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	03/13/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48147 Based on interview and record review, the facility failed to update the plan of care after a resident fell for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, and had no falls prior to admission. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. Interventions included, but were not limited to: Anti-rollbacks to wheelchair Bed against the wall Bed in lowest position as resident allows Anticipate and meet the resident's needs Call light is within reach Ensure pathways are free of clutter Keep personal items within reach Therapy screen/eval/treat as indicated (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An initial fall note, dated 3/10/25 at 6:40 P.M., indicated the resident had an unwitnessed fall while attempting to self-toilet. The care plan was not updated with a new intervention after that fall. The clinical record lacked documentation to indicate the Interdisciplinary Team (IDT) met to review that fall. On 3/12/25 at 1:50 P.M., the Administrator indicated that after a resident fell , the IDT met the next clinical morning to review the fall and determine an appropriate intervention to prevent future falls. The care plan was updated after that meeting. At that time, the Administrator indicated she could not remember if the IDT had met to review Resident D's fall that occurred on 3/10/25 at 6:40 P.M. On 3/13/25 at 1:50 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, revised 8/2024, that indicated The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . In conjunction with the attending physician, staff will identify and implement relevant interventions .to try to minimize serious consequences of falling . The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. This citation relates to complaint IN00453363. 3.1-35(d)(2)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48147 Based on observation, interview, and record review, the facility failed to ensure interventions were in place to prevent falls for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, and had no falls prior to admission. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. Interventions included, but were not limited to: Anti-rollbacks to wheelchair Bed against the wall Bed in lowest position as resident allows Anticipate and meet the resident's needs Call light is within reach Ensure pathways are free of clutter Keep personal items within reach Therapy screen/eval/treat as indicated A fall risk assessment, dated 2/9/25, indicated Resident D was at low risk for falls. The clinical record indicated Resident D fell five times between 2/28/25 and 3/10/25. Fall 1 On 2/28/25 at 3:15 P.M., Resident D had an unwitnessed fall while attempting to transfer from his wheelchair to his bed without assistance. Anti-rollbacks to wheelchair was added to his care plan. A fall risk assessment, dated 2/28/25, indicated the resident was at low risk for falls. Fall 2 (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/25 at 9:30 A.M., Resident D had a witnessed fall while toileting. Medication review as indicated was added to the care plan. A fall risk assessment, dated 3/3/25, indicated the resident was at high risk for falls. Fall 3 On 3/4/25 at 12:15 P.M., Resident D had an unwitnessed fall while in bed. Bed in lowest position as resident allows was added to the care plan. A fall risk assessment, dated 3/4/25, indicated the resident was at high risk for falls. Fall 4 On 3/8/25 at 12:06 A.M., Resident D had a witnessed fall while attempting to get out of bed. Bed against wall was added to the care plan. A fall risk assessment, dated 3/9/25, indicated the resident was at high risk for falls. Fall 5 On 3/10/25 at 6:40 P.M., Resident D had an unwitnessed fall while attempting to self-transfer from his bed to the bathroom. The care plan was not updated with a new intervention. A fall risk assessment, dated 3/10/25, indicated the resident was at high risk for falls. On 3/13/25 at 10:00 A.M., Resident D was observed lying in a low to the ground bed. The bedside table was behind the resident's head and was raised high. The bedside table was observed to have the resident's drink and remote control on it. The resident's reacher was on his wheelchair on the opposite side of his room behind a curtain. On 3/13/25 at 1:47 P.M., the Director of Nursing (DON) indicated she observed Resident D in his room without his personal items in reach and staff were re-educated on following fall interventions at that time. On 3/13/25 at 1:50 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, revised 8/2024, that indicated The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . In conjunction with the attending physician, staff will identify and implement relevant interventions .to try to minimize serious consequences of falling . The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. This citation relates to complaint IN00453363. 3.1-45(a)(2)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for falls (Resident M and Resident D) and 2 of 3 residents reviewed for dialysis (Resident B and Resident H). Findings include: 1. On 3/12/25 at 10:06 A.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnoses included, but were not limited to, cognitive communication deficit. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/3/25, indicated Resident M was severely cognitively impaired, required substantial assistance from staff (staff do more than half of the work) for eating, toileting, bathing, and transfers, and had fallen since the most recent MDS Assessment (1/3/25). A Clinically at Risk Assessment, dated 3/11/25, indicated Resident M had fallen on 2/8/25, 2/25/25, 3/3/25, and 3/10/25. A Fall Risk Assessment, dated 2/26/25, indicated Resident M was alert and oriented x3 (to person, place, and time), and had no falls in the past 3 months. A Fall Risk Assessment, dated 3/11/25, indicated Resident M was alert and oriented x3, and had no falls in the past 3 months. During an interview on 3/13/25 at 11:37 A.M., the Director of Nursing (DON) indicated the fall on 3/3/25 was documented in error. 2. On 3/13/25 at 10:30 A.M., Resident B's clinical record was reviewed. Resident B was admitted on [DATE]. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident B was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Do not obtain blood pressure in the left arm, dated 2/24/25 Pre-Dialysis assessment to be completed prior to dialysis one time a day every Monday, Wednesday, Friday, dated 10/9/24 Post-Dialysis assessment to be completed after to dialysis one time a day every Monday, Wednesday, Friday, dated 10/9/24 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following dates and times included blood pressures documented obtained from the left arm: 2/26/25 7:00 A.M. 2/26/25 3:40 P.M. 2/28/25 3:07 P.M. 3/3/25 5:27 P.M. 3/5/25 3:02 P.M. 3/5/25 3:04 P.M. 3/7/25 9:28 A.M. 3/7/25 2:06 P.M. The clinical record lacked a pre or post dialysis assessment completed on 3/10/25. 48147 3. On 3/12/25 at 11:53 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/18/24, indicated Resident H was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, and received dialysis. Physician orders included, but were not limited to: Complete Post Dialysis Assessment in (name of electronic charting system) one time a day every Monday, Wednesday, and Friday, dated 6/5/24 The clinical record lacked a Post Dialysis Assessment for 3/7/25. The March 2025 Medication Administration Record (MAR) indicated a Post Dialysis Assessment had not been completed on 3/7/25 and included a chart code of other/see progress notes. The clinical record lacked a progress note related to the Post Dialysis Assessment on 3/7/25. On 3/13/25 at 9:00 A.M., the Director of Nursing (DON) provided a (name of dialysis center) Pre Treatment/Post Treatment form, dated 3/7/25. The form indicated the Pre Treatment Assessment was to be completed by the facility nurse and the Post Treatment Assessment was to be completed by the dialysis nurse. Both assessments were signed by the Assistant Director of Nursing (ADON). The completed Post Treatment Assessment did not include the name of the nurse from the dialysis center that completed the assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 10:15 A.M., the ADON indicated that it was her signature on both the Pre and Post Treatment Assessment forms, but she did not perform the Post Treatment Assessment herself. She indicated that she received the Post Assessment information by phone from the dialysis nurse. At that time, she indicated the Pre Treatment/Post Treatment form information was supposed to be entered into the Dialysis Assessment forms in (name of electronic charting system). On 3/13/25 at 1:47 P.M., the DON indicated that the clinical record lacked documentation to indicate the ADON received the Post Treatment Assessment information by phone on 3/7/25 and who performed the assessment. 4. On 3/12/25 at 12:08 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction, repeated falls, and muscle wasting and atrophy. The most recent Admission Minimum Data Set (MDS) Assessment, dated 1/21/25, indicated Resident D was cognitively intact, required substantial to maximal assistance (staff does more than half) with toileting, sit to stand transferring, and lying to sitting bed mobility, had no falls prior to admission, and required the use of a walker and a wheelchair. A current care plan, initiated 1/10/25, indicated Resident D was at risk for falls due to cerebral infarction, neuropathy, and arthritis. A fall risk assessment, dated 2/9/25, resulted in a score of 9.0 indicating Resident D was a low fall risk (a high fall risk was a score of 10.0 or greater). The assessment indicated the resident had one to two falls in the past three months and required the use of assistive devices for mobility (wheelchair, walker, cane, furniture). A nursing progress note, dated 2/28/25, indicated Resident D had an unwitnessed fall while attempting to self-transfer from his wheelchair to the bed. A fall risk assessment, dated 2/28/25, resulted in a score of 2.0 indicating Resident D was a low fall risk. The assessment indicated the resident had no falls in the past three months and did not require the use of assistive devices for mobility. An Interdisciplinary Team (IDT) Note, dated 3/3/25 at 9:10 A.M., indicated the IDT met to review Resident D's fall on 3/2/25. The clinical record lacked documentation to indicate Resident D sustained a fall on 3/2/25. An IDT Note, dated 3/5/25 at 9:24 A.M., indicated Resident D had an unwitnessed fall on 3/4/25 while attempting to get out of bed. A nursing progress note, dated 3/5/25 at 9:51 A.M., indicated Resident D's resident representative was notified of the fall yesterday. The clinical record lacked documentation to indicate an initial falls note and assessment had been completed after the fall on 3/4/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 1:50 P.M., the Administrator indicated she was not sure if the resident fell on [DATE] or 3/4/25 and would need to check on the information. On 3/13/25 at 8:35 A.M., the Administrator indicated that the fall that occurred on 3/4/25 was documented in an incident report which was not part of the clinical record, and that the nurse who filled out the incident report forgot to take the action step to include the fall information in the clinical record. On 3/13/25 at 11:06 A.M., the Director of Nursing (DON) indicated Resident D did not fall on 3/2/25 and the date was documented wrong in the IDT note. On 3/13/25 at 1:47 P.M., the DON indicated that staff needed to be re-educated on documentation. She indicated documentation that Resident D's resident representative was notified of the fall that occurred on 3/4/25 the same day, but the information in the incident report was not carried over into the clinical record. At that time, she indicated the fall risk assessments for Resident D and Resident M were filled out incorrectly resulting in an inaccurate fall risk score. The DON indicated the nurse that took blood pressures for Resident B documented the location of the blood pressure in error and did not take the blood pressure in her left arm On 3/13/25 at 1:50 P.M., the Administrator provided a current Charting and Documentation policy, revised 8/2024, that indicated The following information is to be documented in the resident medical record . Treatments or services performed; .Events, incidents or accidents involving the resident; and Progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . Documentation of procedures and treatments will include care-specific details, including: the name and title of the individuals(s) who provided the care. On 3/13/25 at 1:50 P.M., the Administrator provided a current End-Stage Renal Disease, Care of a Resident with policy, revised 8/2024, that indicated Education and training of staff includes, specifically .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . On 3/13/25 at 1:50 P.M., the Administrator provided a current Change in a Resident's Condition or Status policy, dated 8/2024, that indicated Our facility promptly notified the resident .and the resident representative of changes in the resident's medical/mental condition and/or status . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. This citation relates to complaint IN00453363. 3.1-50(a)(2)