PRINTED:	01/13/2022
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/03/2021 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG F 0000 Bldg. 00 This visit was for the Investigation of Complaints F 0000 IN00366939, IN00367864, IN00367460, IN00367468, and IN00368111. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00366939 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00367864 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00367460 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725 and F741. Complaint IN00367468 - Unsubstantiated due to lack of evidence. Complaint IN00368111 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 30, December 1, 2, and 3, 2021. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 6 Medicaid: 81 Other: 3 Total: 90 TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 12/03/2021	
	PROVIDER OR SUPPLIE		45 BE	tt address, city, state, zip cod EACHWAY DR ANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIE	7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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	
	These deficiencies accordance with 4	reflect State Findings cited in 10 IAC 16.2-3.1.				
	Quality review co	mpleted on December 13, 2021.				
F 0725 SS=E Bldg. 00	with the appropri sets to provide n to assure resider maintain the high mental, and psyc resident, as dete assessments and considering the n diagnoses of the in accordance wi required at §483	cient Staff. have sufficient nursing staff ate competencies and skills ursing and related services at safety and attain or nest practicable physical, chosocial well-being of each rmined by resident d individual plans of care and number, acuity and facility's resident population th the facility assessment .70(e).				
	services by suffic following types o basis to provide in accordance wi (i) Except when y this section, licer	personnel, including but not				
	paragraph (e) of designate a licer charge nurse on Based on observat review, the facility was scheduled and	accept when waived under this section, the facility must used nurse to serve as a each tour of duty. ion, interview, and record a failed to ensure sufficient staff d available to provide a clean, elike environment, meet basic	F 0725	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	12/17/202	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/03/2021 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE activities of daily living needs, and provide practice: person-centered specialized programming for 4 of 4 days of observations on the Mental Health The facility will adhere Wellness unit and 12 of 12 residents randomly to the ppd and review the observed and/or interviewed the secured Mental staffing int he facility daily to Health Wellness unit (Residents AH, AG, W, AJ, meet the need of that facility. AK, AL, U, H, AO, AP, AQ, and F) How other residents having the Findings include: potential to be affected by the same deficient practice will be On 11/30/21 from 2:25 p.m. until 3:10 p.m., the identified and what corrective secured Mental Health Wellness (MHW) unit was action(s) will be taken: initially observed and the finally was observed: All residents have a. Upon entrance to the unit, there was a strong potential to be affected. Current odor of urine and musty body odor at the front of staff will receive specific education the D hall. Several residents were observed to directly related to Mental walk up and down the halls or sit in their Wellness Unit (MWU). wheelchair in the halls with their eyes closed. The activity room door was closed, and locked. What Measures will be put into b. At 2:31 p.m., Resident AH was observed as she place and what systemic sat in a chair at the back of D-hall. Her pants were changes will be made to ripped and stained. She wore a baggy t-shirt ensure that the deficient which was also stained. Her hair appeared greasy, practice does not recur: it was tangled and matted on one side. Resident AH indicated the shower room did not work Mental Wellness Unit anymore, and she washed herself with a Director will be implementing washcloth when she wanted to. training within 30 days of hire and annually for all who work MWU. c. At 2:32 p.m., Resident AG, who was seated across from Resident AH, indicated she thought How will the corrective she had seen a mouse in her room a few days ago, action(s) will be monitored to but she was happy because she thought it was a ensure the deficient practice sign of good luck. She indicated, "if a mouse can will not recur, i.e., what quality survive back here, we can too." Resident AG wore assurance program will be put a large sleep dress, that was thin and faded she into place: wore socks that were very dirty and had a hole in the heel. There was a dried ring of food or Executive beverage stained across her lips and mouth. Director/Designee will complete 5 Z0RV11 Event ID: Facility ID: 000032 Page 3 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	00	_	PLETED
		155077	B. WING		12/03/2021	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP C	COD	
	OF INDIANAPOLI	6		EACHWAY DR NAPOLIS, IN 46224		
EINVIVE		3				
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIC
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	1.4.0.05			random interviews with	•	
	-	the way to observe Resident		– Fri) for four (4) week		
		ent W stopped outside his door		times (3x) a week for t	-	
		eeded help with his bathroom.		four (4) weeks; two-tim		
		observed in poor disrepair, ound the base of his toilet and		week for the following		
		et wash clothes and towels		weeks; once a week (
	-	, soiled with a yellow/brown		following four (4) week times (2x) per month f		
		nt W indicated his bathroom		following eight (8) wee		
		ction and he wanted to know		results of these audits		
		fixed. There was a strong body		reviewed by the facility		
		lent W, and he indicated he		Assurance Performan	-	
		nower because the tub did not		Improvement (QAPI) o		
		were too busy to let him in the		patterns, trends and co		
		pants were too big, he held		recommendations for		
		and and indicated he did not		monitoring and improv		
	-	ore a pair of shoes that had a		100% compliance is a		
	hole in the toe of l					
	e. At 2:42 p.m., R	esident AJ was observed in his				
	_	wheelchair beside his bed. The				
	carpet at the foot of	of his bed was badly stained,				
	and there were for	od crumbs on the floor. His				
	bathroom was obs	erved to have splattered fecal				
	matter on the toile	t bowl and the back of the seat.				
	Resident AJ indic	ated, the "guy across the way"				
	who shared the ba	throom always made a mess,				
	but there was no o	ne to clean it up.				
	f. At 2:52 p.m., Re	esident AK stood in his doorway				
	and indicated he v	vas not "doing so good." He				
		ision (TV) did not work, and no				
		m call his brother. There was				
		skin observed on his eyebrows				
		his ears. He had a				
		rd with flaked dry skin and food				
		lips. His clothes were dirty,				
	and he did not ren	nember his last shower.				
	g. At 3:08 p.m., R	esident AL was observed. He				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/03/2021 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE long. Residents would get upset and lose their patience. The food would be cold, medicine would be late, and the behaviors would "ramp up." It was like a vicious cycle. On top of all the required responsibilities the CNAs had to complete, there was not enough housekeeping so CNAs would have to stop what they were doing and clean as they went through the day. During an anonymous interview, it was indicated, MHW unit desperately needed more staff. The limited staff they did have could not spend enough time with residents who really need the extra encouragement to clean up, or get up, and get dressed. There was a higher risk of accidents because if a CNA was in a room helping someone in the bathroom, and another resident out there decided to start a fight, what could they do? During an interview on 12/3/21 at 8:55 a.m., the MHW Unit Manager (UM) 26 indicated there had been some changes since the new facility ownership had taken over. The intent of the MHW unit however, had not changed. The intent of the unit was to provide safety for the residents, quality of life and to help manage any inappropriate behaviors that could be harmful to themselves or others. All together there were 54-56 residents on the unit which was C and D hall combined. Every resident on the unit had the potential to have serious behavioral outburst, which was one of the primary reasons they would have been admitted to the unit. The facility tried to train staff to spot early warning signs of behaviors or outbursts and intervene before it became problematic. The MHW unit was staffed according to direct care staff per patient, per day and in the last several weeks there had been some adjustments to the staffing schedule. UM 26 was aware there were some staff concerns related to Z0RV11 Event ID: Facility ID: 000032 Page 11 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	Operating Office: recently been acq building had been changes were still taking over the bu- changes, in leade the other departm unit was to provia accountability to residents on the u- heard there were and the new sche the previous sche staff and not other new scheduler was consistency and t to following to th day (PPD). Typic staffed around 2.1 the MHW unit, th closer to 3.3 PPD like, 2.2 for CNA (RN and LPNs co On 12/3/21 at 8:5 of the most recen 2/23/21. The purp tool was to determ necessary to care during day-to-day The Facility Assessm- total number of b 80 to 90 residents	ew on 12/3/21 at 12:10 p.m., Chief r (COO) indicated the facility had uired by a new owner. This a difficult acquisition and many l underway. The priority in ailding had been to make staffing rship mainly but also throughout tents. The intent of the MHW de programming and staffing manage the behaviors of mit. The COO indicated he had some complaints about staffing dule. It was his understanding dule was friendly with some rs and scheduled accordingly. A as hired to ensure more ake a more aggressive approach e direct care staff per patient, per ally, a building like this might be 8-2.85 PPD, but with 88 beds in his building was budgeted for 9. Separated out, that would look s, 0.65 for LPNs, and 0.35 for RNs, ombined it would be 1.0) 3 a.m., the ADM provided a copy t Facility Assessment tool dated pose of the facility assessment nine what resources were for residents competently y operations and emergencies. essment tool was used to make ne direct care staff needs as well apabilities to provide care and sidents in the facility. The ent indicated the facility had 160 eds, but the average census was is with special consideration and to 65 of those residents having				

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	and psychosocia residents with a post-traumatic s been identified i conducted pursu [as linked to hisi post-traumatic s implemented be (Phase 3)]. §483.40(a)(2) In non-pharmacolo Based on observa review, the facilit were scheduled a comfortable, horr activities of daily person-centered s 14 residents rand Health Wellness AK, AL, U, H, A Findings include: During an anonyn since the new corr allowed one CNA Health Wellness work back there. and residents. CN got breaks, and st instance, that mot breakfast trays by trays got to room had run out and th and the behaviors and scream at sta	gical interventions. tion, interview and record y failed to ensure competent staff and available to provide a clean, welke environment, meet basic living needs, and provide pecialized programming for 14 of omly observed on the Mental unit (Residents AH, AG, W, AJ, O, AP, AQ, AN, AM, and F)	F 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Unfortunately, not all residents could be identified in 2567. Mental Wellness Unit Director has been working with residents to change clothes, shower, and shave. How other residents having th potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have potential to be affected. Curren	ne 9 9	

TAG REGULATORY OR LISC DENTIFYING INFORMATION TAG CREAR ADDACES DATE aid would have to do everything: get residents up, dressed, cleaned and ready for the day, pass out meal trays, pick up meal trays, since housekceping staff was short, aids would have to help clean rooms and hathrooms, chart whatever they could, and supervise residents with serious behaviors. It was claotic, stressful, and ummangeable. Several CNAs had put in applications elsewhere because they were afridi, they would get hurt, or get fired for not kceping up. In particular, Residents U, H, AO, and AP were very difficult, and time consuming. Resident U was an "accident waiting to happen," he had a "really bad temper", and a lot of the other residents dud not like him either. The staff were more stressed out and fussed with cardon dher soletide. Exclusive for and the schedule. They had complained to management but was told "corporate worth allow it." Staff was burned out and the residents could sense it and would take advantage of it. There had been an increase of behaviors since the new schedule, but what could the staff do about it? There simply was not enough supervision. Because of the type of residents on the unit, most of them needed a lot of extra time and encouragement to get even the simplest things like showers and clothes changed. If you have aids who are in a hurry to get from one thing to the next just to keep up, then lots of things get missed. Residents were not getting showers like the needed, men could hig et shaved, and some residents could not be helped out of bed. It was indicated, staff had received some behavioral management training back when the unit first opened, but nothing since then, and nothing since then we company had taken over. Total week (the following four (4) weeks; then three to patients, staff wather over. During an anonymous inte		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C	(X3) DATE SURVEY COMPLETED 12/03/2021	
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lots of fights had to be stopped between I I I recommendations for process I			to be stopped between		recommendations for process		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	Α.	MULTIPLE CONSTRUCTION (X3) DATE SU BUILDING 00 WING 12/03/20			PLETED		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	Ī		(X5)		
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TAG	,	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE		
into		not know what to do with		into	monitoring and improv	ement until	DITL		
		ry to keep him in his room			100% compliance is a				
	-	tart a fight with anyone.				Chicved			
		get out of his room, and he was							
	-	e would run up on other							
		them. It seemed like all staff							
		he resident coffee and let them							
	•	d to pass breakfast trays, but							
		n it would take too long.							
		t upset and lose their patience.							
		cold, medicine would be late,							
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		op of all the required							
	-	CNAs had to complete, there							
	-	isekeeping so aids would							
	-	ney were doing and clean as							
	-	he day. It was indicated, the							
		vided any special mental health							
		oon hire, or when the new							
		. Staff just relied on previous							
	experience.								
	. .	ous interview, it was indicated							
		kept promises about new							
		eling, and better staffing with							
	-	w to handle behaviors.							
		iffing on the unit. It was not							
		s. There was nothing for the							
		the activity room closed, staff							
		ect behaviors as needed							
		busy with call lights, toileting,							
	passing and picking	g up trays, charting							
	housekeeping, etc.								
	On 11/30/21 from 2	2:25 p.m. until 3:10 p.m., the							
	Mental Health Well	ness (MHW) unit was initially							
	observed. The follo	wing was observed:							
		the unit, there was a strong							
	odor of urine and m	usty body odor at the front of							
	the D hall. Several		1		1		1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/03/2021 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE walk up and down the halls or sit in their wheelchair in the halls with their eyes closed. The activity room door was closed, and locked. b. At 2:31 p.m., Resident AH was observed as she sat in a chair at the back of D-hall. Her pants were ripped and stained. She wore a baggy t-shirt which was also stained. Her hair appeared to be greasy, it was tangled and matted on one side. Resident AH indicated the shower room did not work anymore, and she washed herself with a washcloth when she wanted to. c. At 2:32 p.m., Resident AG, who was seated across from Resident AH, indicated she thought she had seen a mouse in her room a few days ago, but she was happy because she thought it was a sign of good luck. She indicated, "if a mouse can survive back here, we can too." Resident AG worse a large sleep dress, that was thin and faded, she wore socks that were very dirty and had a hole in the heel. There was a dried ring of food or beverage stained across her lips and mouth. d. At 2:35 p.m., on the way to observe Resident AG's room, Resident W stopped outside his door and indicated he needed help with his bathroom. His bathroom was observed in poor disrepair, there was water around the base of his toilet and several soaking wet wash clothes and towels inside the bathtub, soiled with a yellow/brown substance. Resident W indicated his bathroom was under construction and he wanted to know when it would be fixed. There was a strong body odor around Resident W, and he indicated he could not take a shower because the tub did not work, and the aids were too busy to let him in the shower room. His pants were too big, he held them up with his hand and indicated he did not have a belt. He worse a pair of shoes that had a Z0RV11 Facility ID: 000032 Event ID: Page 18 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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PRINTED: 01/13/2022 FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION hold in the toe of his left shoe. e. At 2:42 p.m., Resident AJ was observed in his room. He sat in a wheelchair beside his bed. The carpet at the food of his bed was badly stained, and there were food crumbs on the floor. His bathroom was observed to have splattered fecal matter on the toilet bowl and the back of the seat. Resident AJ indicated, the guy across the way	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
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	matter on the toilet bowl and the back of the seat. Resident AJ indicated, the guy across the way			
	Resident AJ indicated, the guy across the way			
	who shared the bathroom always made a mess,			
	but there was no one to clean it up.			
	f. At 2:52 p.m., Resident AK stood in his doorway			
	and indicated he was not doing so good. He			
	indicated his TV did not work, and no one would			
	help him call his brother. There was dried and			
	flaking skin observed on his eyebrows and the			
	outside of his ears. He had a long-stubbled beard			
	with flaked dry skin and food crumbs around his			
	lips. His clothes were dirty, and he indicated he			
	did not remember his last shower.			
	g. At 3:08 p.m., Resident AL was observed. He			
	was reclined in his bed, which was in a low			
	position. He was alone in the room, with no T.V.			
	or radio on. The window blinds were closed, and			
	there were no personal items or pictures on the			
	wall. He wore only a hospital gown. His arms were			
	ashy and flaky. He had long stubbled facial hair,			
	and the hair on his head was uncombed, and			
	scruffy. He had only a thin sheet across his waist			
	and his feet were uncovered. His toenails were			
	long, thick, and jagged where sections had broken			
	off. Resident AL indicated he wanted to get out of			
	bed, but no one had helped him yet.			
	During an interview on 11/30/21 at 2:58 p.m.,			
	Registered Nurse (RN) 13 indicated, she had			
	worked at the facility for a couple months and was still learning about the residents. It was a			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/03/2021 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR ENVIVE OF INDIANAPOLIS INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE behavioral health unit, so it was important to supervise and keep an eye on the residents. There were not a lot of "heavy-care" residents on the unit so many would get themselves up and walk around, but there was not much for the residents to do on the unit. The activity room was closed. She did not know why. She had not been provided any special education on mental health wellness or been given any history review of the resident's and their behaviors. On 11/30/21 at 4:37 p.m., Resident AL was observed a second time. He remained in bed as described above. He indicated dinner trays would be out soon, so he would probably not be able to get out of bed for the rest of the evening. On 12/1/21 from 11:00 a.m., until 11:15 a.m., the MHW unit was observed a second time. Residents AH, AG, AK, and W remained in the same clothes as the previous day. Other residents wandered around the unit. The activity room door was closed, and locked, the lights were off. Resident W walked up and down the D hall, holding his pants up with his hands. Resident AL remained in his bed. His eyes were closed. His hospital gown was soiled with a spilled substance down the front of his chest. During an anonymous interview, it was indicated no one wanted to be scheduled for the MHW unit since the new schedule only staffed one CNA on each hall. Many of the CNAs did not feel safe. It was "pure chaos" to work on the unit. During an anonymous interview, it was indicated, even though the residents on MHW could walk and talk better than those outside of the unit, there were still a lot of behaviors to be careful of on the unit. If there was only one CNA on the hall, Z0RV11 Event ID: Facility ID: 000032 Page 20 of 26 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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