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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00366939, IN00367864, IN00367460, IN00367468, and IN00368111. This visit included a COVID-19 Focused Infection Control Survey.<br><br>Complaint IN00366939 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00367864 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Complaint IN00367460 - Substantiated. Federal/State deficiencies related to the allegations are cited at F725 and F741.<br><br>Complaint IN00367468 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00368111 - Substantiated. No deficiencies related to the allegations are cited.<br><br>Survey dates: November 30, December 1, 2, and 3, 2021.<br><br>Facility number: 000032<br>Provider number: 155077<br>AIM number: 100273330<br><br>Census Bed Type:<br>SNF/NF: 90<br>Total: 90<br><br>Census Payor Type:<br>Medicare: 6<br>Medicaid: 81<br>Other: 3<br>Total: 90 | F 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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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| | These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 13, 2021. | | | |
| F 0725<br>SS=E<br>Bldg. 00 | 483.35(a)(1)(2)<br>Sufficient Nursing Staff<br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>Based on observation, interview, and record review, the facility failed to ensure sufficient staff was scheduled and available to provide a clean, comfortable, homelike environment, meet basic | F 0725 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 12/17/2021 |

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| | activities of daily living needs, and provide person-centered specialized programming for 4 of 4 days of observations on the Mental Health Wellness unit and 12 of 12 residents randomly observed and/or interviewed the secured Mental Health Wellness unit (Residents AH, AG, W, AJ, AK, AL, U, H, AO, AP, AQ, and F)<br><br>Findings include:<br><br>On 11/30/21 from 2:25 p.m. until 3:10 p.m., the secured Mental Health Wellness (MHW) unit was initially observed and the finally was observed:<br><br>a. Upon entrance to the unit, there was a strong odor of urine and musty body odor at the front of the D hall. Several residents were observed to 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.<br><br>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 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.<br><br>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 wore 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. | | **practice:**<br><br>**The facility will adhere to the ppd and review the staffing int he facility daily to meet the need of that facility.**<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>All residents have potential to be affected. Current staff will receive specific education directly related to Mental Wellness Unit (MWU).<br><br>**What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Mental Wellness Unit Director will be implementing training within 30 days of hire and annually for all who work MWU.<br><br>**How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Executive Director/Designee will complete 5 | |

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| | 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 wore a pair of shoes that had a hole in the toe of his left shoe.<br><br>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 foot 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" who shared the bathroom always made a mess, but there was no one to clean it up.<br><br>f. At 2:52 p.m., Resident AK stood in his doorway and indicated he was not "doing so good." He indicated his television (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 did not remember his last shower.<br><br>g. At 3:08 p.m., Resident AL was observed. He | | random interviews with staff (Mon – Fri) for four (4) weeks; then three times (3x) a week for the following four (4) weeks; two-time (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved | |

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| | was reclined in his bed, which was in a low position. He was alone in the room, with no TV 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.<br><br>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.<br><br>On 11/30/21 at 10:07 a.m., Certified Nursing Aide (CNA) 9 indicated the facility was short on staff. "We need help, we need help."<br><br>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.<br><br>On 12/2/21 from 8:50 a.m., until 9:25 a.m., the MHW unit was observed a third time and the following was observed:<br><br>a. At 8:50 a.m., Resident AK was observed as he | | | |

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| | stood in the doorway of his room. He wore the same clothes as the days before. His hair remained uncombed, his facial hair was still long and stubbled, with food crumbs.<br><br>b. At 8:58 a.m., Resident U was observed. He walked from his bathroom to his bed. He wore only a brief, and a baggy white t-shirt. The sheets on his bed were observed soiled with a large yellow stain, which Resident U laid back down on top of the sheets.<br><br>During an anonymous interview, it was indicated there was not enough staff to help with the MHW residents and no one wanted to be scheduled for the MHW unit since the new schedule only staffed one Certified Nursing Assistants (CNA) on each hall. Many of the CNAs did not feel safe, and it was too much work for one person. So many things were not able to get done. Residents went without showers and changing clothes because staff could not spend the time they needed with each resident. It used to be at least 2 CNAs on each C and D hall, now only one was allowed. It was "pure chaos" to work on the unit.<br><br>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. If there was only one CNA on the hall, and the nurse was out to pass medication, one CNA was not able to supervise and assist all the residents. A lot of things just would not get done, and there was a higher risk for accidents or fights between residents because there wasn't enough staff supervision.<br><br>During an anonymous interview, it was indicated, the administrative staff indicate there were other | | | |

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| | nurses and aids in the building who can come and help, but the reality was the other staff did not help because they had their own assignments to do. If all the "heavy care" and Hoyer lift residents were on B hall, the aids were busy just trying to get their care completed, and Hoyer lift residents needed two CNAs at all times.<br><br>During an anonymous interview, it was indicated since the new change of only allowing one CNA on each hall for the MHW unit, no one wanted to work back there. It was "dangerous" for the staff and residents. CNAs worked hard all day, never got breaks, and still could not keep up. For instance, that morning one CNA had to pass all 32 breakfast trays by themselves. By the time the last trays got to rooms, the food was cold, the coffee had run out and the residents had lost their patience, and the behaviors started. They would hit, kick, and scream at staff. Some male residents would even take their urinals and throw them at the CNAs. One CNA would have to do everything: get residents up, dressed, cleaned and ready for the day, pass out meal trays, pick up meal trays. Also, since housekeeping staff was short, CNAs would have to help clean rooms and bathrooms, chart whatever they could, and supervise residents with serious behaviors. It was chaotic, stressful, and unmanageable. Several CNAs had put in applications elsewhere because they were afraid, they would get hurt, or get fired for not keeping 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 did not like him either. The staff were more stressed out and fussed with each other about the schedule. They had complained to management but were told "corporate won't allow it." Staff was burned out | | | |

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| | and the residents could sense it and would take advantage of it. There had been an increase of behaviors since the new scheduling. 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 CNAs who were in a hurry to get from one thing to the next just to keep up, then lots of things got missed. Residents were not getting showers like they needed, men couldn't get shaved, and some residents could not be helped out of bed.<br><br>During an anonymous interview, it was indicated "a lot" of staff walked out after the new company took over the facility because they were told all these great things would happen, and nothing did. Instead of keeping promises about new equipment, re-modeling, and better staffing with more training on how to handle behaviors, they cut staffing on the unit. It was not safe for the residents. There was nothing for the residents to do with the activity room closed, and CNAs could not help redirect behaviors as needed because they were busy with call lights, toileting, passing and picking up trays, charting, housekeeping, etc.<br><br>On 12/3/21 at 8:25 a.m., Resident AQ was observed from the hallway through the open bedroom door. He sat on the edge of his bed, and his wheelchair was at the foot of his bed just out of arms reach. He called out for help to get put in his wheelchair. There was a nurse on the medication cart, preparing a medication cup, but was interrupted by a dietary aid who needed a piece of paper signed off on. The nurse put her medication in the cart, locked it, and stepped away to the nurse's station with the dietary aid. There was no CNA on the hall. At 8:29 a.m., Resident | | | |

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| | AQ continued to call out, but began to scootch closer to the edge of his mattress to reach his wheelchair. He leaned over and looked as if he might fall. At this time a CNA exited another resident room and was requested to please check on Resident AQ. CNA 9 indicated he heard AQ yell which was why he came out to check on him. CNA 9 quickly entered the room and assisted Resident AQ into his wheelchair. CNA 9 indicated they had been in another resident's room trying to get them to the toilet when they heard Resident AQ yelling to get in his wheelchair. Because AQ was an impatient resident, the CNA knew they needed to leave what they were doing (assisting another resident to the toilet) to get to AQ as fast as possible.<br><br>On 12/3/21 at 8:40 a.m., Residents AO and AP's room was observed. The room had an overwhelming pungent smell of body odor and musty carpet. The carpet was stained with spills and covered with food crumbs. Residents AO and AP were observed laying on top of their respective beds in filthy clothes. Both residents had long shaggy hair that was greasy and uncombed. The bathroom was observed. Upon opening the bathroom door, a stronger odor of feces wafted out. There were feces caked on the floor with shoeprints that tracked out of the room. The toilet bowl, rim, seat, and surrounding bathroom walls were splattered with feces.<br><br>On 12/3/21 at 8:53 a.m., Resident AL was observed. He remained in bed. He wore the same stained hospital gown. He had slipped down sideways in bed, and his shoulders were almost to the edge of his mattress. He indicated no one had helped him yet that morning and he had not had breakfast. He still wanted to get out of bed but that probably would not happen. | | | |

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| | On 12/3/21 at 8:53 a.m., UM 26 provided a copy of C and D hall (MHW unit) CNA assignment sheets for the month of August which were reviewed at this time. The C Hall Assignment sheet included 30 residents; the D hall sheet included 23 residents. Instructions on the assignment sheet indicated, "fill portable 02 [oxygen] tanks at 5am, 11am, and 4pm; Turn and reposition every 2 hours; Linen change every shower day; Lotion to skin and ROM [Range of Motion] with ADL's [activities of daily living]; oral care after meals and at HS[ hour of sleep]; Remove all dentures and hearing aids at HS; 2 person transfer for Hoyer lift; Float heels in bed; TED hose on in a.m. off in p.m...."<br><br>During an anonymous interview, it was indicated the MHW staff needed more help. It was already almost 9:00 a.m., and not many medication administrations had been completed because the nurse was new, from an agency, and did not know the residents well. There had been a Qualified Medication Aid (QMA) in the middle section, but they got pulled to go help on B hall.<br><br>During an anonymous interview, it was indicated, the MHW unit was badly under-staffed, and accidents such as residents falling out of bed were waiting to happen. The behaviors on the unit seemed out of control, and lots of fights had to be stopped between residents. Staff did not know what to do with Resident U except try to keep him in his room because he would start a fight with anyone. Resident H would get out of his room, and he was younger and fast, he would run up on other residents and scare them. It seemed like all staff could do was give the residents coffee and let them smoke. The CNAs had to pass breakfast trays, but with only one person it would take too | | | |

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| | 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.<br><br>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?<br><br>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 | | | |

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| | the new staffing schedule, but the staff did not give themselves enough credit, plus, several of the "heavy-care" residents had been moved off the unit.<br><br>On 12/3/21 at 9:17 a.m., Resident AJ called out form his room. UM 26 stopped and entered his room. Resident AJ indicated the CNA just came in and dropped off his breakfast tray which was left on his overbed table at the foot of his bed. Resident AJ sat in his wheelchair beside his bed, the breakfast tray out of reach. UM 26 moved the tray over and helped set up his tray.<br><br>On 12/3/21 at 9:20 a.m., CNA 9 approached UM 26 and asked where the vacuum was because he needed to clean a resident's room.<br><br>During an interview, on 12/1/21 at 10:06 a.m., the Executive Director indicated the facility had 4 nursing positions open and no CNA positions open. The facility was fully staffed except for the 4 nursing positions.<br><br>On 12/1/21 at 10:27 a.m., Resident F indicated she did not receive the help she needed because they were not enough staff in the building.<br><br>During an interview, on 12/1/21 at 11:28 a.m., CNA 24 indicated she was the only CNA for one plus hallways which was about 30 residents. These residents were complex care with diseases and mental illnesses with aggressive behaviors. If the residents got into a fight, being one person, she would be unable to stop them. She had about 5 resident who were total care residents. There were days the total care people could not get up because there was not enough time. She indicated the facility hired for all the CNA positions, but the facility would not add the CNAs to the schedule. | | | |

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| | During an interview on 12/3/21 at 12:10 p.m., Chief Operating Officer (COO) indicated the facility had recently been acquired by a new owner. This building had been a difficult acquisition and many changes were still underway. The priority in taking over the building had been to make staffing changes, in leadership mainly but also throughout the other departments. The intent of the MHW unit was to provide programming and staffing accountability to manage the behaviors of residents on the unit. The COO indicated he had heard there were some complaints about staffing and the new schedule. It was his understanding the previous schedule was friendly with some staff and not others and scheduled accordingly. A new scheduler was hired to ensure more consistency and take a more aggressive approach to following to the direct care staff per patient, per day (PPD). Typically, a building like this might be staffed around 2.8-2.85 PPD, but with 88 beds in the MHW unit, this building was budgeted for closer to 3.3 PPD. Separated out, that would look like, 2.2 for CNAs, 0.65 for LPNs, and 0.35 for RNs, (RN and LPNs combined it would be 1.0)<br><br>On 12/3/21 at 8:53 a.m., the ADM provided a copy of the most recent Facility Assessment tool dated 2/23/21. The purpose of the facility assessment tool was to determine what resources were necessary to care for residents competently during day-to-day operations and emergencies. The Facility Assessment tool was used to make decisions about the direct care staff needs as well as the facilities capabilities to provide care and services to the residents in the facility. The Facility Assessment indicated the facility had 160 total number of beds, but the average census was 80 to 90 residents with special consideration and treatments for 55 to 65 of those residents having | | | |

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| | specific mental health/behavioral health conditions. The staffing plan of the Facility Assessment indicated it had been determined on average: For direct care, licensed nursing staff, 85 residents equaled 114.75 hours of nursing care and the allowed PPD was 1.35 (as compared to the weekly averaged PPD noted above at 0.77). For direct care nurse aids, 85 residents equaled 170 hours of resident care and the allowed PPD was 2.0.<br>On 12/3/21 at 8:53 a.m., the Administrator (ADM) provided a copy of current, but undated facility policy titled, "Staffing Policy." The policy indicated, "Envive of Indianapolis... provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment...."<br><br>This Federal tag related to Complaint IN00367460.<br><br>3.1-17(a) | | | |
| F 0741 SS=E Bldg. 00 | 483.40(a)(1)(2)<br>Sufficient/Competent Staff-Behav Health Needs<br>§483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate | | | |

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| | training and supervision for:<br><br>§483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)].<br><br>§483.40(a)(2) Implementing non-pharmacological interventions.<br>Based on observation, interview and record review, the facility failed to ensure competent staff were scheduled and available to provide a clean, comfortable, homelike environment, meet basic activities of daily living needs, and provide person-centered specialized programming for 14 of 14 residents randomly observed on the Mental Health Wellness unit (Residents AH, AG, W, AJ, AK, AL, U, H, AO, AP, AQ, AN, AM, and F) Findings include:<br><br>During an anonymous interview, it was indicated, since the new company had taken over and only allowed one CNA on each hall for the Mental Health Wellness (MHW) unit, no one wanted to work back there. It was dangerous for the staff and residents. CNAs worked hard all day, never got breaks, and still could not keep up. For instance, that morning, one aid had to pass all 32 breakfast trays by themselves. By the time the last trays got to rooms, the food was cold, the coffee had run out and the residents lost their patience, and the behaviors started. They would hit, kick, and scream at staff. Some male residents would even take their urinals and throw at the aids. One | F 0741 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Unfortunately, not all residents could be identified in 2567. Mental Wellness Unit Director has been working with residents to change clothes, shower, and shave.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>All residents have potential to be affected. Current | 12/17/2021 |

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| | 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 housekeeping staff was short, aids would have to help clean rooms and bathrooms, chart whatever they could, and supervise residents with serious behaviors. It was chaotic, stressful, and unmanageable. Several CNAs had put in applications elsewhere because they were afraid, they would get hurt, or get fired for not keeping 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 did not like him either. The staff were more stressed out and fussed with each other about the schedule. They had complained to management but was told "corporate won't 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 couldn't get 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 the new company had taken over.<br><br>During an anonymous interview, it was indicated the MHW unit was badly under-staffed, and the behaviors on the unit seemed out of control, and lots of fights had to be stopped between | | staff will receive specific education directly related to Mental Wellness Unit (MWU).<br><br>**What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Mental Wellness Unit Director will be implementing training within 30 days of hire and annually for all who work MWU.<br><br>**How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Executive Director/Designee will complete 5 random interviews with staff (Mon – Fri) for four (4) weeks; then three times (3x) a week for the following four (4) weeks; two-time (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process | |

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| | residents. Staff did not know what to do with Resident U except try to keep him in his room because he would start a fight with anyone. Resident H would get out of his room, and he was younger and fast, he would run up on other residents and scare them. It seemed like all staff could do was give the resident coffee and let them smoke. The aids had to pass breakfast trays, but with only one person it would take too 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 aids would have to stop what they were doing and clean as they went through the day. It was indicated, the facility had not provided any special mental health wellness training upon hire, or when the new company took over. Staff just relied on previous experience.<br><br>During an anonymous interview, it was indicated the facility had not kept promises about new equipment, re-modeling, and better staffing with more training on how to handle behaviors. Instead, they cut staffing on the unit. It was not safe for the residents. There was nothing for the residents to do with the activity room closed, staff could not help redirect behaviors as needed because they were busy with call lights, toileting, passing and picking up trays, charting housekeeping, etc.<br><br>On 11/30/21 from 2:25 p.m. until 3:10 p.m., the Mental Health Wellness (MHW) unit was initially observed. The following was observed:<br>a. Upon entrance to the unit, there was a strong odor of urine and musty body odor at the front of the D hall. Several residents were observed to | | monitoring and improvement until 100% compliance is achieved | |

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| | 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.<br><br>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.<br><br>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.<br><br>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 | | | |

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| | hold in the toe of his left shoe.<br><br>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 who shared the bathroom always made a mess, but there was no one to clean it up.<br><br>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.<br><br>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.<br><br>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 | | | |

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| | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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, | | | |

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| | and the nurse was out to pass medication, one CNA could not supervise and assist all the residents, so a lot of things just would not get done, and there was a higher risk for accidents or fights between residents because there wasn't enough staff.<br><br>On 12/2/21 from 8:50 a.m., until 9:25 a.m., the MHW unit was observed a third time. The following was observed:<br><br>a. At 8:50 a.m., Resident AK was observed as he stood in the doorway of his room. He wore the same clothes as the days before. His hair remained uncombed, his facial hair was still long and stubbled, with food crumbs.<br><br>b. At 8:52 a.m., Resident AM stood at the C-hall nurses' station. She indicated she was waiting to go outside to smoke, that's all there was all there was to do: Smoke and get her money to buy food. The activity room was closed because the window was broken. There was a problem with the business office because she had not gotten her money at the first of the month like she was supposed to. There was a strong body odor that came from Resident AM, and she indicated she had not showered in several days because the CNAs were too busy to help or open the door for her.<br><br>c. At 8:54 a.m., Resident AN, who also waited at the C-hall nurses' station to go smoke, indicated he had not received his money either. He wanted to buy personal items and shop. There was nothing else to do except wait for food and smoke.<br><br>d. At 8:58 a.m., Resident U was observed. He walked from his bathroom to his bed. He wore only a brief, and a baggy white t-shirt. The sheets | | | |

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| | on his bed were observed soiled with large yellow stains, which Resident U laid back down on top off.<br><br>On 12/3/21 at 8:25 a.m., Resident AQ was observed from the hallway through the open bedroom door. He sat on the edge of his bed, and his wheelchair was at the foot of his bed just out of arms reach. He called out for help to get put in his wheelchair. There was a nurse on the medication cart, preparing a medication cup, but was interrupted by a dietary aid who needed a piece of paper signed off on. The nurse put her medication in the cart, locked it, and stepped away to the nurse's station with the dietary aid. There was no CNA on the hall.<br><br>At 8:29 a.m., Resident AQ continued to call out, but began to scootch closer to the edge of his mattress to reach his wheelchair. He leaned over and looked as if he might fall. At this time a CNA exited another resident room and was requested to please check on Resident AQ. CNA 9 indicated he heard AQ yell which was why he came out to check on him. CNA 9 quickly entered the room and assisted Resident AQ into his wheelchair. CNA 9 had been in another resident's room trying to get them to the toilet when he heard Resident AQ yelling to get in his wheelchair. Because AQ was an impatient resident, he knew they needed to leave what he was doing (assisting another resident to the toilet) to get to AQ as fast as possible.<br><br>On 12/3/21 at 8:40 a.m., Resident AO and AP's room was observed. The room had an overwhelming pungent smell of body odor and musty carpet. The carpet was stained with spills and covered with food crumbs. Resident AO and AP were observed laying on top of their | | | |

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| | respective beds in filthy clothes. Both residents had long shaggy hair that was greasy and uncombed. The bathroom was observed. Upon opening the bathroom door, a stronger odor of feces wafted out. There was feces caked on the floor with shoeprints that tracked out of the room. The toilet bowl, rim, seat, and surrounding bathroom walls were splattered with feces.<br><br>During an anonymous interview, it was indicated MHW staff needed more help. It was already almost 9:00 a.m., and not many medication administrations had been completed because the nurse was new, from an agency, and did not know the residents well. Upon arrival to their shift, they found out it was a MHW unit, but they had not been provided any education, materials, or in-service on how to deal with possible behaviors. They were told to, "just ask an aid."<br><br>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 an aid was in a room helping someone in the bathroom, and another resident out there decided to start a fight, what could they do?<br><br>On 12/3/21 at 8:53 a.m., Resident AL was observed. He remained in bed. He wore the same stained hospital gown. He had slipped down sideways in bed, and his shoulders were almost to the edge of his mattress. He indicated no one had helped his yet that morning and he had not had breakfast. He indicated he still wanted to get out of bed but that probably would not happen.<br><br>During an interview on 12/3/21 at 8:55 a.m., Unit | | | |

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|---|---|---|---|
| | 155077 | A. BUILDING 00<br>B. WING | 12/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| ENVIVE OF INDIANAPOLIS | 45 BEACHWAY DR<br>INDIANAPOLIS, IN 46224 |

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| | 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 PPD (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 the new staffing schedule, but the staff did not give themselves enough credit, plus, several of the "heavy-care" residents had been moved off the unit. Change was hard, and the residents did pick up on staff stress and attitude which is why UM 26 tries to check in with staff as often as possible to see how things were going. Activities were very important on the unit because the Activity Director could come down and change the whole vibe of the unit after 10 minutes. It was important to have appropriate activities and structure for a unit like this to help alleviate and prevent behaviors from occurring in the first place. The activity room however had been closed for several weeks due to disrepair of the roof or window. Supplies for repair had been ordered, but not delivered.<br><br>During an interview on 12/3/21 at 9:26 a.m., Activity Assistant 28 indicated she only came | | | |

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| | over to C and D hall to help the residents on their smoke break. The activity assistant who had been in charge of activities for the C and D hall quit a couple weeks ago, so other than smoking, she did not know what other activities were offered on the MHW unit.<br><br>During an interview on 12/3/21 at 11:12 a.m., the Activity Director (AD) indicated, the activity department did the best they could. They were short a full-time position to help on the MHW unit, and in addition to that the MHW unit activity room had been closed for a couple weeks due to a window was broken. The AD did her best to provided one to one activity, and often walked through the unit to visit with the residents. She hoped the activity room would be fixed soon because it was an important area for the resident to have access too. It was a large space that gave them room to spread out, give a change of scenery, and there was a nice new T.V., and ping pong table the residents like to use. In the meantime, the lounges at the end of each hall were being used as needed to help facilitate activities.<br><br>On 12/3/21 at 8:53 a.m., the Administrator provided a copy of current, but undated facility policy titled, "Staffing Policy." The policy indicated, "Envive of Indianapolis... provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment...."<br><br>On 12/3/21 at 8:53 a.m., the Administrator provided a copy of the most recent Facility Assessment tool dated 2/23/21. The purpose of the facility assessment tool is to determine what resources are necessary to care for residents competently during day-to-day operations and | | | |

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| | emergencies. The Facility Assessment tool is used to make decisions about the direct care staff needs as well as the facilities capabilities to provide care and services to the residents in the facility. The Facility Assessment indicated, the facility had 160 total number of beds, but the average census was 80-90 residents with special consideration and treatments for 55-65 of those residents having specific mental health/behavioral health conditions.<br><br>On 12/3/21 at 8:53 a.m., the Administrator provided a copy of current facility policy titled, "Admission to the Mental Wellness Specialized Unit," dated 8/1/20. The policy indicated, "...a resident or potential resident with a mental illness, or a related disorder will be evaluated for appropriate placement in the Mental Wellness Specialized Unit. The resident, or potential resident, may have a history of, or currently be, exhibiting wandering or exit seeking behavior and/or poor safety awareness. Resident and/or representative will be interviewed concerning the resident's or potential residents metal health history, wandering history, safety awareness, behaviors, moods, daily routines, decision-making abilities, ability to perform activities of daily living, and medical complexity...."<br><br>This Federal tag related to Complaint IN00367460. | | | |