STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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 the Investigation of Complaints IN00444074, IN00445202, IN00445491 and IN00446196. Complaint IN00444074 - Federal/state deficiency related to the allegations is cited at F600. Complaint IN00445202 - Federal/state deficiency related to the allegations is cited at F689. Complaint IN00445491 - No deficiencies related to the allegations are cited. Complaint IN00446196 - No deficiencies related to the allegations are cited. Survey dates: January 22, 23, and 24, 2025 Facility number: 000510 Provider number: 155507 AIM number: 100285440 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Type: Medicare: 7 Medicaid: 19 Other: 2 Total: 28 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 29, 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 Recertification and State Licensure Survey and complaint survey conducted January 22-24, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 14, 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
Elizabeth Cunningham	HFA	02/07/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for verbal abuse. (Resident B) Findings include: The facility completed an incident report and sent it to the Indiana Department of Health (IDOH) Long Term Care division, on 9-25-24, related to Resident B and Certified Nurse Aide (CNA) 4. In a written witness statement, dated 9-25-24, Registered Nurse (RN) 5, indicated on the same date at 5:15 p.m., he and another resident's family member, "overheard [name of CNA 4] using inappropriate language and speaking in a raised tone towards the resident. The resident was heard using a racial slur directed at the staff member. In response, [name of CNA 4] stated 'You will not call me that, do you f-----g understand?' and added, 'You cannot attempt to get out of bed on your own; I already had to help your a-- off the floor once today.' This writer intervened by removing [name of CNA 4] from the room and escorting her to the break room to collect her belongings, followed by an escort to the time clock." In a documented staff interview, conducted on 9-26-24, by the Regional HFA (health facility administrator) with CNA 4, it indicated CNA 4 indicated she had been "overwhelmed" since the beginning of her shift on 9-25-24. Near the beginning of her shift, she found Resident B "half in and out of bed and admitted to increasing her tone to get the resident's attention to not try to	F 0600	**F600 – Free from Abuse and Neglect** **SS - D** *"Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for verbal abuse. (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 alleged deficient practice. ·Resident B was assessed and has reported no ongoing distress and no recent incidents of verbal abuse. ·Employee no longer works at 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 potential to be affected by the deficient practice. ·All residents interviewed and no further concerns regarding verbal abuse noted. **3: What measures will be put into place or what systemic**	02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	get up alone. She stated [name of Resident B] started calling her derogatory names and she stated 'I said, you can't talk to me like that, do you f-----g understand?' Employee stated the words just slipped out and she knew it was wrong and apologized to the resident. Employee stated she was stressed and did not ask for help and aware that she should have. Writer explained that Resident did not feel that she was intentional with her words and felt she was having a bad day. [Name of RN 5] stated he did not feel she was intentional but having a bad day. Employee will be paid for time off and job reinstated. Employee did receive written 1st warning. Employee received Stress/Burnout education." During a telephone interview with CNA 4 on 1-23-25 at 12:28 p.m., she indicated on the day in question, the facility was short-handed. "The resident had asked to be helped to bed and I told her I would be there as soon as possible. In the meantime, [name of Resident B] asked... another resident, who was in a wheelchair, to put her to bed and [name of other resident] helped her. When I came back to her room, a few minutes later, I found out [name of the other resident] had helped her to bed and I became upset and very worried about both [name of Resident B and name of the other resident]'s safety in doing this. I told her she can't just ask other residents to help her lay down. She got really mad at me and called me the N-word and told me I can't tell her what to do. I did cuss at her and I shouldn't have. [Name of RN 5], the nurse on duty, heard us, and he immediately came and talked to me and [name of Resident B] and ended up sending me home. I was suspended for a day or two while they did their investigation and got a written warning and was allowed to come back to work. I did apologize to [name of Resident B] and we are good friends		**changes will be made to ensure that the deficient practice does not recur?** ·Administrator and Director of Nursing have been educated by VP of Clinical Services on Envive abuse policies. ·All staff have been in-serviced on: ·Envive Abuse and Neglect – Clinical Protocol ·Envive Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy ·Envive Abuse, Neglect, Misappropriation, Reporting and Investigating Policy ·Envive Identifying Types of Abuse 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?** ·ED/Designee will complete weekly random staff audits related to policy understanding x6 months and ongoing to ensure staff comprehension of poor customer service and alleged abuse concerns. ·ED/Designee will complete a weekly random audit x 6 months with residents/families and will be ongoing to ensure concerns related to poor customer service and potential abuse claims have been properly addressed. ·The results of these audits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	now. She didn't want me to take care of her for a while, but I can now. I did have [receive] a teachable moment about burnout and received some education on that. I will admit it was all me and I shouldn't have acted that way, but I know better now." During an interview with the Executive Director (ED) on 1-23-25 at 9:30 a.m., she indicated, "As the new interim ED, I am just now looking into this situation, the same as you. As you know, this occurred with the previous company and previous management. I couldn't really see where the investigation said whether or not they considered this an abuse or not, but it does look like a fairly clear verbal abuse with statements made about the aide being overwhelmed. It looks like they did provide her with information on burnout and stress. I assume this may trigger further investigation from the State in regards to the aide. From what I have heard from staff and residents, there was a time in the Fall where the staffing was kind of rough...I've been told the staffing situation has improved a great deal. We are currently using some agency for staffing with the hopes to decrease the agency staffing as soon as possible." On 1-23-25 at 11:10 a.m., the ED provided a copy of a form entitled "Employee Warning," dated 9-27-24. It indicated the document was a "1st Written" warning for CNA 4 for violation of "Page 63 of Employee Handbook, #13 using profane/abusive language towards or around residents or their family members," on 9-25-24. Indicated, "On 9-25-24, Employee [name of CNA 4] was overheard by [name of RN 5] using inappropriate language and speaking to resident with an increased tone stating, "you will not call me that, do you f-----g understand? ...Employee		be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 2/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	re-educated on stress/burnout and appropriate resident interactions. The use of profanity is against facility policy and will not be tolerated. Any further writeups may results in further disciplinary action or termination." The document was signed by CNA 4 and the Regional HFA. During an interview with Resident B on 1-22-25 at 3:28 p.m., she denied any concerns with anyone being rough with care or rough/unkind with speech. She indicated she had several falls with head injuries in the past, but she was unable to determine if she had any falls at the facility. She indicated, "My memory is pretty bad." The clinical record of Resident B was reviewed on 1-22-25 at 1:10 p.m. Her diagnoses included, but were not limited to, unspecified dementia and benign intracranial hypertension. Her most recent Minimum Data Set assessment, dated 9-6-24, indicated she was moderately cognitively impaired. On 1-22-25 at 3:56 p.m., the ED provided a copy of a policy entitled, "Abuse Prohibition, Reporting and Investigation." She indicated this policy was the previous company's policy for Abuse Prohibition which was in effect at the time of the 9-25-24 incident. This policy indicated a revision date of 6/2023. It indicated, "This facility shall prohibit and prevent abuse...Verbal Abuse [defined as] oral, written and/or gestured language that willfully includes disparaging and/or derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or a disability...This facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse...while the investigation is in progress...This facility shall not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	permit residents to be subjected to abuse by anyone, including employees...Supervisory personnel are responsible to monitor through observation and counseling as needed, staff/resident interactions and the provision of care and services to the resident. Facility personnel exhibiting any trend toward impatience or frustration in routine dealings with residents shall be evaluated for possible temporary assignment or unpaid leave of absence...The facility Administrator is designated as the individual responsible for coordinating all efforts in investigation of abuse allegations and for assuring that all policies and procedures are followed...Residents must be protected from abuse through the provisions of this policy, the procedure for investigation of abuse, orientation training and ongoing inservice education...If Resident Abuse, or Suspicion of Abuse is Reported, the resident(s) involved in the incident shall be removed from the situation at once or facility person shall remain with the resident to ensure safety...Any facility personnel implicated in the alleged abuse shall be immediately removed from resident care and shall remain suspended until an investigation is completed. A thorough investigation shall be initiated...As a result of an investigation, the facility shall take any necessary actions which may include, but not be limited to...Analyzing the occurrence(s) to determine why abuse...occurred, and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services..." This citation relates to Complaint IN00444074. 3.1-27(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure falls were investigated and documented thoroughly for 3 of 3 residents reviewed for falls. (Residents E, G and H) Findings include: 1. The clinical record of Resident E was reviewed on 1-23-25 at 2:52 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, chronic pain, spinal stenosis, and general muscle weakness. Her most recent Minimum Data Set (MDS) assessment, dated 11-18-24, indicated she was severely cognitively impaired, used a wheelchair for mobility, and was dependent for walking, toileting, and bed mobility. It indicated she had falls within the last six months, but no fractures. The Director of Nursing (DON) provided a fall log, indicating Resident E had a fall without injury on 10-12-24 at 3:55 p.m. During an interview with the DON on 1-23-25 at 3:16 p.m., she indicated Resident E had a diagnosis of dementia and did have a history of falls. "I will have to look in her old chart and the old records for her information. She is the only person with a fall listed for 10-12-24." A progress note, dated 10-12-24 at 3:55 p.m., indicated "Resident was getting up from w/c [wheelchair] & [sign for and] went down onto her knees. Assisted up to w/c after assessment completed." No additional assessments or documentation of the fall and/or follow-up were located in clinical record until 10-15-24. The DON	F 0689	**F689 – Free of Accidents Hazards/Supervision/Devices SS - D** *"Based on interview and record review, the facility failed to ensure falls were investigated and documented thoroughly for 3 of 3 residents reviewed for falls. (Residents E, G and H)"* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident E no longer resides at facility. ·Resident G and H had all falls from alleged previous falls until current date investigated, reviewed and appropriate documentation verified. **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 at risk residents for falls have the potential to be affected by the deficient practice. ·All falls for the past 30 days have been reviewed for thorough documentation and appropriate documentation was verified or entered.	02/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	provided a copy of a document entitled "Initial 3-Day Post Fall Interdisciplinary Review," dated 10-12-24, as "Day One," which indicated Resident E "was getting up from w/c & went down on knees." Day two documented as "10-15-24," and Day three as "10-16-24." The DON indicated documentation of Resident E's fall did not get conducted timely related to "we were having documentation issues at the time." During an interview with the DON on 1-24-25 at 2:55 p.m., she indicated the date of Resident E's fall would have been under previous ownership and with a different electronic health record (EHR) system, and the previous management/owners were not providing access to the EHR at the present time. "They have told us that we will have to gain access through a third party for those records," and the current facility ownership does not know when that might take place. 2. The clinical record of Resident G was reviewed on 1-24-25 at 10:42 a.m. Her diagnoses included, but were not limited to, hyponatremia (low serum sodium level), general muscle weakness, unspecified protein-calorie malnutrition, unsteadiness on feet, and diabetes. Her most recent MDS assessment, dated 11-15-24, indicated she was cognitively intact, used a wheelchair for mobility, and required moderate assistance with transfers, walking, toileting, bathing and hygiene, and was independent with bed mobility. It indicated she had no falls since her last MDS assessment. During an interview with Licensed Practical Nurse (LPN) 7 on 1-22-25 at 11:55 a.m., she indicated Resident G had a recent fall without injuries and was recently diagnosed with hyponatremia with associated cognitive decline.		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·Administrator and Director of Nursing have been educated by VP of Clinical Services on Envive Falls policies. ·Clinical staff have been educated on the following, but not limited to: ·Envive Assessing Falls and Their Cause Procedure ·Envive Falls – Clinical Protocol ·Envive Falls and Fall Risk, Managing Policy ·Envive Fall Risk Assessment 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?** ·ED/Designee will audit all falls and associated documentation weekly x 1 month, 3 times a week x 1 month, 2 times a week x1 month and weekly x 3 months to ensure falls are appropriately investigated, reviewed and documented. ·The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	A review of Resident G's unwitnessed fall, dated 1-21-25 at 1:12 p.m., indicated Resident G "Fell out of wheel chair while self transferring," and was found by staff lying on the floor in front of her wheelchair. It indicated the resident was assessed and appeared to have no injuries, had no pain, and was alert and oriented to person, place, time, and situation. It indicated the physician, the DON, and family were notified of the fall within minutes of the fall. A review of the nursing progress notes indicated no documentation as to why Resident G was later sent out to the hospital on the same date. An associated progress note, dated 1-21-25 at 11:12 p.m., indicated the resident was admitted to an area hospital with a "diagnosis of hyponatremia." A progress note, dated 1-23-25 at 11:14 p.m., referred to placement of geri-sleeves (used for skin protection). No progress notes were located as to the resident returning to the facility from the hospital. A care plan entry for falls/fall risk, dated 1-21-25, indicated the resident had been sent to the emergency room "for evaluation and change of condition." A re-admission nursing assessment was conducted, on 1-22-25, which indicated Resident G was alert and oriented to person, place, situation, had no current skin issues, was a known fall risk, was at risk for skin breakdown, was incontinent of bowel and bladder, and denied pain. In an interview with Resident G on 1-23-25 at 10:35 a.m., she indicated she had returned late last evening from a stay at an area hospital but was unsure of the reason for her hospitalization. She did recall a fall with no injury from her wheelchair several days prior.		reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. **5. Date of completion:** 2/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	3. The clinical record of Resident H was reviewed on 1-24-25 at 2:10 p.m. Her diagnoses included, but were not limited to, unspecified convulsions, anxiety, depression, unsteadiness on feet, nontraumatic subarachnoid hemorrhage, history of a traumatic brain injury, transient ischemic attacks [mini strokes], and cerebral infarction, CVA (cardiovascular attacks or stroke), high blood pressure, cognitive communication deficit, dementia, and a history of falls. Her most recent MDS assessment, dated 12-28-24, indicated she was severely cognitively impaired, required substantial assistance with toileting, bathing and hygiene, and required moderate assistance with bed mobility, transfers, and walking, and used a wheelchair for mobility. It indicated she was usually incontinent of bowel and bladder, received routinely scheduled pain medication and denied pain, and had two falls since her prior MDS assessment. A "Fall Investigation" document, dated 12-31-24 at 7:40 a.m., indicated Resident H was found on the floor of the lounge area by facility staff. It indicated she had a wheelchair alarm in place. An assessment by the licensed nurse indicated she sustained a hematoma to the right forehead to which an ice pack was applied, active range of motion to her upper and lower extremities was performed, she was alert to her name, and able to answer questions appropriately. Resident H was assisted to stand with the assistance of two people and returned to her wheelchair. Her blood pressure was elevated. Her physician was notified of the fall and made aware of being on aspirin therapy, with no change in cognition, with no verbal or non-verbal signs of pain. Resident H was able to indicate she had fallen out of the wheelchair and struck her head. Neurological			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LIBERTY	215 WEST HIGH STREET LIBERTY, IN 47353

(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
	checks were initiated and were within normal range. The documented history included multiple falls and unsteady gait. It indicated the family was notified and it indicated she was sent to a local emergency room for further evaluation. No further documentation was in Resident H's clinical record until 1-12-25. During an interview with the DON on 1-24-25 at 2:55 p.m., she indicated Resident H returned to the facility on the same date as when she was sent out, 12-31-24, but she could not locate additional information in regard to this. "Yes, there should have been a readmission assessment conducted, but I cannot find it. Once again, that would have been under the previous ownership and with the other [EHR] system, and they are not giving us access to it at the present time. They have told us that we will have to gain access through a third party for those records," and the current facility ownership does not know when that might take place. The DON indicated Resident H had another fall, on 1-12-25, and was sent out to the emergency room for further evaluation and returned from the hospital on 1-14-25. She was unable to locate any handwritten or electronic records for a readmission assessment. This citation relates to Complaint IN00445202. 3.1-45(a)(1) 3.1-45(a)(2)			