STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2025		
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	F	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
F 0000							
Bldg. 00	the Recertification completed on Janu included a PSR to IN00448749 comp visit included a PS Licensure Survey of This visit was in continuous Investigation of Continuous Investigation I	00439 155716 275070 e: reflect State Findings cited in	F 000	00	Preparation or execution of the plan of correction does not constitute admission or agree of provider of the truth of the falleged or conclusions set for the Statement of Deficiencies Plan of Correction is prepared executed solely because it is required by the position of Ferand State Law. The Plan of Correction is submitted to rest to the allegation of noncomplicited during the Annual Surver revisit conducted March 12-13 2025. Please accept this Plan of Correction as the provider's credible allegation of compliant as of April 7, 2025. The provider respectfully requests desk rewith paper compliance to be considered in establishing that provider is in substantial compliance.	ment facts th on . The d and deral pond ance y 3,	

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

TITLE

(X6) DATE

Tara Trevino Executive Director 03/26/2025

Any defiency statement 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 disclodays 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) M	(X2) MULTIPLE CONSTRUCTION (X3) E			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155716	B. W	ING		03/13/	/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8			BOEKE RD			
ENVIVE	OF EVANSVILLE				SVILLE, 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0657	483.21(b)(2)(i)-(iii)							
SS=D	Care Plan Timing	and Revision						
Bldg. 00	.	1 1 1 1 1 0 11					00/05/0005	
	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.		F 0	657	F 657 – Care Plan and Revisi		03/25/2025	
					"Facility failed to update the pi			
		ents reviewed for falls.			of care after a resident fell for	1 01		
	(Resident D)				3 residents reviewed for falls.			
	Einding in aludaar		(Resident D)."		(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.				1: What corrective action(s)	sazill			
				be accomplished for those	WIII			
				residents found to have been	n			
				affected by the deficient	11			
				practice?				
	rans, and muscle wasting and atrophy.				Resident D was affected	d by		
	The most recent Ad	lmission Minimum Data Set			the alleged deficient practice.	u by		
		, dated 1/21/25, indicated		Resident D immediatel		/		
	1 1	gnitively intact, required		had a care plan for falls reviewed				
	_	nal assistance (staff does more			and updated as appropriate.			
	than half) with toile	eting, sit to stand transferring,						
	and lying to sitting	bed mobility, and had no falls			2: How other residents having	ng		
	prior to admission.				the potential to be affected b	y		
					the same deficient practice v	vill		
		, initiated 1/10/25, indicated			be identified and what			
		isk for falls due to cerebral			corrective action will be take			
	_	hy, and arthritis. Interventions			- Residents at risk for falls	or		
	included, but were i				with history of falls have the			
	Anti-rollbacks to w				potential to be affected by the			
	Bed against the wal				alleged deficient practice.			
	_	ion as resident allows			All current in-house			
		t the resident's needs			residents were audited on 3/2			
	Call light is within i				by the DON/designee for care			
	Ensure pathways ar				plans related to falls. No furth			
	Keep personal items				residents were appropriate for	care		
	Therapy screen/eval	i/treat as indicated			plan updates.			
		dated 3/10/25 at 6:40 P.M.,			3: What measures will be put	t		
		nt had an unwitnessed fall			into place or what systemic			
		self-toilet. The care plan was			changes will be made to			
	not updated with a r	new intervention after that fall.			ensure that the deficient			

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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	LETED
		155716	B. W	ING		03/13	/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG			DATE
		lacked documentation to			practice does not recur?	_	
		ciplinary Team (IDT) met to			The DON/designee wer		
	review that fall.				educated on Envive Care Plan	•	
	On 2/12/25 at 1.50	D.M. the Administrator			- Interdisciplinary Team Polic	-	
		P.M., the Administrator			and procedure with concentra		
	indicated that after a resident fell, the IDT met the next clinical morning to review the fall and				on, but not limited to, managir falls.	iy	
	determine an appropriate intervention to prevent				- Education and trainir	ng.	
	future falls. The care plan was updated after that				were provided to DON/design	•	
	meeting. At that time, the Administrator indicated				3/25/25 by the clinical support		
	she could not remember if the IDT had met to				consultant.	•	
	review Resident D's fall that occurred on 3/10/25				Education provided:		
	at 6:40 P.M.				Envive Care Planning –		
	0. 10 1				Interdisciplinary Team Policy		
	On 3/13/25 at 1:50	P.M., the Administrator			Envive Falls and Fall Risk	C .	
		Falls and Fall Risk, Managing			Managing Policy	-,	
	-	24, that indicated "The staff,					
		e attending physician, will			4: How the corrective action		
	_	nt-centered fall prevention plan			will be monitored to ensure		
	-	ic risk factor(s) of falls for			deficient practice will not red		
	-	or with a history of falls In			i.e., what quality assurance		
	conjunction with the	e attending physician, staff			program will be put into place	:e?	
	will identify and im	plement relevant			DON/designee will		
		to minimize serious			complete daily monitoring thro	ough	
	_	ling The staff will monitor			the clinical care meeting to en	sure	
		resident's response to			that any resident with falls is		
		led to reduce falling or the			reviewed for proper procedure		
	_	the resident continues to fall,			documentation for monitoring	5	
		e the situation and whether it is			days a week for 4 weeks, 3 da	-	
		nue or change current			a week for 4 weeks and 2 day		
	interventions".				week for 4 weeks, then month	ıly in	
					QAPI for 6 months.		
		s cited on 1/27/25. The facility					
	-	a systemic plan of correction			DON/designee will be		
	to prevent recurrence	ce.			responsible for monitoring		
	2.1.25(1)(2)				compliance for 6 months. The		
	3.1-35(d)(2)				results of these audits will be		
					reviewed by the QA committe	е	
					overseen by the Executive		
			1		Director If a threshold of 95%	IS	I

PRINTED: 04/03/2025 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X	(3) DATE SURVEY COMPLETED 03/13/2025
	PROVIDER OR SUPPLIE	R	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				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 lethan 6 months. 5. Date of completion: March 25, 2025	ugh ne
F 0689 SS=D Bldg. 00	review, the facility were in place to provide reviewed for falls. Finding includes: On 3/12/25 at 12:0 record was reviewed were not limited to falls, and muscle w The most recent Ac (MDS) Assessmen Resident D was consubstantial to maxiful than half) with toile and lying to sitting	on, interview, and record failed to ensure interventions event falls for 1 of 3 residents (Resident D) 8 P.M., Resident D's clinical ed. Diagnoses included, but cerebral infarction, repeated rasting and atrophy. dmission Minimum Data Set t, dated 1/21/25, indicated gnitively intact, required mal assistance (staff does more eting, sit to stand transferring, bed mobility, and had no falls	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 accomplished for those resident found to have been affected by 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 th potential to be affected by the	be ts the e
	Resident D was at a	, initiated 1/10/25, indicated risk for falls due to cerebral thy, and arthritis. Interventions		same deficient practice will be identified and what corrective action will be taken. Residents at risk for falls or will history of falls have the potentia	

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included, but were not limited to:

Anti-rollbacks to wheelchair

Bed against the wall

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practice.

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be affected by the alleged deficient

- All current in-house residents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLE	TED
		155716	B. W	ING		03/13/2	025
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L					
	OF EVANOVII I E				BOEKE RD		
ENVIVE	OF EVANSVILLE			EVANS	WILLE, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	Bed in lowest positi	on as resident allows			were audited on 3/25/25 by the	е	
	Anticipate and mee	t the resident's needs			DON/designee for falls		
	Call light is within reach				intervention. No further reside	nts	
	Ensure pathways ar				were appropriate for care plan		
	Keep personal item				updates.		
	Therapy screen/eva				3: What measures will be put i	into	
					place or what systemic change		
	A fall risk assessme	ent, dated 2/9/25, indicated			will be made to ensure that the		
	Resident D was at l				deficient practice does not rec		
	Trestactive was aver	0 W 11011 101 1 0 1101			- The DON/designee were	ш.	
	The clinical record	indicated Resident D fell five			educated on Envive Care Plar	nning	
	times between 2/28/25 and 3/10/25.				Interdisciplinary Team Policy		
	times between 2/20/25 and 5/10/25.				and procedure with concentra		
	Fall 1				on, but not limited to, managin		
	On 2/28/25 at 3:15 P.M., Resident D had an				falls.	ig	
		ile attempting to transfer from			- Education and training were		
		s bed without assistance.			provided to DON/designee on		
		wheelchair" was added to his			3/25/25 by the clinical support		
		k assessment, dated 2/28/25,			consultant.		
		nt was at low risk for falls.			Education provided:		
	maleated the reside.	it was at low lisk for fails.			· Envive Care Planning –		
	Fall 2				Interdisciplinary Team Policy		
		M., Resident D had a			· Envive Falls and Fall Risk,		
		e toileting. "Medication review			·		
		dded to the care plan. A fall			Managing Policy 4: How the corrective action w	مط الن	
		red 3/3/25, indicated the					
					monitored to ensure the defici		
	resident was at high	risk for fails.			practice will not recur i.e., wha	I .	
	Fall 3				quality assurance program wil	i be	
		DM D '1 (D1 1			put into place?		
		P.M., Resident D had an			- DON/designee will complete		
		tile in bed. "Bed in lowest			daily monitoring through the		
	1 ^	allows" was added to the care			clinical care meeting to ensure	•	
	1 ^	essment, dated 3/4/25,			that any resident with falls is	.	
	indicated the reside	nt was at high risk for falls.			reviewed for proper procedure		
					documentation for monitoring		
	Fall 4				days a week for 4 weeks, 3 da	· .	
		A.M., Resident D had a			a week for 4 weeks and 2 day		
		attempting to get out of bed.	week for 4 weeks, then monthly in		ly in		
	_	was added to the care plan. A			QAPI for 6 months.		
	fall risk assessment	, dated 3/9/25, indicated the			- DON/designee will be		

AND PLAN OF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE (A. BUILDING B. WING	00	COME	E SURVEY PLETED 3/2025
NAME OF PRO	OVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	COD	
ENVIVE OF	EVANSVILLE			SVILLE, IN 47711		
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
FOCULUM SET OF THE SET	resident was at high Fall 5 On 3/10/25 at 6:40 II Inwitnessed fall whereom his bed to the least updated with a resistency of the least updated with a resident of the least updated with the least updated and least updated a current of the least updated and least updated with the least updated and least updated with the least updated with the least updated with the least updated updated with the least updated updated with the least updated u	P.M., Resident D had an ile attempting to self-transfer pathroom. The care plan was new intervention. A fall risk (10/25, indicated the resident falls. A.M., Resident D was low to the ground bed. The chind the resident's head and to be bedside table was observed as drink and remote control on the chind the behind a curtain. P.M., the Director of Nursing to observed Resident D in his resonal items in reach and staff following fall interventions at (P.M., the Administrator falls and Fall Risk, Managing (24, that indicated "The staff, attending physician, will tecentered fall prevention plan to risk factor(s) of falls for or with a history of falls In the attending physician, staff		responsible for monit compliance for 6 mor results of these audits reviewed by the QA coverseen by the Executive Director. If a threshol not achieved, an active developed. The fathe QAPI program, we update, and make cheap DPOC as needed for substantial compliance than 6 months. 5. Date of completion 2025	onths. The s will be committee cutive d of 95% is on plan will acility through will review, anges to the s sustaining ce for no less	

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		X1) PROVIDER/SUPPLIER/CLIA	· ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155716		A. BUILDING <u>00</u> B. WING			COMPLETED 03/13/2025	
		1557 10	D. W			03/13/	2023	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BOEKE RD			
ENVIVE	OF EVANSVILLE		<u>.</u>	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	
IAG		LISC IDENTIFYING INFORMATION		IAG	DEFERRET		DATE	
F 0712 SS=D Bldg. 00	interventions". This deficiency was failed to implement to prevent recurrence. This citation relates 3.1-45(a)(2) 483.30(c)(1)-(4) Physician Visits-Final NPP Based on interview failed to ensure a rephysician for 1 of 3 dialysis. (Resident Finding includes: On 3/13/25 at 10:30 record was reviewed 10/8/24. Diagnoses to, renal failure and The most recent Qu (MDS) Assessment, Resident B was cog substantial assistance than half of the wortransfers. A physician progress A.M., stated "patient complaints, exam unissues per nursing."	requency/Timeliness/Alt and record review, the facility sident was assessed by a residents reviewed for B) A.M., Resident B's clinical d. Resident B was admitted on included, but were not limited peripheral vascular disease. arterly Minimum Data Set dated 1/16/25, indicated nitively intact and required the from staff (staff does more k) for toileting, bathing, and as note, dated 2/10/25 at 12:38 at assessed and no new inchanged, orders reviewed, no	F 0'	712	F 712 – Physician Visits – Frequency/Timeliness/Alt PF "Facility failed to ensure a rest was assessed by a physician of 3 residents reviewed for dialysis. (Resident B)" 1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? Resident B was affected the alleged deficient practice. Resident B physician wonotified to perform resident vis Resident B returned to hospital March 14, 2025 and conot return to facility. 2: How other residents havin the potential to be affected by the same deficient practice was deficient what corrective action will be taken	ident for 1 will d by as sit. did	03/25/2025	
	Resident B indicate	d she had not been assessed			 All residents have the 			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155716	B. W	'ING		03/13/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	8			BOEKE RD		
ENVIVE	OF EVANSVILLE				SVILLE, IN 47711		
	ı	CT L MEN ADVIT OF DEFENSIVE VOICE	1		, T	1	are.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	by a physician in th	e facility since admission.			potential to be affected by the		
	D	2/12/25 -4 9.44 A N. 41 -			alleged deficient practice.		
	1	on 3/13/25 at 8:44 A.M., the			All current in-house	F.10F	
		ated she was unsure if the			residents were audited on 3/2	5/25	
		physician was actually in the facility, there was no			by the DON/designee for		
	record of a physical assessment completed by Resident B's physician, and that the physician's				physician visits. No other		
					residents needed to be seen to	ру	
	office was responsible for billing insurance for visits.				the physicians.		
	v151t5.	visits.			3: What measures will be pu	.	
	During an interview on 3/13/25 at 10:57 A.M., the				into place or what systemic	•	
	clinical staff of Resident 3's physician office				changes will be made to		
	stated there was no record of a physician				ensure that the deficient		
	assessment of Resident 3, and there was no				practice does not recur?		
	billable visits record				The DON/designee wer	·e	
	omadie visits receiv	aca for Resident 5.			educated on Envive Physiciar		
	On 3/13/25 at 1:50	P.M., the Director of Nursing			Services Policy	'	
		tled Physician Services, dated			- Education and trainir	na	
		"Supervising the medical care			were provided to DON/design	-	
		s, but is not limited to:			3/25/25 by the clinical support		
		resident assessments and care			consultant.	•	
		visits, frequency of visits,			Education provided:		
		residents, etc., are provided in			Envive Physician Policy		
		rrent OBRA regulations and					
	facility policy."				4: How the corrective action		
					will be monitored to ensure		
	3.1-22(d)(1)				deficient practice will not red		
					i.e., what quality assurance		
	This deficiency was	s cited on 1/27/25. The facility			program will be put into place	e?	
	failed to implement	a systemic plan of correction			DON/designee will		
	to prevent recurrence	ce.			complete weekly rounding wit	h	
					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 committe	е	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIP A. BUILDIN B. WING		oo	(X3) DATE : COMPL 03/13/	ETED
	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 PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 0842 SS=E	483.20(f)(5), 483.7 Resident Records	'0(i)(1)-(5) - Identifiable Information			overseen by the Executive Director. If a threshold of 95% not achieved, an action plan where developed. The facility threshold the QAPI program, will review, update, and make changes to DPOC as needed for sustaining substantial compliance for no I than 6 months. 5. Date of completion: March 25, 2025	ill ough the g	
Bldg. 00	failed to ensure doc accurate for 2 of 3 r (Resident M and Re reviewed for dialysi Findings include: 1. On 3/12/25 at 10: record was reviewed 3/13/21. Diagnoses to, cognitive common The most recent Qu (MDS) Assessment, Resident M was sev required substantial more than half of th bathing, and transfe most recent MDS A A Clinically at Risk	arterly Minimum Data Set dated 3/3/25, indicated erely cognitively impaired, assistance from staff (staff do e work) for eating, toileting, rs, and had fallen since the ssessment (1/3/25). Assessment, dated 3/11/25, M had fallen on 2/8/25, 2/25/25,	F 0842		F 842 – Resident Records – Identifiable Information "Facility failed to ensure documentation was complete a accurate for 2 of 3 residents reviewed for falls (Resident M Resident D) and 2 of 3 resident and Resident H)." 1: What corrective action(s) was 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.	and tts t B vill	03/25/2025

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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	construction 00	(X3) DATE SURVEY COMPLETED 03/13/2025		
NAME OF F	PROVIDER OR SUPPLIEF	.		ADDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF EVANSVILLE			SVILLE, 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 DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	A Fall Risk Assessi	ment, dated 2/26/25, indicated		2: How other residents having	na	
		ert and oriented x3 (to person,		the potential to be affected by	<u> </u>	
place, and time), and had no falls in the past 3			the same deficient practice v	-		
	months.			be identified and what		
				corrective action will be take	en.	
	A Fall Risk Assessment, dated 3/11/25, indicated			- All residents with history	of	
	Resident M was alert and oriented x3, and had no			falls have the potential to be		
	falls in the past 3 m	onths.		affected by the alleged deficie	ent	
				practice.		
During an interview on 3/13/25 at 11:37 A.M., the				- All dialysis residents have		
Director of Nursing (DON) indicated the fall on				potential to be affected by the		
3/3/25 was documented in error.				alleged deficient practice.		
				All current in-house		
	2. On 3/13/25 at 10:30 A.M., Resident B's clinical			residents were audited on 3/2		
		d. Resident B was admitted on		by the DON/designee for complete		
	1	included, but were not limited		documentation related to falls	and	
	to, renal failure and	peripheral vascular disease.		dialysis. No further action is		
	The 4			required currently.		
		arterly Minimum Data Set , dated 1/16/25, indicated		2. What we are well be made		
		gnitively intact and required		3: What measures will be pu	t	
	_	ce from staff (staff does more		into place or what systemic changes will be made to		
		rk) for toileting, bathing, and		ensure that the deficient		
	transfers.	ix) for toffering, batting, and		practice does not recur?		
				The DON/designee wer	re l	
	Current physician o	orders included, but were not		educated on Envive Charting		
	limited to:	,		Documentation Policy		
	Do not obtain blood	d pressure in the left arm, dated		- Education and trainir	ng	
	2/24/25			were provided to DON/design	-	
				3/25/25 by the clinical support		
		ment to be completed prior to		consultant.		
	dialysis one time a			Education provided:		
	Wednesday, Friday	, dated 10/9/24		Envive Charting and		
				Documentation Policy.		
		sment to be completed after to				
	dialysis one time a			4: How the corrective action		
	Wednesday, Friday	, dated 10/9/24		will be monitored to ensure		
				deficient practice will not red	cur	
The following dates and times included blood		1	i.e., what quality assurance			

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155716	B. W	ING		03/13/	/2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			BOEKE RD		
ENI\/I\/E	OF EVANSVILLE				SVILLE, IN 47711		
LINVIVL	OI EVANSVILLE			LVANO	, VILLE, IIV 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	ΛΤΕ.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	^	ted obtained from the left arm:			program will be put into place	:e?	
	2/26/25 7:00 A.M.				DON/designee will		
	2/26/25 3:40 P.M.				complete daily monitoring thro	ough	
	2/28/25 3:07 P.M.				the clinical care meeting to en	sure	
	3/3/25 5:27 P.M.				accurate documentation is		
	3/5/25 3:02 P.M.				monitored 5 days a week for 4		
	3/5/25 3:04 P.M.				weeks, 3 days a week for 4 w		
	3/7/25 9:28 A.M.				and 2 days a week for 4 week	S,	
	3/7/25 2:06 P.M.				then monthly in QAPI for 6		
					months.		
		lacked a pre or post dialysis					
	assessment completed on 3/10/25. 3. On 3/12/25 at				DON/designee will be		
	11:53 A.M., Resident H's clinical record was				responsible for monitoring		
	reviewed. Diagnoses included, but were not				compliance for 6 months. The		
	limited to, end stag	ge renal disease.			results of these audits will be		
					reviewed by the QA committe	е	
		uarterly Minimum Data Set			overseen by the Executive		
		t, dated 12/18/24, indicated			Director. If a threshold of 95%		
		gnitively intact, required			not achieved, an action plan v		
		mal assistance (staff does more			be developed. The facility the		
	than half) with toil	eting, and received dialysis.			the QAPI program, will review		
	l				update, and make changes to		
	1	cluded, but were not limited to:			DPOC as needed for sustainii	-	
	_	lysis Assessment in (name of			substantial compliance for no	less	
	_	system) one time a day every			than 6 months.		
	Monday, Wednesd	ay, and Friday, dated 6/5/24			.		
	T 1: 1 1	1 1 1 D (D) 1 '			5. Date of completion: March	ĺ	
		lacked a Post Dialysis			25, 2025		
	Assessment for 3/7	/25.					
	TI M 1 2025 N	r it at a A i i i a at					
		fedication Administration					
		icated a Post Dialysis					
		of the total street to the street of the str					
		it code of other/see progress					
	notes".						
	The clinical reserva	looked a progress material at a					
		lacked a progress note related					
	to the Post Dialysis	s Assessment on 3/7/25.					
	On 3/13/25 at 9:00	A.M., the Director of Nursing					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY TPLETED 13/2025
	PROVIDER OR SUPPLIER		601 N E	ADDRESS, CITY, STATE, ZIP (BOEKE RD SVILLE, IN 47711	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Treatment/Post Tre form indicated the last to be completed by Treatment Assessment the dialysis nurse. It by the Assistant Dia The completed Post not include the name dialysis center that On 3/13/25 at 10:15 that it was her signare Treatment Assessment informedialysis nurse. At the Treatment/Post Tre supposed to be entered Assessment forms it system). On 3/13/25 at 1:47 the clinical record landicate the ADON Assessment informedialysis nurse. At the clinical record landicate the ADON Assessment informed the 4. On 3/12/25 at 12 record was reviewed were not limited to, falls, and muscle were not limited to, falls, and muscle were not limited to, falls, and muscle were substantial to maxing than half) with tolled.	:08 P.M., Resident D's clinical d. Diagnoses included, but cerebral infarction, repeated				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/13/2025			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF A SUPERITURNING PROPERTY TO A SUPERIOR OF THE SUPE			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION equired the use of a walker and		TAG	DEI CERCIT		DATE	
	-	, initiated 1/10/25, indicated isk for falls due to cerebral thy, and arthritis.						
	score of 9.0 indicated risk (a high fall risk). The assessment ind two falls in the past	ent, dated 2/9/25, resulted in a ing Resident D was a low fall was a score of 10.0 or greater). icated the resident had one to three months and required the ices for mobility (wheelchair, ure).						
	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.							
	score of 2.0 indicaterisk. The assessment no falls in the past t	ent, dated 2/28/25, resulted in a ing Resident D was a low fall at indicated the resident had three months and did not ssistive devices for mobility.						
	l	y Team (IDT) Note, dated , indicated the IDT met to s fall on 3/2/25.						
		lacked documentation to sustained a fall on 3/2/25.						
		1 3/5/25 at 9:24 A.M., indicated unwitnessed fall on 3/4/25 get out of bed.						
	A.M., indicated Res	note, dated 3/5/25 at 9:51 sident D's resident notified of the "fall yesterday".						

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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	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2025					
NAME OF PROVIDER OR SUPPLIER ENVIVE OF EVANSVILLE			601 N	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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION				
	indicate an initial fabeen completed after the completed after the completed after the complete of the complet	lacked documentation to alls note and assessment had er the fall on 3/4/25. P.M., the Administrator of sure if the resident fell on d would need to check on the A.M., the Administrator all that occurred on 3/4/25 was neident report which was not eccord, and that the nurse who are treport forgot to take the de the fall information in the A.M., the Director of Nursing esident D did not fall on 3/2/25 cumented wrong in the IDT							
	staff needed to be re She indicated docur resident representat occurred on 3/4/25 information in the it over into the clinical indicated the fall rist and Resident M we resulting in an inaccindicated the nurse Resident B docume pressure in error and pressure in her left at On 3/13/25 at 1:50	P.M., the DON indicated that e-educated on documentation. mentation that Resident D's ive was notified of the fall that the same day, but the neident report was not carried all record. At that time, she is assessments for Resident D are filled out incorrectly curate fall risk score. The DON that took blood pressures for need the location of the blood did did not take the blood arm P.M., the Administrator Charting and Documentation							

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/13/2025			
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE			
	policy, revised 8/2024, that indicated "The following information is to be documented in the resident medical recordTreatments 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, specificallythe 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 residentand 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.						

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

PRINTED: 04/03/2025 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	A. BU	22) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2025	
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	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 9999 Bldg. 00			F 99	999			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 0	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.			

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