STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Evansville	601 N Boeke Rd Evansville, IN 47711

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35733 Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to Resident C, an aggressive resident, to protect Resident B, a cognitively impaired resident, from being pushed to the floor for 1 of 3 residents reviewed for accidents. This deficient practice resulted in Resident B falling and requiring hospitalization for surgical repair of a right femur fracture. (Resident B, Resident C) Finding includes: On 5/13/24 at 9:33 a.m., during interview, Resident B indicated a man got mad, pushed, and threw her, reached down, and grabbed her hair. Resident B indicated it happened in [name of city]. On 5/13/24 at 10:01 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur, anxiety disorder, vascular dementia, unspecified severity, without behavioral disturbance. A Quarterly MDS (Minimum Data Set) assessment dated [DATE], indicated Resident B's cognition was moderately impaired, ROM (range of motion) no impairment upper or lower, bed mobility independent, 1 (one) person assist, transfer independent set up help only, toilet independent set up, sit to lying supervision or touching assistance, sit to stand supervision or touching assistance, walk 10 feet supervision or touching assistance, mobility device, walker. The 5/14/24 MDS was still in progress. A care plan for surgical wound to right hip, dated 5/9/24, included, but was not limited to interventions of, treatments as ordered, notify provider of worsening or s/sx (signs and symptoms) of infection. A care plan for risk for emotional and/or physical distress r/t (related to) history of sexual assault, dated 9/12/23, included, but was not limited to interventions of, allow me to express my concerns, fears, feelings, and expectations. Progress notes included, but were not limited to: (continued on next page)

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	4/21/24 at 11:33 p.m., Called to room by CNA, resident was sitting on floor in front of bathroom door, resident stated that resident in [Resident C room] came in her room and attacked her, resident was then checked for injuries, resident had large raised area noted to the top of her head and stated that her right hip was hurting, notified NP (nurse practitioner) with findings, received order to transfer resident to [name of hospital] for eval, resident was transferred via [name of ambulance service], DON, RP (representative), and NP notified. A state reportable incident form was reviewed and indicated on 4/21/24 at 11:35 p.m., Resident C made contact with Resident B causing her to fall to the floor sustaining a reddened area to her head. An orthopedic surgery discharge summary with a discharge date of [DATE], included, but was not limited to: . Closed fracture of neck of right femur, initial encounter .Open treatment of right displaced femoral neck fracture with right hip hemiarthroplasty. A progress note dated 5/8/24 at 3:51 p.m., indicated: Resident came to facility around 1400 (2:00 p.m.) via wheelchair, accompanied by driver. Escorted to room and oriented to room with instructions on how to use call lights and bed controls. VS (vital signs) checked and recorded. Assessed operative site with 7-8 stitches draining scant amount of yellowish fluids. No distress noted. Current Physician orders for May 2024 included but were not limited to: OT (occupational therapy) 5x/week for 8 weeks. Tx will consist of self-care training, therapeutic exercises, neuromuscular re-education, therapeutic activities, and group activities, order date 5/10/24. A follow up to the state reportable dated 4/21/24, added on 5/13/24, indicated: Let this serve as follow up to incident # 439. [Resident C] entered [Resident B] room while she was sleeping. She got up and confronted the resident. [Resident C] pushed [Resident B] down resulting in hitting her head and a fractured hip. Residents separated and diversional activities provided for [Resident C]. [Resident B] was sent to ER for evaluation of injury. [Resident C] became increasingly agitated and was sent to ER for evaluation. No change in mood or behavior for [Resident B's] roommate and no signs of psychosocial distress with other residents. On 5/13/24 at 12:50 p.m., Resident C's clinical record was reviewed. Diagnoses included but were not limited to Alzheimer's disease with early onset, unspecified dementia, moderate, with agitation. An Admission MDS (Minimum Data Set) assessment dated [DATE], indicated Resident C's cognition was severely impaired, physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): behavior of this type occurred 1 to 3 days during the assessment period. Care plans were included but were not limited to: Resident refuses care/is non- compliant with care r/t: adjustment to nursing home, dementia, dated initiated 4/9/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident is/has potential to be physically aggressive as evidenced striking out/hitting, getting angry, and being aggressive with staff and other r/t dementia, He gets agitated when staff try to provide care, tends to be more aggressive with male staff, date initiated 4/22/24. A psych progress note dated 4/8/24 included but was not limited to: Chief Complaint/Reason for this Visit Follow up for dementia. HPI Relating to this Visit Patient seen for follow up for previous reports of agitation and adjustment to facility. Staff states patient is often combative with staff when trying to provide care. He does slightly better with female staff than male staff. He is quiet and does not say much according to staff. He is calm on assessment playing balloon ball during a group activity and says he is doing ok. Current Risk Factors - Danger to self or others Patient is NOT currently a danger to self/others. Aggression: Physical, Verbal during care. Progress notes included, but were not limited to: 4/13/24 at 3:20 p.m., Resident noted with the room coming behind a CNA in the resident's room while CNA was straightened up the bed and grabbed ahold of CNA's ponytail pulling back on her head and notified this writer. Resident was also throwing things around the room as well. 4/21/24 at 4:40 a.m., Behavior note: Resident has frequent episodes of anger and frustration. Verbally threatens to hit staff trying to assist him, often refuses care with ADL's (activities of daily living). Resident was able to be redirected this morning and did assist in changing clothes. 4/21/24 10:37 p.m., Incident note: Called to Unit by CNA, noticed resident very angry and attempting to attack resident B, received order to transfer resident to ER for eval and treatment. 4/21/24 at 11:25 p.m., Behavior note: Called to room by CNA, noted resident in violent, agitated state, resident was reported to have walked into room [Resident B] and attacked occupant of that bed, resident also attacked staff and myself included, resident 1 was separated from resident 2 to ensure safety, received order to transfer resident to [name of hospital] for Psychiatric eval, carried out order as noted, resident transferred via [name of ambulance service] The record lacked documentation of any previous outbursts towards other residents. On 5/14/24 at 11:10 p.m., LPN 1 indicated Resident C had not been observed with aggressive behaviors towards another resident before the night of 4/21/24, only staff. On 5/14/24 at 1:06 p.m., the Administrator indicated written statements were not done by the involved staff, she had handwritten notes of the statements that were taken by phone by herself and the Assistant Director of Nursing. On 5/14/24 at 1:30 p.m., the handwritten statements were reviewed and included the following: 4/21/23(sic) Sunday 2332 (11:32 p.m.) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[RN1]. RN charge called and reported that [Resident C] attacked [Resident B]. He went in room; staff heard her yelling and ran to room. Found her on floor by the bathroom. She stated he came in her room & He pushed her down. She had open area to top of head and c/o hip pain. Staff was able to get him out of room, but he continued to try to come back in door. 2 staff stayed at out on unit to watch and try to redirect him. While nurses attended to her. Another staff called 911 to transport. Staff informed to immediately notify [Administrator] and both families. Phone call [RN 1] 4/21 around Midnight (11:45pm) [Resident C] went in [Resident B's] room. Clarified which [resident name]. She said he pushed her down and is now very agitated and aggressive with staff. Asked if other residents were around- she said no. Roommate asleep. Asked if [Resident B] was ok- she reported that she has a red spot/bleeding Where she hit her head. Stated they were sending her out. She said staff was with [Resident B] & she came to help. Asked if [Resident C] was still agitated. She said yes- He kept trying to hit staff who were nearby. Reported that [staff name] had blood on his scrubs. (From [Resident B] laceration) Discussed 911 for [Resident C] as well. [RN1] called back (11:57 pm) when 911 arrived. Police wanted to know the end goal with [Resident C]. Notified them we wanted evaluation for inpatient psych due to escalated behaviors. [RN1] passed message. Police had no further questions. [RN1] said no other residents were up or around & police were handling [Resident C]. EMS taking [Resident B]. Reported no staff injuries. On 5/14/24 at 11:28 a.m., the Administrator provided the current policy for unmanageable residents with a revision date of April 2010. The policy included but was not limited to: Each resident will be provided with a safe place of residence . This citation relates to Complaint IN00433087 and IN00434508. 3.1-45(a)(1)