STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 27, 2025. This visit included a PSR to the Investigation of Complaint IN00448749 completed on January 27, 2025. This visit included a PSR to the State Residential Licensure Survey completed on January 27, 2025. This visit was in conjunction with the Investigation of Complaints IN00453363 and IN00455155. Complaint IN00448749 - Not Corrected. Survey dates: March 12 & 13, 2025 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 116 SNF: 8 Residential: 13 Total: 137 Census Payor Type: Medicare: 9 Medicaid: 83 Other: 32 Total: 124 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 18, 2025.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey revisit conducted March 12-13, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 7, 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	TITLE	(X6) DATE
Tara Trevino	Executive Director	03/26/2025

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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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to update the plan of care after a resident fell for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, and had no falls prior to admission. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. Interventions included, but were not limited to: Anti-rollbacks to wheelchair Bed against the wall Bed in lowest position as resident allows Anticipate and meet the resident's needs Call light is within reach Ensure pathways are free of clutter Keep personal items within reach Therapy screen/eval/treat as indicated An initial fall note, dated 3/10/25 at 6:40 P.M., indicated the resident had an unwitnessed fall while attempting to self-toilet. The care plan was not updated with a new intervention after that fall.	F 0657	**F 657 – Care Plan and Revision** *"Facility failed to update the plan of care after a resident fell for 1 of 3 residents reviewed for falls. (Resident D)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D was affected by the alleged deficient practice. Resident D immediately had a care plan for falls reviewed and updated as appropriate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents at risk for falls or with history of falls have the potential to be affected by the alleged deficient practice. All current in-house residents were audited on 3/25/25 by the DON/designee for care plans related to falls. No further residents were appropriate for care plan updates. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	03/25/2025

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	The clinical record lacked documentation to indicate the Interdisciplinary Team (IDT) met to review that fall. On 3/12/25 at 1:50 P.M., the Administrator indicated that after a resident fell, the IDT met the next clinical morning to review the fall and determine an appropriate intervention to prevent future falls. The care plan was updated after that meeting. At that time, the Administrator indicated she could not remember if the IDT had met to review Resident D's fall that occurred on 3/10/25 at 6:40 P.M. On 3/13/25 at 1:50 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, revised 8/2024, that indicated "The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls ... In conjunction with the attending physician, staff will identify and implement relevant interventions...to try to minimize serious consequences of falling ... The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling ... If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions". This deficiency was cited on 1/27/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(d)(2)		**practice does not recur?** The DON/designee were educated on Envive Care Planning – Interdisciplinary Team Policy and procedure with concentration on, but not limited to, managing falls. - Education and training were provided to DON/designee on 3/25/25 by the clinical support consultant. Education provided: Envive Care Planning – Interdisciplinary Team Policy Envive Falls and Fall Risk, Managing Policy **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DON/designee will complete daily monitoring through the clinical care meeting to ensure that any resident with falls is reviewed for proper procedure and documentation for monitoring 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is	

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			not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** March 25, 2025	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure interventions were in place to prevent falls for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, and had no falls prior to admission. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. Interventions included, but were not limited to: Anti-rollbacks to wheelchair Bed against the wall	F 0689	F 689 – Free of Accident Hazards/Supervision/Devices "Facility failed to ensure interventions were in place to prevent falls for 1 of 3 residents reviewed for falls. (Resident D)." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - Resident D was affected by the alleged deficient practice. - Resident D immediately had a care plan for falls reviewed and updated as appropriate to include fall interventions. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents at risk for falls or with history of falls have the potential to be affected by the alleged deficient practice. - All current in-house residents	03/25/2025

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	Bed in lowest position as resident allows Anticipate and meet the resident's needs Call light is within reach Ensure pathways are free of clutter Keep personal items within reach Therapy screen/eval/treat as indicated A fall risk assessment, dated 2/9/25, indicated Resident D was at low risk for falls. The clinical record indicated Resident D fell five times between 2/28/25 and 3/10/25. Fall 1 On 2/28/25 at 3:15 P.M., Resident D had an unwitnessed fall while attempting to transfer from his wheelchair to his bed without assistance. "Anti-rollbacks to wheelchair" was added to his care plan. A fall risk assessment, dated 2/28/25, indicated the resident was at low risk for falls. Fall 2 On 3/3/25 at 9:30 A.M., Resident D had a witnessed fall while toileting. "Medication review as indicated" was added to the care plan. A fall risk assessment, dated 3/3/25, indicated the resident was at high risk for falls. Fall 3 On 3/4/25 at 12:15 P.M., Resident D had an unwitnessed fall while in bed. "Bed in lowest position as resident allows" was added to the care plan. A fall risk assessment, dated 3/4/25, indicated the resident was at high risk for falls. Fall 4 On 3/8/25 at 12:06 A.M., Resident D had a witnessed fall while attempting to get out of bed. "Bed against wall" was added to the care plan. A fall risk assessment, dated 3/9/25, indicated the		were audited on 3/25/25 by the DON/designee for falls intervention. No further residents were appropriate for care plan updates. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - The DON/designee were educated on Envive Care Planning – Interdisciplinary Team Policy and procedure with concentration on, but not limited to, managing falls. - Education and training were provided to DON/designee on 3/25/25 by the clinical support consultant. Education provided: · Envive Care Planning – Interdisciplinary Team Policy · Envive Falls and Fall Risk, Managing Policy 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? - DON/designee will complete daily monitoring through the clinical care meeting to ensure that any resident with falls is reviewed for proper procedure and documentation for monitoring 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. - DON/designee will be	

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	resident was at high risk for falls. Fall 5 On 3/10/25 at 6:40 P.M., Resident D had an unwitnessed fall while attempting to self-transfer from his bed to the bathroom. The care plan was not updated with a new intervention. A fall risk assessment, dated 3/10/25, indicated the resident was at high risk for falls. On 3/13/25 at 10:00 A.M., Resident D was observed lying in a low to the ground bed. The bedside table was behind the resident's head and was raised high. The bedside table was observed to have the resident's drink and remote control on it. The resident's reacher was on his wheelchair on the opposite side of his room behind a curtain. On 3/13/25 at 1:47 P.M., the Director of Nursing (DON) indicated she observed Resident D in his room without his personal items in reach and staff were re-educated on following fall interventions at that time. On 3/13/25 at 1:50 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, revised 8/2024, that indicated "The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls ... In conjunction with the attending physician, staff will identify and implement relevant interventions...to try to minimize serious consequences of falling ... The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling ... If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current		responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: March 25, 2025	

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	interventions". This deficiency was cited on 1/27/25. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Complaint IN00448749. 3.1-45(a)(2)			
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP Based on interview and record review, the facility failed to ensure a resident was assessed by a physician for 1 of 3 residents reviewed for dialysis. (Resident B) Finding includes: On 3/13/25 at 10:30 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 10/8/24. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident B was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. A physician progress note, dated 2/10/25 at 12:38 A.M., stated "patient assessed and no new complaints, exam unchanged, orders reviewed, no issues per nursing." During an interview on 3/13/25 at 9:30 A.M., Resident B indicated she had not been assessed	F 0712	**F 712 – Physician Visits – Frequency/Timeliness/Alt PP** *"Facility failed to ensure a resident was assessed by a physician for 1 of 3 residents reviewed for dialysis. (Resident B)"* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B was affected by the alleged deficient practice. Resident B physician was notified to perform resident visit. Resident B returned to hospital March 14, 2025 and did not return to facility. **2: 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	03/25/2025

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	by a physician in the facility since admission. During an interview on 3/13/25 at 8:44 A.M., the Administrator indicated she was unsure if the physician was actually in the facility, there was no record of a physical assessment completed by Resident B's physician, and that the physician's office was responsible for billing insurance for visits. During an interview on 3/13/25 at 10:57 A.M., the clinical staff of Resident 3's physician office stated there was no record of a physician assessment of Resident 3, and there was no billable visits recorded for Resident 3. On 3/13/25 at 1:50 P.M., the Director of Nursing provided a policy titled Physician Services, dated 8/24, that indicated "Supervising the medical care of residents includes, but is not limited to: participating in the resident assessments and care planning. Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy." 3.1-22(d)(1) This deficiency was cited on 1/27/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		potential to be affected by the alleged deficient practice. All current in-house residents were audited on 3/25/25 by the DON/designee for physician visits. No other residents needed to be seen by the physicians. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee were educated on Envive Physician Services Policy - Education and training were provided to DON/designee on 3/25/25 by the clinical support consultant. Education provided: Envive Physician Policy **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DON/designee will complete weekly rounding with physician to ensure visits are monitored weekly for 8 weeks then monthly for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee	

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			overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** March 25, 2025	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for falls (Resident M and Resident D) and 2 of 3 residents reviewed for dialysis (Resident B and Resident H). Findings include: 1. On 3/12/25 at 10:06 A.M., Resident M's clinical record was reviewed. Resident M was admitted on 3/13/21. Diagnoses included, but were not limited to, cognitive communication deficit. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/3/25, indicated Resident M was severely cognitively impaired, required substantial assistance from staff (staff do more than half of the work) for eating, toileting, bathing, and transfers, and had fallen since the most recent MDS Assessment (1/3/25). A Clinically at Risk Assessment, dated 3/11/25, indicated Resident M had fallen on 2/8/25, 2/25/25, 3/3/25, and 3/10/25.	F 0842	**F 842 – Resident Records – Identifiable Information** *"Facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for falls (Resident M and Resident D) and 2 of 3 residents reviewed for dialysis (Resident B and Resident H)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident M, D, B, and H were affected by the alleged deficient practice. Resident M and D immediately had documentation completed for falls. Resident B and H immediately had documentation completed for dialysis.	03/25/2025

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	A Fall Risk Assessment, dated 2/26/25, indicated Resident M was alert and oriented x3 (to person, place, and time), and had no falls in the past 3 months. A Fall Risk Assessment, dated 3/11/25, indicated Resident M was alert and oriented x3, and had no falls in the past 3 months. During an interview on 3/13/25 at 11:37 A.M., the Director of Nursing (DON) indicated the fall on 3/3/25 was documented in error. 2. On 3/13/25 at 10:30 A.M., Resident B's clinical record was reviewed. Resident B was admitted on 10/8/24. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident B was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Do not obtain blood pressure in the left arm, dated 2/24/25 Pre-Dialysis assessment to be completed prior to dialysis one time a day every Monday, Wednesday, Friday, dated 10/9/24 Post-Dialysis assessment to be completed after to dialysis one time a day every Monday, Wednesday, Friday, dated 10/9/24 The following dates and times included blood		**2: 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 with history of falls have the potential to be affected by the alleged deficient practice. - All dialysis residents have the potential to be affected by the alleged deficient practice. All current in-house residents were audited on 3/25/25 by the DON/designee for complete documentation related to falls and dialysis. No further action is required currently. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee were educated on Envive Charting and Documentation Policy - Education and training were provided to DON/designee on 3/25/25 by the clinical support consultant. Education provided: Envive Charting and Documentation Policy. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	

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	pressures documented obtained from the left arm: 2/26/25 7:00 A.M. 2/26/25 3:40 P.M. 2/28/25 3:07 P.M. 3/3/25 5:27 P.M. 3/5/25 3:02 P.M. 3/5/25 3:04 P.M. 3/7/25 9:28 A.M. 3/7/25 2:06 P.M. The clinical record lacked a pre or post dialysis assessment completed on 3/10/25. 3. On 3/12/25 at 11:53 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/18/24, indicated Resident H was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, and received dialysis. Physician orders included, but were not limited to: Complete Post Dialysis Assessment in (name of electronic charting system) one time a day every Monday, Wednesday, and Friday, dated 6/5/24 The clinical record lacked a Post Dialysis Assessment for 3/7/25. The March 2025 Medication Administration Record (MAR) indicated a Post Dialysis Assessment had not been completed on 3/7/25 and included a chart code of "other/see progress notes". The clinical record lacked a progress note related to the Post Dialysis Assessment on 3/7/25. On 3/13/25 at 9:00 A.M., the Director of Nursing		**program will be put into place?** DON/designee will complete daily monitoring through the clinical care meeting to ensure accurate documentation is monitored 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** March 25, 2025	

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	155716	A. BUILDING 00 B. WING	03/13/2025

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	(DON) provided a (name of dialysis center) Pre Treatment/Post Treatment form, dated 3/7/25. The form indicated the Pre Treatment Assessment was to be completed by the facility nurse and the Post Treatment Assessment was to be completed by the dialysis nurse. Both assessments were signed by the Assistant Director of Nursing (ADON). The completed Post Treatment Assessment did not include the name of the nurse from the dialysis center that completed the assessment. On 3/13/25 at 10:15 A.M., the ADON indicated that it was her signature on both the Pre and Post Treatment Assessment forms, but she did not perform the Post Treatment Assessment herself. She indicated that she received the Post Assessment information by phone from the dialysis nurse. At that time, she indicated the Pre Treatment/Post Treatment form information was supposed to be entered into the Dialysis Assessment forms in (name of electronic charting system). On 3/13/25 at 1:47 P.M., the DON indicated that the clinical record lacked documentation to indicate the ADON received the Post Treatment Assessment information by phone on 3/7/25 and who performed the assessment. 4. On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, had no falls prior			

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	to admission, and required the use of a walker and a wheelchair. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. A fall risk assessment, dated 2/9/25, resulted in a score of 9.0 indicating Resident D was a low fall risk (a high fall risk was a score of 10.0 or greater). The assessment indicated the resident had one to two falls in the past three months and required the use of assistive devices for mobility (wheelchair, walker, cane, furniture). A nursing progress note, dated 2/28/25, indicated Resident D had an unwitnessed fall while attempting to self-transfer from his wheelchair to the bed. A fall risk assessment, dated 2/28/25, resulted in a score of 2.0 indicating Resident D was a low fall risk. The assessment indicated the resident had no falls in the past three months and did not require the use of assistive devices for mobility. An Interdisciplinary Team (IDT) Note, dated 3/3/25 at 9:10 A.M., indicated the IDT met to review Resident D's fall on 3/2/25. The clinical record lacked documentation to indicate Resident D sustained a fall on 3/2/25. An IDT Note, dated 3/5/25 at 9:24 A.M., indicated Resident D had an unwitnessed fall on 3/4/25 while attempting to get out of bed. A nursing progress note, dated 3/5/25 at 9:51 A.M., indicated Resident D's resident representative was notified of the "fall yesterday".			

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	The clinical record lacked documentation to indicate an initial falls note and assessment had been completed after the fall on 3/4/25. On 3/12/25 at 1:50 P.M., the Administrator indicated she was not sure if the resident fell on 3/2/25 or 3/4/25 and would need to check on the information. On 3/13/25 at 8:35 A.M., the Administrator indicated that the fall that occurred on 3/4/25 was documented in an incident report which was not part of the clinical record, and that the nurse who filled out the incident report forgot to take the action step to include the fall information in the clinical record. On 3/13/25 at 11:06 A.M., the Director of Nursing (DON) indicated Resident D did not fall on 3/2/25 and the date was documented wrong in the IDT note. On 3/13/25 at 1:47 P.M., the DON indicated that staff needed to be re-educated on documentation. She indicated documentation that Resident D's resident representative was notified of the fall that occurred on 3/4/25 the same day, but the information in the incident report was not carried over into the clinical record. At that time, she indicated the fall risk assessments for Resident D and Resident M were filled out incorrectly resulting in an inaccurate fall risk score. The DON indicated the nurse that took blood pressures for Resident B documented the location of the blood pressure in error and did not take the blood pressure in her left arm On 3/13/25 at 1:50 P.M., the Administrator provided a current Charting and Documentation			

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	policy, revised 8/2024, that indicated "The following information is to be documented in the resident medical record...Treatments or services performed; ...Events, incidents or accidents involving the resident; and Progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate ... Documentation of procedures and treatments will include care-specific details, including: the name and title of the individuals(s) who provided the care". On 3/13/25 at 1:50 P.M., the Administrator provided a current End-Stage Renal Disease, Care of a Resident with policy, revised 8/2024, that indicated "Education and training of staff includes, specifically...the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...". On 3/13/25 at 1:50 P.M., the Administrator provided a current Change in a Resident's Condition or Status policy, dated 8/2024, that indicated "Our facility promptly notified the resident...and the resident representative of changes in the resident's medical/mental condition and/or status ... The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status". This deficiency was cited on 1/27/25. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Complaint IN00448749. 3.1-50(a)(2)			

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F 9999 Bldg. 00		F 9999	.	03/25/2025
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on January 27, 2025. This visit included a PSR to the Recertification and State Licensure Survey completed on January 27, 2025. This visit included a PSR to the Investigation of Complaint IN00448749 completed on January 27, 2025. This visit was in conjunction with the Investigation of Complaints IN00453363 and IN00455155. Survey dates: March 12 & 13, 2025 Facility number: 000439 Residential Census: 13 Envive of Evansville was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey revisit conducted March 12-13, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 7, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	