STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING _____ B. WING _____	R-C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVIVE OF INDIANAPOLIS	**45 BEACHWAY DR INDIANAPOLIS, IN 46224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00365995 and IN00366036 completed on November 5, 2021.

This visit was in conjunction with a PSR to the Investigation of Complaints IN00362208, IN00363081, IN00363498, and IN00364184 completed on October 7, 2021. This visit included a PSR to a COVID-19 Focused Infection Control Survey completed on October 7, 2021.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00367460 completed on December 3, 2021.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00369620 completed on January 7, 2022. This visit included a PSR to a COVID-19 Focused Infection Control Survey completed on January 7, 2022.

This visit was in conjunction with a PSR to the Investigation of Complaints IN00370780 and IN00371831 completed on January 28, 2022.

This visit was in conjunction with Investigation of Complaint IN00373899. This visit included a COVID-19 Focused Infection Control Survey.

Complaint IN00373899- Unsubstantiated due to lack of evidence.

Complaint IN00362208 - Corrected.

Complaint IN00363081 - Corrected.

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING _____ B. WING _____	R-C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Complaint IN00363498 - Corrected. Complaint IN00364184 - Corrected. Complaint IN00365995 - Corrected. Complaint IN00366036 - Corrected. Complaint IN00367460 - Corrected. Complaint IN00369620 - Corrected. Complaint IN00370780 - Corrected. Complaint IN00371831 - Corrected. Survey dates: March 8, 9, and 10, 2022 Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 1 Medicaid: 78 Other: 5 Total: 84 Envive of Indianapolis was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to Complaints IN00365995 and IN00366036. Quality review completed on March 16, 2022.	{F 000}		