

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/22/2025
NAME OF PROVIDER OR SUPPLIER  Envive of Lawrenceburg		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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
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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on record review and interview the facility failed to provide appropriate assistance to prevent an avoidable accident for 1 of 3 residents reviewed for accidents hazards. This deficient practice resulted in the resident acquiring right medial and right posterior orbital fractures. (Resident D) Findings include: The clinical record for Resident D was reviewed on 9/22/2025 at 3:15 P.M. An admission Minimum Data Set (MDS) assessment, dated 9/3/2025, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, heart failure, asthma, and respiratory failure. The Resident required maximal assistance to transferring from lying to sitting and sitting to standing. The At Risk for Falls Care Plan, dated 8/27/25 and revised on 9/8/25, indicated the resident will be free of falls. The interventions included, but were not limited to, dated 8/27/25, anticipate and meet the resident's needs; and, dated 9/6/25, resident's room closer to nurses station for closer monitoring. The Physical Therapy Progress Report, dated 8/23/25, indicated the resident required maximum assistA facility incident report, dated 9/6/25, indicated staff found Resident D lying on the floor near the resident's room doorway. The resident had gotten up unassisted and lost balance, the resident was unsure where she was going or what she was needing. The resident had a laceration to the left side of her forehead. During an interview, on 9/22/2025 at 10:45 A.M., Certified Nursing Assistant (CNA) 3 indicated she was getting Resident D up for breakfast on 9/12/2025 and left the resident sitting on the side of the bed while she walked to the far corner of the room to retrieve the resident's wheelchair. While her back was to the Resident, she heard a loud noise and turned to find the resident lying face first on the ground. The resident hit her head hard and broke her dentures. CNA 3 said sometimes Resident C can hold herself up and sometimes she can't. She was told by other staff that the resident had been declining and to be careful with her. Ever since the resident came back from the hospital after this incident, she has required a mechanical lift for transfer and used a specialized mobility challenges ergonomic wheelchair instead of regular wheelchair. During an interview, on 9/22/2025 at 1:30 P.M., Therapy Staff Member 4 indicated Resident C came from home and was at the facility for therapy. Resident C required maximal verbal direction. For example, if you asked her to stand up, she wouldn't understand what you were asking. She was not following direction. She was dropped from seeing therapy after her last fall on 9/12/2025. The last few times Therapy Staff Member 4 helped Resident C she required maximal assistance. She required maximal assistance with two staff members just to get her out of the chair when she was in therapy doing exercises. Therapy Staff Member 4 indicated she would not have left Resident C sit on the side of her bed alone while she retrieved her wheelchair from across the room. During an interview, on 9/22/2025 at 3:40 P.M., RN 5 indicated she was the nurse who responded to Resident C's fall on 9/12/2025. Upon entering the room Resident C was laying on the floor face first with her hands alongside her body like she did not attempt to catch herself. She had a laceration on the side of her face and bruising was already starting. A Hospital Document, dated 9/12/2025 at 8:47 A.M., showed the findings from the computed tomography (CT) scan indicating the resident had a new right medial orbital blowout fracture with opacification of the adjacent ethmoid sinuses. Additionally, a subtle new acute fracture within the posterior right orbital wall. A hematoma in the right cheek with extensive surrounding inflammation. Also, a laceration with a total repaired wound length of 5 centimeters (cm). The current facility policy, titled Falls and Fall Risk, managing, with a revision date of August 2024, was provided by the Administrator on 9/22/2025 at 4:20 P.M. The policy indicated, the staff will identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The current facility policy, titled Safe lifting and Movement of Residents, with a revision date of August 2024, was provided by the Administrator on 9/22/2025 at 4:20 P.M. The policy indicated, In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. This citation relates to Intake 2616965.3.1-45(a)(1)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review the facility failed to provide adequate equipment to allow residents to call for assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from the residents bedside for 1 of 3 residents reviewed. (Resident C) Findings include: During an interview, on 9/22/2025 at 9:08 A.M., Resident C indicated he had no call light available. When Resident C moved into his room Maintenance came in, and he told the resident there was no spot to hook a call light up. He had been in the room for a few months, and had never received a call light. The facility provided a bell to ring, but he was unable to find it anymore. When he did have access to the bell staff were never able to hear it no matter how much he rang because he was located at the last room at the end of the hallway. Usually if he needed someone he would go into the bathroom and use the call light in there. There was one night he was unable to get out of bed, and needed to vomit and he had to yell out for help because he had no call light available. During an interview and observation, on 9/22/25 at 10:14 A.M., Registered Nurse (RN) 2 indicated Resident C used a wheelchair, and was able to make his needs known. The resident should have had a call light at the bedside at all times. During an observation with RN 2 in Resident C's room she confirmed there was no call light plugged into the wall above the residents bed. She identified where it should have been and asked Resident C if he had ever had a call light. Resident C replied he had not ever had a call light. During an interview, on 9/22/2025 at 10:40 A.M., the Maintenance Supervisor indicated he was aware there was no call light in Resident C's room. He said the room was a single room initially, so a second call light was never installed. A facility documented email was provided on 9/22/2025 at 1:50 P.M. by the Administrator, the email document titled call light boxes indicated that on 7/22/2025 they had not received the call light boxes yet and asked if they were on backorder. The next email was dated 9/22/2025 at 10:48 A.M. and stated following up here. An email reply was returned on 9/22/2025 at 1:01 P.M. and indicated the boxes were being shipped out that day. During an interview, on 9/22/2025 at 1:50 P.M., the Administrator indicated Resident C had a functioning call light now. The old call light for the room was hooked up. There were no additional emails from 7/22/2025 to 9/22/2025 about the call light boxes order. During an observation, on 9/22/2025 at 3:30 P.M., Resident C pressed his call light button while laying in bed. The light above the residents room door did not light up nor was there a sound. Resident C then hit the bell now placed on his bedside table three times, and then dropped the bell onto the floor. No staff responded from the sound. During an interview, on 9/22/2025 at 3:35 P.M., the Administrator indicated Resident C's call light was on and indicated the light overtop of the stairwell beside his room was the light associated with his call light not the light over his room. She also indicated there was no sound at the nurses station from the resident hitting the call light like the other call lights. The clinical record for Resident C was reviewed on 9/22/2025 at 3:00 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 6/26/2025, indicated the Resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, stroke, and depression. The resident was impaired on one side for upper and lower extremities. He used a wheelchair, and required moderate assistance with lower body dressing. The current facility policy, titled Answering the Call Light, with a revision date of August 2024, was provided by the Administrator on 9/22/2025 at 4:20 P.M. The policy indicated, .Be sure that the call light is plugged in and functioning at all time . Ensure that the call light is accessible to the resident when in bed . Report all defective call lights to the nurse supervisor promptly .3.1-19(u)</p>		