours in 2024 and 2025.			
	Licensed Practical Nurse (LPN) 3 started employment with the facility on 9/5/23 and had no dementia inservice hours since her hire date.				
	11/24/24 and had no date.	loyment with the facility on o dementia hours since her hire			
		mployment with the facility on lementia inservice hours in			
		RN) 9 started employment with 1/24 and had no dementia the hire date.			
		yment with the facility on dementia inservice hours since			
		te (CNA) 11 started ne facility on 8/21/24 and had ce hours since her hire date.			
	Administrator indic	on 1/24/25 at 3:15 P.M., the ated all employee inservices and if dementia hours were not			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155716	A. BU	A. BUILDING <u>00</u> B. WING		COMPLETED 01/27/2025		
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	ΓE	(X5) COMPLETION DATE	
R 0000 Bldg. 00	During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated that the facility did not have a policy related to dementia inservices specifically, but they followed the regulations as set forth by the State. On 1/27/25 at 12:31 P.M., the Administrator provided a current In-service Training, All Staff policy, revised 8/2024, that indicated " All staff must participate in initial orientation and annual in-service training required training topics includedementia management".		R 0000		Preparation or execution of this plan of correction does not	S		
	Complaints IN0044 IN00448749, and IN Survey dates: Janua 2025 Facility number: 000 Residential Census:	ry 16, 17, 21, 22, 23, 24, and 27, 0439 11 Itial Findings are cited in			constitute admission or agreed of provider of the truth of the far alleged or conclusions set forth the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fed and State Law. The Plan of Correction is submitted to resp to the allegation of noncomplia citedduring the Recertification State Licensure with Complain survey conducted January 27, 2025. Please accept this Plan of Correction as the provider's credible allegation of complian as of February 26, 2025. The provider respectfully requests or review with paper compliance.	acts n on The and leral loond lince and t ce		

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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	ЛLDING	00	COMPL	ETED
155716		155716	B. W	ING		01/27	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			BOEKE RD		
ENVIVE (OF EVANSVILLE				VILLE, IN 47711		
(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	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					be considered in establishing t	that	
					the provider is in substantial		
					compliance.		
R 0216	440 140 16 2 5 2/	a)(1,4)(d)					
11.0210	410 IAC 16.2-5-2(Evaluation - Nonc						
Bldg. 00	Lvaluation - NOIIC	omphanoe					
5.4g. 00	Based on interview	and record review, the facility	R 0	216	R 216		02/26/2025
		dents semi-annual evaluations	10.	210	What corrective action will be	e	02/20/2023
		tion of medication evaluations			accomplished for those	-	
		3 of 7 residents reviewed for			residents found to have beer	1	
	•	n (Resident 4, Resident 3, and			affected by the deficient		
		f 5 residents reviewed for self			practice:		
	administration of m	edications (Resident 2,			A semi-annual evaluation was		
	Resident 4, Residen	t 3, Resident 5, and Resident			completed for residents 3, 4, a	ınd	
	1)				5.		
					A medication self-administration	on	
	Findings include:				assessment was completed for residents 1, 2, 3, 4, and 5.	r	
	1. During an initial	tour of the residential facility					
	on 1/23/25 at 12:45	P.M., Licensed Practical Nurse			How other residents having t	he	
	(LPN) 19 indicated	Resident 2 administered her			potential to be affected by th	е	
	own medications.				same deficient practice will b	е	
					identified and what corrective	е	
		.M., Resident 2's clinical record			action will be taken:		
		dent 2 was admitted on			Residents in the Residential		
	_	s included, but were not limited			portion of the facility have the		
	to, wound infection				potential to be affected. All		
	Th	dinistration necessary to a f			residents will have a semi-ann	ual	
		ninistration record indicated tered her own medications. The			evaluation completed. All		
		ered her own medications. The ed a self-administration of			residents who self-administer medication will have a		
	medication evaluati				medication will have a self-administration assessmen	.t	
	medication evaluati	OII.			completed.	ıı	
	2 During an initial	tour of the residential facility			Completed.		
	_	P.M., Licensed Practical Nurse			What measures will be put in	to	
		Resident 4 administered her			place and what systemic		
	own insulin.				changes will be made to		
					ensure that the deficient		
	On 1/24/25 at 10:32	2 A.M., Resident 4's clinical			practice does not recur:		

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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	JILDING	00	COMPL	ETED
		155716	B. W	ING		01/27/	/2025
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD BOEKE RD		
	OF EVANOVII I E						
ENVIVE	OF EVANSVILLE			EVANS	SVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	record was reviewe	ed. Resident 4 was admitted on			IDT was educated on the		
	7/1/23. Diagnoses included, but were not limited				necessity to have a semi-annu	ual	
	to, diabetes mellitu	s.			evaluation and self-administra	ıtion	
					of medication assessment		
	The medication add	ministration record indicated			completed for Residential		
	Resident 4 adminis	tered her own insulin			residents.		
	medication. The cli	inical record lacked a			IDT will review any new Resid	lential	
	self-administration	of medication evaluation since			admissions in clinical meeting	s	
	7/2/23.				five days a week to determine	: if	
					the semi-annual evaluation ar	ıd	
	The clinical record	lacked a semi-annual			self-administration assessmer	nt	
	evaluation complet	ed since 1/4/24.			were completed. A monthly a	udit	
	3. During an initial tour of the residential facility				will be completed and any		
		5 P.M., Licensed Practical Nurse			assessments due in the next		
	(LPN) 19 indicated	Resident 3 administered her			month will be scheduled for		
	own medications.				completion.		
	On 1/24/25 at 10:2	1 A.M., Resident 3's clinical			How the corrective action wi	ill	
	record was reviewe	ed. Diagnoses included, but			be monitored to ensure the		
	were not limited to	, hypertension. Resident 3 was			deficient practice will not		
	admitted to the faci	ility on 11/1/22.			recur, i.e., what quality		
					assurance program will be p	ut	
		lacked a semi-annual			into place:		
	evaluation complet	ed since 11/27/23.			An audit will be completed		
					monthly for all residential		
		lacked a self administration of			residents to determine if the		
	medication evaluat	ion completed since 11/7/22.			semi-annual evaluation and th	ıe	
					self-administration assessmer	nt	
	_	tour of the residential facility			are in compliance.		
		5 P.M., Licensed Practical Nurse			Results of the audit will be		
	, ,	Resident 5 administered her			reviewed by QA team during (
	own medications.				meetings. POC may be revise		
	0 1/04/27	5 4 3 5 B 11 1 5 W 11 1			updated, based on QA review		
		7 A.M., Resident 5's clinical			needed to achieve, and maint	ain	
		ed. Diagnoses included, but			compliance. Audits may be	***	
		, hypokalemia. Resident 5 was			discontinued after six months		
	admitted to the faci	llity on 11/23/21.			at least two consecutive mont	hs of	
					100% compliance achieved.		
		lacked a semi-annual			By what date the systemic		
evaluation completed since 4/5/24.				changes for each deficiency			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/27/2025				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711					
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
		lacked a self administration of on completed since 11/23/21.		will be completed: February 26, 2025				
	on 1/23/25 at 12:45	tour of the residential facility P.M., Licensed Practical Nurse Resident 1 administered her						
	record was reviewe	A.M., Resident 1's clinical d. Diagnoses included, but osteoporosis. Resident 1 was lity on 7/3/21.						
		lacked a self administration of on completed since 7/3/21.						
	Administrator indic semi-annual evalua 5, and Resident 2 or	on 1/24/25 at 2:45 P.M., the ated she was unable to find tions for Resident 3, Resident reself administration of ons for Resident 1, Resident 2, and Resident 5.						
	Administrator indic related to semi-anni administration of m facility followed the State. She expected medication evaluati	on 1/27/25 at 12:31 P.M., the ated there was no policy hal evaluations or self edication evaluations, but the regulations as set forth by the a self administration of on to be completed every six revice plans are updated.						
	provided a policy ti Medications, dated of the evaluation co interdisciplinary tea cognitive and physi	P.M., the Administrator tled Self-Administration of 8/2024, that indicated "As part imprehensive assessment, the im assesses each resident's cal abilities to determine istering medications is safe and						

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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. BUILDING 00			COMPLETED	
155716		155716	B. W	NG	_	01/27	/2025
NAME OF T	DOLUBER OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .	601 N BOEKE RD				
ENVIVE	OF EVANSVILLE			EVANS	VILLE, IN 47711		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	clinically appropriat	to for the resident"		TAG	DEFICIENCE!		DATE
	сппсану арргорна	te for the resident.					
R 0217	410 IAC 16.2-5-2(e)(1-5)					
	Evaluation - Defici						
Bldg. 00		•					
		and record review, the facility	R 02	217	R 217		02/26/2025
		vice plans were completed and			What corrective action will b	е	
		ent every six months for 4 of 7			accomplished for those		
		(Resident 3, Resident 5,			residents found to have been	ו	
	Resident 4, and Res	ident o)			affected by the deficient		
	Findings include:				practice: Service plans were completed	and	
	i manigs meiade.				signed by the resident for	anu	
	1. On 1/24/25 at 10:	21 A.M., Resident 3's clinical			Residents 3, 4, and 5.		
		d. Diagnoses included, but			Resident 6 was discharged from	m	
	were not limited to,	hypertension. Resident 3 was			the facility.		
	admitted to the facil	lity on 11/1/22.					
					How other residents having		
		lacked a signed service plan			potential to be affected by th		
	completed since 11/	/17/23.			same deficient practice will be		
	2 On 1/24/25 at 10:	47 A.M. Dogidant 5's alinical			identified and what correctiv	е	
		:47 A.M., Resident 5's clinical d. Diagnoses included, but			action will be taken: Residents in the Residential		
		hypokalemia. Resident 5 was			portion of the facility have the		
	admitted to the facil				potential to be affected. All		
		,			residents will have a semi-ann	ıual	
	The clinical record	lacked a signed service plan			evaluation completed and sigr	ned	
	completed since 4/5				by the resident.		
		:32 A.M., Resident 4's clinical					
		d. Resident 4 was admitted on			What measures will be put in	ito	
	_	ncluded, but were not limited			place and what systemic		
	to, diabetes mellitus	3.			changes will be made to		
	The clinical record	lacked a service plan reviewed			ensure that the deficient		
	and signed in the pa				practice does not recur: IDT was educated on the		
	and digited in the pa				necessity to have a semi-annu	ıal	
	4. On 1/24/25 at 10:	:48 A.M., Resident 6's clinical			evaluation completed and sign		
		d. Resident 6 was admitted on			by the resident for Residential		
	3/4/24 and discharg	ed on 12/13/24.			residents.		
_				IDT will review any new Resid	ential	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/27/2025			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) admissions in clinical meeting five days a week to determine the semi-annual evaluation wa completed and signed by the resident. A monthly audit will completed and any assessme due in the next month will be scheduled for completion. How the corrective action wi be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p into place: An audit will be completed monthly for all residential residents to determine if the semi-annual evaluation is	DATE s if as be nts		
R 0409	410 IAC 16.2-5-12 Infection Control -	• •		completed and signed by the resident. Results of the audit will be reviewed by QA team during 0 meetings. POC may be review updated, based on QA review needed to achieve, and maint compliance. Audits may be discontinued after six months at least two consecutive mont 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	ed or , as ain with		
Bldg. 00		and record review, the facility sician orders contained an	R 0409	R 409 What corrective action will b	02/26/2025		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
15		155716	B. W	ING	_	01/27/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BOEKE RD		
ENVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711				
(X4) ID		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ment for 3 of 7 residents			accomplished for those		
	reviewed. (Resident 7, Resident 2, and Resident 6) Findings include:				residents found to have been	ו ו	
					affected by the deficient		
	Findings include.				practice: Resident 6 and 7 have been		
	1 On 1/24/25 at 10	:57 A.M., Resident 7's clinical			discharged from the facility.		
		ed. Diagnoses included, but			An annual physician health		
		hypertension. Resident 7 was			statement has been included i	'n	
		lity on 11/21/24. Resident 7			the physician orders for Resid		
		higher level of care on			2.		
	12/13/24.						
					How other residents having t	the	
	The clinical record	lacked an annual health			potential to be affected by th	е	
	statement for Resid	lent 7.			same deficient practice will k	ре	
	2. On 1/24/25 10:17	7 A.M., Resident 2's clinical			identified and what correctiv	е	
		d. Resident 2 was admitted on			action will be taken:		
	1	es included, but were not limited			Any resident in Residential ca		
	to, wound infection	ı.			has the potential to be affected		
					All residents in Residential car		
		lacked an annual health			have an annual health stateme	ent	
	statement for Resid	ent 2.			in their physician orders.		
	3. On 1/24/25 at 10	:48 A.M., Resident 6's clinical			What measures will be put in	ito	
	record was reviewe	d. Resident 6 was admitted on			place and what systemic		
	3/4/24.				changes will be made to		
					ensure that the deficient		
		lacked an annual health			practice does not recur:		
	statement for Resid	lent 6.			IDT has been educated on the	•	
		1/01/07 0.1======			requirements for an annual		
	~	v on 1/24/25 at 2:45 P.M., the			physician health statement for		
		cated she was unable to find			residential residents.		
		ments for Resident 7, Resident			IDT will review any new Resid		
	2, and Resident 6.				admissions in clinical meeting		
	During an interview	v on 1/27/25 at 12:31 P.M., the			five days a week to determine	"	
		eated there was no policy			the annual physician health statement is in place. A month	hlv	
		ealth statements, but the			audit will be completed and ar	-	
		e regulations as set forth by the			resident due for an updated an	-	
	State.				physician health statement wil		
					scheduled for completion.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE				601 N E	ADDRESS, CITY, STATE, ZIP COD BOEKE RD VILLE, IN 47711		
(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 APPROPRI DEFICIENCY) How the corrective action we be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place: A monthly audit will be condured on all Residential residents to determine that the annual heat statement is in place. Results of the audit will be reviewed by QA team during meetings. POC may be reviewed to achieve, and main compliance. Audits may be discontinued after six months at least two consecutive mon 100% compliance achieved. By what date the systemic changes for each deficiency will be completed: February 26, 2025	ill cted calth QAPI ced or d, as tain with ths of	(X5) COMPLETION DATE

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