STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155507	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Liberty	215 West High Street Liberty, IN 47353

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify a resident's physician and emergency contact/resident representative when a resident fell and hit his head for 1 of 3 residents reviewed for accidents (Resident B). Finding include:Review of the clinical record of Resident B on 11/6/25 at 11:02 a.m., indicated the resident's diagnoses included, but were not limited to sick sinus syndrome, syncope and collapse, hypertensive heart disease, diabetes, anemia, anxiety, coronary artery disease, cerebral vascular accident (CVA) and hypertension. The progress note for Resident B, dated 10/22/25 at 8:58 p.m., indicated the resident fell in the shower room around 8:20 p.m., the Emergency Medical technician (EMT) was called to assist the resident off the floor because the resident had a pacemaker placed on 10/21/25. The Director of Nursing (DON) was notified. There was no documentation of the physician or the resident's representative being notified. During an interview with CNA 1, on 11/5/25 at 11:20 a.m., she indicated she was assisting Resident B with a shower on 10/22/25 when he fell. CNA 1 indicated the resident slipped and hit his head on the wall and hit his head on the floor. CNA 1 indicated she reported to LPN 2 who was the nurse on duty that the resident hit his head when he fell. During an interview with LPN 2, on 11/5/25 at 12:55 p.m., she indicated she was the nurse caring for Resident B on 10/22/25 when he fell in the shower. LPN 2 indicated she did not know why she did not call the physician or the resident's representative when the resident fell and hit his head. LPN 2 indicated she was so scared and had another emergency down the other hallway with another resident. During an interview with Resident B's Emergency Contact 1, on 11/5/25 at 1:15 p.m., she indicated she was not notified when Resident B fell in the shower and hit his head. The assessing for falls and their causes policy provided by the DON on 11/5/25 at 12:50 p.m., indicated after a resident fall the attending physician and family would be notified in an appropriate time frame. The accidents and incidents reporting policy provided by the DON on 11/6/25 at 10:55 a.m., indicated the it would be documented the date and time the attending physician and family member was notified of the accident. This citation relates to Intake 2654128. 3.1-5(a)(1)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete neurological assessments after two residents fell and hit their head resulting in Resident B sustaining a subdural hematoma (collection of blood that forms between the dura mater (the outer layer of the brain's protective membranes) and the brain itself) and requiring hospitalization for 2 of 3 residents reviewed for accidents (Residents B and D). Findings include:1. Review of the clinical record of Resident B on 11/6/25 at 11:02 a.m., indicated the resident's diagnoses included, but were not limited to sick sinus syndrome, syncope and collapse, hypertensive heart disease, diabetes, anemia, anxiety, coronary artery disease, cerebral vascular accident (CVA) and hypertension. The clinical record for Resident B indicated the resident was admitted to the facility on [DATE] from the local hospital. The local hospital note for Resident B indicated the resident was in the hospital from [DATE] to 10/22/25. The resident was riding his 3 wheeled electric bike and had a syncopal (fainting) episode. The resident had on a helmet. Neurological assessments were completed with no abnormal findings. The CT (Computed Tomography) scan of Resident B's head, completed on 10/17/25 indicated no acute intracranial findings, generalized atrophy and mild left maxillary sinus disease, no fractures, the ventricles were normal, no midline shift. The CT of the Resident B's spine indicated no acute fractures or dislocations. The CT of Resident B's chest indicated no pneumothorax or fractures. The resident had a pacemaker successful placed on 10/20/25. The baseline functional status assessment for Resident B, dated 10/22/25 at 12:51 p.m., indicated the resident was cognitively intact for daily decision making. The resident required substantial/maximal assistance for showering. The (late entry) progress note for Resident B, dated 10/22/25 at 8:58 p.m., indicated the resident had a fall in the shower room around 8:20 p.m. CNA 1 reported the resident slipped and fell. Emergency Medical Technician (EMT) was called to assist the resident off the floor because the resident had a pacemaker put in on 10/21/25. LPN 2 left the shower room and called 911. The resident was talkative, no apparent injuries. The EMT got behind the resident and put his arms around the residents waist and lifted him up into the shower chair. The resident moved eyes, followed all commands. The resident's blood pressure was 118/68, pulse was 87 and oxygen saturation was between 93 % and 94%. LPN 2 went back into the shower room after completing some task and took the resident's vital signs, his blood pressure was 118/64, pulse 84 and oxygen saturation was 93%. LPN 2 looked at the back of his head and neck as she was passing the resident and no injuries were noted. LPN 2 gently took her left hand and felt up his neck and behind his head. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	The (late entry) progress note for Resident B, dated 10/22/25 at 8:58 p.m., indicated LPN took another resident's blood sugar at 9:00 p.m. and done a treatment. LPN 2 checked on residents around 9:15 p.m., to 9:20 p.m., LPN 2 went into Resident B's room and asked how he was doing and he did not respond. The resident was breathing rapidly. LPN 2 yelled for the CNA to call 911, but the CNA said she could not because she did not know what to say. LPN 2 walked rapidly to the front of the building and called 911. LPN 2 went back to Resident B's room and did a sternal rub with no response. The resident's oxygen saturation was 94%, was not able to get a blood pressure cuff on the resident because his arm was jerking. EMT's arrived. LPN 2 gave Resident B Tylenol at 4:30 p.m., for a bad head ache but accidently documented it was for back pain. The EMS (Emergency Medical Service) report for Resident B, dated 10/22/25 at 9:57 p.m., indicated the unit was dispatched to the facility for an immediate urgency, Resident B was found unconscious . This indicated there was 1 hour and 37 minutes from the time Resident B fell and from the time he was found unresponsive. The local hospital note for Resident B, dated 10/22/25 at 10:37 p.m., indicated the resident had a subdural hematoma. The resident's CT scan findings were there was a large right holohemispheric (affecting the entire hemisphere of the brain) acute subdural hematoma. There was a 26 millimeter (mm) right to left midline shift. The impression was a large holohemispheric acute subdural hematoma measuring 26 mm in thickness with 26 mm right to left midline shift and uncal herniation. The resident was placed on a ventilator (life support machine that helps the patient breathe). Resident B was transported via helicopter to a major medical hospital. During an interview with CNA 1, on 11/5/25 at 11:20 a.m., indicated she was assisting Resident B with a shower on 10/22/25 and he slipped and fell backwards and hit his head on the wall and on the floor. CNA 2 indicated she did report to LPN 2 that he had hit his head on the wall and the floor. The resident went unresponsive later that evening in his bed. During an interview, on 11/5/25 at 12:20 p.m., the Director of Nursing indicated neurological assessments were not completed after Resident B fell because LPN 2 did not feel that he hit his head. The DON indicated neurological assessments should have been conducted if the facility policy says they should have been. During an interview with LPN 2, on 11/5/25 at 12:55 p.m., she indicated she did not complete neurological assessments on Resident B after he fell and hit his head twice because the resident said he was fine and she waved her hand at him and he looked at her hand and she looked at the back of his head and did not see any swelling. LPN 2 indicated she was unsure how long it was from the time he fell to the time he was found unresponsive, but thought it was approximately 20 minutes. 2. The clinical record for Resident D was reviewed on 11/5/25 at 1:00 P.M. The diagnoses included, but were not limited to, unsteadiness on feet, muscle weakness, cognitive communication deficit, and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 8/29/25, indicated Resident D was moderately to highly cognitively impaired and used a wheelchair for ambulation. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	A nurses note, dated 10/27/25 at 8:58 A.M., indicated Resident D had an un-witnessed fall by the nurse's station. Resident D was found laying on the floor with left arm in wheelchair. Resident D stated they had hit their head. Orders received from on call provider to send Resident D to the ER (Emergency Room) for head CT (Computed Tomography) and evaluation. A Fall Risk Evaluation note, dated 10/27/25 at 8:20 P.M., indicated Resident D had a fall, and was at high risk for falls. Immediate intervention was to send to the ER for evaluation. The nurses notes indicated resident D left the facility at 8:55 pm and returned from the hospital on [DATE] at 1:12am with no new orders. A Change in Condition Evaluation, dated 10/27/25 at 9:33 P.M., indicated a neurological assessment was relevant to the change in condition being reported and no changes were observed. No neurological assessments were completed or documented in Resident D's EHR (Electronic Health Record). A plan of care for Resident D, dated 9/30/25, indicated Resident D was at risk for falls due to impaired cognition/safety awareness and unsteadiness on feet. The interventions included, but were not limited to, prevent injuries due to falling. During an interview, on 11/6/25 at 1:53 P.M., the Director of Nursing indicated neurological checks were not completed after Resident D's fall and hitting her head because the assessment of Resident D included no findings and they only do neurological checks as ordered by the provider and no neurological checks were ordered post fall. A Neurological Assessment policy was provided by the DON on 11/5/25 at 12:50 P.M. It indicated,.General Guidelines: 1. Routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury.2. Routine neurological exams include assessing: a. mental status and level of consciousness; b. pupillary response; c. motor strength; d. sensation; and e. gait. Nursing standards for neurological checks after a head injury involve a comprehensive assessment of the patient's consciousness, pupillary response, motor function, and vital signs, with a frequency that depends on the injury's severity. Initially, checks are performed very frequently (e.g., every 15 to 30 minutes for a Glasgow Coma Scale (GCS) less than 15 or for the first few hours), with the frequency gradually decreasing as the patient stabilizes and their condition improves. Key components include monitoring the Glasgow Coma Scale, pupillary size and reaction, motor strength, and vital signs while also checking for signs of Cerebrospinal fluid (CSF) leakage or other injury. Core components of neurological checks: Glasgow Coma Scale (GCS): A standardized score from 3 to 15 to assess the level of consciousness based on eye-opening, verbal response, and motor response. Pupillary response: Assess the size, equality, and reaction to light of the pupils. Motor function: Evaluate for motor strength, symmetry, and any specific deficits like pronator drift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Vital signs: Monitor blood pressure, heart rate, respiratory rate, and oxygen saturation, as changes can indicate a worsening condition. Neurological symptoms: Ask about and monitor for symptoms such as headache, nausea, dizziness, vision changes, or numbness. Signs of CSF leakage: Inspect the nose and ears for clear, watery fluid, which can indicate a basilar skull fracture. Frequency of checks The frequency of neurological checks is guided by the initial severity of the injury and any changes in the patient's condition. Severe injury (GCS < 15): Perform neurological observations every 30 minutes until the GCS reaches 15. Mild injury (GCS 15 or higher): Perform observations every 30 minutes for the first two hours. Perform hourly observations for the next four hours. Perform every two hours thereafter. If deterioration occurs: Immediately revert to checks every 30 minutes and restart the protocol. Nursing responsibilities Frequent reassessment: Continue to monitor the patient's condition closely and adjust the frequency of checks based on clinical judgment and the patient's stability. Communication: Report any deterioration or new findings immediately to the physician or nurse practitioner. Documentation: Document all findings accurately and thoroughly in the patient's chart. Care plan management: Update the care plan to reflect the patient's changing status and any interventions being performed. https://www.ncbi.nlm.nih.gov/books/NBK593206/ (chapter 6) and www.aacnnursing.org This citation relates to intake 2654128 3.1-37

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe environment in the shower room (wet/slick floor) with two residents suffering a fall in the shower room (Resident B and C). This deficiency resulted in Resident B acquiring a large right acute subdural hematoma with left midline shift and uncal herniation. Findings include: 1. Review of the clinical record of Resident B on [DATE] at 11:02 a.m., indicated the resident's diagnoses included, but were not limited to sick sinus syndrome, syncope and collapse, hypertensive heart disease, diabetes, anemia, anxiety, coronary artery disease, cerebral vascular accident (CVA) and hypertension. The clinical record for Resident B indicated the resident was admitted to the facility on [DATE] from the local hospital. The baseline functional status assessment for Resident B, dated [DATE] at 12:51 p.m., indicated the resident was cognitively intact for daily decision making. The resident required substantial/maximal assistance for showering. The plan of care for Resident B, dated [DATE], indicated the resident was at risk for fall related injury due to recent pacemaker placement and non weight bearing left arm. The (late entry) progress note for Resident B, dated [DATE] at 8:58 p.m., indicated the resident had a fall in the shower room around 8:20 p.m. CNA 1 reported the resident slipped and fell. Emergency Medical Technician (EMT) was called to assist the resident off the floor because the resident had a pacemaker put in on [DATE]. LPN 2 left the shower room and called 911. The resident was talkative, no apparent injuries. The EMT got behind the resident and put his arms around the residents waist and lifted him up into the shower chair. The resident moved his eyes and followed all commands. The resident's blood pressure was 118/68, pulse was 87 and oxygen saturation was between 93 % and 94%. LPN 2 went back into the shower room after completing some task and took the resident's vital signs, his blood pressure was 118/64, pulse 84 and oxygen saturation was 93%. LPN 2 looked at the back of the resident's head and neck as she was passing the resident and no injuries were noted. LPN 2 gently took her left hand and felt up his neck and behind his head. The (late entry) progress note for Resident B, dated [DATE] at 8:58 p.m., indicated LPN took another resident's blood sugar at 9:00 p.m. and done a treatment. LPN 2 checked on residents around 9:15 p.m., to 9:20 p.m., LPN 2 went into Resident B's room and asked how he was doing and he did not respond. The resident was breathing rapidly. LPN 2 yelled for the CNA to call 911, but the CNA said she could not because she did not know what to say. LPN 2 walked rapidly to the front of the building and called 911. LPN 2 went back to Resident B's room and did a sternal rub with no response. The resident's oxygen saturation was 94%, was not able to get a blood pressure cuff on the resident because his arm was jerking. EMT's arrived. LPN 2 gave Resident B Tylenol at 4:30 p.m., for a bad head ache but accidently documented it was for back pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The local hospital note for Resident B, dated [DATE] at 10:37 p.m., indicated the resident had a subdural hematoma. The resident's CT scan findings included, but were not limited to, a large right holohemispheric (affecting the entire hemisphere of the brain) acute subdural hematoma. There was a 26 millimeter (mm) right to left midline shift. The impression was a large holohemispheric acute subdural hematoma measuring 26 mm in thickness with 26 mm right to left midline shift and uncal herniation (a life-threatening neurological emergency where the innermost part of the temporal lobe, is squeezed through the tentorial notch due to increased intracranial pressure). The resident was placed on a ventilator (life support machine that helps the patient breathe). Resident B was transported via helicopter to a major medical hospital. The progress note for Resident B, dated [DATE] at 12:58 p.m., indicated the writer placed a call to Major medical hospital and spoke with on the medical surgical intensive care unit nurse. The nurse reported that the resident was currently intubated, sedated, and medically stable at this time. The resident had sustained a severe neurological insult deemed non-operable. The hospital social worker was in the process of identifying the resident's next of kin and was planning to facilitate a goals-of-care discussion with them. The progress note for Resident B, dated [DATE] at 12:00 p.m., indicated the resident was pronounced deceased on [DATE] at the Major medical hospital. During an observation and interview with CNA 1 on [DATE] at 11:20 a.m., she indicated she was assisting Resident B with a shower on [DATE] and he slipped and fell backwards and hit his head on the wall and on the floor. CNA 1 indicated the resident's whole body smacked the floor. CNA 1 indicated she did report to LPN 2 that he had hit his head on the wall and the floor. The resident went unresponsive later that evening in his bed. Observation of the shower room, the floor was a smooth flat surface with no ridges. There was non skid strips on the shower floor, CNA 1 indicated the non skid strips were not in place of [DATE] when Resident B fell. CNA 2 indicated there was not a bath mat in place or a towel on the shower floor when Resident B fell. CNA 2 indicated the shower floor was slippery when it wet and she herself had slipped on it before when giving showers. During an interview with the Maintenance Director on [DATE] at 10:58 a.m., he indicated the shower floors were a fiber glass acrylic material. 2. The clinical record for Resident C was reviewed on [DATE] at 11:47 A.M. The diagnoses included, but were not limited to, respiratory failure, chronic pain syndrome, and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident C was cognitively intact, required substantial/maximal assist with ability to bathe self, and had limited range of motion to bilateral lower extremities. A nurses note, dated [DATE] at 8:00 P.M., indicated Resident C had a fall in the shower room while transferring. Shower room floor was wet and resident slipped and was lowered to floor by CNA (Certified Nursing Assistant). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Resident C on [DATE] at 1:52 P.M., the resident indicated he did fall in the shower room on [DATE]. The resident was sitting on the shower commode in front of the sink when the CNA (Certified Nursing Assistant) who Resident C indicated he did not know the name of, but she was an agency CNA who does not normally work in the facility, had him stand up to wipe his back off. Resident C indicated as soon as he stood up, his feet slid right out from underneath him and he fell and hit his bottom on the floor. The shower room floor was wet and very slippery. The CNAs will usually place a towel down on the shower floor because of how slippery it gets when wet. The resident usually would wear his non-skid socks in the shower because of how slippery the floors always were and did not want to fall, but he just forgot to wear them that day. The CNA was also unaware how the other CNAs would usually place a towel on the floor in anticipation of the floor becoming so slippery. Resident C indicated there were no non-skid grippers on the shower room floor. A Fall Risk Evaluation note, dated [DATE] at 8:41 P.M., indicated Resident C was a low fall risk. Immediate interventions included, but were not limited to, make sure shower room floor is dry before transferring. An Assessing Falls and Their Causes policy was provided by the Director of Nursing (DON) on [DATE] at 12:50 P.M. It indicated,.Steps in the Procedure- After the Fall:.10. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities.15. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. A Fall Risk Assessment policy was provided by the DON on [DATE] at 10:55 A.M. It indicated,.8. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout.9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. This citation relates to intake 2654128 3.1-45(a)