PRINTED: 04/02/2025

DEPARTMENT	Γ OF HEALTH AND HU	JMAN SERVICES				FO	RM APPROVED	
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		155716	B. WING			03/13/	/2025	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD BOEKE RD			
ENVIVE	OF EVANSVILLE		EVANSVILLE, IN 47711					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		ATE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
F 0000								
Bldg. 00								
Blug. 00	This visit was for t	the Investigation of Complaints	F 00	200	Preparation or execution of the	nic		
	This visit was for the Investigation of Complaints IN00455155 and IN00453363.		1 0	300	plan of correction does not	115		
	The visit was in conjunction with a Post Survey				constitute admission or agree	ment		
					of provider of the truth of the			
	Revisit (PSR) to the Recertification and State					alleged or conclusions set forth on		
	Licensure Survey completed on January 27, 2025.				the Statement of Deficiencies			
	This visit included a PSR to the Investigation of				Plan of Correction is prepare			
	Complaint IN00448749 completed on January 27,				executed solely because it is			
	_	cluded a PSR to the State			required by the position of Fe			
	Residential Licens	ure Survey completed on			and State Law. The Plan of			
	January 27, 2025.	-			Correction is submitted to respond			
	-				to the allegation of noncompl	-		
	Complaint IN0045	5155 - No deficiencies related to			cited during the Annual Surve			
	the allegations are	cited.			revisit conducted March 12-1	3,		
					2025.			
	Complaint IN0045	3363 - Federal/State deficiencies			Please accept this Plan of			
	_	ations are cited at F657, F689,			Correction as the provider's			
	and F842.				credible allegation of complia			
					as of March 25, 2025. The pr			
	Survey dates: Mare	ch 12 & 13, 2025			respectfully requests desk re	<u>view</u>		
					with paper compliance to be			
	Facility number: 0				considered in establishing the	at the		
	Provider number:				provider is in substantial			
	AIM number: 1002	2/50/0			compliance.			
	Census Bed Type:							
	SNF/NF: 116							
	SNF: 8							
	Residential: 13							

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

Total: 137

Census Payor Type: Medicare: 9 Medicaid: 83 Other: 32 Total: 124

(X6) DATE

TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UY9511 Facility ID: 000439 If continuation sheet Page 1 of 13

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155716	B. W	ING		03/13	/2025
	PROVIDER OR SUPPLIER		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	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	These deficiencies raccordance with 410	reflect State Findings cited in 0 IAC 16.2-3.1.					
Quality review completed on March 18, 2025.							
F 0657	483.21(b)(2)(i)-(iii)						
SS=D Bldg. 00	Care Plan Timing and Revision						
	Based on interview	and record review, the facility	F 00	657	F 657 – Care Plan and Revisi	on	03/25/2025
	_	plan of care after a resident			"Facility failed to update the p		
	fell for 1 of 3 reside	ents reviewed for falls.			of care after a resident fell for	1 of	
	(Resident D)				3 residents reviewed for falls. (Resident D)."		
	Finding includes:						
	On 3/12/25 at 12:08	P.D.M. Dasident D's clinical			1: What corrective action(s)	WIII	
	On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but				be accomplished for those	_	
		cerebral infarction, repeated			residents found to have been	n	
	falls, and muscle wa	-			affected by the deficient		
	lans, and muscle wa	asting and atrophy.			practice?	d by	
	The most recent Ad	mission Minimum Data Set			Resident D was affecte	и бу	
		, dated 1/21/25, indicated			the alleged deficient practice.	,	
		nitively intact, required			Resident D immediately had a care plan for falls review		
	~	nal assistance (staff does more				veu	
		ting, sit to stand transferring,			and updated as appropriate.		
	· · · · · · · · · · · · · · · · · · ·	bed mobility, and had no falls			2: How other residents havir	.~	
	prior to admission.	bed modifity, and had no fans			the potential to be affected by	•	
	prior to admission.				the same deficient practice v	_	
	A current care nlan	initiated 1/10/25, indicated			be identified and what	VIII	
	_	isk for falls due to cerebral			corrective action will be take	'n	
		hy, and arthritis. Interventions			- Residents at risk for falls		
	included, but were i				with history of falls have the	OI .	
	Anti-rollbacks to w				potential to be affected by the		
	Bed against the wal				alleged deficient practice.		
	_	on as resident allows			All current in-house		
	_	t the resident's needs			residents were audited on 3/2	5/25	
	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		
	Therapy screen/eva				plan updates.	Jaio	

	ENT OF DEFICIENCIES IN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/13/2025
	F PROVIDER OR SUPPLIEF	R	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 BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) COMPLETION DATE
	indicated the reside while attempting to not updated with a rather condition of the clinical record indicate the Interdistreview that fall. On 3/12/25 at 1:50 indicated that after next clinical morning determine an approfuture falls. The can meeting. At that times the could not remere review Resident D's at 6:40 P.M. On 3/13/25 at 1:50 provided a current lepolicy, revised 8/20 with the input of the implement a resident to reduce the specific each resident at risk conjunction with the will identify and implement a resident and document each interventionsto traconsequences of fall and document each interventions intender in the continuous interventions It is staff will re-evaluate appropriate to continuous	dated 3/10/25 at 6:40 P.M., and had an unwitnessed fall a self-toilet. The care plan was new intervention after that fall. lacked documentation to sciplinary Team (IDT) met to sciplinary Team (IDT) met to sciplinary Team (IDT) met to a resident fell, the IDT met the neg to review the fall and priate intervention to prevent the plan was updated after that the, the Administrator indicated amber if the IDT had met to as fall that occurred on 3/10/25 P.M., the Administrator Falls and Fall Risk, Managing 1024, that indicated "The staff, the attending physician, will intercentered fall prevention plan for risk factor(s) of falls for a cor with a history of falls In the attending physician, staff applement relevant by to minimize serious serious lling The staff will monitor resident's response to the ded to reduce falling or the of the resident continues to fall, the the situation and whether it is the sinue or change current as to complaint IN00453363.		3: What measures will be pinto place or what systemic changes will be made to ensure that the deficient practice does not recur? The DON/designee we educated on Envive Care Planterdisciplinary Team Policy and procedure with concentron, but not limited to, managfalls. Education and train were provided to DON/designaty Team Policy allows and Fall Risk Managing Policy Envive Care Planning — Interdisciplinary Team Policy Envive Falls and Fall Risk Managing Policy 4: How the corrective action will be monitored to ensure deficient practice will not refice, what quality assurance program will be put into planter disciplinary monitoring the clinical care meeting to eat that any resident with falls is reviewed for proper procedu documentation for monitoring days a week for 4 weeks, and 2 day week for 4 weeks, then mon QAPI for 6 months. DON/designee will be	ere anning cy ration ing ing nee on ort / sk, n e the ecur ace? rough ensure re and g 5 days ays a
ĺ	3 1-35(d)(2)		1	responsible for monitoring	ı

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	F OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2025	
	PROVIDER OR SUPPLIE	R	•	601 N I	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
F 0689	483 25(d)(1)(2)				compliance for 6 months. The results of these audits will be reviewed by the QA committed overseen by the Executive Director. If a threshold of 95% not achieved, an action plan who be developed. The facility thre QAPI program, will review update, and make changes to DPOC as needed for sustaining substantial compliance for not than 6 months. 5. Date of completion: March 25, 2025	is vill ough the ng less	
SS=D Bldg. 00	review, the facility were in place to pr reviewed for falls. Finding includes: On 3/12/25 at 12:0 record was review were not limited to falls, and muscle v The most recent A	failed to ensure interventions event falls for 1 of 3 residents	F 00	589	F 689 – Free of Accident Hazards/Supervision/Devices "Facility failed to ensure interventions were in place to prevent falls for 1 of 3 resident reviewed for falls. (Resident D 1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? Resident D was affected the alleged deficient practice.	ts)." will	03/25/2025

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prior to admission.

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

Event ID:

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If continuation sheet

Resident D immediately

had a care plan for falls reviewed

and updated as appropriate to

2: How other residents having

include fall interventions.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155716	B. WI	ING		03/13/	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	R	601 N BOEKE RD				
ENVIVE	OF EVANSVILLE		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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A current care plan, initiated 1/10/25, indicated				the potential to be affected b	у	
	Resident D was at r	risk for falls due to cerebral			the same deficient practice v	vill	
	infarction, neuropat	thy, and arthritis. Interventions			be identified and what		
	included, but were	not limited to:			corrective action will be take	n.	
	Anti-rollbacks to w	heelchair			- Residents at risk for falls	or	
	Bed against the wal	11			with history of falls have the		
	Bed in lowest position as resident allows				potential to be affected by the		
	Anticipate and meet the resident's needs Call light is within reach				alleged deficient practice.		
					All current in-house		
Ensure pathways are free of clutter				residents were audited on 3/2	5/25		
	Keep personal items within reach				by the DON/designee for falls	0,20	
	Therapy screen/eval/treat as indicated				intervention. No further reside	ents	
					were appropriate for care plan		
	A fall risk assessme	ent, dated 2/9/25, indicated			updates.		
	Resident D was at 1				apaates.		
	resident B was at 1	TOW TISK TOT TURIS.			3: What measures will be put		
	The clinical record	indicated Resident D fell five			into place or what systemic	•	
	times between 2/28				changes will be made to		
	times octween 2/20	725 and 3/16/23.			ensure that the deficient		
	Fall 1				practice does not recur?		
		P.M., Resident D had an			The DON/designee wer	_	
		hile attempting to transfer from			educated on Envive Care Plar		
		is bed without assistance.			Interdisciplinary Team Policy	•	
		wheelchair" was added to his			1		
		k assessment, dated 2/28/25,			and procedure with concentration		
	_	ent was at low risk for falls.			on, but not limited to, managin	ig	
	indicated the reside	the was at low risk for fails.			falls.	_	
	E-11.2				- Education and trainin	-	
	Fall 2	AM Decident Divide			were provided to DON/design		
		A.M., Resident D had a			3/25/25 by the clinical support		
		e toileting. "Medication review			consultant.		
		dded to the care plan. A fall			Education provided:		
		ted 3/3/25, indicated the			Envive Care Planning –		
	resident was at high	n risk for falls.			Interdisciplinary Team Policy		
	 				Envive Falls and Fall Risk	ζ,	
	Fall 3				Managing Policy		
	On 3/4/25 at 12:15 P.M., Resident D had an						
		hile in bed. "Bed in lowest			4: How the corrective action		
position as resident allows" was added to the care				will be monitored to ensure t	he	İ	

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plan. A fall risk assessment, dated 3/4/25,

indicated the resident was at high risk for falls.

Event ID:

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If continuation sheet

deficient practice will not recur

i.e., what quality assurance

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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 03/13/2025	
	PROVIDER OR SUPPLIES	R	60	1 N B	DDRESS, CITY, STATE, ZIP COD OEKE RD VILLE, IN 47711		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	Fall 4 On 3/8/25 at 12:06 witnessed fall whil "Bed against wall" fall risk assessment resident was at high Fall 5 On 3/10/25 at 6:40 unwitnessed fall with from his bed to the not updated with a assessment, dated 3 was at high risk for On 3/13/25 at 10:0 observed lying in a bedside table was to was raised high. The to have the resident it. The resident's rethe opposite side of the oppo	P.M., Resident D had an hile attempting to self-transfer bathroom. The care plan was new intervention. A fall risk 3/10/25, indicated the resident falls. O A.M., Resident D was low to the ground bed. The behind the resident's head and he bedside table was observed the drink and remote control on acher was on his wheelchair on this room behind a curtain. P.M., the Director of Nursing he observed Resident D in his ersonal items in reach and staff in following fall interventions at P.M., the Administrator Falls and Fall Risk, Managing 124, that indicated "The staff, he attending physician, will intervented fall prevention plans fice risk factor(s) of falls for the original residence of the control of the staff, he attending physician, staff	TA	G	program will be put into place DON/designee will complete daily monitoring through the clinical care meeting to end that any resident with falls is reviewed for proper procedured documentation for monitoring days a week for 4 weeks, 3 day week for 4 weeks, and 2 day week for 4 weeks, then month 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 committed overseen by the Executive Director. If a threshold of 95% not achieved, an action plan who be developed. The facility that the QAPI program, will review update, and make changes to DPOC as needed for sustaining substantial compliance for nothan 6 months. 5. Date of completion: March 25, 2025	e and 5 ays s a ly in e is rough the ng less	DATE

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155716	B. W	NG		03/13/	2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ſΈ	DATE
F 0842 SS=E Bldg. 00	consequences of fall and document each interventions intend risks of falling If staff will re-evaluate appropriate to contininterventions". This citation relates 3.1-45(a)(2) 483.20(f)(5), 483.7 Resident Records Based on interview failed to ensure docuaccurate for 2 of 3 released for dialysis Findings include: 1. On 3/12/25 at 10: record was reviewed 3/13/21. Diagnoses to, cognitive common. The most recent Que (MDS) Assessment, Resident M was sever equired substantial more than half of the bathing, and transfermost recent MDS A. Clinically at Risk	ling The staff will monitor resident's response to ed to reduce falling or the the resident continues to fall, ethe situation and whether it is nue or change current to complaint IN00453363. (70(i)(1)-(5) - Identifiable Information and record review, the facility umentation was complete and esidents reviewed for falls sident D) and 2 of 3 residents is (Resident B and Resident H). (1) (1) (2) (3) (4) (4) (5) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	F 08		F 842 – Resident Records – Identifiable Information "Facility failed to ensure documentation was complete accurate for 2 of 3 residents reviewed for falls (Resident M Resident D) and 2 of 3 resident reviewed for dialysis (Resident and Resident H)." 1: What corrective action(s) to 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 ints it B will	03/25/2025

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Event ID:

UY9511

Facility ID: 000439

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155716	(X2) MULTI A. BUILDI B. WING		nstruction <u>00</u>	(X3) DATE COMPI 03/13	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF EVANSVILLE				OEKE RD VILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	4G	DEFICIENCY)		DATE
		ment, dated 2/26/25, indicated			2: How other residents having	•	
		ert and oriented x3 (to person,			the potential to be affected I	-	
	months.	d had no falls in the past 3			the same deficient practice	WIII	
	months.				be identified and what corrective action will be take		
	A Fall Rick Access	ment, dated 3/11/25, indicated			- All residents with history		
		ert and oriented x3, and had no			falls have the potential to be	OI .	
falls in the past 3 months.				affected by the alleged deficie	ent		
	initial in the pust 5 months.				practice.) I I	
During an interview on 3/13/25 at 11:37 A.M., the				- All dialysis residents hav	e the		
Director of Nursing (DON) indicated the fall on					potential to be affected by the		
	3/3/25 was docume				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	25/25	
	record was reviewed. Resident B was admitted on			by the DON/designee for complete			
		included, but were not limited	documentation related to falls and				
	to, renal failure and	peripheral vascular disease.			dialysis. No further action is		
					required currently.		
		arterly Minimum Data Set					
		, dated 1/16/25, indicated			3: What measures will be pu	ıt	
	-	gnitively intact and required			into place or what systemic		
		ce from staff (staff does more			changes will be made to		
		k) for toileting, bathing, and			ensure that the deficient		
	transfers.				practice does not recur?		
	Current physician	orders included, but were not			The DON/designee we		
	limited to:	nacis included, but were not			educated on Envive Charting Documentation Policy	anu	
		d pressure in the left arm, dated			- Education and traini	na	
	2/24/25	a pressure in the fest arm, dated			were provided to DON/design	_	
					3/25/25 by the clinical suppor		
	Pre-Dialysis assessi	ment to be completed prior to			consultant.	-	
	dialysis one time a				Education provided:		
	Wednesday, Friday				Envive Charting and		
					Documentation Policy.		
	Post-Dialysis assess	sment to be completed after to			•		
	dialysis one time a	day every Monday,			4: How the corrective action		
	Wednesday, Friday	, dated 10/9/24			will be monitored to ensure	the	
					deficient practice will not re	cur	
	The following dates	s and times included blood			i.e., what quality assurance		
nressures documented obtained from the left arm:				program will be put into place	202	1	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
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		155716	B. W	ING		03/13/	2025
				CERTE	A DDDDGG GITTY GT ATE TID GOD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
	OF F\/ANG\/!! F				BOEKE RD		
ENVIVE	OF EVANSVILLE			EVANS	SVILLE, IN 47711		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2/26/25 7:00 A.M.				DON/designee will		
	2/26/25 3:40 P.M.				complete daily monitoring thro	ugh	
	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		
	3/7/25 2:06 P.M.				then monthly in QAPI for 6		
					months.		
	The clinical record lacked a pre or post dialysis						
	assessment completed on 3/10/25.				DON/designee will be		
	3. On 3/12/25 at 11:53 A.M., Resident H's clinical				responsible for monitoring		
	record was reviewed. Diagnoses included, but				compliance for 6 months. The		
	were not limited to, end stage renal disease.				results of these audits will be		
					reviewed by the QA committed	е	
	The most recent Qu	arterly Minimum Data Set			overseen by the Executive		
	(MDS) Assessment	, dated 12/18/24, indicated			Director. If a threshold of 95%	is	
	Resident H was cog	gnitively intact, required			not achieved, an action plan v	/ill	
	substantial to maxing	mal assistance (staff does more			be developed. The facility thi	ough	
	than half) with toile	eting, and received dialysis.			the QAPI program, will review	,	
					update, and make changes to	the	
	Physician orders in	cluded, but were not limited to:			DPOC as needed for sustaining	ng	
	Complete Post Dial	ysis Assessment in (name of		substantial compliance for			
	electronic charting	system) one time a day every			than 6 months.		
	Monday, Wednesda	ay, and Friday, dated 6/5/24					
					5. Date of completion: March		
		lacked a Post Dialysis			25, 2025		
	Assessment for 3/7	/25.					
		edication Administration					
	Record (MAR) indi	icated a Post Dialysis					
		t been completed on 3/7/25					
	and included a char	t code of "other/see progress					
	notes".						
The clinical record lacked a progress note related							
to the Post Dialysis Assessment on 3/7/25.							
		A.M., the Director of Nursing					
(DON) provided a (name of dialysis center) Pre							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/13/	ETED		
		ROVIDER OR SUPPLIER OF EVANSVILLE			601 N B	DDRESS, CITY, STATE, ZIP COD OEKE RD VILLE, IN 47711		
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		form indicated the It to be completed by Treatment Assessm the dialysis nurse. Eby the Assistant Din The completed Post not include the name dialysis center that the Con 3/13/25 at 10:15 that it was her signar Treatment Assessm perform the Post Treatment Assessment informated dialysis nurse. At the Treatment/Post Treatment/Post Treatment/Post Treatment forms it system). On 3/13/25 at 1:47 the clinical record Is indicate the ADON Assessment informated who performed the 4. On 3/12/25 at 12 record was reviewed were not limited to, falls, and muscle was the most recent Ad (MDS) Assessment Resident D was cog substantial to maximate the It is the most recent Ad (MDS) Assessment Resident D was cog substantial to maximate the It is the most recent Ad (MDS) Assessment Resident D was cog substantial to maximate the It is the most recent Ad (MDS) Assessment Resident D was cog substantial to maximate the It is the	:08 P.M., Resident D's clinical d. Diagnoses included, but cerebral infarction, repeated					

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I I	03/13/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 601 N BOEKE RD EVANSVILLE, IN 47711
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRECEDED BY FULL PROBLEM TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (X5) REFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DEFICIENCY) (X5) COMPLETION DATE
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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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155716		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/13/2025	
	PROVIDER OR SUPPLIER		601 N	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 I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
mo	The clinical record indicate an initial fa	lacked documentation to alls note and assessment had ber the fall on 3/4/25.	mo		Bills
	indicated she was n	P.M., the Administrator ot sure if the resident fell on d would need to check on the			
	indicated that the fa documented in an in part of the clinical r filled out the incide	A.M., the Administrator II that occurred on 3/4/25 was neident report which was not ecord, and that the nurse who nt report forgot to take the le the fall information in the			
	(DON) indicated Ro	6 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	P.M., the DON indicated that e-educated on documentation. mentation that Resident D's live was notified of the fall that the same day, but the neident report was not carried all record. At that time, she sk assessments for Resident D re 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			
	provided a current (P.M., the Administrator Charting and Documentation 24, that indicated "The			

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

PRINTED: 04/02/2025 FORM APPROVED OMB NO. 0938-039

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 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				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	

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