STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. Building B. Wing	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Lawrenceburg	403 Bielby Rd Lawrenceburg, IN 47025

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 38239 Based on interview and record review, the facility failed to thoroughly investigate a resident's allegation of abuse for 1 of 1 abuse allegations reviewed. (Resident B) Findings include: During an interview on 08/13/24 at 10:14 A.M., the SSD (Social Services Director) indicated Resident B made some allegations of physical abuse during a meeting on 08/08/24. The SSD followed up with the resident for 72 hours related to the allegations and the resident did not repeat the allegations or have any other concerns. She did not interview any other residents about abuse. When she brought the allegation to the Administrator, he took over the investigation. The incident was reported to the State Department of Health by the Administrator on 08/08/24 at 3:28 P.M. The brief description of the incident indicated the resident told a social worker she had been locked in her closet and locked in her room and that someone choked her at night. The resident stated she had a bruise above her eye. The resident was assessed and had no bruising above her eye or on her throat. The resident had a cupboard for clothing that did not lock and there were no locks on the residents' room doors. The resident's Psychiatric Health Care Provider was notified of the resident's increased hallucinations and would look at adjusting the resident's medications at their next visit. The resident's clinical record was reviewed on 08/12/24 at 7:26 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/30/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, alcohol abuse with alcohol-induced psychotic disorder with hallucination, anxiety, depression, and seizure disorder. The resident resided on the third floor of the facility. During an interview on 08/13/24 at 10:43 A.M., the Administrator indicated the SSD came to him with the resident's allegations. He typed up the reportable and sent it to the State. They looked at the complaint. The resident had no closets to lock her in, and no locks on her doors. The resident reported being choked, but the resident was assessed and had no injuries. Normally, they would interview the other residents that resided on the same floor the resident lived on, but they were all too confused and non-interviewable. The DON (Director of Nursing) may have assessed the non-interviewable residents for signs or symptoms of abuse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/24 at 11:52 A.M., the DON indicated she completed a head-to-toe assessment of Resident B, with no findings. She assessed the other residents that resided on the third floor on the side of the hall that Resident B lived on. There were some residents that were interviewable that lived on the third floor. She did not ask any of the interviewable residents about abuse. She thought the SSD was interviewing residents. Several residents could have been interviewed; she did physical assessments on residents that were not interviewable. A document signed by the DON on 08/09/24 at 2:00 P.M., indicated the names and room numbers of the seven residents that were assessed and found to have no bruising or skin discoloration. A Bed Board for 08/09/24 indicated twenty residents resided on the third floor at the time the allegation of abuse was made. Seven of those residents (Residents B, E, F, G, H, J, and K) were assessed for bruises and skin discoloration. The other thirteen residents (Residents L, M, N, O, P, Q, R, S, T, V, W, X, and Z) that lived on the third floor were not assessed for signs or symptoms of abuse. Of the thirteen residents not assessed, six of them (Residents L, M, S, V, W, and X) were determined to be cognitively intact and interviewable based on their most recent MDS assessments. The current facility policy, titled Accidents/Incidents/Investigation, with an effective date of 10/2022, was provided by the Administrator on 08/13/24 at 1:25 P.M. The policy indicated, .All accidents or incidents involving residents .shall be investigated .The following data, as applicable, shall be included .Other pertinent data as necessary or required . This citation relates to Complaint IN00440606. 3.1-28(d)