AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
		155077	B. W			09/20/2	2022
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
F 0000							
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0038	Recertification and State This visit included the implaint IN00389598. 9598 - Substantiated. iencies related to the	F 00	000	PLAN OF CORRECTION FOR ENVIVE OF INDIANAPOLIS F000 INITIAL COMMENTS Preparation or execution of the plan of correction does not		
	allegations are cited	d at F686.			constitute admission or agreed of provider of the truth of the factors.	acts	
	Survey dates: September 12, 13, 14, 15, 16, 19, and 20, 2022.				alleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared	The	
	Facility number: 00			executed solely because it is			
	Provider number: 1				required by the position of Fed	deral	
	AIM number: 1002	773330			and State Law. The Plan of Correction is submitted to resp		
	Census Bed Type:				to the allegation of noncomplia		
	SNF/NF: 82 Total: 82				cited during the Recertification State Licensure with a Compla Survey IN IN00389598 comple	aint	
	Census Payor Type	»:			on September 20, 2022.		
	Medicare: 5 Medicaid: 74				Please accept this Plan of		
	Other: 3				Correction as the provider's		
	Total: 82				credible allegation of compliar as of October 21, 2022. The provider respectfully requests		
		reflect State Findings cited in			review with paper compliance	to	
	accordance with 41	0 IAC 16.2-3.1.			be considered in establishing	that	
į	Quality review con	npleted on October 3, 2022.			the provider is in substantial compliance.		
F 0578 SS=D Bldg. 00	Dir §483.10(c)(6) The and/or discontinu or refuse to partic	O(12)(i)-(v) Oscntnue Trmnt;FormIte Adv e right to request, refuse, e treatment, to participate in cipate in experimental formulate an advance					'
	1.55561511, 4114 10 1	omalate an advance					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	/2022
			1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			CHWAY DR		
FNI\/I\/E	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVE.	CI INDIANAI OLIO		_	וואטואוו	7.1 OLIO, IIV 70224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	directive.						
	- , , , ,	hing in this paragraph					
		ed as the right of the					
		e the provision of medical					
		cal services deemed					
	medically unneces	ssary or inappropriate.					
		<u></u>					
	(0)()	ne facility must comply with					
		specified in 42 CFR part					
		vance Directives).					
		nents include provisions to					
	· ·	e written information to all					
		ncerning the right to accept					
		or surgical treatment and,					
		ption, formulate an advance					
	directive.						
	, ,	written description of the					
	• •	o implement advance					
	directives and app						
		permitted to contract with					
		rnish this information but					
		ponsible for ensuring that					
	•	of this section are met.					
	, ,	vidual is incapacitated at					
		sion and is unable to					
		n or articulate whether or					
		executed an advance					
		ty may give advance					
		on to the individual's					
		tative in accordance with					
	State Law.						
	, ,	not relieved of its obligation					
	-	ormation to the individual					
		able to receive such					
		w-up procedures must be in					
		ne information to the					
		at the appropriate time.					
		view and interview, the facility	F 0:	578	F578 –		10/21/2022
	failed to ensure that	t residents had orders for			Request/Refuse/Discontinue		

0Z2N11

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLE	ETED	
		155077	B. W	ING		09/20/2	2022	
				CTREET	ADDRESS CITY STATE ZIR SOD			
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
END //D /E	OF INDIANADOLIC				ACHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE	
	advanced directives	s for 2 of 2 residents			Treatment; Formulate			
	(Residents 286 and	145).			Advanced Directive			
					SS=D			
	Findings include:				"Based on record review and			
					interview, the facility failed to			
	1. On 9/14/22 at 11	:08 a.m. Resident 286's record			ensure that residents had orde	ers		
	was reviewed. Dia	gnoses included, but were not			for advanced directives for 2 d	of 2		
	limited to chronic k	kidney disease, hyperlipidemia,			residents (Residents 286 and	45)."		
	iron deficiency ane	mia, and unspecified tremors.			·	,		
					1. What corrective action(s	s)		
	Resident 286's reco	ord lacked an order for			will be accomplished for tho	se		
	advanced directives	s.			residents found to have been	n		
					affected by the deficient			
	On 9/15/22 at 9:36	a.m., Registered Nurse (RN) 27			practice?			
	was interviewed. I	He was unable to find an order			· Advanced directive order	rs		
	for Resident 286's	advanced directive. In the			have been obtained for reside	nts		
	absence of an order	r for an advanced directive,			286 and 45.			
	Resident 286 would	d be considered a full code.						
					2. How other residents			
	2. On 9/14/22 at 11	:44 a.m., Resident 45's record			having the potential to be			
	was reviewed. His	diagnoses included, but were			affected by the same deficien	nt		
	not limited to chron	nic obstructive pulmonary			practice will be identified and	d		
	disease, weakness,	and hypertension.			what corrective action will be	e		
					taken?			
	_	sheet indicated that his						
		was for a Do Not Resuscitate			· All residents admitted ha	ve		
		hysician's order, dated 5/8/22,			the potential to be affected by	the		
		45 had a Physician's Order for			alleged deficient practice.			
	_	ent (POST) dated 6/23/22. The						
		indicated that the resident			DNS/designee will audit			
	desired to have Car	rdiopulmonary Resuscitation			current residents by 10/21/202			
	(CPR).				ensure advanced directives or	ders		
					are in place.			
		0 a.m., the Vice President (VP) of						
	_	s indicated that a building wide			3. What measures will be p	out		
		cords was being conducted.			in place or what systemic			
		was corrected to indicate that			changes will be made to			
	he was to have CPI	R.			ensure that the deficient			
					practice does not occur?			
1	On 9/20/22 at 4:21	p.m., a current policy, dated						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. W	ING		09/20/	2022
	PROVIDER OR SUPPLIEF			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIS DI AN OE CORRECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE
	9/2022, titled, "Care	diopulmonary Resuscitation,"			 All licensed clinical staff a 	and	
		e VP of Clinical Operations.			Admissions team will be		
		d, "A physician order shall			in-serviced on:		
	be obtained to corre	-			o "Advanced Directives Polic	у"	
	resident/responsible party's wishes"						
	2 1 4(4)				4. How the corrective action		
	3.1-4(d) 3.1-38(f)				will be monitored to ensure t		
	3.1-36(1)				deficient practice will not rec	ur	
					i.e., what quality assurance program will be put into place	۵2	
					program will be put into plac	C :	
					DNS/designee will audit :	5	
					newly admitted residents three		
					times a week x4 weeks, then		
					twice a week x8 weeks, then		
					weekly x 3 months to ensure		
					advanced directive orders are	in	
					place, POST completed, and o	care	
					planned.		
					The results of these audits will		
					reviewed by the QAPI commit		
					overseen by the Executive Dir		
					for no less than six months. Th	ne	
					results will be reviewed for		
					patterns, trends and continued		
					recommendations for process		
					monitoring and improvement t		
					100% compliance is achieved 5. Date of completion:	•	
					10/21/2022		
F 0582	483.10(g)(17)(18)	(i)-(v)					
SS=D	Medicaid/Medicar	e Coverage/Liability Notice					
Bldg. 00	§483.10(g)(17) Th	ne facility must					
	(i) Inform each Me	edicaid-eligible resident, in					
	writing, at the time	e of admission to the					
		d when the resident					
	becomes eligible t						
		services that are included					
	L in nursina facility s	services under the State	1				Ī

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155077	B. Wl	ING		09/20/	/2022
	PROVIDER OR SUPPLIE		•	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWNDEDIC DI ANI OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	A1E	DATE
TAG	plan and for which charged; (B) Those other it facility offers and be charged, and those services; ar (ii) Inform each M when changes are services specified (B) of this section §483.10(g)(18) The resident before, of and periodically discrives available charges for those charges for service Medicare/ Medic	ems and services that the for which the resident may he amount of charges for and edicaid-eligible resident e made to the items and a in §483.10(g)(17)(i)(A) and a feacility must inform each a rat the time of admission, uring the resident's stay, of the in the facility and of services, including any the services, including any the services are made to service to residents of the services that the facility are to residents of the services that the facility must inform the resident in days prior to a feacility to the change. The change is or is hospitalized or is the change is or is hospitalized or is the change in the facility, and to the resident, the facility action to the resident, the facility of the change is or is hospitalized or is the change in the facility, and to the resident, the facility is per diem rate, for the actually resided or reserved in the facility, regardless of yor discharge notice		TAG		O.I.E.	DATE
	(iv) ine iacility mt	ust refund to the resident or	1				I

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET		
		155077	B. W	ING		09/20/2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	resident represent	tative any and all refunds				
		vithin 30 days from the				
		discharge from the facility.				
		n admission contract by or				
		dividual seeking admission				
		not conflict with the				
	requirements of th					
		on, interview, and record	F 0:	582	F582 – Medicaid/Medicare	10/21/2022
	· ·	failed to ensure a resident			Coverage/Liability Notice	
		received Medicare services,			SS=D	
		priate and timely notification			"Based on observation, intervi	
		services came to an end for 1			and record review, the facility	
		yed for Notice of Medicare			failed to ensure a resident	
	Non-Coverage (NO	MNC).			(Resident 11) who received	-11
	Findings include:				Medicare services, was provide	
	Findings include.				appropriate and timely notifications when her Medicare services of	
	On 9/12/22 at 10:55	5 a.m., Resident 11 was			to an end for 1 of 3 resident	airie
		m. She was sitting upright in			reviewed for Notice of Medica	ore
		her body hunched forward			Non-Coverage (NOMNC)."	
		ght. Her head was also tilted to			Their coverage (Inclinio).	
		nable to answer simple yes/no			1. What corrective action(s	s)
	_	unable to maintain eye			will be accomplished for tho	-
	_	red off during conversation.			residents found to have been	
	,				affected by the deficient	
	On 9/13/22 at 11:53	3 a.m., a second attempt was			practice?	
		Resident 11. She remained alert			Resident 11's POA was	
	and occasionally ma	ade eye contact, but she was			notified of situation and provid	led
	unable to state her r	name, or answer simple yes/no			copy of NOMNC.	
	questions.					
					2. How other residents	
		p.m., Resident 11's medical			having the potential to be	
		d. She had a current diagnosis			affected by the same deficie	
		disorder that affect a person's			practice will be identified and	
	ability to move and	maintain balance and posture).			what corrective action will be	e
					taken?	
		er (NP) progress note, dated			· All residents receiving	
		esident 11 had a history of			Medicare services have poter	ntial
		sy after a left hemisphere			to be affected by this alleged	
	stroke at an early ag	ge which also resulted in a			deficient practice.	

PRINTED: 08/28/2023

	R MEDICARE & MEDIC		MB NO. 0938-039			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMI	PLETED
		155077	B. WING		09/20/2022	
NAME OF	DROLUDED OD CLIDDLIEF		STRE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	· ·	45 E	BEACHWAY DR		
ENVIVE	OF INDIANAPOLIS		IND	IANAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		BE PRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE
	developmental dela	y.		 An audit was complet 	ed from	
				April 8, 2022, to date, for re		
		mprehensive Minimum Data		receiving Medicare Service	s to	
		ent was an annual assessment,		ensure proper notification,		
		MDS indicated Resident 11		signature and date are in p		
	•	inderstand or make herself		Notice of Medicare Non-Co	_	
	understood and was	s severely mentally impaired.		(NOMNC). Any issues note	d were	
				corrected immediately		
		er had legal guardianship as				
	declared by the loca	al Superior Court on 5/10/2002.		3. What measures will be	-	
	AND	1 . 1 (/00/20 10 04		in place or what systemic		
		e, dated 6/29/22 at 10:24 p.m.,		changes will be made to		
		d been contacted to review		ensure that the deficient		
		d not discuss the results with		practice does not occur?		
		her cerebral palsy disease		Business Office Mana		
	process.			(BOM) will be in-serviced of		
	D 11 411	1 N CM 1		"NOMNC Form Instructions	3 "	
		sued a Notice of Medicare				
		MNC) notice. The notice d Medicare services would end		4. How the corrective a		
				will be monitored to ensu		
		n lacked the date the notice was		deficient practice will not		
	with Resident 11's i	ed was signed electronically		i.e., what quality assurance		
	with Resident 11 s i	name in cursive.		program will be put into p	lace ?	
	During an interview	v, on 9/20/22 at 10:15 a.m., with		· BOM/designee will au	dit 5	
	the Social Service I	Director (SSD) and the		residents receiving Medica	re	
	_	ent, the SSD indicated Resident		services three times a wee	k x 4	
	_	ent to sign her name and the		weeks, then twice a week		
		been provided to Resident		weeks, then weekly x 3 mo	nths to	
		Administrator indicated the		ensure proper notification,		
		anager was responsible for		signature and date are in p		
		notifications, but there had		Notice of Medicare Non-Co	verage	
		es in the department. The		(NOMNC).		
		not sure who had incorrectly				
		esident 11's guardian was		The results of these audits		
		d should have received the		reviewed by the QAPI com		
	notice instead.			overseen by the Executive	Director	

During an interview on 9/20/22 at 10:30 a.m., the

SSD indicated there was no specific policy for the

for no less than six months. The

patterns, trends and continued

results will be reviewed for

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		 UILDING	00	COMPI 09/20		
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	included on each fo at least 48 hours' no incompetent, it show	on, but the instructions were rm and should be issued with stice. If the resident was ald be provided to the tive and/or next of kin.		recommendations for proce monitoring and improvemer 100% compliance is achiev 5. Date of completion: 10/21/2022	nt until	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comforment §483.10(i) Safe Enter resident has a comfortable and hincluding but not literatment and sup The facility must p §483.10(i)(1) A sa homelike environt to use his or her p extent possible. (i) This includes environdes and the same and the sam	nvironment. a right to a safe, clean, omelike environment, imited to receiving oports for daily living safely. provide- fe, clean, comfortable, and ment, allowing the resident rersonal belongings to the				
	the physical layou resident independ safety risk. (ii) The facility sha for the protection of from loss or theft. §483.10(i)(2) Hour	and services safely and that t of the facility maximizes ence and does not pose a all exercise reasonable care of the resident's property sekeeping and maintenance				
	services necessar orderly, and comfo	y to maintain a sanitary, ortable interior; in bed and bath linens that				
	§483.10(i)(4) Priva	ate closet space in each				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPL	
		155077	B. Wl	ING		09/20/	12022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION	DER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	(iv);						
	§483.10(i)(5) Adea lighting levels in a substantial state of the substa	affortable and safe as. Facilities initially certified as. Facilities initially certified as a facilities initially certified as a facility of the maintenance of a levels. ation and interview, the ation and interview, the ation and interview, the ablishing an effective anance and housekeeping an carpets that were growing as mold, an empty resident room as ceiling caved in, a room with attention and infestation of gnats. This and the potential to effect 43 of asided on the Behavioral Health ation and interview, the facility asident on the C hall of the Unit had a safe functioning aresident reviewed for a broken at C). ation and interview, the facility ation and interview on the Behavioral ation and interview on the Behavioral	F 05	584	F584 – Safe/Clean/Comfortable/Homike Environment SS=E "A. Based on observation and interview, the facility failed to ensure the Behavioral Health was maintained in a clean, comfortable, homelike environment by establishing a effective preventative mainten and housekeeping program resulting in carpets that were growing what appeared to be an empty resident room not cleaned after the ceiling caved a room with feces smeared on mattress and carpet after the resident vacated, and an infestation of gnats. This defic practice had the potential to end and interview, the facility failed to ensure a resident on the C had	Unit n ance mold, d in, the ient ffect d on	10/21/2022
	A1. During a tour o	f the Behaviors Health Unit			the Behavioral Health Unit had safe functioning toilet seat for		

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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 09/20/2022 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 (BHU) on 9/12/22 from 1:04 p.m., until 1:15 p.m., 1 resident reviewed for a broken the following was observed. toilet seat (Resident C). C. Based on observation and Upon entrance onto the BHU, D-hall, there was a interview, the facility failed to smell of stagnant, musty humid air. ensure 1 of 2 hallways on the Behavioral Health unit were The door to room D3 was closed but unlocked maintained in a homelike and opened freely. The back corner ceiling had environment (Residents 66 and completely caved in. Parts of drywall, insulation, 83)." and splintered wood still hung down from the What corrective action(s) ceiling, and were scattered across the floor and all will be accomplished for those remaining furniture. When stepped on, the carpet residents found to have been was spongey and saturated with moisture, and affected by the deficient there were irregular shaped patches of practice? green/yellow/white substances growing on the Room number D3, D13, D15, carpet which appeared to be mold. D20. D22 have been and will remained locked until repairs have The door to room D13 was closed but unlocked been completed. and opened freely. Upon opening the door, a Resident C has a new toilet putrid odor was noted, the carpeted floor was seat in place. All holes in the observed to be fully discolored with large patches ceiling on C and D hall have been of green/yellow/white substances that sprouted patched. up from the carpet and appeared to be mold. A Residents 66 and 83 have copious amount of gnats were observed flying had ceiling and walls repaired. throughout the room. How other residents The door to room D15 was closed but unlocked having the potential to be and opened freely. Although the room appeared affected by the same deficient neat and cleaned, the carpets were spongey and practice will be identified and saturated underfoot. There were patches of what corrective action will be discoloration throughout the carpet that appeared taken? to be mold. All residents have the potential to be affected by this The door to room D22 was closed and locked. A alleged deficient practice. potted plant was placed in front of the door, 100 % audit was completed however, the bathroom door shared between D22 on all active resident rooms and and D20 was unlocked. The bathroom door common areas on C and D hall

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opened into D22 and there was a foul odor of

excrement as a brown smeared substances was

noted on the mattress and enmeshed in the carpet.

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(Behavior Unit). Any issues noted

were fixed immediately.

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		45 B	ET ADDRESS, CITY, STATE, ZIP COD EACHWAY DR		
ENVIVE	OF INDIANAPOLIS		INDI	ANAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON (X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DATE	
	The D-Hall commo for activities, televi vending machines withe floor surface are with moisture. The densely speckled with count. When a new the gnats took to fli away. During an interview Administrator indice leaks previously and leaked in several plan issue with the rowould usually patch at that time, but he keep up with as well to her knowledge the by corporate for repnot determined a determined a determined a determined and the replacement. Admalfunction in the sago which caused waffected several are meantime, the Administrator in the sago which caused waffected several are meantime, the Administrator in the sago which caused waffected several are meantime, the Administrator in the sago which caused waffected several are so that the new floor During an interview Maintenance Direction issue with the spring pressurized test had caused a backup and system throughout the contractor could be contractor could be contractor could be a surfaced as a surfaced	n area where residents gathered sion (T.V.), and use of the was observed. The majority of ea was discolored and damp wall under the T.V. was ith gnats too great in number earby trash can was disturbed, ght and needed to be swatted 7 on 9/12/22 at 2:15 p.m., the ated there had been several d when it rained really hard it aces. When there was a leak or of, the Maintenance Director in the repairs as best he could had the rest of the building to all. The Administrator indicated the roof had been outsourced blacement and they had still efinitive timeframe to complete additionally, there had been a sprinkler system several weeks water to be released and as of the building. In the consistent of the roof was fixed aring would not be ruined. 7 on 9/12/22 at 3:07 p.m., the consistent of the majority of the deep when a leen conducted which dad sprung leaks in the consistent of the majority. There had been ceiling that the Maintenance when the repairs were made a get to the pipes. As for the pleak when it rained and was a leak or on 9/12/22 at 3:07 p		3. What measures will to in place or what systemic changes will be made to ensure that the deficient practice does not occur? • Maintenance and Housekeeping will be in-seon: "Homelike Environment" 4.How the corrective action be monitored to ensure the deficient practice will not i.e., what quality assuran program will be put into pomention of the monitored to ensure the deficient practice will not i.e., what quality assuran program will be put into pomention of the monitor of the	rviced rviced rviced recur recur rece lace? adom e times re a ly x 3 rtable ment. will be mittee Director . The ued ress nt until	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. WI	ING		09/20/	2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ENIVIVE A	OF INDIANAPOLIS				CHWAY DR APOLIS, IN 46224		
	T			l	AI OLIO, IIN 40224		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		placement. However, he was		TAU			DATE
		t and could not to it by					
		know if or when the roof					
	would be repaired.	In the meantime, he made trips					
		re to get materials to patch as					
	needed, sometimes	daily.					
	A2 On 9/12/22 at 3	:15 p.m., an environmental tour					
		the Maintenance Director.					
		concern were reviewed.					
		intenance Director indicated					
	1	y if the ceiling had caved due					
	to the sprinkler syst	em or the leaking roof.					
	At room D13 the M	Taintenance Director indicated					
		d by Housekeeping (HK) the					
	previous Friday tha	t the carpet needed to be					
	1 -	I not been given any specifics.					
		the room and carpet he					
		ally bad" and needed to come					
		ble (ASAP) but he had not					
	seen it until now.						
	At room D15 the M	aintenance Director indicated					
	sometimes the Pack	aged Terminal Air Conditioner					
	(PTAC) units leake	d and it was a "quick easy"					
	repair. It appeared t	hat the PTAC unit in D15 had					
		when the resident left, so it					
		ak which had caused the					
	carpets to become s	aturated.					
	In the D-Hall comm	non area, the Maintenance					
		ne was not able to locate the					
	source of the leak w	which had caused the carpets					
	to become wet, but	he assumed it had probably					
	_	nkler malfunction. He indicated					
	the carpets needed t	to be cleaned.					
	At room D22 the M	laintenance Director indicated					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. WI	NG		09/20/	/2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS				APOLIS, IN 46224		
CINVIVE	OF INDIANAPOLIS	•		INDIAN	APOLIS, IN 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	he had shut and loc	ked the entrance to that room					
	because when the s	prinkler system malfunctioned					
	it had caused some	water to leak around some					
	electrical cords and	he did not want any residents					
	to get into the room	because of the potential for					
	accidents. He obser	rved the smeared substance on					
	the mattress and flo	oor and indicated he was aware					
	of the issue because	e he saw it when he came in to					
		. He had let HK know, but					
	evidently it had not	been cleaned yet.					
		3:48 p.m., an environmental tour					
	was conducted with	n the Administrator and Vice					
	President of Clinica	al Operations (VPCO) to					
	observe the above a	areas of concern.					
		dministrator indicated she did					
		en leaks but not specifically					
		ffected, and was unaware the					
		n. She indicated it needed to be					
		om should have been cleaned					
	up immediately.						
		Administrator indicated she had					
		e previous Friday that the					
	_	replaced but was unaware of					
		ncern. She raised her arm to					
	her face due to the	smell and left the room.					
		Administrator indicated the					
		m the PTAC unit and the					
		tor was usually able to fix that					
		fied. She indicated the carpet					
	would need to be pr	ulled up.					
		Administrator indicated the door					
		om needed to be locked to					
	_	sident from going in and when					
		neared brown substance, she					
	indicated it was sto	ol and rooms should be deep					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. WI	NG		09/20	/2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	cleaned as soon as a	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE
	cleaned as soon as a	resident vacated.					
	During an interview	on 9/12/22 at 4:00 p.m., the					
	Administrator was asked about the roof being						
		ng a previous complaint survey					
	on 12/4/21, the Chie	ef Operation Officer at that time					
	-	e budget had been granted					
	•	tention to replace the roof and					
		he Administrator indicated she					
		y but, "every month, it is					
	supposed to be next	montn."					
	On 9/13/22 at 9:50 a.m., D3, D13, D15 and D22 had						
		rith a sign that indicated, "out					
	of order."						
	-	on 9/13/22 at 10:00 a.m., the					
	-	cated, she split her time					
	_	Supervisor, Laundry					
	-	ntral Supply Coordinator. Even					
	-	aff had been hired, they still in daily tasks given the overall					
		lding and behavior of the					
		ust been able to hire a floor					
		pet shampooer had arrived the					
		had been walking down					
	-	oted, "a funky smell." She					
	traced it to D13 and	when she opened the door,					
	_	see how bad it had gotten.					
		months ago, the Administrator					
		on to move residents around					
		e a male and female hall. So,					
		s moved out of their room on					
	_	re to deep clean the room and					
	_	one had made regular checks					
	into the closed rooms since there were no residents.						
	On 9/21/22 at 1:06	p.m., the VPCO provided a copy					
	of current facility p	olicy title "Clean Carnet Furn	1				I

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MUL A. BUIL B. WING	DING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIEI			45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	[Furniture]," datedCarpeting and cloregularly and repair deep-cleaned periomonth), or more of becomes wet shall hours"B. On 9/11 room was observed pulled to his side or chipping material in the corner of the rowhite foam was obtoilet seat was broken pin. During an interview Resident C indicate toilet seat to mainted toilet seat was unsate toilet seat was unsate being broken. During an interview Administrator was being broken. During an observate toilet seat remained a.m., a large water fixture to the right was observed. The of the light, one side ceiling. The ceiling out with brown stain the ceiling was a 7" in size. On 9/12/22 at 10:20 ceiling repair was of the seat remained a	8/2022. The policy indicated, " oth furnishings shall be cleaned red promptlyCarpets shall be dically (approximately once per ren as neededCarpet that be dried thoroughly within 72 3/22 at 11:35 a.m., Resident C's l. Resident C had his curtain f the bed. A hole with nother ceiling was observed in om. A large amount of hard, served behind the bed. The ten and attached by only one won 9/13/22 at 11:35 a.m., and that he reported his broken enance. He indicated that the after to sit on. In one 9/13/22 at 12:05 p.m., the made aware of the toilet seat Soliton on 9/14/22 at 11:00 a.m., the labroken. C. On 9/12/22 at 10:21 stain around the ceiling light of the C Hall nurse's station water stain was around 3 sides le had a large hole in the griles were observed bowing into on the water stain. The hole approximately 3 inches (") by (x) 6 a.m., another large, unfinished observed in the C hall between 5. It was plastered, not sanded					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY IPLETED 20/2022
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP ACHWAY DR IAPOLIS, IN 46224	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	observed to be peele covering the plaster small gouges were area was about 15" peeled and curled w floor under the reside was observed on top indicated he had a he wallboard. On 9/19/22 at 8:54 bowing, stained tile hole in the ceiling he ceiling repair was or rooms C13 and C15 finished. The plaster not painted. On 9/19/22 at 9:10 outside of a resident hole in the ceiling. On 9/19/22 at 9:38 hole, about 10" x 10 83's bedroom. A lar secured in the hole completely. Two how was about 1" x 2," to approximately 1" x and it was not paint. On 9/20/22 at 10:07 behavior unit, the Method the large area of peer room was vandalistrand, and he did not	oles were still visible, one hole he other hole was 3." No plaster had been applied				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		155077	B. WINC	·		09/20/	2022
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	L			CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		ΓAG	DEFICIENCY		DATE
		he resident punched the hole nonth ago. He indicated this					
		too. He indicated he had been					
	busy the last 3 days pulling up carpet in 3 rooms						
		ssues in the resident's rooms					
		He indicated the two large					
		C Hall were related to the					
		iking. The sprinkler system					
	worked but did not	drain correctly. An outside					
	company was going	to complete the repairs with					
	the sprinkler system drainage and repair the water stains. Since they had not started the work yet, he						
would only be able to put a temporary patch on							
	the hole.						
	of current facility p Environment," date "Residents are pr comfortable and ho facility staff and ma the extent possible, facility that reflect a setting. These chara	p.m., the VPCO provided a copy olicy title, "Homelike d 8/2022. The policy indicated, ovided with a safe, clean, melike environmentThe magement shall maximize, to the characteristics of the a personalized, homelike acteristics includeClean, we environmentPleasant,					
F 0585 SS=E Bldg. 00	voice grievances to agency or entity the without discrimina	nces. resident has the right to to the facility or other nat hears grievances tion or reprisal and without ion or reprisal. Such					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	8			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	.		INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	grievances include those with respect to care and treatment which has been furnished as						
		has not been furnished,					
		aff and of other residents,					
		ns regarding their LTC					
	facility stay.						
	§483.10(j)(2) The resident has the right to and						
	• • • • • • • • • • • • • • • • • • • •	nake prompt efforts by the					
		grievances the resident may					
		ce with this paragraph.					
	mave, in accordan	oo marane paragrapii.					
	§483.10(j)(3) The facility must make						
	information on how to file a grievance or						
	complaint availabl	le to the resident.					
	, ,	facility must establish a					
		o ensure the prompt					
	_	ievances regarding the					
	_	ontained in this paragraph.					
		provider must give a copy					
	-	policy to the resident. The					
	grievance policy n						
		ent individually or through					
		nent locations throughout					
		ight to file grievances orally					
		or in writing; the right to file					
	-	mously; the contact					
		grievance official with whom					
	_	e filed, that is, his or her ddress (mailing and email)					
		ne number; a reasonable					
	•	me for completing the					
	-	vance; the right to obtain a					
	_	egarding his or her					
		e contact information of					
		es with whom grievances					
	· ·	is, the pertinent State					
		nprovement Organization,					
		ncy and State Long-Term					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF I	PROVIDER OR SUPPLIEF	· R			DDRESS, CITY, STATE, ZIP COD	•	
ENVIVE	OF INDIANAPOLIS	3			CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		n program or protection and					
	advocacy system						
		rievance Official who is					
	1	rerseeing the grievance					
	1 '	g and tracking grievances					
	-	onclusions; leading any					
	maintaining the co	gations by the facility;					
	1	iated with grievances, for					
	example, the identity of the resident for those grievances submitted anonymously, issuing						
	written grievance decisions to the resident;						
	and coordinating with state and federal						
	agencies as necessary in light of specific						
	allegations;						
	(iii) As necessary, taking immediate action to						
		tential violations of any					
	resident right whil	e the alleged violation is					
	being investigated	d;					
	(iv) Consistent wit	th §483.12(c)(1),					
	immediately repor	rting all alleged violations					
		abuse, including injuries of					
		and/or misappropriation of					
		by anyone furnishing					
		f of the provider, to the					
		ne provider; and as required					
	by State law;	all written griever					
		all written grievance the date the grievance was					
		ary statement of the					
		ce, the steps taken to					
	•	evance, a summary of the					
	"	or conclusions regarding					
		cerns(s), a statement as to					
		ance was confirmed or not					
	1	rrective action taken or to					
		icility as a result of the					
	1	e date the written decision					
	was issued;	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
		oriate corrective action in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLE	
		155077	B. WI	NG		09/20/2	022
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with Silviolation of the resilviolation of the resilviolation of the resilviolation of the resilviolation for authorized and the SD indicate the local home last signed and the SD indicate for the substitute of the sub	State law if the alleged sidents' rights is confirmed an outside entity having as the State Survey improvement Organization, seement agency confirms a fithese residents' rights esponsibility; and vidence demonstrating the inces for a period of no less the issuance of the inces for a period of no less the issuance of the inces information ocked Behavioral Health Unitation, and the potential to dents who resided in the locked Unit. If a.m., the locked Behavioral served for resident rights and imprinformation posted.	F 05		F585 - Grievances SS=E "Based on observation, intervand record review, the facility failed to ensure resident's right and elder advocacy agencies information were posted in the locked Behavioral Health Unit This potential deficiency had to potential to affect 43 of 43 residents who resided in the locked Behavioral Health Unit 1. What corrective action(swill be accomplished for tho residents found to have been affected by the deficient practice? The resident's rights and elder advocacy agency inform was posted on Behavioral head unit. How other residents having the potential to be affected by the same deficient practice will be identified anywhat corrective action will be	iew, its, ie iche if n ithe ithe ithe ithe ithe ithe ithe ithe	10/21/2022

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DEPARTMENT OF HEALTH AND HUMAN 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 00 COMPLETED 155077 B. WING 09/20/2022 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 indicated this conversation was upsetting to him. taken? He said he received the facility papers but did not understand what the notice of discharge or All residents residing on the Behavioral Health unit have request for a hearing meant. He was sent to local homeless shelter and the staff at homeless shelter potential to be affected by this indicated the facility had no right to send him alleged deficient practice. there. The SSD used to say that she would send him to homeless shelter as a "threat" to get him to All Behavior residents were go the psychiatric hospital. He had 3 to 4 big bags

gone to the local homeless shelter. He was not aware of any elder agencies to help him. He resided on the locked Behavioral Health Unit. On 9/20/22 at 10:39 a.m., Certified Nursing Assistant (CNA) 48 indicated the elderly agencies information was in the Behavioral Health Unit

of clothes and medications sent with him but he

did not know how to take medications or when. The homeless shelter staff called the facility and

put all his stuff in a van and brought him back to

nursing facility. He indicated he did not know he

could have called the health department to make a

complaint. If he known that, he would have never

On 9/20/22 at 10:41 a.m., the Activity Director indicated the resident's rights were on the wall in the Behavioral Health Unit activity room.

On 9/20/22 at 10:43 a.m., a folder was observed stapled to the wall. It was labeled resident's rights. In the folder were several pages stapled together with elderly advocacy agencies on the last page.

On 9/20/22 at 11:09 a.m., the Administrator indicated the resident rights and elder agency posting were in the main part of the building. The residents in the locked behavior unit could have come to the main activity area to see further information about resident rights and elder

- reviewed and no unsolved grievances noted.
- What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur?
- All staff will be in serviced on the following
- o "Grievance process"
- o "Resident Rights"
- How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?
- ED/Designee will complete an audit one time a month for 6 months to ensure Resident rights and elder advocacy agency information is posted in plane sight for all residents.

The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued

activity room.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	00	COMPLETED 09/20/2022
NAME OF P	PROVIDER OR SUPPLIER			ACHWAY DR	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		dicated some residents cannot		recommendations for process	
		nit. The Administrator		monitoring and improvement	
		nt it was enough to have that in one place in the building		100% compliance is achieved	
	-	ral Health Unit in the activity		5. Date of completion:	
	room.			10/21/2022	
	0 0/10/00 : 0.10	at a state to the			
		p.m., the Activity Director g/night shift and weekends			
		Behavioral Health Unit			
		as kept. The activity personnel			
		7 days a week until 7:00 p.m.			
	On 9/12/22, the Adr	missions Agreement was			
		lity. A document within the			
	admission agreemer	nt was titled, "Federal Resident			
		Responsibilities," was			
		ed, "Required PostingsA			
		sses (mailing and email), and			
	_	of all pertinent State agencies			
		s, such as the State Survey			
		censure office, adult where state law provides for			
	_	term care facilities, the Office			
		erm Care Ombudsman			
		tion and advocacy network,			
		ty based services programs,			
		raud Control Unit; and a			
		esident may file a complaint			
	with the State Surve	ey Agency concerning any			
	suspected violation	of state or federal nursing			
		include but not limited to			
	resident abuse, negl				
		resident property in the			
		ance with the advanced			
	-	entsand requests for			
		ng returning to the community			
		osting and Access. The			
		a place readily accessible to y members and legal			
	residents, and family	y members and legal			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
	155077	B. WING		09/20/2022
		45 BE	ACHWAY DR	
SUMMARY S	STATEMENT OF DEFICIENCIE	ID		(X5)
		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
*				
3.1-3(1) 3.1-3(t)				
Right to be Free fr §483.10(e) Respe The resident has a	om Physical Restraints oct and Dignity. a right to be treated with			
physical or chemic purposes of discip not required to treat	cal restraints imposed for line or convenience, and at the resident's medical			
abuse, neglect, mi property, and expl subpart. This inclu freedom from corp involuntary seclus chemical restraint	isappropriation of resident oitation as defined in this udes but is not limited to poral punishment, ion and any physical or not required to treat the			
§483.12(a) The fa	cility must-			
from physical or cl for purposes of dis that are not require medical symptoms restraints is indica the least restrictive amount of time an re-evaluation of th	hemical restraints imposed scipline or convenience and ed to treat the resident's s. When the use of ted, the facility must use e alternative for the least d document ongoing e need for restraints.	F 0604	F604 – Right to be Free from	10/21/2022
	PROVIDER OR SUPPLIER OF INDIANAPOLIS SUMMARY: (EACH DEFICIEN REGULATORY OR representative of rerecent survey of the 3.1-3(1) 3.1-3(t) 483.10(e)(1), 483. Right to be Free fr §483.10(e) Respect and dignit §483.10(e)(1) The physical or chemical purposes of discipnot required to tre symptoms, consis §483.12 The resident has transported to the symptoms, consis §483.12 The resident has transported to the symptoms, consis §483.12 The resident has transported to the symptoms, consis §483.12 The resident has transported to the symptoms and explosive the symptoms	OF CORRECTION IDENTIFICATION NUMBER 155077 PROVIDER OR SUPPLIER OF INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION representative of residents, the results of the most recent survey of the facility" 3.1-3(I) 3.1-3(I) 3.1-3(I) 483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	DENTIFICATION NUMBER 155077 A. BUILDING B. WING 155077 STREET 45 BE INDIA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION representative of residents, the results of the most recent survey of the facility" 3.1-3(1) 3.1-3(1) 483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints \$483.10(e) (Respect and Dignity.) The resident has a right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with \$483.12(a)(2). \$483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. \$483.12(a) The facility must-\$483.12(a) (Panumeter) Ensurement is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	OF CORRECTION IDENTIFICATION NUMBER 155077 ROVIDER OR SUPPLIER OF INDIANAPOLIS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS CIDENTIFYING INFORMATION) representative of residents, the results of the most recent survey of the facility" 3.1-3(1) 3.1-3(1) 483.10(e)(1). 483.12(a)(2) Right to be Free from Physical Restraints \$483.10(e) (1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with \$483.12(a)(2). \$483.10(e) (1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with \$483.12(a)(2). \$483.12(a) (The facility must-sident's medical symptoms. \$483.12(a) (The facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	1B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMP	LETED
		155077	B. W.	ING		09/20	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD	L	
NAME OF	PROVIDER OR SUPPLIE	ER			ACHWAY DR		
ENVIVE	OF INDIANAPOLI	S		INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	TION (X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	review, the facility	y failed to ensure a resident,			Physical Restraints		
	(Resident 12) who	was in a fully enclosed bed was			SS=D		
	assessed on a regu	lar basis and provided with					
	stimulus to preven	ntion isolation while in her bed			"Based on observation, intervi	iew,	
	and failed to asses	s safety precautions of the			and record review, the facility		
	enclosed bed on a	regular basis for 1 of 2			failed to ensure a resident,		
	residents reviewed	l for restraints.			(Resident 12) who was in a fu	ılly	
					enclosed bed was assessed of	on a	
	Findings include:				regular basis and provided with	th	
		stimulus to prevention isolation					
	On 9/12/22 at 10:52 a.m., Resident 12 was				while in her bed and failed to		
	observed sitting up in her Broda chair in her room.				assess safety precautions of t	the	
	Her bed was a solid wood frame, with four fully				enclosed bed on a regular bas	sis	
	enclosed walls, with blue plastic covered padding.				for 1 of 2 residents reviewed f	for	
		s hinged at the bottom of the			restraints."		
		wn to open and close. There					
	-	h which secured the wall in its			1. What corrective action(s)	
		The bed looked like a crib, but			will be accomplished for tho	se	
		dows, or mesh. Attached to the			residents found to have been		
	1 -	of the bed, was a long metal			affected by the deficient		
		wn into the enclosed bed. There			practice?		
		ap between the head of the bed			· Resident 12 has been		
	frame and the mat	tress.			assessed and the bed has be		
					found appropriate for resident		
		vision (T.V.) within line of sight			prevent injury. Resident has h		
		she were in the bed. There were			personal items placed within s	•	
	1 *	pictures, posters, comfort items			for viewing while resting in he	r bed.	
	1 -	ounding walls or ceilings, and			Resident's TV has also been		
		vindow remained closed			relocated so resident may vie		
		evey timeframe. Additionally,			while in bed. Care plan has be	een	
	-	staff could visualize Resident B			reviewed and updated with		
	from the hallway i	if she were in bed.			appropriate interventions. MD		
	<u></u>	0/10/22 + 10 22			order has been placed for crib		
		ew on 9/19/22 at 10:39 a.m.,			Bolster has been placed to pro	event	
		Assistant (CNA) 52 indicated			entrapment.		
	Resident B used the padded bed to prevent her from falling.						
					2. How other residents		
		0/40/00 46			having the potential to be		
	During an intervie	ew on 9/19/22 at 10:40 a.m., CNA			affected by the same deficie	nt	

52 indicated she usually worked the night shift

practice will be identified and

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155077	B. W	ING		09/20/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
	Г		1		I		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG			DATE
		ne bed had been put in to keep			what corrective action will be	е	
	her from falling since she had lots of spasms. She				taken?	al a	
	was usually put in bed after dinner around 6 p.m.,				All residents with crib be		
	and got up around 6 a.m.				have the potential to be affect by the alleged deficient praction		
	During an interview	in 9/19/22 at 10:44 a.m. CNA			by the alleged delicient practic	Je.	
	During an interview in 9/19/22 at 10:44 a.m., CNA 51 indicated Resident B's bed was to help keep her				DNS/designee will audit.	all	
	from falling. The long metal wire that hung at the				residents with crib beds by	ali	
	foot of the bed used to hold personal items like				10/20/22 to ensure residents h	nave	
		liar objects, but he did not			been assessed and stimulus i		
	know where they went, and it was no longer				place to prevent isolation while		
	utilized.			bed and safety precautions are in			
					place. No additional residents		
	On 9/19/22 at 12:39 p.m., the Director of Nursing				in crib beds at this time.		
		ditional documentation from					
		chart. At this time, she			3. What measures will be p	out	
	indicated she had pr	rovided all she could find, but		in place or what systemic			
	she did not have a r	evised care plan, the initial	changes will be made to				
	assessment or addit	ional safety screenings or			ensure that the deficient		
	assessments which	should have been conducted			practice does not occur.		
	at least quarterly. T	he initial care plan she located			· All licensed clinical staff	will	
		nad not been transcribed into		be in-serviced on:			
		d and the nursing staff did not			o "Restraints"		
	have 24-7 access to	the medical records.			 Maintenance and all lice 	nsed	
					clinical staff will be in serviced	l on:	
		p.m., Resident 12's bed was			o "Bed Rails/Side Rails"		
		Maintenance Director. At this					
		he gap between the head of			4. How the corrective action		
		nattress as the mattress was			will be monitored to ensure t		
	_	easured 4 inches. When the			deficient practice will not rec	ur	
		elevated to an approximate			i.e., what quality assurance	•	
		e measurements increased to			program will be put into place	e?	
		Maintenance Director			DNIO/41: "" ""	_	
	indicated the gap w	as too wide.			DNS/designee will audit		
	On 0/10/22 -+ 2:22	m m Davidant 121a 1:1			residents in crib beds three tin		
		p.m., Resident 12's medical			a week x8 weeks, then twice a		
		d. Her primary active diagnosis			week x4 weeks, then weekly x		
	was Huntington's di	ISCASC.			months to ensure residents ha		
	She had a current physician order for padded side				been assessed and stimulus i		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CONST A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 09/20/2022
NAME OF PROVIDER OR SUI		45 BEACH	RESS, CITY, STATE, ZIP COD WAY DR OLIS, IN 46224	•
PREFIX TAG REGULATO rails and an or per resident or breath while ly bed elevated a her tube feedi	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION rails and an order to elevate the head of her bed per resident comfort to alleviate shortness of breath while lying flat, and to keep the head of bed elevated at a 34-40 degree angle 1-hour after her tube feedings. There was no order for a crib/cradle-bed.		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION OF APPROPRIATION OF A CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION OF A CORRECTIVE ACTION OF A CORRECTIVE	COMPLETION DATE as are in as will be mmittee be Director
" new bed a bed is fully en enclosure will may be able to hung on wall up from the ha	gress note, dated 2/27/20, indicated, rrived assessed for safety in bed closed with padded siding full prevent falls TV relocated so she see and provide stimulus. Mirror o staff may visualize with bed walls ll MD in agreement with bed ntinue to evaluate to further mitigate	re pa re m 10	r no less than six monthesults will be reviewed for atterns, trends and continuous for proconitoring and improvem 20% compliance is achies. Date of completion: 0/21/2022	or inued cess ient until
lacked specificheck marked reasons: Enab Seizure Precar allowed between restricted to le	een, dated 5/31/21, was provided but cation for the intent which should be for one of the three following er, Provide Bed Parameters or ations. Parameters for the gap en the rails and the mattress were ss than 4 and 3/4 inches.			
The record lac The record lac measures had	ked additional safety checks. ked documentation less restrictive been tried by the interdisciplinary on to be ineffective.			
last revised 2/ Huntington's of enclosed bed	ive care plan, initiated 1/21/19 but 20/22, indicated Resident 12 had isease and required a fully with padded sides. 3:45 p.m., the Administrator			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/20	LETED
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS		•	45 BEA	.DDRESS, CITY, STATE, ZIP COI CHWAY DR APOLIS, IN 46224	D	
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION
TAG	provided a copy of "Bed Rails/Side Ra indicated," the re shall be assess by the considering the resi- conditions, comfort movement try to p problems from the (including frame, n footboards, and becomment the follow maintenance staff of equipment as part of program to identify potential entrapment the bed system are established by the I consider situations resident's weight, n side rails should no restraints" On 9/19/22 at 3:45 provided a copy of	current facility policy titled, ils," dated 8/2022. The policy sident's sleeping environment the interdisciplinary team, ident's safety, medical the and freedom of forevent deaths/injuries and teds and related equipment thattress, side rails, headboards, if accessories), the facility shall approaches; Inspection by of all beds and related of our regular bed safety the risks and problems including that risks; Review gaps within within the dimension FDA (note: the review shall that could be caused by the the rovement or bed position) t be used as protective p.m., the Administrator current facility policy titled, 8/2022. The policy indicated, "		TAG	DEFICIENCY		DATE
F 0622 SS=G Bldg. 00	Restraints shall or resident's medical shall of resident's medical shall of resident's medical shall of falls" 3.1-26(a) 3.1-26(s) 483.15(c)(1)(i)(ii)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	only be used to treat the ymptoms and never for onvince, or for the prevention					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED					
		155077	B. W	ING		- 09/20/2022		
NAME OF I	PROVIDER OR SUPPLIER	· }	-		ADDRESS, CITY, STATE, ZIP COD	-		
					CHWAY DR			
ENVIVE	OF INDIANAPOLIS			INDIAN.	APOLIS, IN 46224			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE	
	unless-							
	' '	r discharge is necessary for						
		fare and the resident's						
	needs cannot be i	•						
	, ,	r discharge is appropriate						
		ent's health has improved						
		resident no longer needs						
		ded by the facility;						
	. ,	individuals in the facility is						
	I	o the clinical or behavioral						
	status of the resid	•						
	` '	individuals in the facility						
	would otherwise b	-						
	, ,	nas failed, after reasonable						
		otice, to pay for (or to have						
	1 '	are or Medicaid) a stay at						
		yment applies if the						
		submit the necessary						
		d party payment or after the						
		ng Medicare or Medicaid,						
		and the resident refuses to						
	1	stay. For a resident who						
	_	for Medicaid after admission						
		cility may charge a resident						
		arges under Medicaid; or						
	(F) The facility cea	•						
		y not transfer or discharge						
		the appeal is pending,						
		.230 of this chapter, when a						
		s his or her right to appeal a						
		rge notice from the facility						
		.220(a)(3) of this chapter,						
		to discharge or transfer						
	_	he health or safety of the						
		ndividuals in the facility.						
	•	document the danger that						
	tailure to transfer	or discharge would pose.						
	§483.15(c)(2) Dod	cumentation.						
	- ' ' ' '	ransfers or discharges a						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

If continuation sheet

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						PRIN	ΓED: 08/28	8/2023
DEPARTMENT	PARTMENT OF HEALTH AND HUMAN SERVICES					FOI	RM APPROVE	ED
CENTERS FOR	CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	B NO. 0938-03	39
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155077	B. WING			09/20/2022		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		CHWAY DR				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO	ON	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	regident under en	of the circumstances						

			•	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	resident under any of the circumstances			
	specified in paragraphs (c)(1)(i)(A) through (F)			
	of this section, the facility must ensure that			
	the transfer or discharge is documented in			
	the resident's medical record and appropriate			
	information is communicated to the receiving			
	health care institution or provider.			
	(i) Documentation in the resident's medical			
	record must include:			
	(A) The basis for the transfer per paragraph			
	(c)(1)(i) of this section.			
	(B) In the case of paragraph (c)(1)(i)(A) of this			
	section, the specific resident need(s) that			
	cannot be met, facility attempts to meet the			
	resident needs, and the service available at			
	the receiving facility to meet the need(s).			
	(ii) The documentation required by paragraph			
	(c)(2)(i) of this section must be made by-			
	(A) The resident's physician when transfer or			
	discharge is necessary under paragraph (c)			
	(1) (A) or (B) of this section; and			
	(B) A physician when transfer or discharge is			
	necessary under paragraph (c)(1)(i)(C) or (D)			
	of this section.			
	(iii) Information provided to the receiving			
	provider must include a minimum of the			
	following:			
	(A) Contact information of the practitioner			
	responsible for the care of the resident.			
	(B) Resident representative information			
	including contact information			
	(C) Advance Directive information			
	(D) All special instructions or precautions for			
	ongoing care, as appropriate.			
	(E) Comprehensive care plan goals;			
	(F) All other necessary information, including			
	a copy of the resident's discharge summary,			
	consistent with §483.21(c)(2) as applicable,			
	and any other documentation, as applicable,			
	to ensure a safe and effective transition of			
	· ·		1	

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0Z2N11

Facility ID: 000032

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1		COMPLETED	
		155077	B. Wl	NG		09/20/2022
NAME OF A	DROWDER OF GUIDNING			STREET A	ADDRESS, CITY, STATE, ZIP COD	•
NAME OF I	PROVIDER OR SUPPLIER	i.			CHWAY DR	
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE
	care.		F 0.			10/21/2022
		ation, interview, and record	F 06	522	F622 – Transfer and Dischar	ge 10/21/2022
		failed to ensure a resident			Requirements	
		avior unit with diagnoses of			SS=G	
		e, psychotic disorder with			"A. Based on observation,	
		zoaffective disorder was not			interview, and record review,	
		charged due to behaviors			facility failed to ensure a resid	
		tion of failed interventions			admitted to the behavior unit	
	_	sychosocial harm when			diagnoses of Alzheimer's dise	· ·
		charged from the facility to a			psychotic disorder with delusion	
		e to not controlling his			and schizoaffective disorder v	
		residents reviewed for			not threatened to be discharge	ed
	discharge (Resident	: D).			due to behaviors without	
					documentation of failed	
		ation, interview, and record			interventions which resulted in	
		failed to communicate pertinent			psychosocial harm when Res	
		D status, and an assessment of			D was discharged from the fa	-
		on to a receiving hospital for a			to a homeless shelter due to r	
	_	for 1 of 3 residents reviewed			controlling his behaviors for 1	of 3
	for transfer and disc	charge (Resident 81).			residents reviewed for dischai	rge
					(Resident D).	
	Findings include:				B. Based on observation,	
					interview, and record review,	the
	_	iew, on 9/20/22 at 10:11 a.m.,			facility failed to communicate	
		d the Social Services Director			pertinent information, COVID	
	(SSD) did not like h	nim. He came in from outside			status, and an assessment of	а
		ted to him he needed to go to			resident's condition to a receiv	/ing
	the local homeless s	shelter for no reason. He			hospital for a change in condi	tion
	indicated he was given	ven documents that were a 30			for 1 of 3 residents reviewed t	or
	day notice and a rig	ht to appeal. He provided the			transfer and discharge (Resid	ent
	documents to review	w. Resident D began shaking			81)."	
	badly and indicated	this conversation was			1. What corrective action(s	s)
	upsetting to him. He	e said he received the papers			will be accomplished for tho	se
	but did not understa	and what the notice of			residents found to have been	n
	discharge or reques	t for a hearing meant. On the			affected by the deficient	
	day of his discharge	e, he was in his room at the			practice?	
		indicated it was time to go. He			Resident D remains in	
		g down. He indicated he was			facility and failed interventions	s are
		neless shelter and the staff at			being documented. Resident	
	local homeless shel	ter indicated the facility had no			no plan for discharge.	

0Z2N11

08/28/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN 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 09/20/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (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 right to send him there. How other residents He indicated the SSD used to say that she would having the potential to be send him to the local homeless shelter as "a affected by the same deficient threat" to get him to go the psych hospital. On the practice will be identified and local homeless shelter day, he was mad and he what corrective action will be faced the wall. The police came and got him to go taken? to the front door. The police said if he didn't go to All residents with behaviors the local homeless shelter then he would go to jail and scheduled discharges have in the police car. He had 3 or 4 big bags of clothes the potential to be affected by this and medications. He indicated he did not know alleged deficient practice. how to take medications or when. The people at Social Service (SS) has local homeless shelter told him they do not reviewed all residents with dispense medications. He did not take any behaviors and pending discharges medications during his stay at local homeless to ensure failed interventions are shelter because he didn't know how to take it. The documented and communication local homeless shelter staff called the facility and with receiving facility has been put all his stuff in a van and brought him back to completed. No residents with the nursing facility. behaviors are currently pending discharge. One resident at local homeless shelter tried to "start something with him," he just turned and 3. What measures will be put walked away. His medication remained locked in in place or what systemic his locked locker the whole time he was at Local changes will be made to homeless shelter. Resident D indicated with his ensure that the deficient occasional severe shaking he was unable to read. practice does not occur? He indicated he did not try to read the medication All licensed clinical staff and packaging. He did not know how to take the Social Services will be in-serviced medication, he did not know what kind of medications he takes now, so he left them alone. o "Discharge/Transfer/Death" policy He indicated sometimes he thought about killing people. He had never killed anyone or tried to kill How the corrective action anyone. He only thought about killing his brother will be monitored to ensure the

and sister because they took his money and threw

him out. He indicated he was mad at the SSD but

During an interview on 9/20/22 at 10:47 a.m., the

had not thought about killing her. Sometimes he

felt like fighting, but not fighting to kill them.

deficient practice will not recur

program will be put into place?

with pending discharges three

SSD /Designee will complete an audit on 5 behavior residents

i.e., what quality assurance

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMP		LETED		
		155077	B. WING 09/20/			/2022	
		l .	1	STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			CHWAY DR		
	OF INDIANAPOLIS				APOLIS, IN 46224		
CINVIVE !	OF INDIANAPOLIS			INDIAN	AFOLIS, IN 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	` ′	and SSD indicated they were			times a week x8 weeks, then		
		Resident D from the facility			twice a week x4 weeks, then		
		viors. The psych physician			weekly x3 months to ensure		
	-	personality disorder, not			residents have failed intervent	ions	
		viors were at a very high level			documented and receiving fac	ility	
	-	er residents. The facility was			has received communication		
		s needs. They were able to			regarding COVID status, resid	ent	
		But this was a personality			assessment and change of		
		t "need to be around other			condition.		
	people."				The results of these audits will		
					reviewed by the QAPI commit		
		a.m., Resident D's record was			overseen by the Executive Dir		
		D was admitted on 10/15/21.			for no less than six months. Th	ne	
	-	ded, but were not limited to,			results will be reviewed for		
		(progressive deterioration of			patterns, trends and continued		
	· ·	zheimer's disease(progressive			recommendations for process		
		n), Homicidal Ideations			monitoring and improvement เ		
		nsidering, or planning a			100% compliance is achieved.		
		ic disorder with delusions (a			5. Date of completion:		
		h a disconnection from reality			10/21/2022		
		red reality), anxiety disorder					
	1	rder of feelings of worry, or					
		rith daily activities), diabetes					
		ar disorder), cognitive decline					
		ive ability such as memory,					
		nt and/or mental acuity), and					
		order, bipolar type (includes					
		izophrenia, affects a person's					
	_	elf, and perceptions, and a					
		as bipolar disorder which					
		depression). He resided on the					
	locked behavior uni	IL.					
	On 0/15/22 at 11:5/	lam a ravious of Davidant Dla					
		a.m., a review of Resident D's pleted. They were created on					
		ans lacked documentation of no					
	_						
		esident's 2 psychiatric hospital					
		22 and 7/20 to 7/29/22, and 5					
		residents. The care plan					
	problems were:		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022		
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD CHWAY DR	-	
ENVIVE	OF INDIANAPOLIS		INDIAN	IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		
mo	+	diagnosis of homicidal	1710		DATE	
	behavior.	5				
	2. The resident uses	anti-anxiety medication				
	related to anxiety d					
		anti-psychotic medications				
		ective disorder, bipolar type. ent, Potential for injury to self				
	or others.	ent, i otentiai for injury to sen				
		oits restlessness, nervousness				
	and/or other anxiety	y symptoms related to a				
	diagnosis of anxiety					
	5. Resident D had in	-				
		hought process related to				
	1 -	mer's and is at risk for decline. processes/altered mental				
		gnoses of schizoaffective				
		be and Psychotic disorder with				
		own physiological condition.				
	_	on 9/22/22, indicated the				
	1 *	ent D had (Auditory, Visual)				
	~	eption of something not episodes, talking to himself in				
	1 -	room, he had a history of				
	-	ors towards others, history of				
		owards others, abusive				
		f throwing items, making				
		males and wanting a girlfriend.				
		ve towards others, lunging at				
	_	s, and making threatening and interventions had not				
		the care plan was created on				
	5/4/22.	ane care plan was created on				
	•	able incidents to the Indiana				
	Department of Heal as follows:	th for the last 8 months were				
		s reported that Resident D				
		Lesident 16's cell phone. She				
	denied him and he					
l	i		1	I	I	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2022		
NAME OF P	ROVIDER OR SUPPLIER			ACHIMAN DD	DD	
ENVIVE	OF INDIANAPOLIS			ACHWAY DR NAPOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION PPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION as reported that Resident D	TAG	DEFICIENCY	DATE	
		Resident 17. Resident 17 was				
	hallucinating and w	vas sent to the hospital.				
		as reported that Resident 83				
		ents to Resident D, and Resident				
	D made contact wit					
		reported that Resident 17				
		ents to Resident D, and Resident				
	•	17. It was known that Resident				
	17 was in need of p	-				
		as reported that Resident 83 Resident D for no reason.				
		is reported that Resident D				
		Resident C fell and fractured				
	his wrist.	resident e fen und nuctured				
	1115 1111511					
	On 9/15/22 at 11:50	a.m., Resident D's "soft file"				
		e SSD. These were dated				
		mation regarding Resident D				
	and his progress to	discharge. No times were				
	noted.					
		no time noted, the Social				
	,	SSD) indicated she had a				
		he Ombudsman 41. She				
		SSD to schedule a discharge				
		issue 30-day notice and allow				
		e an appeal within 10 days. She				
	1.1	nad not been made within 10 ity had the right to discharge				
		ocal homeless shelter. She				
		SSD set the resident up with an				
		he local mental health				
	* *	SD had told the Ombudsman				
	-	made sexual comments, verbal				
		ssion towards staff and peers,				
		nt with all ADLs, scored high				
		erview for mental status) and				
	· ·	harge to the local homeless				
	shelter.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì	ULTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE COMP	
		155077	B. W	ING		09/20	/2022
	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OF CORRECTIO	.T	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NATE	DATE
	-On 3/9/22 with no	time noted, SSD indicated she					
	contacted the office	of the Ombudsman but was					
	unable to get through	gh, left a voicemail and emailed					
	Ombudsman 43. Th	ne SSD received a phone					
	number for the loca	l homeless shelter.					
		time noted, SSD received a call 42 who stated she was filling in.					
		mation to Ombudsman 42 on					
	_	plained safety concerns with					
		ng to the facility. She stated					
		uld decide based on the safety					
		e facility but indicated to					
	^	psych hospital can call the					
		ile a complaint and there could					
		mbudsman 42 recommended					
	_	k with psych hospital to find					
	-	ent that would agree to accept					
	him, especially all 1	-					
	inni, especially and	nare racinty.					
	-On 3/11/22 with no	o time noted, Resident D scored					
	13/15 on BIMS. SS	D contacted Ombudsman 42 to					
	discuss the facility's	s right to discharge Resident D					
	to Local homeless s	shelter due to concerns with					
	him. She stated the	facility had the right to					
	discharge him to the	e Local homeless shelter. SSD					
	informed Ombudsn	nan 42 that Resident D was					
	independent with al	ll ADLs, recommended for					
	_	ment, and informed					
	Ombudsman 42 tha	t SSD had already contacted					
	the local mental hea	alth outpatient center regarding					
		intment. The SSD had					
		portation number that was					
		om the mental health outpatient					
		ed information of the discharge					
		sportation provider, and					
	transportation state	d they just needed a contact					
	number at the local	homeless shelter to inform					
	them of pick-up tim	nes for Resident D on					

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appointment days. The transportation provider

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	l í	JILDING	nstruction 00	(X3) DATE COMPL 09/20/	ETED
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			45 BEA	NDDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	stated the local mer would contact trans transport with date does not need to sold the contact transport with date does not need to sold the contact transport with date does not need to sold the contact transport with neeting was held we have an inpatient process asked Resident D if psych stay, Resident fight. SSD agreed a becoming very loudy yelling and screaming (activity of daily livindependent with all management., discurdent of the concerns of other revery agitated and be SSD and ADON, stomated to stay at the speaking to Resider out. SSD educated behavior and disrupt continued to yell are redirect him but was SSD and ADON to the contact of the contact of the contact of the contact of the chair is regarding the significant D this after behaviors. He denied SSD re-educated him the expressed under	ntal health outpatient center portation to schedule and time, they stated SSD hedule this with them. In time noted, a care plan with SSD, Assistant Director of and Resident D. SSD discussed mitted to facility this morning sychiatric (psych) stay. SSD The recalled the reason for the at D indicated he got into a and discussed behaviors of a with threatening behavior and out. We discussed his ADL wing) status of being all ADLS except medication assed his potential 30-day neless shelter due to safety esidents. Resident D became began yelling and screaming at ated he's not leaving, and he are facility. SSD had difficulty and D due to yelling, screaming Resident D on current verbal betion to other peers. Resident and scream. SSD attempted to sunsuccessful. He screamed at		TAG	DEPICIENCY		DATE
	during this visit.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING B. WING	00	COMPLI 09/20/2	ETED	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS			APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	N DE	(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	RIATE	COMPLETION DATE
IAG		54 p.m., a Social Services (SS)	IAG			DATE
		lent D was visited by Psych				
		with no concerns regarding				
	behavior, psychosoc	cial well-being, or mood. The				
	Social Service Direct	ctor (SSD) also visited with				
		s pleasant. No signs or				
		osocial well-being, mood				
	concerns, or behavior	ors noted.				
		o time noted, the SSD was				
		was upset with a female peer				
		not have another boyfriend.				
	-	oke with him. He admitted to				
	SSD educated Resid	r and state he was jealous.				
		having behaviors and the				
		ny discharge. He expressed				
	_	his behavior could cost him a				
	-	sked for a second chance. SSD				
	-	eak with the Administrator.				
	They would speak to	o him again next week.				
		3 p.m., an SSD note indicated				
		h Resident D who was in good				
	_	no behaviors, no signs or				
		osocial well-being or mood				
	concerns.					
	- On 3/24/2022 at 2	:34 p.m., an SSD note indicated				
		Visited with Resident D. SSD				
		ng behaviors towards staff				
		eaming out, his impulsive				
		y concerns. Resident D was				
		Discharge Notice that was				
		s day. He was educated on the				
		al, and provided details on ducated Resident D that he				
	· ·	the local homeless shelter.				
		D on being followed by the				
		outpatient center for				
		-	I	l		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIEF OF INDIANAPOLIS		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Resident D became voice, he continued SSD educated Resid	ment after his discharge. agitated and began to raise his to ask for another chance. dent D again on his behaviors. Day Notice to Discharge bmbudsman.			
	the Assistant Direct currently the Interir scored at a high rish	a.m., a nursing note indicated for of Nursing (ADON), m DON, indicated Resident D con an elopement assessment endently mobile and having			
	40 indicated in a lat discharge visit with was being seen toda the local homeless a past medical histo Alzheimer's disease Parkinson's disease age-related cognitive tremor, muscle wea and insomnia. He dacute distress at this	a.m., the Nurse Practitioner (NP) the entry that she had a Resident D. She indicated he ay for discharge planning to shelter per the facility. He had been by of psychotic disorder, the schizoaffective disorder, diabetes mellitus type 2, the decline, anxiety disorder, theness, difficulty in walking, the in a chair. He was oriented to			
	was pleasant and co sent with Resident I - On 4/22/22 at 2:5; indicated the SSD I several times throug upcoming discharge Resident D of the c from the facility to appointment on 4/2 transported to the lo	ith periods of confusion. He properative. Medications were D upon his discharge. By p.m., the Discharge Summary and spoken with Resident D ghout this week regarding his e on 4/22/22. She informed linic providing transportation their clinic for an initial 2/22, then would be local homeless shelter. agitated throughout these			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTI A. BUILDI B. WING		nstruction 00	(X3) DATE COMPI 09/20	LETED	
	PROVIDER OR SUPPLIE OF INDIANAPOLIS		45	BEAG	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	IE PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	another chance. SS Resident D by eduction due to him yelling with Resident D or discharge to the location of the 30-day discharge to the location of the second of	6 p.m., the Staffing Manager indicated Resident D at 5:15 p.m. today. Resident cations and his belongings. He om on the locked behavior unit. were received to give him his on now per NP 40. He was alert 3. He ambulated on own e device. His gait was steady. 0 p.m., Resident D's ission form indicated he was local homeless shelter. He was place, time, and situation. He dementia and used 9 or more					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	•			APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		was notified of Resident D					
		fied Nursing Aide (CNA) on					
		sked Resident D why he did it,					
		propriate behaviors and					
	_	vior was inappropriate.					
	Resident D apologi						
	1 0						
	- On 6/1/22 with no	time noted, SSD was notified					
	of Resident D becom	ming agitated and verbally					
	aggressive as he sta	ted he was jealous of the					
	other peers wanting	g a girlfriend. SSD was able to					
	redirect him with co	onversation, walking on the					
	unit and offered act	ivities of interest. He appeared					
	in a better mood wi	th no further behaviors noted.					
		no time noted, the SSD, DON					
	_	sych physician and the					
		P discussed Resident D and					
		ible in-patient referral was					
		nding Psych physician who					
		cal inpatient Psych denied him					
		stating medications would not					
	_	This was his personality and					
		not change or help him. He					
		acility send Resident D to the					
		outpatient center emergency					
		nded the facility to not accept					
	him back to the faci	inty.					
	- On 8/4/22 with no	time noted, the SSD attempted					
		mental health outpatient					
		oup home placement but was					
		gh and unable to leave a voice					
	message.	2					
	- On 8/9/22 with no	time noted, SSD spoke with					
	Ombudsman 44 and	d requested recommendations					
	and thoughts regard	ling placement for Resident D.					
	Ombudsman 44 ind	licated a place to try who					
	accepted residents v	with behaviors.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	СОМ	e survey pleted 0/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	she received a call the and he indicated the said you must have accept him. On 9/19/22 at 2:32 had provided all tra D. He did not sign a documents. On 9/19/22 at 2:33 indicated Resident 1 contract with the farmage of the farmage	p.m., the Activity Director (AD) Aide 36 had a good esident D and was able to ent D liked to do crafts, loved tivity staff talked to him. She of know if the evening/night ad special activities for him, where the activity room key uld have had access to ure. The facility also bought in he was out. Activity he building 7 days a week until p.m., the SSD indicated deaning and organizing things aff knew the resident very well. but cars. He liked to compare icated she would take a look at ads. The SSD indicated o making a binder of activities					
	On 9/20/22 at 10:33	3 a.m., the SSD indicated the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2022
	PROVIDER OR SUPPLIER OF INDIANAPOLIS	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	psych physician indicated to the facility to send Resident D to the local mental health outpatient center emergency room and not accept him back. They did not follow these instructions.			
	On 9/20/22 at 11:00 a.m., the SSD provided a list of referred facilities to whom she had applied to send Resident D. Many of these buildings did not have a locked unit. Her documentation indicated she referred him to 37 buildings, 3 of them twice.			
	On 9/20/22 at 11:16 a.m., the SSD indicated the Director of the Local homeless shelter called and talked to SSD and Administrator. He was very upset about Resident D arriving at the homeless shelter. He indicated the facility had to have permission. He called on 4/25/22 and insisted Resident D come back to the facility.			
	On 9/12/22, the Admissions Agreement was provided by the facility. A document within the Admission Agreement titled, "Indiana Resident Rights and Facility Responsibilities," was reviewed. It indicated, "The resident has the right to be cared for in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individualityA copy of the resident's			
	rights must be available in a publicly accessible area. The copy must be at least 12-point typeThe transfer and discharge rights of residents of a facility are as followsbefore an interfacility transfer or discharge occurs, the facility mustplace a copy of the notice in the resident's clinical record and transmit a copy to the followingthe local long term care ombudsman program for involuntary relocations or discharges onlythe notice of transfer or dischargemust be made by the facility at least thirty (30) days before the resident is transferred			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022
	PROVIDER OR SUPPLIE		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
TAG	or dischargedAt resident's medical, with respect to the and a plan devised relocation plan is or prior to the relocat or her designee, the legal representative shall be to discuss proposed relocation was completed for a.m. She had the delimited to chronic atrial fibrillation, and diabetes mellitus, or edema. A Nurse Practition at 12:32 p.m., indicated that Refineer extremit (diuretic) was increased. A nursing progress a.m., indicated that weighed indicating did not want to be a nursing progress indicated that Resindicating that the mouth/thirst of tormovement making. A nursing progress indicated that the mouth/thirst of tormovement making medication made in diuretic) indicating medication made in diuretic indicating medication made in diuretic indicating medication made in diuretic indication made in diuretic indicating medication made in diuretic indication in diu	the planning conference, the psychosocial, and social needs relocation shall be considered to meet these needsIf the lisputed, a meeting shall be held ion with the administrator or his e resident, and the resident's eThe purpose of the meeting possible alternatives to the n plan" B. A record review Resident 81 on 9/20/22 at 9:41 iagnoses including, but not obstructive pulmonary disease, cute kidney failure, type 2 congestive heart failure, and er progress note, dated 9/2/22 cated a blood pressure of 99/58. esident 81 had pitting edema in ites and hands. Torsemide eased on 8/29/22. Sonote, dated 9/3/22 at 10:13 at the resident refused to be gethat she did not feel good and rolled (turned) yet. Sonote, dated 9/3/33 at 2:33 p.m., dent 81 refused torsemide side effects, unusual dry semide and uncontrollable hand it hard for her to eat.	TAG	DEFICIENCY)	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (0) COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING 00 COMPLETED B. WING 09/20/2022		
		100011		CADDRESS CITY OF THE SID COS	33/20/2022
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	A nursing progress indicated that Resid 129/84. A nursing progress indicated a blood pressure 80mg of La increased swelling, with no shortness or saturation of 96% of her blood pressure and her metoprolol high blood pressure labs ordered for late metabolic profile), and BNP (b-natrium status. Resident 81 was ser 9/7/22 for unstable pupil, and difficulty signs documented a was admitted to the (low blood pressure). The VP of Clinical 9/20/22 at 12:49 p.r. discharge/transfer supon transfer of Recommunicate Resid and assessment of her A policy titled, Disc date of 8/2022, was on 9/21/22 at 1:06 pthe following will by the state of the following will by the state of the state of the following will by the state of the state of the following will by the state of the state of the following will by the state of the state of the following will by the state of the following will by the state of the following will by the state of the following will be stated to the following will be sta	note, dated 9/4/22 at 4:21 p.m., lent 81 had a blood pressure of note, dated 9/6/22 at 6:17 p.m., ressure reading of 109/57 and a daily diuretics but had to six intramuscular due to She was noted to be anxious f breath and oxygen n room air. It indicated that was slightly low the day prior (a medication used to treat) was held as a result. She had er in the day, BMP (basic CBC (complete blood count) etic profile) to evaluate volume of to the local hospital on vital signs, weakness, dilated a speaking. There were no vital t time of transfer. Resident 81 hospital with hypotension e) and altered mental status. Services was interviewed on m. She indicated that a ummary was not completed sident 81 to the hospital to ent 81's pertinent information	TAG	CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)	ATE DATE
ı	resident's medical re	ecords: a. An evaluation of the			

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SENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		155077	B. WING		_	09/20/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS	}			CHWAY DR APOLIS, IN 46224		
(VA) ID	CLIMANA DAY	CTATEMENT OF DEFICIENCIE		-	,		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		needs, b. The post-discharge					
	plan, c. The dischar						
	2.1.12(.)(1)						
	3.1-12(a)(4)						
	3.1-12(a)(6)(A)						
F 0623	483.15(c)(3)-(6)(8	3)					
SS=D	Notice Requireme						
Bldg. 00	Transfer/Discharg	je					
	. , , ,	ice before transfer.					
	1	ansfers or discharges a					
	resident, the facili	-					
		ent and the resident's					
		of the transfer or discharge					
		or the move in writing and in nanner they understand. The					
		a copy of the notice to a					
	· ·	the Office of the State					
	Long-Term Care (
	-	asons for the transfer or					
		esident's medical record in					
	accordance with p	paragraph (c)(2) of this					
	section; and						
		notice the items described					
	in paragraph (c)(5	o) of this section.					
	§483.15(c)(4) Tim	ning of the notice					
		cified in paragraphs (c)(4)(ii)					
		section, the notice of					
		rge required under this					
	section must be m	nade by the facility at least					
	30 days before the	e resident is transferred or					
	discharged.						
		e made as soon as					
	•	transfer or discharge when-					
	` '	individuals in the facility					
	_	ered under paragraph (c)(1)					
	(i)(C) of this section						
	(B) The health of i	individuals in the facility					

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would be endangered, under paragraph (c)(1)

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EPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 093			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>00</u>	COMPLETED			
	155077	D. WINC	00/20/2022			

	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	
X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE
	(i)(D) of this section (C) The resident's to allow a more im discharge, under presection; (D) An immediate required by the research of the control of the co	health improves sufficiently mediate transfer or paragraph (c)(1)(i)(B) of this transfer or discharge is sident's urgent medical graph (c)(1)(i)(A) of this not resided in the facility Itents of the notice. The cified in paragraph (c)(3) of include the following: transfer or discharge; ate of transfer or discharge; which the resident is harged; fithe resident's appeal e name, address (mailing lephone number of the res such requests; and we to obtain an appeal form completing the form and real hearing request; lress (mailing and email) mber of the Office of the Care Ombudsman; cility residents with velopmental disabilities or the mailing and email hone number of the agency exprotection and advocacy developmental disabilities			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SO			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155077	B. W	ING		09/20/	2022
	PROVIDER OR SUPPLIER		<u>.</u>	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	FIX (EACH CORRECTION FOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mailing and email number of the age protection and admental disorder exprotection and Ad Individuals Act. §483.15(c)(6) Chalf the information is to effecting the trafacility must update notice as soon as updated information. §483.15(c)(8) Not closure. In the case of faci who is the administ provide written not impending closure.	r related disabilities, the address and telephone ency responsible for the vocacy of individuals with a stablished under the vocacy for Mentally III anges to the notice. In the notice changes prior ansfer or discharge, the te the recipients of the practicable once the on becomes available. It is in advance of facility It is closure, the individual estrator of the facility must tification prior to the et to the State Survey et of the State Long-Term in, residents of the facility,					
		epresentatives, as well as					
	the plan for the tra	ansfer and adequate					
		esidents, as required at §					
	review, the facility the locked behavior of discharge and fai of a facility initiated	on, interview, and record failed to ensure a resident in ral unit received proper notice filed to notify the ombudsman d resident discharge for 1 of 3 towed for discharge (Resident	F 00	523	F623 – Notice Requirements Before Transfer/Discharge SS=D "Based on observation, intervie and record review, the facility failed to ensure a resident in the locked behavioral unit received proper notice of discharge and failed to notify the ombudsman	ne d	10/21/2022
	-				a facility initiated resident		
	_	v on 9/19/22 at 2:17 p.m., the			discharge for 1 of 3 residents		
		ctor (SSD) indicated she e of Transfer or Discharge to			reviewed for discharge (Reside D)."	ent	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155077	B. W	TNG		09/20/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER				CHWAY DR	
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224		
	T				,	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE
		/22 at 4:30 p.m. It was at the			1. What corrective action(s	-
	end of the business day and did not count as day				will be accomplished for tho	
	1. It indicated the effective date for the discharge				residents found to have been	n
		ent D was removed from the			affected by the deficient	
	locked unit and escorted by the police out of the				practice?	
	building on 4/22/22. The SSD indicated she did					
	not realize the date was different on the Notice of Transfer/Discharge. The reason indicated the				Resident D remains in th	e
					facility and has no plan for	
	safety of the individuals in the facility was endangered. Resident D was removed from the				discharge currently.	
	_					
	building after 28 da	ys had expired on 4/22/22.			2. How other residents	
	4 D' 1 I C				having the potential to be	
	A Discharge Information document with Resident D name and dated 4/22/22 indicated Resident D				affected by the same deficien	
					practice will be identified and	
	_	d with 30 days' worth of			what corrective action will be	e
	_	escriptions would be filled			taken?	
	1	clinic. Part of his discharge				
	information was a c	opy of his April MAR.			All residents in the locked	d
		0/10/00 0.00			behavior unit with planned	
	_	on 9/19/22 at 2:20 p.m., the			discharges have the potential	to
		ated Resident D did not sign			be affected by this alleged	
		ments. The ombudsman had			deficient practice.	
		nt would have 10 days to			00/5	.
		d he was not appealing by			SS/Designee will audit al	
		ng when escorted out of the			pending discharges from the	
	building by the poli	ce.			locked behavior unit to ensure	
	0 0/15/22 11.56) - m Daridant DI			resident, and ombudsman hav	/e
		a.m., Resident D's record was			been notified.	
		D was admitted on 10/15/21.			0 14/1-24	4
	~	ded, but were not limited to,			3. What measures will be p	out
		(progressive deterioration of			in place or what systemic	
	· · · · · · · · · · · · · · · · · · ·	zheimer's disease(progressive			changes will be made to	
		n), Homicidal Ideations			ensure that the deficient	
		nsidering, or planning a			practice does not occur?	
	1	ic disorder with delusions (a			All licensed clinical staff a	and
		h a disconnection from reality			SS will be in-serviced on:	
		red reality), anxiety disorder			o "Discharge Policy"	
	1	der of feelings of worry, or				
		ith daily activities), diabetes			4. How the corrective action	
	mellitus (blood suga	ar disorder), cognitive decline			will be monitored to ensure t	the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155077	B. WING		09/20/2022
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIER	2		CHWAY DR	
ENVIVE	OF INDIANAPOLIS			IAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		tive ability such as memory,		deficient practice will not red	cur
	1	nt and/or mental acuity), and		i.e., what quality assurance	
		order, bipolar type (includes		program will be put into place	e?
		izophrenia, affects a person's		· SSD/Designee will audit	
	_	elf, and perceptions, and a		residents in the locked behavi	
		as bipolar disorder which		unit with pending discharges t	hree
		depression). He resided on the		times a week x8 weeks, then	
	locked behavior uni	t.		twice a week x4 weeks, then	
				weekly x3 months to ensure	
	_	able incidents to the Indiana		resident and ombudsman hav	е
	_	th for the last 8 months were		received notice of discharge.	
	as follows:			The results of these audits wil	
	·	as reported that Resident D		reviewed by the QAPI commit	
		desident 16's cell phone. She		overseen by the Executive Dir	
	denied him and he			for no less than six months. T	he
		as reported that Resident D		results will be reviewed for	
		Resident 17. Resident 17 was		patterns, trends and continued	
		as sent to the hospital.		recommendations for process	
		s reported that Resident 83		monitoring and improvement u	
		nts to Resident D, and Resident		100% compliance is achieved	
	D made contact with				
		reported that Resident 17		5. Date of completion:	
		nts to Resident D, and Resident		10/21/2022	
	_	17. It was known that Resident			
	17 was in need of p	-			
		is reported that Resident 83			
		Resident D for no reason.			
	· ·	s reported that Resident D			
	1 -	Resident C fell and fractured			
	his wrist.				
	On 9/15/22 at 11.50	a.m., Resident D's "soft file"			
		e SSD. These were dated			
	paragraphs of information regarding Resident D and his progress to discharge. No times were				
	noted.				
	- On 2/23/22 with no time noted, the Social				
		SSD) indicated she had a			
		he Ombudsman 41. She			

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recommended the SSD to schedule a discharge

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	care plan meeting, i Resident D to make stated if an appeal h days, then the facili Resident D to the lo recommended the S appointment with th outpatient center. S 41 the resident had and physical aggres but was independen on BIMS (brief inte inquired about discl shelter. -On 3/9/22 with no contacted the office unable to get throug Ombudsman 43. Th number for the loca -On 3/9/22 with no was asked to contact outpatient center on established and she appointment. The lo center provided their contact. Resident w months by a psychia month. -On 3/9/22 with no from Ombudsman 4 SSD provided infor Resident D. She exp the resident returning that the facility shou of the patients in the understand that the	ssue 30-day notice and allow an appeal within 10 days. She had not been made within 10 ty had the right to discharge hocal homeless shelter. She had solve the resident up with an hae local mental health had told the Ombudsman hade sexual comments, verbal has not towards staff and peers, hat with all ADLs, scored high harview for mental status) and harge to the local homeless time noted, SSD indicated she had of the Ombudsman but was had, left a voicemail and emailed he SSD received a phone			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS						
EINVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX CRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	be repercussions. O	mbudsman 42 recommended					
	that SSD try to work with psych hospital to find						
	alternative placement that would agree to accept						
	him, especially all male facility.						
	-On 3/9/22 with no time noted, SSD referred Resident D to several facilities, most have denied						
	him.						
		o time noted, Resident D scored					
		D contacted Ombudsman 42 to					
	discuss the facility's right to discharge Resident D						
		shelter due to concerns with					
		facility had the right to					
	_	e Local homeless shelter. SSD					
		nan 42 that Resident D was					
		ll ADLs, recommended for					
	_	ment, and informed					
		t SSD had already contacted					
		alth outpatient center regarding					
	scheduling an appo	intment.					
	On 3/11/22 with n	o time noted, a care plan					
		vith SSD, Assistant Director of					
	_	nd Resident D. SSD discussed					
		mitted to facility this morning					
		sychiatric (pysch) stay. SSD					
		The recalled the reason for the					
		at D indicated he got into a					
		nd discussed behaviors of					
		l with threatening behavior					
		ng out. We discussed his ADL					
		ving) status of being					
	1 ' -	Il ADLS except medication					
		ussed his potential 30-day					
	_	neless shelter due to safety					
		esidents. Resident D became					
		egan yelling and screaming at					
		rated he's not leaving, and he					
		e facility. SSD had difficulty					
]	, ,					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20/	ETED
	PROVIDER OR SUPPLIER OF INDIANAPOLIS			45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	out. SSD educated behavior and disrupt continued to yell arredirect him but was SSD and ADON to On 3/16/22 at 2:55 the DON of Reside staff regarding the significant of the chair Resident D this after behaviors. He denied SSD re-educated him He expressed under during this visit. On 3/18/22 at 12:10 note indicated Resident D who was symptoms of psychosomological Service Direct Resident D who was symptoms of psychological Service Direct Resident D who was symptoms of psychological Service Direct Resident D who was symptoms of psychological Service Direct Resident D who was symptoms of psychological Service Direct Resident D who was symptoms of psychological Service Direct Resident D and told her she can SSD and ADON sphaving this behavior SSD educated Resiconversation of him potential for a 30-dunderstanding that 30-day notice. He a stated she would spin spin spin spin spin spin spin spin	B p.m., the SSD was notified by int D had become agitated with smoking time. He slammed his in hallway. SSD spoke with ernoon regarding his ed having these behaviors. In on appropriate behaviors in appropriate behaviors noted. 54 p.m., a Social Services (SS) dent D was visited by Psych y with no concerns regarding cial well-being, or mood. The ctor (SSD) also visited with its pleasant. No signs or osocial well-being, mood ors noted. The time noted, the SSD was was upset with a female peer mot have another boyfriend. The oke with him. He admitted to it and state he was jealous.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	r í	UILDING	NSTRUCTION 00	(X3) DATE COMPI 09/20	LETED
	PROVIDER OR SUPPLIEI			45 BEA	.DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	•	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	ROPRIATE	DATE
		3 p.m., a SSD note indicated the					
		esident D who was in good no behaviors, no signs or					
		nosocial well-being or mood					
	concerns.	C					
		2:34 p.m., a SS note indicated the					
		sited with Resident D. SSD					
		ng behaviors towards staff reaming out, his impulsive					
	, ,	ty concerns. Resident D was					
	educated on 30 Day Discharge Notice that was						
	issued to him on this day. He was educated on the						
	right to file an appeal, and provided details on						
		educated Resident D that he the local homeless shelter.					
		D on being followed by the					
		outpatient center for					
		ement after his discharge.					
		e agitated and began to raise his					
		I to ask for another chance.					
		dent D again on his behaviors.					
	Resident D to the C	0-Day Notice to Discharge					
		29 p.m., an SSD note indicated					
		an outpatient clinic and					
		ule an initial primary care pointment the outpatient clinic					
		m admissions would contact					
		schedule initial appointment.					
	The outpatient clin						
	transportation to an	nd from his appointments.					
		6 a.m., a nursing note indicated					
		tor of Nursing (ADON),					
	1 '	m DON, indicated Resident D					
		k on an elopement assessment endently mobile and having					
	dementia.	chachay moone and having					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20/	ETED
	PROVIDER OR SUPPLIEI			45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	40 indicated in a lar discharge visit with was being seen took the local homeless a past medical history. Alzheimer's disease age-related cognitive tremor, muscle were and insomnia. He discute distress at this was resting quietly person and place with was resting quietly person and place with Resident. - On 4/22/22 at 2:5 indicated the SSD I several times through upcoming discharge scheduling an initial local outpatient clinic providing tratheir clinic for an inthen would be transported to the transportational mental health initial appointment transport him to an mental health outpative back with incleft a voice mail. Rethroughout these vioccasions for anoth redirect Resident District the discountry of the providence of t	a.m., the Nurse Practitioner (NP) the entry that she had a a Resident D. She indicated he ary for discharge planning to shelter per the facility. He had any of psychotic disorder, to except the facility. He had any of psychotic disorder, to except the facility to have the facility to have the facility in walking, and not appear to be in any as time or during this visit. He in a chair. He was oriented to ith periods of confusion. He coperative. Medications were D upon his discharge. By p.m., the Discharge Summary and spoken with Resident D ghout this week regarding his to en 4/22/22. She discussed all PCP appointment through and, informed Resident D of the insportation from the facility to initial appointment on 4/22/22, apported to the local homeless ent clinic would refill his by. She provided Resident D ion number. She contacted the outpatient center to schedule they indicated they would deform appointment date as writer esident D became agitated sits and asked on different er chance. SSD attempted to by educating him but was in yelling at writer. Staff					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTI A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 09/20/	ETED
	PROVIDER OR SUPPLIER		4	5 BEAC	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	regarding his dischashelter related to the Resident refused to and screaming, with told the staff the on the cops were called contacted to assist an outpatient clinic. Resident D outside contact the outpatien D's initial appointment had arrived and word discharged with mentand discharge information. On 4/25/22 at 5:50 Coordinator/Unit M returned to facility are turned with media was placed in a roo Physician's orders without an assistive without an assistive. On 4/25/22 at 6:00 Admission/Readmin admitted from the Loriented to person, had a diagnosis of comedication. His cognitive spoke with the Director. He indicated back to the facility inform them of Resinformed the Shelter informed the sh	Janager indicated Resident D at 5:15 p.m. today. Resident cations and his belongings. He m on the locked behavior unit. Evere received to give him his on now per NP 40. He was alert 3. He ambulated on own device. His gait was steady. D p.m., Resident D's sesion form indicated he was ocal homeless shelter. He was place, time, and situation. He dementia and used 9 or more					

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETIO DATE	ΝC
arrival because they	took walk-ins. The Shelter nat was no longer the case.				
indicated Ombudsman the Ombudsman prothe SSD entry for the Ombudsman Leader facility several times information or quest discharge never cam received a Notificati from the facility for got a notice of disch facility to advocate facility to a	udsman spoke with Resident in would have known they is Resident D to the local y would not have agreed to SSD never asked us to see y asked questions about how ischarge residents, nothing atte for the residents. o.m., Ombudsman 42 indicated in SSD on 3/9/22. The SSD				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20/	ETED
	PROVIDER OR SUPPLIER			45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	homeless shelter, sl homeless shelter. S possibility of conse him back, someone and file a complain "dumping" (residen are often released e care for themselves On 9/12/22, the Ad provided by the fac Admission Agreem Rights and Facility reviewed. It indicat right to be cared for	he told them to call the local he warned the SSD of the quences if she refused to take could call the Board of Health t because that was considered tts suffering from mental illness ven though they are unable to). missions Agreement was ility. A document within the ent, titled, "Indiana Resident Responsibilities," was ed, "The resident has the r in a manner and in an		IAU	DIA CHIACTI		DATE
	resident's dignity and his or her individual rights must be available area. The copy musum. The transfer and a facility are as foll transfer or discharge implace a copy of the clinical record and following in the local residual record.	aintains or enhances each and respect in full recognition of lityA copy of the resident's able in a publicly accessible at be at least 12-point type discharge rights of residents of owsbefore an interfacility e occurs, the facility must be notice in the resident's transmit a copy to the allong term care ombudsman					
	onlythe notice of be made by the fact before the residentAt the planning comedical, psychosocomespect to the relocation plan is deprior to the relocation plan is deprived by the plan is deprived by the factor of the plan is deprived by the factor of the plan is deprived by the factor of the factor of the plan is deprived by the factor of the factor of the plan is deprived by the factor of the factor of the plan is deprived by the factor of the factor of the plan is deprived by the factor of the factor of the plan is deprived by the factor of the factor o	ntary relocations or discharges f transfer or dischargemust lity at least thirty (30) days is transferred or discharged conference, the resident's ial, and social needs with ation shall be considered and a set these needsIf the isputed, a meeting shall be held on with the administrator or his resident, and the resident'sThe purpose of the meeting cossible alternatives to the a plan"					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		45 BEA	ACHWAY DR	
ENVIVE	OF INDIANAPOLIS		INDIAN	NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	was provided by the A review of the pol discharge summary the resident's stay a summary of the resident's stay a summary of the resident's information and as discharge summary the resident's As summary, the nurse medication with the medications. The medications. The medications. The medication of the resident's caregiver, capacity and capabination of the resident's condition of the resident's condition of the resident's condition of the resident's condition of the final post-discharge pof the final post-discharge pof the final post-discharge preferred to local age that can assist in accommunity. If the returning to the control of the contr	cled, "Discharge," dated 8/2022, e VPCS on 9/21/22 at 1:03 p.m. icy indicated, " The will include a recapitulation of a this facility and a final ident's status at the time of the ance with established ing release of resident permitted by the resident. The shall include a description of part of the discharge will reconcile all pre-discharge resident's post-discharge indication reconciliation will be post-discharge plan will be are Planning/Interdisciplinary stance of the resident A esident's stated goals; the support person availability, lity to perform required care make the resident vulnerable mission The discharge plan all based on changes in the or needs prior to discharge esentative will be involved in planning process and informed charge plan Residents will resident indicates an interest in informity, he or she will be encies and support services commodating the resident's erences If it is deterred that munity is not feasible, it will a this is the case and who tion A member of the IDT am) will review the final with the resident and family (24) hours before the			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	NG		09/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				CHWAY DR		
ENIVIVE (OF INDIANAPOLIS				APOLIS, IN 46224		
	OI INDIANAI OLIO			INDIANAI OLIO, IN 40224			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	placeA copy of the					
		ovided to the resident and					
	receiving facility and a copy will be filed in the						
		ecords: An evaluation of the					
	_	needs; the post-discharge					
	pan; and the dischar	ge summary"					
	3.1-12(a)(6)(A)(iv)						
	3.1-12(a)(7)						
E 0004	400 45()(7)						
F 0624 SS=G	483.15(c)(7)	f- 10 - d - d - T f 1/D d					
Bldg. 00		fe/Orderly Transfer/Dschrg					
Blug. 00	- , , , ,	entation for transfer or					
	discharge.	uide and decument					
	•	vide and document ion and orientation to					
		e safe and orderly transfer					
		the facility. This orientation					
	_	in a form and manner that					
	the resident can u						
		on, interview, and record	F 00	524	F624 – Preparation for		10/21/2022
		failed to ensure a resident was	1 1 00)24	Safe/Orderly		10/21/2022
		ed for discharge with no plan			Transfer/Discharge		
	with the receiving fa				SS=G		
		social harm for 1 of 3 residents			"Based on observation, intervi	ew.	
	reviewed for discha				and record review, the facility	,	
		,			failed to ensure a resident was	S	
	Findings include:				oriented and prepared for		
	-				discharge with no plan with the	e	
	On 9/15/22 at 11:50	a.m., Resident D's chart and			receiving facility, the resident		
	the "soft file" from	the Social Services Director			experienced psychosocial har	m for	
	(SSD) were reviewe	ed. The "soft file," was			1 of 3 residents reviewed for		
	provided by the SSI	D. These were dated			discharge (Resident D)."		
	paragraphs of inform	nation regarding Resident D			1. What corrective action(s	s)	
	and his progress to	discharge. No times were			will be accomplished for thos	se	
	noted. Resident D w	vas admitted on 10/15/21.			residents found to have beer	1	
					affected by the deficient	ļ	
	-	ded, but were not limited to,			practice?	ļ	
		(progressive deterioration of			· Resident D remains in the	е	
	motor function), Ala	zheimer's disease(progressive			facility and has no plan for		

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	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOEICIENCY)	
TAG	mental deterioration (thinking about, corhomicide), Psychotic mental disorder with with a belief in alter (mental health disorfear that interfere with mellitus (blood sugareduction in cognitic awareness, judgmer Schizoaffective disorfeatures of both schithinking, sense of somood disorder such includes mania and locked behavior unit On 9/15/22 at 11:50 care plans were con 5/4/22, with no revi	LSC IDENTIFYING INFORMATION a), Homicidal Ideations sidering, or planning a c disorder with delusions (a n a disconnection from reality red reality), anxiety disorder der of feelings of worry, or ith daily activities), diabetes ar disorder), cognitive decline ive ability such as memory, at and/or mental acuity), and order, bipolar type (includes izophrenia, affects a person's elf, and perceptions, and a as bipolar disorder which depression). He resided on the	TAG	discharge. 2. How other residents having the potential to be affected by the same deficie practice will be identified ar what corrective action will be taken? All residents with planned discharge have potential to be affected by deficient practice. SS/Designee will audit a residents with pending discharge to ensure residents are orien and prepared for discharge a plan is in place with receiving facility. 3. What measures will be in place or what systemic changes will be made to	ent nd pe ed ee
	5 incidents with oth sustained a fractured Resident D. The car 1. Resident D had a behavior. 2. The resident uses related to anxiety di 3. The resident uses related to schizoaffe Behavior managemor others. 4. Resident D exhib and/or other anxiety diagnosis of anxiety 5. Resident D had in function/impaired the diagnosis of Alzheir 6. Impaired thought	er residents. Resident C d wrist after he was pushed by e plan problems were: diagnosis of homicidal anti-anxiety medication sorder. anti-psychotic medications ective disorder, bipolar type. ent, Potential for injury to self its restlessness, nervousness symptoms related to a		ensure that the deficient practice does not occur? All licensed clinical and staff will be in-serviced on: o "Discharge Policy" How the corrective activity will be monitored to ensure deficient practice will not reive., what quality assurance program will be put into pla DNS/designee will audit pending discharges three tim week x8 weeks, then twice a week x4 weeks, then weekly months to ensure discharging residents are oriented and prepared for discharge and a	ion the ccur ce? : 5 es a x3

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
	SUMMARY SUMMAR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION DOE and Psychotic disorder with Down physiological condition. Siese dated 9/22/22, it indicated Sident D had (Auditory, Ins (perception of something Donal episodes, talking to Donal episodes, talking Donal episodes			DATE ty. I be tee rector he
	his wrist.	Resident C fell and fractured			

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Facility ID: 000032

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	
ENVIVE	OF INDIANAPOLIS			IAPOLIS, IN 46224	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
		time noted, the SSD indicated			
		ion with the Ombudsman 41.			
		the SSD to schedule a			
		meeting, issue 30-day notice			
		D to make an appeal within 10			
	-	n appeal had not been made the facility had the right to			
	-	D to the Wheeler Mission.			
		the SSD set the resident up			
		nazi (mental health center).			
		mbudsman 41 the resident had			
		ents, verbal and physical			
		staff and peers, but was			
	*	l ADLs, scores high on BIMS mental status) and inquired			
	,	he Wheeler Mission.			
	about discharge to t	ne wheeler wission.			
	On 3/9/22 with no t	ime noted, SSD indicated she			
	contact the office of	f the Ombudsman but was			
	-	th, left a voicemail and emailed			
		e SSD received a phone			
	number for Wheele	r Mission.			
		ime noted, SSD indicated she			
		t Midtown once a discharge			
		d and she would set up an			
		Midtown provided their			
	_	oer through Eskenazi to ould be seen once every 3			
		atrist, and a therapist twice a			
	month.				
	0.0000				
		ime noted, SSD received a call			
		2 who stated she is filling in. mation to Ombudsman 42 on			
	•	plained safety concerns with			
	-	ng to the facility. She stated			
		ald decide based on the safety			
	of the patients in the	e facility but indicated to			
	understand that the	psych hospital can call the			

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. W	ING		09/20/	/2022
NAME OF I	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD	•	
				1	CHWAY DR		
ENVIVE	OF INDIANAPOLIS	·		INDIAN.	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		ile a complaint and there could	+	TAG	BEIGERGI		DATE
		mbudsman 42 recommended					
	that SSD try to work with psych hospital to find						
	alternative placement that would agree to accept him, especially all male facility.						
	0.2/0/22 14	' 1 CCD					
		ime noted, SSD referred					
	Resident D to several facilities, most have denied him.						
	111111.						
	On 3/11/22 with no	time noted, Resident D scored					
		D contacted Ombudsman 42 to					
		s right to discharge Resident D					
		due to concerns with him.					
	She stated the facili	ty had the right to discharge					
	him to the Wheeler	Mission. SSD informed					
	Ombudsman 42 tha	t Resident D was independent					
	with all ADLs, reco	ommended for medication					
	_	nformed Ombudsman 42 that					
		ontacted Midtown Eskenazi					
		ig an appointment. The SSD					
		ansportation number that was					
	_	om Midtown. SSD provided					
		discharge location to the					
		ider, and transportation stated					
		contact number at the Wheeler					
		hem of pick-up times for					
	Resident D on appo						
		ider stated Midtown Eskenazi					
	_	ortation to schedule transport					
	to schedule this wit	they stated SSD does not need					
	to senedule this wit	ii uiciii.					
	On 3/11/22 with no	time noted, a care plan meeting					
	was held with SSD,	, ADON and Resident D. SSD					
	discussed recently b	being readmitted to facility this					
	morning from Assu	rance Psych. SSD asked					
	Resident D if he red	calls the reason for the psych					
		dicated he got into a fight. SSD					
	agreed and discusse	ed behaviors of becoming very					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	screaming out. We daily living) status of ADLS except medic his potential 30-day due to safety concer Resident D became yelling and screamine's not leaving, and facility. SSD had did due to yelling, screated Resident D on curred disruption to other pyell and scream. SS was unsuccessful. HADON to leave his 3/16/22 at 2:53 p.m DON of Resident D staff regarding the significant point of the chair in Resident D this after behaviors. He denied SSD re-educated him He expressed under during this visit. On 3/18/22 at 12:54 note indicated Resident D this after behaviors are garding well-being, or mood (SSD) also visited well-being, mood compared to the concerns regarding well-being, and to the concerns regarding well-being, mood compared to the concerns regarding well-being, and the concerns regarding well-being well-b	n, the SSD was notified by the had become agitated with smoking time. He slammed his n hallway. SSD spoke with			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIEI OF INDIANAPOLIS		•	45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)			(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION of previous conversation of	+	TAG	DEFICIENCY)		DATE
		ors and the potential for a					
		He expressed understanding					
		ould cost him a 30-day notice.					
		and chance. SSD stated she					
	would speak with the Executive Director (ED). They will speak to him again next week.						
	They will speak to	mm agam next week.					
	On 3/23/22 at 1:33	p.m., a SS note indicated the					
		esident D who was in good					
	spirits. He showed	no behaviors, no signs or					
	symptoms of psych	osocial well-being or mood					
	concerns.						
	On 3/24/2022 at 2:	34 p.m., a SS note indicated the					
		sited with Resident D. SSD					
		ng behaviors towards staff					
		reaming out, his impulsive					
	outbursts, and safet	y concerns. Resident D was					
	·	Discharge Notice that was					
		is day. He was educated on the					
		eal, and provided details on					
		ducated Resident D that he					
	_	Wheeler Mission. Educated g followed by Midtown					
		r medication management after					
		dent D became agitated and					
	_	oice, he continued to ask for					
	1 -	D educated Resident D again					
	on his behaviors. W	/riter emailed a 30-Day Notice					
	to Discharge Resid	ent D to the Ombudsman.					
	On 3/25/22 at 12:20	9 p.m., a SS note indicated the					
		St. Health and attempted to					
		primary care physician (PCP)					
		St. Health stated someone from					
		ntact SSD next week to					
		ointment. Oak St. Health would					
	provide transportat	ion to and from his					
	appointments.						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	, ,	JILDING	NSTRUCTION 00	(X3) DATE COMPL 09/20	LETED	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	On 4/8/22 at 10:46 the Assistant Direct currently the Intering scored at a high rist due to being independentia. On 4/22/22 12:21 at 40 indicated in a lared discharge visit with was being seen took the Wheeler Missist past medical history. Alzheimer's disease Parkinson's disease age-related cognitive tremor, muscle wear and insomnia. He discute distress at this was resting quietly person and place were was pleasant and consent with Resident. On 4/22/22 at 2:53 indicated the SSD I	a.m., a nursing note indicated tor of Nursing (ADON), in DON, indicated Resident D is on an elopement assessment endently mobile and having in Don. The Nurse Practitioner (NP) to entry that she had a in Resident D. She indicated he ary for discharge planning to on per the facility. He had a sy of psychotic disorder, in the discharge planning to on per the facility in the property of the property			CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE		
	upcoming discharg scheduling an initia Oak St. Health, info Health providing tr to their clinic for at then will be transpo St. Health would re She provided Resid number to Southeas contacted Midtown initial appointment.	ghout this week regarding his e on 4/22/22. She discussed al PCP appointment through borned Resident D of Oak St. ansportation from the facility in initial appointment on 4/22/22, borted to Wheeler Mission. Oak fill his medications monthly. Hent D with the transportation st Trans for transportation. She Eskenazi Health to schedule they indicated they can d from appointments, Midtown						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ì í	ILDING	00	COMPL 09/20/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL]	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG		L LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	date as writer left a Eskenazi. Resident these visits and aske another chance. SSI Resident D by educ due to him yelling a visited with Residen discharge to the Wh 30-day discharge no facility. He was yel threatening behavio way I'm leaving wa Non-emergency pol with escorting Resid vehicle. The police and into van. SSD h Health regarding Re they stated Residen checked in. He was contact numbers, ar On 4/25/22 with no Eskenazi Midtown scheduling an appoint	ck with initial appointment voice mail at Midtown D became agitated throughout ed on different occasions for D attempted to redirect ating him but was unable to at writer. Staff members have int D on this day regarding his neeler Mission related to the otice. Resident refused to leave ling and screaming, with it. He told the staff the only is if the cops were called. Lice were contacted to assist dent to an Oak St. Health escorted Resident D outside had made contact Oak St. esident D's initial appointment; to D had arrived and would be discharged with medications, and discharge information. Time noted, the SSD contacted to follow up regarding intment for Resident D's town indicated she recalled in March and informed SSD.					
	that their policy had appointments and so clients. She stated the appointments or trainow walk-ins only of a.m. to 12:00 p.m. It transportation numbrick up to and from patient would now appointments. On 4/25/22 at 5:56	nsportation because it is all on Monday - Friday, from 9:00 Midtown provided SSD a per to contact to schedule for Midtown. Midtown indicated need to schedule their own					
	Coordinator/Unit M	Ianager indicated Resident D					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	IG	00	COMPL	ETED
		155077	B. WING			09/20/	/2022
			ÇTD	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2			CHWAY DR		
ENI/II/E	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVE !	CI INDIANAI OLIO			- I/~\ N/	7.11 OLIO, IIN 70224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAC	ì	DEFICIENCY)		DATE
	-	at 5:15 p.m. today. Resident					
		cations and his belongings. He					
	was placed in a room on the locked behavior unit.						
	-	vere received to give him his					
		on now per NP 40. He was alert					
		e ambulated on own without an					
	assistive device. Hi	s gait was steady.					
	0 1/25/22	n no Docident Die					
	On 4/25/22 at 6:00	p.m., Resident D's ssion form indicated he was	1				
		eler Mission. He was oriented					
		ne, and situation. He had a					
	diagnosis of dementia and used 9 or more medication. His cognition was intact.						
	medication. His cog	gnition was intact.					
	On 4/26/22 with no	time noted, the SSD indicated					
		Wheeler Mission Director					
	-	ted the facility send Resident D					
		as no one contacted them to					
		ident D being dropped off. SSD					
		at she was unaware of needing					
		esidents' arrival because they					
		WMD indicated that was no					
	longer the case.	William March 110					
	On 5/26/22 SSD wa	as notified of Resident D					
		fied Nursing Aide (CNA) on					
	~	sked Resident D why he did it,					
		propriate behaviors and					
		vior was inappropriate.					
	Resident D apologi	zed.					
	, ,						
	On 6/1/22 with no t	ime noted, SSD was notified of					
	Resident D becomin	ng agitated and verbally					
	aggressive as he sta	ted he was jealous of the					
	other peers wanting	a girlfriend. SSD was able to					
	redirect him with co	onversation, walking on the					
		ivities of interest. He appeared	1				
		th no further behaviors noted.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETION
TAG	REGULATORY OR On 7/20/22 with no the Rounding Psych Psych NP discussed behaviors. Possible discussed. The Rou also works at Assur Assurance stating medication will not recommended the factorial Eskenazi ER and reaccept him back to on 8/4/22 with not to contact Eskenazi home placement bu and unable to leave On 8/8/22 with not Ombudsman office Ombudsman 44 and Ombudsman 44 and and thoughts regard Ombudsman 44 ind accepted residents work on 9/19/22 at 8:31 a call from the WM not accept him. He permission, we will On 9/19/22 at 2:32 provided all transfer did not sign any transfer on 9/19/22 at 2:35 provided at 2:35	time noted, the SSD, DON and a physician and the Rounding Resident D and his in-patient referral was unding Psych physician who ance Psych denied him at nedications will not help his was his personality and change or help him. He acility send Resident D to commended the facility to not the facility. ime noted, the SSD attempted Midtown to discuss group t was unable to get through a voice message. ime noted, SSD emailed and attempted to contact I left a voice mail. ime noted, SSD spoke with I requested recommendations ling placement for Resident D. icated a place to try who with behaviors. a.m., ED indicated she received D and he indicated they would said you must have our	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE DATE

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
		155077	B. WIN	G		09/20/	2022
			- 	CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS	•		INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	On 9/19/22 at 2:36	p.m., the SSD indicated she					
	believed Resident I	O left with a 30-day supply of					
	all April MAR med	lications because he was a					
	Medicaid recipient.						
	Aripiprazole tab	20 mg (milligram), take 1 tablet					
	by mouth once daily	y for schizophrenia.					
	2. Quetiapine fuma	rate (anti-psychotic) tab 50 mg,					
	take 1 tablet by mor	uth every morning.					
	3. Quetiapine fuma	rate tab 300 mg, take 1 tablet by					
	mouth every night a	at bedtime.					
	4. Buspirone Hcl (a	inti-anxiety) tab 5 mg, take 5 mg					
	by mouth 3 times a day for anxiety.						
	5. Lactulose (laxative) 10 gr (grams)/15 mL, take 30						
	mL by mouth once	daily for hyperammonemia					
	(high ammonia).						
	6. Trazodone Hcl (a	antidepressant/sedative) tab 50					
	mg, take 1 tablet by	mouth every night at bedtime					
	for insomnia.						
	7. Carbidopa/Levoc	lopa (dopamine promotor for					
	Parkinson's disease) tab 25-100 mg, take 1 tablet					
	by mouth once daily	y.					
	8. Amantadine Hcl	(dopamine promotor) cap 100					
	mg, take 100 mg by	mouth once daily at 9:00 a.m.					
	for Parkinson's.						
		ylate (calcium channel blocker					
		sure) tab 10 mg, take 1 tablet					
	, ,	y for hypertension.					
	_	ab 10 mg, take 1 tablet by					
		or major depressive disorder.					
		300 mg, take 1 capsule by					
		laily for bipolar disorder.					
		azide tab 25 mg, take 1 tablet by					
	mouth daily for hyp						
	_	200 mg, take 1 tablet by mouth					
	once daily for bipol						
	_	1.25 mg (50,000 units), take q					
		very week for vitamin daily					
	deficiency.						
	15. Acetaminophen	tabs 325 mg, take 2 tablets by					

, ´		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155077	B. WI	NG		09/20/	/2022
		ı	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			CHWAY DR		
	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	mouth every 6 nour	s as needed for pain.					
	On 9/19/22 at 3:12 :	p.m., the ED indicated Resident					
		f-administration assessment,					
	but the resident had						
	On 9/19/22 at 3:13 p.m., the Activity Director (AD)						
	indicated Activity Aide 36 had a good						
	-	esident D and was able to					
		ent likes to do crafts, loves					
		e talked to him. She indicated					
		the evening/night shift or					
	•	al activities for him, but they					
		activity room key was kept so					
	-	l access to supplies for his					
		also buys him cigarettes when					
	days a week until 7:	ersonnel are in the building 7					
	days a week until 7:	.00 p.m.					
	On 9/19/22 at 3:14 i	p.m., the SSD indicated					
		eaning and organizing things					
		off knows the resident very					
		k about cars. He like to compare					
	prices. The AD indi	cated she would take a					
	computer to him to	look at ads. The SSD indicated					
	_	o making a binder of activities					
	of interest for him.						
	0.0/10/02 : 2.12	d ED: 1: 1:1 0: 6:					
		p.m., the ED indicated the Staff					
		ined to run the locked					
		t and for the most part there If on the behavioral health					
		led the specific training the					
	-	id to be over the locked					
		vatched 6 YouTube videos,					
		s. Then, she educated the					
		aff, who also watched the 6					
		be videos were provided					
		avioral Health. They were					
	•	That: Providing Care for					
	i		1				1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155077	B. WING		09/20/2022	09/20/2022	
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE,	ZIP COD		
				EACHWAY DR			
ENVIVE OF INDIANAPOLIS			INDI	INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN (F CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO	THE APPROPRIATE	PLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	TAG DEFICIENCY)		ATE	
	Medical Patients with Psychiatric Issues.						
	1. The video to educate about anxiety issues was						
	9:09 minutes long.						
	2. The video to educate about anger and						
	aggression issues was 11:57 minutes long.						
	3. The video to educate about delusions issues						
	was 9:37 minutes long.						
	4. The video to educate about suicide risk issues						
	was 11:52 minutes long. 5. The video to educate about depression issues						
	was 10:15 minutes long.						
	6. The video to educate about hallucination issues						
	was 9:47 minutes long.						
	was 7.47 minutes long.						
	On 9/19/22 at 2:17 p.m., the SSD indicated she						
	provided the Notice of Transfer or Discharge to						
	Resident D on 3/24/22 at 4:30 p.m. It was at the						
	end of the business day and did not count as day						
	1. It indicated the effective date for the discharge						
	was 4/23/22. Resident D was removed from the						
	locked unit and escorted by the police out of the						
	building on 4/22/22. The SSD indicated she did						
	not realize the date was different on the Notice of						
	Transfer/Discharge. The reason indicated the						
	safety of the individuals in the facility was						
	endangered. Resident D was removed from the						
	building after 28 days had expired on 4/22/22.						
	A Distance Information d						
	A Discharge Information document with Resident						
	D name and dated 4/22/22 indicated Resident D						
	would be discharged with 30 days' worth of medications. His prescriptions would be filled						
	_	-					
	monthly by Oak St. Health. Part of his discharge information was a copy of his April MAR.						
	information was a copy of his April MAR.						
	On 9/19/22 at 2:20 p.m., the ED indicated Resident						
	l	discharge documents. The					
		dicated the resident would					
	have 10 days to appeal. She believes he was not appealing by screaming and yelling when						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155077	B. W	TNG		09/20/	/2022
NAME OF P	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP COD	•	
					CHWAY DR		
<u>ENVIVE</u>	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION building by the police.		TAG	DEFICIENCT		DATE
	escorted out of the t	building by the police.					
	On 9/19/22 at 2:22	p.m., the SSD indicated during a					
	7/20/22 meeting with the psychiatric physician 47						
	and the NP, it was o	lisclosed Resident D was					
		to Assurance. Physician 47					
	indicated to send Re	esident D to Eskenazi ER and					
	not accept him back.						
	On 9/19/22 at 2:26 p.m., the SSD indicated the						
	ombudsman corresp	-					
		, and 44. A review of					
documents provided by the SSD on 9/19/22 at 2:17							
	p.m., provided typed narratives of several conversations.						
	conversations.						
	On 9/19/22 at 3:11	p.m., the SSD indicated that the					
	information regardi	ng the contact with the					
	ombudsman progra	m was in the "soft file"					
	narrative.						
	On 0/20/22 at 0:41	a.m., the DON indicated she					
		virector of Nursing (ADON)					
		ft for Wheeler Mission on					
		as here and he did not want to					
		s over and he had to go. He sat					
		chair. The police indicated he					
		lding or the police would					
		not aware he was asked to					
		days were over. He was					
		about how he didn't want to					
		stay here. In the begin, he					
	_	e an appeal of the 30 day					
), and ADON, were present. It					
	probably would hav	ve been an appropriate idea to					
	begin an appeal if h	e had said or was yelling he					
		re here. She indicated she					
	didn't know of anyo	one was advocating for the					
	resident's wants and	l needs. He had his					
	medications with hi	m in bubble pack cards. He did					
			1				I

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. W	ING		09/20/	2022
	PROVIDER OR SUPPLIER		-	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERIG TV . IV OT CORRE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	not have any narcot						
	During an interview Resident D indicate came in from outsid he needed to go to treason. He indicated were a 30 day notic provided the docum Resident D began sl conversation was up received the papers the notice of discharmeant. He indicated Mission and they (thindicated the facility there. He was in rocindicated it was timedown. He indicated she use him to Wheeler Mission to Wheeler Mission the (psych) hospiday, he was mad an came and got him to police said if he did then he would go to 3-4 big bags of clothindicated he did not medications or wheeler Mission told him the medications. He did	d the SSD doesn't like him. He de and the SSD indicated to him the Wheeler Mission for no de he was given documents that e and a right to appeal. He dents to review. Thaking badly, this posetting to him. He said he but did not understand what arge or request for a hearing dent he staff at Wheeler Mission) by had no right to send him om at the facility and the SSD de to go. He had been laying ded to say that she would send assion as a threat to get him to dital. On the Wheeler Mission dent he faced the wall. The police of go to the front door. The first go to the Wheeler Mission dent in the police car. He had the hes and medications. He know how to take no. The people at Wheeler					
	didn't know how to	take it. The Wheeler Mission					
		ity and put all his stuff in a van					
	and brought him ba	ck to Envive.					
		indicated he could stay at the did not know why the ED let					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	A. BUILDING 00 B. WING		COMPLETED 09/20/2022				
		ROVIDER OR SUPPLIER DF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
	X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	TAG	him come back. He medications. At the medications were lookey. One resident at Whe something with him away. His medication locked locker the wide Mission because did medications, so he land the locked locker the wide medications, so he land locked locker the wide medicated someting the locked locker that him out the locked locker that him out. He indicated had not thought about the lindicated he did the health department knew that, he would mission. He was no to help him. On 9/20/22 at 10:46	came back with his Wheeler Mission, his cked in a locker, he had the eeler Mission tried to start , he just turned and walked on remained locked in his hole time he was at Wheeler In't know how to take the		TAG	DEFICIENCY)		DATE	
		she provided the not progress note in his On 9/20/22 at 10:47	22 at 4:34 p.m She indicated tice and immediately put the chart. a.m., the ED and SSD were leave the facility because of						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 09/20/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	his behaviors. The phad a personality dehaviors were at a the other residents. for his needs. We were But this was a personal to be around other procession of the procession	psych physician indicate he isorder, not behaviors. His very high level compared to The facility was trying to care tere able to care for his needs. It is onality disorder. He didn't need beeple. By a.m., the SSD indicated the licated to the facility to send mazi ER and not accept him follow these instructions. Dy a.m., the SSD provided a list of the whom she had applied to send of these buildings did not have documentation indicated she buildings, 3 of them twice. Dy a.m., the SSD indicated the eleer Mission called and talked was very upset about Resident der Mission. He indicated the permission. He called on the Resident D come back to the selection of the April MAR and D's discharge documents, medications we not part of the selections given to Resident D cone is called to Resident D.						
	would have comple	ted a disposition of the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ILDING	00	COMPL 09/20/	ETED	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Clinical Services (V believed because Referecipient he left here his medications. The did not count how medications he return indicated we do not out or came beck in requiring we do so. On 9/20/22 at 12:32 the medications were being at the Wheele in use for Resident 1. On 9/21/22 at 2:44 (OL) indicated Omby the Ombudsman believed the SSD er The OL indicated she several times for other or questions regardinever came up. She a Notification of Difacility for Resident notice of discharge, advocate for the restonet spoke with Resident have known they pl. D to Wheeler Missing agreed to this placer to see Resident D. Sabout how to help the service of the restonet of the public see Resident D. Sabout how to help the service of the public see Resident D. Sabout how to help the service of the public see Resident D. Sabout how to help the service of the public see Resident D. Sabout how to help the service of the public see Resident D. Sabout how to help the service of the public serv	p.m., the Vice President of PCS) indicated the SSD esident D was a Medicaid with a 30 day supply of all e VPCS indicated the facility many medications Resident D and did not count how many med with on 4/25/22. She know how many pills went. There are no regulations p.m., the DON indicated when returned to the building after mission they were put back D. p.m., the Ombudsman Leader budsman 41 was not employed program on 2/23/22 and stry for that date was invalid. The had been in the facility mer residents but information many Resident D's discharge indicated they never received scharge document from the D. Whenever they get a they will go to the facility to ident. In our training, we learn to specific places, and we do a discharges. No ombudsman at D. If the Ombudsman would anned to discharge Resident on they would not have ment. The SSD never asked us the only asked questions are facility discharge residents, to advocate for the residents.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ì í	JILDING	instruction 00	(X3) DATE COMPL 09/20 /	ETED			
		ROVIDER OR SUPPLIER DF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
		she talked with the provided no name a information, she just who had aggressive women. The SSD in discharge him to W 42 indicated she did appropriate to send needed to talk to the aggressive and had indicated it was appethat information. On not advise or tell the Mission, she told the She warned the SSI consequences if she someone could call complaint because to "dumping" (residen are often released er care form themselved on 9/12/22, the Admission Agreem Rights and Facility reviewed. It indicate right to be cared for environment that more resident's dignity are his or her individual area. The copy must a facility are as followed that the copy of the transfer or dischargeplace a copy of the supplementation of the copy of the	st indicated they had a resident behaviors, especially with adicated they wanted to heeler Mission. Ombudsman I not think that was him there, and the SSD em first because he was behaviors. Ombudsman 42 barent that the SSD did not like mbudsman 42 indicated she did em to send him to Wheeler heem to call Wheeler Mission. O of the possibility of the refused to take him back, the Board of Health and file a that was considered ts suffering from mental illness wen thought they are unable to						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD CHWAY DR	
ENVIVE	OF INDIANAPOLIS			IAPOLIS, IN 46224	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG	`	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
		al long term care om			
	1	m for involuntary relocations			
	1	lythe notice of transfer or			
	dischargemust be made by the facility at				
	least thirty (30) days before the resident is				
		schargedAt the planning			
		resident's medical,			
	1	d social needs with respect			
	to the relocation shall be considered and a				
	1 -	neet these needsIf the			
	_	s disputed, a meeting shall			
	be held prior to the relocation with the				
		his or her designee, the			
	resident, and the	-			
	_	The purpose of the meeting.			
	shall be to discus	ss possible alternatives to			
	the proposed relo	ocation plan" A current			
	policy, titled, "D	ischarge," dated 8/2022,			
	_	the VPCS on 9/21/22 at			
	1:03 p.m. A revi	ew of the policy indicated, "			
	The discharge	summary will include a			
	recapitulation of	the resident's stay at this			
	1 '	al summary of the resident's			
		of the discharge in			
		established regulations			
	governing releas	e of resident information and			
		he resident. The discharge			
	1	nclude a description of the			
	_	part of the discharge			
	summary, the nu	rse will reconcile all			
	1 -	edication with the resident's			
	post-discharge m	nedications. The medication			
1	1		1	I	I

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155077		(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 09/20/2022				
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE			
	reconciliation w	ill be documentedThe						
	post-discharge p	lan will be developed by the						
	Care Planning/Ir	nterdisciplinary Team with						
	the assistance of	the residentA						
	description of th	e resident's stated goals; the						
	degree of caregiver/support person							
	availability, capacity and capability to							
	perform required carewhat factors may							
	make the resident vulnerable to preventable							
	readmissionT	The discharge plan will be						
	re-evaluated based on changes in the							
	resident's condition or needs prior to							
	dischargeThe	resident/representative will						
	be involved in the	ne post-discharge planning						
	process and info	rmed of the final						
	post-discharge p	lanResidents will be						
	asked about their	r interest in returning to the						
	community. If the	ne resident indicates an						
	interest in return	ing to the community, he or						
	she will be refer	red to local agencies and						
	support services	that can assist in						
	accommodating							
	1	referencesIf it is						
		arning to the community is						
		ill be documented why this						
		who made the determination						
		the IDT (interdisciplinary						
	1	w the final post-discharge						
	1 ^	sident and family at least						
		hours before the discharge						
	_	A copy of the following						
	will be provided	to the resident and receiving						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2022		
	PROVIDER OR SUPPLIER		45 BEA	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0641 SS=E Bldg. 00	resident's medica the resident's disc post-discharge pasummary"3.1483.20(g) Accuracy of Asses §483.20(g) Accuration assessment resident's status. Based on record revisited to accurately Screening and Residents 7, 57, 39 (Residents 7, 57, 39 (Residents 11) on the assessment for 5 of assessments Findings include: 1. On 9/14/22 at 2:2 completed for Resident of the resident currilevel II PASRR provibles and/or intellection and the resident did not require for the resident did not require resident did not requirements.	ssments acy of Assessments. In the second second interview, the facility code the Preadmission dent Review (PASRR) section 1, and 56) and restraints section 2, and 56) and restraints section 3. The second	F 0641	F641 – Accuracy of Assessments SS=E "Based on record review and interview, the facility failed to accurately code the Preadmis Screening and Resident Review (PASRR) section (Residents 57, 39, and 56) and restraints section (Resident 11) on the Minimum Data Set (MDS) assessment for 5 of 5 resident reviewed for MDS assessment. What corrective action(will be accomplished for the residents found to have been affected by the deficient practice? The MDS assessments for resident 7, 57, 39 and 56 have been corrected ensuring the Preadmission Screening and Resident Review (PASRR) and Restraint sections are accurated. How other residents having the potential to be affected by the same deficient practiced by the same deficient pract	ew 7, ts ots ots" s) se n for e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF I	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD	
ENVIVE	OF INDIANAPOLIS	3			ACHWAY DR NAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		dent 57. He had diagnoses of order, unspecified mood			practice will be identified an what corrective action will be	
		anxiety, major depressive			taken?	oe
	disorder, and inson				· All residents have the	
					potential to be affected by the	e
	Resident 57 had a '	'Notice of PASRR Level II			alleged deficient practice.	
	Outcome" on 2/16/	21. It indicated that the facility				
		r question A1500 on the MDS,			· MDS/Designee audited	I
		rently considered by the state			residents to ensure the MDSs	
	_	ocess to have a serious mental			were completed appropriately	/ for
		or intellectual disability or a			PASRR and restraints.	
	related condition?'.				2 What was some will be	4
	A comprehensive N	MDS with an ARD of 8/5/22			3. What measures will be in place or what systemic	put
	A comprehensive MDS with an ARD of 8/5/22 was reviewed. Question A1500 was marked no, indicating that the resident did not require a level				changes will be made to	
					ensure that the deficient	
	II.	4			practice does not occur?	
					MDS Coordinator will be	
	3. On 9/14/22 at 12	2:25 p.m., a record review was			in-serviced on:	
	_	dent 39. He had the following			o "RAI manual and Section .	A"
	_	imited to schizophrenia and				
	depression.				4. How the corrective acti	
	D 11 (201 1 1	1 1 1 1 1 1 1 1 1 1 1			will be monitored to ensure	
		evel II that indicated he was term without specialized			deficient practice will not re	cur
		short term approval ended on			i.e., what quality assurance program will be put into place	002
	8/2/22.	short term approval chaca on			MDS/designee will audit	
	0,2,22				MDSs three times a week x8	
	A comprehensive N	MDS with an ARD of 8/5/22			weeks, then twice a week x4	
	was reviewed. Que	estion A1500 was marked no,			weeks, then weekly x3 month	ns to
	indicating that resid	dent C did not require a level II.			ensure the Preadmission	
):15 a.m., Resident 56's record			Screening and Resident Revi	
		Pre-Admission Screening and			(PASRR) and Restraint section	ons
	`	PASRR), dated 11/22/21,			are coded accurately.	
		II screening indicated he had			The manufacture of the control of th	31 6 6
	Long Term Approv	ved without Services			The results of these audits wi	
	Resident 56 was di	scharged from 2/26/22 to			reviewed by the QAPI commi overseen by the Executive Di	
					for no less than six months. T	
	3/17/22. The mental healthcare documentation, dated 3/18/22, indicated he had new onset of				results will be reviewed for	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u> COMPLE			ETED
		155077	B. W	ING		09/20/2022	
				CTDEET A	DDDFGG CITY GTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
	OE INDIANADOLIO				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	mental health issue	s on 2/17/22 of visual			patterns, trends and continued	ł	
	hallucinations, seve	ere major depression with			recommendations for process		
	psychotic features,	generalized anxiety disorder,			monitoring and improvement ເ	ıntil	
	and suicidal though	its. The severity indicated he					
	had no desire to con	ntinue living, had made a			•		
	suicide plan, and ha	ad access to means to carry out			5. Date of completion:		
	suicide plan.			10/21/2022			
	A Minimum Data Set (MDS) assessment, dated						
	1/5/22, indicated Resident 56 was not considered						
	by the state level II PASRR process to have						
serious mental illness. His active diagnoses							
	included, but were not limited to, anxiety disorder,						
depression, and psychotic disorder.							
	On 9/13/22 at 10:00	0 a.m., the Administrator and					
	Social Service Dire	ector (SSD) were interviewed.					
	They indicated that	an audit was completed for					
	level II assessments	s and there was a plan in place					
	to address level II's	on 8/22/22.					
	On 9/19/22 at 3:45	p.m., a policy titled, Indiana					
	PASRR was provid	led by the ED. It indicated, "					
	Screening levels,	the level I screen is completed					
	to identify residents	s who may have a mental					
	illness (MI), menta	l retardation/development					
	disability (MR/DD)), mental illness/mental					
	retardation/develop	mental disability (MI/MR/DD),					
	or related condition	s. The Ascend generated					
	outcome letter will	indicate if a level II is					
	necessary. The NF	(nursing facility) (if a resident					
	is at home or comm	nunity setting at the time of the					
	assessment) or hosp	pital (if resident is currently in					
		onsible for referring the					
		opriate agency, such as a					
	community mental health center (CMHC) or						
	_	mental Disability Services					
	` ′	III assessment typically					
	_	h clinical evaluation by a					
	trained mental heal	th professional to verify					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/20/2022					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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			
IAU	whether an individing The level II assessment on the level II screen in illness, a two-prong whether the individing mental health services (specific to application is made followed for resident retardation/develop diagnosed with MI complete these indeplication. Although wheelchair, her book leaned to the right. Tight. She was unable questions, she was contact, and stared restraint device was contact, and stared restraint device was contact. And stared restraint device was contact and she was unable to simple yes/no questions observed in place. On 9/14/22 at 2:11 record was reviewed of Cerebral Palsy (a ability to move and She had a current properties. A nursing progress.	nal has a serious mental illness. ment must be completed within from the date of the referral. If s positive for serious mental ged determination is made as to qual requires a.) specialized ces and b.) nursing facility the facility where that else. The same process is ents with mental mental disability or dually and MR/DD; D&E teams elepth evaluations"5. On else was sat upright in her else was hunched forward and else to answer simple yes/no unable to maintain eye off during conversation. No	IAG			DATE			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	r í	ILDING	NSTRUCTION 00	(X3) DATE COMPL 09/20/	ETED		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E NATE	(X5) COMPLETION DATE		
	The annual MDS as indicated Resident type of restraints or During an interview Vice President of C indicated abdomina a restraint and shou The "CMS (Centers Services) RAI (Res Version 3.0 Manual indicated, "A1500 Resident Review (P InstructionsCode screening determine serious mental illnessident resident reside	on 9/19/22 at 11:00 a.m., the linical Operations (VPCO) 1 binders were not considered ld not be coded on the MDS. 5 for Medicaid and Medicare ident Assessment Instrument) 1," dated October 2017, 1: Preadmission Screening and PASRR)Coding 1, yes: if PASRR Level II ed that the resident has a ssand continue to A1510, on Screening and Resident							
F 0657 SS=D Bldg. 00	§483.21(b)(2) A comust be- (i) Developed with of the comprehension of the comprehension of the comprehension of the attending (B) A registered number resident. (C) A nurse aide was resident.	and Revision rehensive Care Plans comprehensive care plan sin 7 days after completion sive assessment. In interdisciplinary team, that I limited to							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		45 BEA	CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	(E) To the extent	R LSC IDENTIFYING INFORMATION		TAG	Dia relation		DATE
	• •	e resident and the resident's					
		An explanation must be					
		dent's medical record if the					
		e resident and their resident					
		determined not practicable					
	-	ent of the resident's care					
	plan.						
	(F) Other appropr	iate staff or professionals in					
	disciplines as dete	ermined by the resident's					
	needs or as reque	ested by the resident.					
	(iii)Reviewed and	revised by the					
		eam after each assessment,					
	_	comprehensive and					
	quarterly review a						
		view and interview, the facility	F 00	557	F657– Care plan Timing and		10/21/2022
		evise care plans for 3 of 5		Revision			
		for care plans (Residents 23,			SS=D		
	78, and 55).				"Based on record review and		
	Findings include:				interview, the facility failed to		
	rindings include.				revise care plans for 3 of 5 residents reviewed for care pla	anc	
	1 On 9/16/22 at 12	:08 p.m., a record review was			(Residents 23, 78, and 55)."	1113	
		dent 23. Resident 23 had			1. What corrective action(s	٠,	
	•	g but not limited to cerebral			will be accomplished for thos	-	
	-	weakness, difficulty in walking,			residents found to have been		
		nrombosis, history of falling,			affected by the deficient		
	-	with delusions, major			practice?		
	depression, Alzheir]		
	hypertension.				· Residents 23, 78 and 55		
					have had all care plans review	red	
		current care plan indicating that			and updated.		
	_	and symptoms of depression.					
		s to administer medications as			2. How other residents		
	ordered.				having the potential to be		
	D 11 . 22				affected by the same deficier		
	_	cation administration record			practice will be identified and		
		e for anti-depressant side			what corrective action will be)	
	effects every shift.				taken?		
	I				 All residents have the 		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155077	B. W	ING _		09/20/2022	
		1	1	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			CHWAY DR		
FN\/I\/F	OF INDIANAPOLIS				IAPOLIS, IN 46224		
	- 114D1/114A1 OLIO			INDIAN	OLIO, III TOZZT		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETIO	ON
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		d lacked a current order for an			potential to be affected by the		
	antidepressant med	ication.			same deficient practice.		
	2. On 9/16/22 at 10:03 a.m., a record review was				· MDS/designee will audit		
	_	dent 56. He had the diagnoses			residents with a MDS assessr		
	_	mited to chronic obstructive			in the last 30 days to ensure o	are	
		(COPD), pneumonia, type 2			plans are up to date.		
		ression, nicotine dependence,				_ [
	and vitamin D defic	ciency.			3. What measures will be p	out	
					in place or what systemic		
		order, dated 9/15/22, for			changes will be made to		
		our transdermal patch one time			ensure that the deficient		
	a day for smoking o	essation remove per schedule.			practice does not occur?		
					· MDS Coordinator will be		
	_	plan lacked a care plan			in-serviced on:		
	_	tine patch or smoking			o "Comprehensive Care Plar	1"	
	cessation.						
					4. How the corrective action		
		are plan indicating that he had			will be monitored to ensure t		
	emphysema/COPD	related to smoking.			deficient practice will not rec	ur	
		e de la calación de la calación			i.e., what quality assurance		
	_	indicating that he had a history			program will be put into place	e?	
	_	ence. The goal indicated that				_	
		the smoking policy.			MDS/designee will audit		
		led to assist him to the			residents three times a week	ď	
	designated smoking	g area during scheduled time.			weeks, then twice a week x4		
	2 0 0/14/22 + 11	.47			weeks, then weekly x3 months		
		:47 a.m., a record review was			ensure care plans are up to da	ale.	
	_	dent 78. She had diagnoses			The manufacture of the control of th	l ha	
	_	mited to schizophrenia,			The results of these audits wil		
		ic obstructive pulmonary d difficulty swallowing.			reviewed by the QAPI commit		
	uisease, obesity, and	u difficulty swaffowing.			overseen by the Executive Dir		
	Dagidant 70	y quit smaking. A misstins			for no less than six months. The	ie	
		y quit smoking. A nicotine			results will be reviewed for		
	ordered on 8/29/22.	one time daily for 6 weeks was			patterns, trends and continued		
	ordered on 8/29/22.				recommendations for process		
	Dagidant 70 had	are plan indicating that she			monitoring and improvement t		
		are plan indicating that she			100% compliance is achieved	·	
		eath related to chronic			5 Date of a constitution		
	oostructive pulmon	ary disease. Non adherent to	1		5. Date of completion:		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		155077	B. WINC			09/20/	2022
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				CHWAY DR		
ENVIVE (OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG			DATE
	wearing oxygen dur	ring the day due to smoking.			10/21/2022		
	Resident 78's record	l lacked a care plan to address					
	the nicotine patch or smoking cessation.						
	1	5					
	On 9/20/22 at 12:30	p.m., an interview was					
		ident 78. She indicated she					
	•	eft shoulder. She indicated					
		top smoking and that it had					
	been a month since	she quit smoking.					
	A policy titled: "Co	mprehensive Care Plan" dated					
		d by the ED on 9/19/22 at 3:45					
	•	care plan problems, goals and					
	-	e updated on changes in					
	resident assessment	-					
	preference or family	input.					
	3.1-35(a)						
F 0661	483.21(c)(2)(i)-(iv)						
SS=D	Discharge Summa						
Bldg. 00	§483.21(c)(2) Disc	•					
	When the facility a	inticipates discharge, a					
	resident must have	e a discharge summary					
		s not limited to, the					
	following:						
	.,	of the resident's stay that					
		t limited to, diagnoses, eatment or therapy, and					
		earment or merapy, and blogy, and consultation					
	results.	blogy, and consultation					
		y of the resident's status to					
	` '	aragraph (b)(1) of §483.20,					
	at the time of the	discharge that is available					
	for release to auth	orized persons and					
	-	consent of the resident or					
	resident's represei						
		of all pre-discharge					
	medications with t	he resident's					

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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 09/20/2022 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 post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. F 0661 Based on observation, interview, and record F661- Discharge Summary 10/21/2022 review, the facility failed to ensure a resident's SS=D medications were counted pre-discharge and "Based on observation, interview, post-discharge for 2 of 2 residents reviewed for and record review, the facility medication upon discharge (Residents D and 57). failed to ensure a resident's medications were counted Findings include: pre-discharge and post-discharge for 2 of 2 residents reviewed for 1. On 9/15/22 at 11:50 a.m., Resident D's was medication upon discharge reviewed. Resident D was admitted on 10/15/21. (Residents D and 57)." His diagnoses included, but were not limited to, What corrective action(s) Parkinson's disease (progressive deterioration of will be accomplished for those motor function), Alzheimer's disease (progressive residents found to have been mental deterioration), Homicidal Ideations affected by the deficient practice? (thinking about, considering, or planning a homicide), Psychotic disorder with delusions (a mental disorder with a disconnection from reality Residents D and 57 had with a belief in altered reality), anxiety disorder medication audits completed and (mental health disorder of feelings of worry, or resident has all prescribed fear that interfere with daily activities), diabetes medications available for mellitus (blood sugar disorder), cognitive decline administration. (reduction in cognitive ability such as memory, awareness, judgment and/or mental acuity), and How other residents Schizoaffective disorder, bipolar type (includes having the potential to be features of both schizophrenia, affects a person's affected by the same deficient

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thinking, sense of self, and perceptions, and a

mood disorder such as bipolar disorder which

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practice will be identified and

what corrective action will be

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	F OF HEALTH AND HUN R MEDICARE & MEDIC.					TED: 08/28/2023 RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION depression). He resided on the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) taken?	TE	(X5) COMPLETION DATE
	On 4/22/22 at 2:53 pindicated the SSD h several times throug upcoming discharge scheduling an initial appointment throug D of the clinic proving acility to their clinic 4/22/22, then would homeless shelter. The medications monthl with the transportational clinic to sched indicated they would appointments. Resident D unable to due to him members visited with regarding his discharshelter related to the	c.m., the Discharge Summary and spoken with Resident D shout this week regarding his ton 4/22/22. She discussed Primary Care Provider (PCP) the the clinic, informed Resident adding transportation from the cofor an initial appointment on the transported to the local me clinic would refill his ye. She provided Resident D on number. She contacted the initial appointment, they do transport him to and from the lent D became agitated sits and asked on different the chance. SSD attempted to the by educating him but was an yelling at writer. Staff the Resident D on this day arge to the local homeless to 30-day discharge notice.		All discharging residents have the potential to be affecte by this alleged deficient practice. All current residents pend discharge will be audited to en medications are counted pre-discharge and post discharge and post discharge. 3. What measures will be prin place or what systemic changes will be made to ensure that the deficient practice does not occur? All licensed clinical staff of the in-serviced on: o "Discharge Policy" 4. How the corrective action will be monitored to ensure the deficient practice will not recite, what quality assurance program will be put into place.	ce. ding asure arge. out will on the cur	
		leave the facility. He was		DNS/designee will audit 5	5	

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yelling and screaming, with threatening behaviors.

He told the staff the only way he was leaving was

if the cops were called. Non-emergency police

to the local health clinic's vehicle. The police

escorted Resident D outside and into van. SSD had made contact with the local health clinic

regarding Resident D's initial appointment. They

checked in. He was discharged with medications,

On 4/22/22 12:21 a.m., the Nurse Practitioner (NP)

discharge visit with Resident D. She indicated he

stated Resident D had arrived and would be

contact numbers, and discharge information.

40 indicated in a late entry that she had a

were contacted to assist with escorting Resident

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discharges three times a week x8

weeks, then weekly x3 months to

ensure medications are counted

pre-discharge and post discharge.

The results of these audits will be

reviewed by the QAPI committee

for no less than six months. The

patterns, trends and continued

recommendations for process

monitoring and improvement until

results will be reviewed for

overseen by the Executive Director

weeks, then twice a week x4

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	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING B. WING	00	COMPLETED 09/20/2022
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	was being seen toda the homeless shelter medical history of p disease, Schizoaffed disease, diabetes me cognitive decline, at weakness, difficulty did not appear to be time or during this was chair. He was orie periods of confusion cooperative. Medica D upon his discharge Inform D name and dated 4 would be discharged medications. His promonthly by the local discharge information MAR. The Social Services "soft file" which was information regarding progress to discharge On 4/25/22 at 5:56 p Coordinator/Unit M returned to facility a returned with medical was placed in a room health unit. Physicial give him his 9:00 a. Practitioner (NP) 40.	y for discharge planning to per the facility. He had a past sychotic disorder, Alzheimer's edive disorder, Parkinson's ellitus type 2, age-related existly disorder, tremor, muscle in walking, and insomnia. He in any acute distress at this visit. He was resting quietly in ented to person and place with the enterior was pleasant and entions were sent with Resident etc. Action document, with Resident etc. Action document, with Resident D di with 30 days' worth of escriptions would be filled I health clinic. Part of his on was a copy of his April Director (SSD) provided a stated paragraphs of eng Resident D and his etc. No times were noted. Director (SSD) provided a stated paragraphs of eng Resident D and his etc. No times were noted. Director (SSD) provided the stated end on the locked behavior end orders were received to end on the locked behavior ends orders were received to end medication now per Nurse end on without an endication own without an		100% compliance is achieved 5. Date of completion: 10/21/2022	DATE
	On 4/25/22 at 6:00 p Admission/Readmis	o.m., Resident D's ssion form indicated he was			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20/	ETED	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	admitted from the I oriented to person, had a diagnosis of of medication. His cognormal medication. On 9/15/22 at 11:5 care plans were considered. I. Resident D had a behavior. The resident used related to anxiety downward. The resident used related to schizoaff. Behavior managem or others. Resident D exhibit and/or other anxiety diagnosis of anxiety. Resident D had in function/impaired the diagnosis of Alzheid decline. Impaired though status related to diagnosis of Alzheid decline. A care plan, revision problem was Resid Visual) hallucination not present), delusion himself in hallway history of threatenin history of verbal agents.	ocal homeless shelter. He was place, time, and situation. He dementia and used 9 or more gnition was intact. 4 a.m., a review of Resident D's appleted. They were created on assions. The care plan problems a diagnosis of homicidal dianti-anxiety medication isorder. If anti-psychotic medications ective disorder, bipolar type, ent, Potential for injury to self of the problems of the problems and problems are disorder, bipolar type.		TAG	DEFICIENCY		DATE	
	girlfriend. He was i	about females and wanting a manipulative towards others, cing threats, and making						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. W	ING		09/20/	2022
				CTREET	DDDFGG CITY CTATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
END/07/E					CHWAY DR		
ENVIVE OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	threatening gestures	s. The goal and interventions					
	had not been update	ed since the care plan was					
	created on 5/4/22.						
	During an interview	v on 9/19/22 at 2:32 p.m., the					
	SSD indicated she l	had provided all transfer					
	documents to Resid	lent D. He did not sign any					
	transfer or discharg						
	On 9/19/22 at 2:36	p.m., the SSD indicated she					
	believed Resident I	I left with a 30-day supply of					
	all April MAR med	lications because he was a					
	Medicaid recipient.						
	_	20 mg (milligram), take 1 tablet					
		y for schizophrenia.					
	1 -	rate (anti-psychotic) tab 50 mg,					
	take 1 tablet by mor						
	1	rate tab 300 mg, take 1 tablet by					
	mouth every night a	-					
		inti-anxiety) tab 5 mg, take 5 mg					
	by mouth 3 times a						
	1 -	ve) 10 gr (grams)/15 mL, take 30					
		daily for hyperammonemia					
	(high ammonia).						
		antidepressant/sedative) tab 50					
		mouth every night at bedtime					
	for insomnia.	, ,					
	7. Carbidopa/Levoc	dopa (dopamine promotor for					
	Parkinson's disease) tab 25-100 mg, take 1 tablet					
	by mouth once dail	у.					
	1 -	(dopamine promotor) cap 100					
		mouth once daily at 9:00 a.m.					
	for Parkinson's.	•					
		ylate (calcium channel blocker					
		sure) tab 10 mg, take 1 tablet					
	by mouth once daily	· ·					
	1 -	tab 10 mg, take 1 tablet by					
		or major depressive disorder.					
		300 mg, take 1 capsule by					
		laily for bipolar disorder.					
	mount unce times t	iany for dipotat disorder.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. WI	ING		09/20/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
FNVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
	T			L			(X5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	mouth daily for hyp	azide tab 25 mg, take 1 tablet by					
		200 mg, take 1 tablet by mouth					
	once daily for bipol	-					
		1.25 mg (50,000 units), take q					
	_	very week for vitamin daily					
	deficiency.	very week for vitalism daily					
	1	tabs 325 mg, take 2 tablets by					
	_	rs as needed for pain.					
	,						
	On 9/19/22 at 3:12	p.m., the Administrator					
	indicated Resident	D did not have a					
	self-administration	assessment, but the resident					
	had no narcotics.						
		p.m., the SSD indicated she					
	_	e of Transfer or Discharge to					
		/22 at 4:30 p.m. It was at the					
		day and did not count as day					
		ffective date for the discharge					
		ent D was removed from the					
		orted by the police out of the					
	_	2. The SSD indicated she did					
		was different on the Notice of . The reason indicated the					
	_	duals in the facility was					
	•	ent D was removed from the					
	_	hys had expired on 4/22/22.					
	ountaing area 20 and	ys mad enphod on waz.					
	During an interview	v on 9/20/22 at 9:41 a.m., the					
	_	was the Assistant Director of					
	Nursing (ADON) w	when Resident D left for the					
	homeless shelter on	4/22/22. She indicated he had					
	his medications wit	h him in bubble pack cards. He					
	did not have any na	rectics with him.					
		3 p.m., the DON indicated the					
		were on the April MAR					
	-	nt D's discharge documents,					
	but the quantity of	medications we not part of the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUIL B. WINC	DING	00	COMPL 09/20/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION		ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
		. She indicated the facility did ications given to Resident D					
	Clinical Services (V not need to count th Those medications would have destroy	b p.m., the Vice President of VPCS) indicated the facility did the non-narcotic medications. belonged to Resident D. If we teed them, we would have the ition of the medications.					
	sSD believed becau recipient he left her his medications. Th did not count how r left with on 4/22/22 medications he retuindicated we do not out or came back in requiring they coun at 12:32 p.m., the D medications were re	D p.m., the VPCS indicated the use Resident D was a Medicaid e with a 30 day supply of all e VPCS indicated the facility many medications Resident D and did not count how many rned with on 4/25/22. She know how many pills went the medications. On 9/20/22 DON indicated when the eturned to the building after er Mission they were put back D.					
	(OL) indicated Oml by the Ombudsman believed the SSD er The OL indicated sl several times for other or questions regardinever came up. She a Notification of Difacility for Resident notice of discharge, advocate for the residence to not send people to	p.m., the Ombudsman Leader budsman 41 was not employed program on 2/23/22 and ntry for that date was invalid. The had been in the facility ther residents but information ing Resident D's discharge indicated they never received scharge document from the t D. Whenever they get a they will go to the facility to ident. In our training, we learn o specific places, and we do r discharges. No ombudsman					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022		
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COI ACHWAY DR IAPOLIS, IN 46224	D	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU	ULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION t D. If the Ombudsman would	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE
		anned to discharge Resident helter they would not have				
	them to see Resider	ment. The SSD never asked at D. She only asked questions				
	nothing about how	ne facility discharge residents, to advocate for the residents.				
	completed for Resid	255 a.m., a record review was lent 74. He had the following				
	pulmonary disease,	nited to chronic obstructive heart failure, hypertensive				
	heart, chronic kidne hyperlipidemia, and					
		ed to the facility on 6/22/21. He facility to an assisted living				
	indicated that reside discharge planning. the assisted living v	ted 8/31/22 at 11:49 a.m., ent was being seen for All medications were sent to with Resident 74. He was sent 3 (a medication to treat anxiety)				
		nedication to treat pain).				
	of Clinical Services provide disposition	on 9/19/22 at 3:05 p.m., the VP indicated she was unable to and accountability of				
		ications. She also indicated re of the need to account for ications.				
	provided by the fact Admission Agreem Rights and Facility reviewed. It indicate right to be cared for environment that m	missions Agreement was ility. A document within the ent, titled, "Indiana Resident Responsibilities," was ed, "The resident has the in a manner and in an aintains or enhances each id respect in full recognition of				

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STATEMENT OF DEFICIENCIES >		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	00	COMPL	ETED
		155077	B. WING	÷		09/20/	2022
			c	TDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			CHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVL					AI OLIO, IIV 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T	ΓAG	DEFICIENCY)		DATE
		lityA copy of the resident's					
	_	able in a publicly accessible					
	area. The copy must be at least 12-point type						
		discharge rights of residents of					
	1	owsbefore an interfacility					
	_	e occurs, the facility must					
		e notice in the resident's					
		transmit a copy to the					
	_	al long term care ombudsman					
		ntary relocations or discharges					
	1	f transfer or dischargemust lity at least thirty (30) days					
		is transferred or discharged					
		onference, the resident's					
		ial, and social needs with					
		ation shall be considered and a					
	_	et these needsIf the					
	_	sputed, a meeting shall be held					
		on with the administrator or his					
	1 ~	resident, and the resident's					
		The purpose of the meeting					
		possible alternatives to the					
	proposed relocation						
		•					
	A current policy, tit	eled, "Discharge," dated 8/2022,					
		e VPCS on 9/21/22 at 1:03 p.m.					
	A review of the pol	icy indicated, "The					
	discharge summary	will include a recapitulation of					
	the resident's stay a	t this facility and a final					
	summary of the resi	ident's status at the time of the					
	discharge in accord	ance with established					
	regulations governing	ng release of resident					
	information and as	permitted by the resident. The					
		shall include a description of					
	l '	part of the discharge					
		will reconcile all pre-discharge	1				
		resident's post-discharge					
		edication reconciliation will be					
		post-discharge plan will be					
	developed by the Ca	are Planning/Interdisciplinary					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUI	A. BUILDING 00 B. WING		COMPLETED 09/20/2022			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR					
ENVIVE	OF INDIANAPOLIS			INDIANA	APOLIS, IN 46224			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION tance of the residentA	+	TAG	DEFICIENCY		DATE	
	description of the re	sident's stated goals; the support person availability,						
	-	lity to perform required care						
	what factors may	make the resident vulnerable						
	-	missionThe discharge plan						
		based on changes in the						
		or needs prior to discharge						
		esentative will be involved in						
		planning process and informed						
	of the final post-dis							
		interest in returning to the						
		esident indicates an interest in						
		nmunity, he or she will be encies and support services						
	_	commodating the resident's						
		erencesIf it is deterred that						
		nmunity is not feasible, it will						
	-	this is the case and who						
		tionA member of the IDT						
		am) will review the final						
		with the resident and family						
		(24) hours before the						
	_	placeA copy of the						
	-	ovided to the resident and						
		d a copy will be filed in the						
		ecords: An evaluation of the						
		needs; the post-discharge						
	pan; and the dischar							
	3.1-36(a)(1)							
	3.1-36(a)(1) 3.1-36(a)(2)							
F 0686	483.25(b)(1)(i)(ii)							
SS=G	Treatment/Svcs to	Prevent/Heal Pressure						
Bldg. 00	Ulcer							
	§483.25(b) Skin Ir							
	§483.25(b)(1) Pre							
		prehensive assessment of						
	a resident, the fac	ility must ensure that-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/20/2022		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	(i) A resident receiprofessional stand pressure ulcers are pressure ulcers are pressure ulcers unavoidable; and (ii) A resident with necessary treatment with professional surpromote healing, promote healing, pr	ives care, consistent with lards of practice, to prevent and does not develop pless the individual's clinical trates that they were pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent eveloping. In interview, and record failed to monitor for new or which resulted in actual harm pondition in his skin integrity action and a diagnosis of a alcer and coccygeal the facility failed to ensure event the wound from polace per his plan of care and chniques were taken during for 1 of 1 resident reviewed for 1 of 1 resident reviewed for 1 of 1 resident reviewed for 1 of 1 resident B was observed. In flat on his back. Although the did not respond estions and closed his eyes ep. His bed was a low air loss as observed to be operating at ang. In a.m., Resident B was observed.	F 06		F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=G "Based on observation, intervand record review, the facility failed to monitor for new or worsening wounds which rest in actual harm when a change condition in his skin integrity to his hospitalization and a diagnosis of a necrotic decub ulcer and coccygeal osteomy and the facility failed to ensur interventions to prevent the w from worsening were in place his plan of care and infection control techniques were taked during wound treatments for resident reviewed for wounds (Resident B)." 1. What corrective action(will be accomplished for the residents found to have bee affected by the deficient practice? Resident returned to face and wound monitoring/treatmers are in place. Care plan undate	ulted e of ed itus elitis; ee round per n 1 of 1	10/21/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155077	B. WING 09/20/2022			09/20/2022	
NAME OF P	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	_
NAME OF P	KOVIDEK OK SUPPLIER	•			ACHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		a.m., Resident B was observed			include wound prevention and		
	and remained lying	tlat on his back.			infection control measures.		
	On 9/14/22 at 9:57	a.m., Resident B was observed.			2. How other residents		
	He was lying in bed				having the potential to be		
					affected by the same deficie	nt	
	On 9/14/22 at 2:10	p.m., Resident B remained flat			practice will be identified an		
	on his back.				what corrective action will be		
					taken?		
	On 9/15/22 at 10:00 a.m., Resident B was observed.				· All residents with wound:	s	
	He was lying flat on his back.				have the potential to be affect	ed	
					by this alleged deficient practi	ce.	
	On 9/15/22 from 11:45 a.m., Resident B was				· All residents with wound:	s	
	observed. He was ly	ying flat on his back.			were assessed and records		
					reviewed to ensure wound		
		05 p.m., until 2:35 p.m., a			monitoring/treatments and car		
		tion was conducted for			plan interventions are in place		
		gh he had been assisted to try			being completed per physicial		
		dent B was never turned or			orders. No deficiencies noted.		
	-	oad the pressure from his			All licensed nursing staff		
	bottom.				received training on infection		
	On 0/16/22 -+ 12 12	B a.m., Resident B was observed.			control practices/hand hygien	e	
	He remained in bed				during wound treatments.		
	The remained in Ded	, That off file back.			3. What measures will be	out	
	During an interview	on 9/16/22 at 12:33 a.m., LPN			in place or what systemic		
	_	ent B should be turned or			changes will be made to		
		oad the sore on him bottom at			ensure that the deficient		
	least every two hou				practice does not occur?		
	•				All licensed nurses will b	e	
	On 9/19/22 at 3:05	p.m., Resident B's medical			educated on:		
	record was reviewe	d. His record indicated he had			o "Handwashing/Hand Hygie	ne"	
	been a long-term ca	re resident for many years, and			o "Dressing Change"		
	previously resided on the Behavioral Health Unit.						
		ease diagnoses which			4. How the corrective action	on	
	· ·	not limited to schizoaffective			will be monitored to ensure		
	disorder, type II diabetes, and chronic obstructive				deficient practice will not red	cur	
	pulmonary disease	(COPD).			i.e., what quality assurance		
					program will be put into place	e?	
	He had an active order for weekly skin						

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022		
	PROVIDER OR SUPPLIEI		45 BE	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	assessments to be con day shift. On 9/16/22 at 10:23 (DON) provided conskin assessments are On 3/30/22, no skin weekly skin check Practitioner (NP) provided construction of the construc	ompleted every Wednesday 8 a.m., the Director of Nursing pies of Resident B's weekly and were reviewed at this time. In alterations were noted on the log. However, a Nurse rogress note, dated 3/31/22 at ed Resident B was being seen for "rash on buttocks." are of onset of rash, and ditenderness, local pain and re." The NP diagnosed inital herpes and prescribed antiviral medication). 11 logs indicated from 3/16/22 di LPN 23 had conducted the new alterations in his skin di. 12 documentation of a change in the development of a new documentation of continued authorate area. 13 documentation that the did to his comprehensive plan 14 a.m., the DON provided copies rech and April Certified Nursing		DNS/designee will obser and audit wound treatments, orders and interventions on 5 residents with wounds twice a week x8 weeks, then weekly weeks, then monthly x3 montensure all orders, wound treatments, and care plan interventions are in place and infection control being followed during wound treatments. The results of these audits wireviewed by the QAPI commit overseen by the Executive Differ no less than six months. Tresults will be reviewed for patterns, trends and continuer recommendations for process monitoring and improvement 100% compliance is achieved. 5. Date of completion: 10/21/2022	a x4 hs to If be ttee rector the d s until	

was at risk for behaviors and monitored each shift with no refusal of care noted. Resident B was at risk for alterations in skin integrity but only

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/20	LETED	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	blank, NA (not app March 25, 26 and 2 30th, a new area of also coded "no," it 31st, was coded NA no bed baths or sho each observation w Shower sheets were not able to be provided and the provi	id. March 1st-24th were all licable), or 5 (none observed). The were left blank. On March discoloration" was noted but was not a new area. March a (not applicable). It appeared overs had been provided as as blank or coded NA. The requested for March but were ded by survey exit. The mentation for the month of sident B was at risk for intered each shift with no d. Resident B was at risk for integrity but still only ind. On April 24th, 25th and were noted. On the 27th and dibut not coded a "new." The resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned The Resident was repositioned the nurse educated the mportance of being turned						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155077	B. WING		09/20/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	did not include mea	surements.					
	A Pressure Ulcer Skindicated Resident I acquired on 4/24/22 Wound 1: Stage III fat is visible) pressure moderate serosangut 3 cm (centimeters) I deep. Wound 2: Unstageat where the wound be or eschar) to the left which measured 11 Wound 3: Unstageat in color which measured in color which measured in color which measured resident I swallowing pills and with signs/symptom On-Call doctor was orders, "just continut (oxygen) was not in (sats) was 87%. Whincreased to 94%. A Pressure Ulcer Sk Resident B's areas when the signs of the same with sa	kin Log, dated 4/27/22, B had three areas that were c. (full thickness skin loss where are ulcer to the coccyx with ainous drainage that measured long by 3 cm side and 0.5 cm able (full thickness skin loss ed is not visible due to slough at buttock, purple in color cm long by 6.8 cm wide. able to the left glute, red/purple sured 8 cm long by 6 cm wide. note, dated 5/1/22 at 6:15 a.m., B was noted to have difficulty d was shaking uncontrollably as of shortness of breath. The notified and gave no new the to monitor." His O2 a place and his 02 saturation then his 02 was placed his sats kin Log, dated 5/4/22, indicated were "improved." able to the left glute, purple/red ared 7.5 cm long by 5.5 cm wide, kin prep.					
	_	ble to the sacrum, red in color osanguineous drainage that					
	_	m long by 9 cm wide.					
	A NP progress note	, dated 5/4/22 at 2:28 a.m.,					
		B was being seen after nursing					
		d a decreased level of					
	orientation for the la	ast day, and she ordered labs	İ				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULT A. BUILI B. WING	DING	nstruction 00	(X3) DATE : COMPL 09/20/	ETED		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	A nursing progress a.m., indicated Res (emergency room) continued decrease On 5/16/22 Resider and required a surg and a bone biopsy on necrosis of the bone. A hospital Dischargindicated, "Colla at his ECF [extended stated that normally oriented to person, baseline but this more remained somnoler or swallow his medication from his them. When asking symptoms he did endicated the primary diagnoulcer and coccygeal bone). An MRI confindings consistent coccygeal segments. Resident B's current reviewed and indicated the way are throughout Resident B was never the record lacked or refusals to get out to the continuous continuous to get out to the continuous continu	ge Summary dated 6/1/22 Iteral was obtained via his nurse ed care facility]. His nurse y patient is AAx4 [alert and time, place and situation] at forning he woke up and at and would not open his eyes licines. He stated that he was d had to manually remove the s mouth after he administered g patient regarding his morse feeling confused" Tosis was a necrotic decubitus I osteomyelitis (infection of the mpleted on 5/8/22 revealed with osteomyelitis of s with subjacent cellulitis. At CNA assignment sheet was ated, "up for all meals," at the surveyor timeframe, wer observed out of bed. Idocumentation of Resident B's						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155077	B. WING 09/20/2022			/2022	
		STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF F	PROVIDER OR SUPPLIER	₹					
END (I) (E	OF INDIANIADOLIO				CHWAY DR		
ENVIVE OF INDIANAPOLIS				INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1. A wound treatme	ent observation occurred on					
	9/14/22 from 3:15 p.m., until 4:00 p.m. The						
	following was observed: Licensed Practical Nurse (LPN 23) indicated she						
	would be changing	the wound vacuum (vac)					
		t B's coccyx wound. Certified					
		CNA) 23, CNA 51, and CNA					
		the treatment of wounds.					
	1						
	CNAs 23 and CNA	51 entered room after using					
		e hall and applied a clean pair					
		indicated it usually took two					
	_	position the resident during					
	1	CNAs stood on the right side					
		held him over to his left side.					
	of the resident and i	neid him over to his left side.					
	I PN 23 put on a cle	ean pair of gloves at the door,					
	_	ipes and wiped off the					
		ce, placed a plastic barrier on					
		station with supplies to					
	provide wound care						
	provide would care	.					
	I DN 23 removed th	ne old dressing dated with					
		m the resident's ischium.					
	1 -	al amount of yellow fluid on the					
		23 did not have the ordered					
	1	apply to the wound. LPN 23					
		rm dressing and applied it to					
		tact skin around the					
		plied a dressing over the					
		red the dressing with a white					
		the xeroform. CNA 23 was					
	waving away gnats	during the treatment.					
	I D. 1.00						
	_	hat resident had a wound on his					
		ing to change the wound vac					
		xited the room and came back					
		linens. She placed a new pair of					
	gloves on and did n	ot perform hand hygiene prior					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DESCRIPTION NUMBER A. BUILDING 00 B. WING			COMPLETED 09/20/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREI TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	scissors with a disin Resident B by name tubing and lowered measured from the peri-wound instead removed the wound the wound that was thickness skin and t and/or tendon visibl and pushed saline ir to clean the wound. resident's indwelling sanitizer and then ap She used a saline sy into the wound on h wound vac dressing LPN 23 indicated the wound was 2.2 cent tipped applicator to undermining around of clinical operation LPN 23. LPN 23 we dressing to the periprep to the peri	LPN 23 cleaned a pair of fectant. LPN 23 called a djusted his nasal cannula the head of his bed. LPN 23 peri-wound to the opposite of the wound edges. LPN 23 vac dressing. She measured a stage 4 pressure ulcer (full issue loss with muscle, bone, e). She used a saline syringe ato the wound on his sacrum LPN 23 adjusted the gratheter. She used hand opplied a new pair of gloves. ringe and pushed the saline is sacrum. She opened the sacral imeters and used a cotton obtain the depth. There was a the entire the wound. The VP is came into the room to assist as cutting a clear adhesive wound after applying skin and. LPN 23 was using the ing and placing on the fithe wound (windowpane) clear dressing sheet and wound. LPN 23 cut the foam the foam dressing against her 2 at 3:56 p.m., the Vice linical Operations was om. She attempted to identify and with a tongue depressor. Operations placed gloved nd. She cut the foam dressing ere laying on the bed on and ssing into the wound. The VP ns stayed with LPN 23 and						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION G 00	COM	(X3) DATE SURVEY COMPLETED 09/20/2022			
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION g change.	ID PREFIX TAG	CROSS-REFERENCED TO THE AI	OULD BE	(X5) COMPLETION DATE		
	abnormal areas obscalf. LPN 23 indicand shearing. One a edge at the top of the identified as deep to Clinical Operations. When asked when the been turned or repogive an answer, but who indicated, "it's have been turned at treatment observatifollowing was obse At 1:18 p.m., Residulcer change order cleanse with normal wound vac on every Wednesdays, and F to a stage 4 sacral properties of the sacral word wash her hands gloves that she had At 1:38 p.m., the D before she put on g	lying on his side, there were erved on the back of his left ated that the areas were bruising area was open and had a black he wound. These areas were assue injuries by the VP of . the last time Resident B had sitioned, CNA 51 started to was interrupted by the LPN 23 4:00 p.m. now, so he would 2:00 p.m." 2. A second wound on occurred on 9/16/22. The rved: lent B's active sacral pressure was reviewed. It indicated to I saline (NS) and apply the y dayshift on Mondays, ridays for wound care related by the company of the positioning the resident bund dressing change. She did before putting on disposable						
	up included wound an Optifoam gentle dressing supplies. T and did not wash he	ag on it. The DON's table set vac supplies, hand sanitizer, dressing, and a pink bin of The DON removed her gloves er hands but used hand hands. The resident's door						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		î ´	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20/	ETED		
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE		
1110		and the resident's privacy		mo			DATE	
	When CNA 22 rem the resident's body DON and CNA 22 side. Bodily fluids calf pillow that was heels. A weeping we posterior-lateral caltannish color, some pillowcase in sever. The wound was not larger than the size. At 1:43 p.m., LPN permission to enter called out "knock ke with holding the resident's legs." portion of the previous hand sanitizer gethe resident's legs. The portion of the previous portion of the previous hands laid a white towel of area. She removed the resident's deep gloves, sanitized her gloves, sanitized her gloves. The DON in resident's wound we observed digging in supplies with her glows yinge of NS as the policy of the previous sanitized her gloves. The DON in resident's wound we observed digging in supplies with her glows.	did not shift to center. The moved the resident onto his left were observed on the resident's used to relieve pressure on his round was observed on his left of. The bodily fluids were a fluids were dried on the al places, some were still wet. It dressed, and it was slightly of a quarter. 23 did not knock and wait for the resident's room, she just nock." She requested to assist sident in position for the sacral ne did not wash her hands or gel. She put on gloves and held The DON removed the outer ous sacral dressing and have the date, time, or initials who placed it. It should have thy. She removed her gloves, and put on new gloves. She on the resident's bed as a clean the soiled black sponge from wound. She removed her er hands, and put on new indicated she would clean the ith normal saline (NS). She was a the pink bin of dressing loved hands. She retrieved a 10 and opened it. Without						
	surface of the cente there was undermin	ne squirted the NS into the er of the wound. She indicated using of the wound from 3:00 to lean the undermined areas.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BUILDING 00 B. WING			COMPLETED 09/20/2022		
	PROVIDER OR SUPPLIER		4	5 BEAC	ddress, city, state, zip cod CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	square over the end the center of the res wipe the undermine wound measured 3 would measure the changed her contain the gloves and sanit on new gloves she of for the wound vac of the wound vac of the wound vac system the black sponge in black strip. She place inside the sterile parthe DON indicated granulation tissues a indicated she forgot At 1:53 p.m., the Deplastic strips on the sacral wound. The final 12:00, the second structure was from 12:00 to 6 the round black sponges but we have been placed the lond began placing cut as black sponges but we LPN 23 lifted her hunwashed legs and hand on the long place was sealed. She pretrying to affect a sea adhesive plastic strips on the second strips on the second strips of the top of the second strips of the top of the second strips of the second strip	of her index finger and wiped ident's wound, she did not area. She the indicated the cm (centimeter) x 6 cm and she depth of wound after she iniated gloves. She removed ized her hands. After putting opened the sterile packaging bressing and suction system. In the bin of dressing supplies of scissors. She did not clean the plastic adhesive part of the plastic adhesive part of the cut wound supplies chaging to keep them clean. The resident's wound was 70% and 30% slough. She is to measure the depth. ON began placing adhesive resident skin around the first strip was from 9:00 to crip, slightly over the wound 5:00 o'clock position. She placed onge in the wound. She placed strip and adhesive plastic wound to the left lateral hip. In g black sponge over it. She dhesive plastic strips over the was not able to make a seal. In and off of the resident's pressed her unwashed gloved astic covered sponge before it is seed down with her hand all. The DON was cutting more ps with the unwashed need to place them, trying the number of the country in the place them, trying the number of the country in the number of them, trying the number of the country in the number of them, trying the number of the place them, trying the number of the country in the number of them, trying the number of the country in the number of them, trying the number of the place them trying the number of the place them, trying the number of the place them trying the number of the p					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP CO ACHWAY DR IAPOLIS, IN 46224	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE COMPLETION
	attached to it at the covered black spon tubing and then atta machine. She check again. She placed a strip over the woun plastic covered spo create a seal. She cowound and the long several places for 3 She was unable to plastic strips. At 2:09 p.m., LPN removed her gloves get more adhesive protectioner (NP) droom, she was in a exposed in his bed. QMA's cart. As soot technician did not keep was in a positic in his bed. She wan finished with him. At 2:12 p.m., the Extra Resident B's left lost stage 3 pressure we over a bony promining the indicated were. These areas were now CNA 22, with her whad been holding the on the purple areas. They did not. CNA	suction device with tubing end of the long plastic ge. She attached additional ached it to the wound vac aced the wound vac machine in additional plastic adhesive did. She pressed down on the inges many times trying to continued to push on the graphic growth of the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
140	At 2:15 p.m., the Viservices (VPCS) castaff needed assistant see the resident experiment of the resident experiment experiment of the resident experiment e	ice President of Clinical ame in the room to see if the nee, she was in a position to osed in his bed. ON indicated there was an during Resident B's dressing and privacy curtains should ed. asking about hand washing nges, the DON left to wash observed to wash her hands abbed the paper towels on her hands to her elbows, then hands with contaminated 23 provided another packaged The DON opened it, cut more ps with the contaminated nem on the resident's new at to complete the seal. 7 on 9/16/22 at 9:20 a.m., the was DON at the time Resident bund) indicated at the time of the wound, weekly skin eing conducted by the nurse cumented on paper. 7 on 9/16/22 at 10:30 a.m., with mistrator present, the DON in assessments should have the floor nurse on duty. Any integrity were reported to the A turning and repositioning and practice. In the weeks	IAU		DATE
	caumg up to me de	velopment of the area he was	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MUL A. BUIL B. WINC	DING	ISTRUCTION 00	(X3) DATE : COMPL 09/20/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	lot of care. Care pla continuity of care so	ed more, and he did refuse a ns were put into place for that all the nursing staff ete picture of the resident and						
	the Administrator p typically did not we then she would be c floor with insulin if the floor for call-ins responsibility to con assessments. She ha a weekly basis, and bottom after it had of there was a dressing	or on 9/16/22 at 10:36 a.m., with resent, LPN 23 indicated she ork on the floor. Every now and alled to help the nurse on the needed or would be pulled to a. It was the floor nurses' mplete the weekly skin ad not assessed Resident B on only saw the area on his opened up, and at that time a in place. So, she never ad until the resident returned						
	DON indicated it w responsibility to con assessments and it v	on 9/16/22 at 11:07 a.m., the as the nurse on duty's nduct the weekly skin was important for the direct ete skin checks to maintain						
	a.m., LPN 23 indicated weekly skin check lindicated, "oh, well indicated if she was assessment, it was to	interview on 9/16/22 at 11:22 ated she had reviewed the og with her signature and if I signed it I did it." LPN 23 called down for a skin asually just a quick look over have been cleaning him up.						
	Former DON indica current DON, Admi assumed that Reside	on 9/19/22 at 8:40 a.m., the ated, after a discussion with the inistrator, and VPCO, it was ent B's osteomyelitis infection m the genital herpes outbreak.						

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STATEMENT O AND PLAN OF O		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 09/20/	ETED
	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
h		sked like the new diagnosis to his medical record which for care planning.					
H V pp m	Hygiene," dated 9/2 /PCS, on 9/19/22 a colicy indicated, " most important factor infectionsAll I	led, "Handwashing/Hand 022, was provided by the t 10:53 a.m. A review of the .Handwashing is the single or in preventing transmission nealthcare workers shall utilize ently and appropriately"					
9, 3. en gr m an d:	/2022, was provide :45 p.m. A review on sure measure that good skin integrity was neasures that will made a clean fiel and water. Open dre disposable gloves. R	ded, "Dressing Change," dated by the VPCS, on 9/19/22 at of the policy indicated, "to will promote and maintain while maintaining standard ninimize/control contamination dWash hands with soap ssing pack. Put on first pair of temove soiled dressing and					
g w di re ai n	loves in plastic bag with soap and water isposable gloves. F ecommendations for and secure with tape ecessary. If using s	or treatment. Apply dressing when done with treatment if cissors make sure, it is clean emoves gloves and discard.					
pi "] R 	rovided by the faci Federal Resident R Responsibilities," w .The resident has a .includes accommo	nissions Agreement was lity. A document titled, ights and Facility as reviewed. It indicated, "right to personal privacy odations, medical treatment"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/20	LETED	
	PROVIDER OR SUPPLIER		•	45 BEA	DDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
F 0728 SS=D Bldg. 00	483.35(d)(1)-(3) Facility Hiring and §483.35(d) Requirement use of nurse aides §483.35(d)(1) Ger A facility must not in the facility as a months, on a full-t (i) That individual nursing and nursirement (ii)(A) That individual nursing and nursirement (ii)(A) That individual competency evaluated the State as meet §483.151 through (B) That individual determined compe §483.150(a) and (1) §483.35(d)(2) Nor A facility must not diem, leased, or a permanent employ not meet the requirement (1)(i) and (ii) of this §483.35(d)(3) Min A facility must not worked less than a facility unless (i) Is a full-time entraining and compercial (ii) Has demonstrated aide training evaluation program program; or	neral rule. use any individual working nurse aide for more than 4 ime basis, unlessis competent to provide a grelated services; and ual has completed a training evaluation program, or a sation program approved by ing the requirements of §483.154; or I has been deemed or etent as provided in b). n-permanent employees. use on a temporary, per ny basis other than a yee any individual who does irements in paragraphs (d) is section. imum Competency use any individual who has 4 months as a nurse aide in the individual-inployee in a State-approved etency evaluation program; ated competence through pation in a State-approved					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155077	B. Wl	ING		09/20/2022	
	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	competent as prov	vided in §483.150(a) and					
	(b).						
	Based on interview failed to ensure 2 of employee records (factive licenses.) Findings include: 1. Certified Nursing by the facility as a Gactive license in Flot 5/31/2024. CNA 49 worked as until 7:00 p.m., on the days in September: 9/10/22, and 9/11/2 2. CNA 50 was hire 8/1/22. CNA 50 was and had not yet worked and had not yet worked and had not yet worked as until 7:00 p.m., on the days in September: 9/10/22, and 9/11/2 2. CNA 50 was hire 8/1/22. CNA 50 was and had not yet worked and had not y	and record review, the facility f 10 employees reviewed for CNAs 49 and 50) had a current g Assistant (CNA) 49 was hired CNA on 8/1/21. She had an orida with an expiration date of a CNA on dayshift, 7:00 a.m. the B wing unit on the following 9/2/22, 9/3/22, 9/4/22, 9/9/22, 2. ad by the facility as a CNA on as considered PRN (as needed)	F 07	728	F728 – Facility Hiring and Us of Nurse Aide SS=D "Based on interview and recorreview, the facility failed to en. 2 of 10 employees reviewed for employee records (CNAs 49 a 50) had a current active licensemant. What corrective action(swill be accomplished for the residents found to have been affected by the deficient practice? CNA's 49 and 50 are no longer employed with the facil. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the deficient practice All licensed staff files will audited to ensure up to date license/certification is in place. What measures will be it	rd sure or and se." s) se n lity I be	
	license. 3.1-14(b)				in place or what systemic changes will be made to ensure that the deficient practice does not occur BOM will be in-serviced of verifying license and certifications.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	ROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	(X5) COMPLETION DATE		
TAG	REGULTION CO		TAG	with the state of Indiana prior to employment offer. 4. How the corrective action will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. BOM/Designee will audity newly hired licensed staff and random, previously employed licensed staff employee files of time a week for 6 months to ensure up to date license/certifications are in placed in the results of these audits will reviewed by the QAPI committy overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved. 1. 5. Date of completion: 10/21/2022	n he ur e? all 5 ne ce. be ee ector ne	
F 0740 SS=G Bldg. 00	must provide the r care and services highest practicable psychosocial well- the comprehensive					

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resident's whole emotional and mental

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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 09/20/2022 155077 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR INDIANAPOLIS, IN 46224 **ENVIVE OF INDIANAPOLIS** (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 well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record F 0740 F740 - Behavior Health 10/21/2022 review, the facility failed to ensure a resident on Services the behavior unit with Alzheimer's disease, SS=G psychotic disorder with delusions, and "Based on observation, interview, schizoaffective disorder was supervised and had and record review, the facility interventions implemented to prevent resident to failed to ensure a resident on the resident altercations which resulted in Resident D behavior unit with Alzheimer's pushing Resident C, and Resident C breaking his disease, psychotic disorder with arm for 1 of 2 residents reviewed for abuse delusions, and schizoaffective (Residents D, C, 16, 17, and 83). disorder was supervised and had interventions implemented to Findings include: prevent resident to resident altercations which resulted in 1. On 9/15/22 at 11:50 a.m., Resident D's record Resident D pushing Resident C, was reviewed. Resident D was admitted on and Resident C breaking his arm 10/15/21. His diagnoses included, but were not for 1 of 2 residents reviewed for limited to, Parkinson's disease (progressive abuse (Residents D, C, 16, 17, deterioration of motor function), Alzheimer's and 83)." disease(progressive mental deterioration), Homicidal Ideations (thinking about, considering, 1. What corrective action(s) or planning a homicide), Psychotic disorder with will be accomplished for those delusions (a mental disorder with a disconnection residents found to have been from reality with a belief in altered reality), anxiety affected by the deficient disorder (mental health disorder of feelings of practice? worry, or fear that interfere with daily activities), Resident D is currently diabetes mellitus (blood sugar disorder), cognitive receiving treatment in neuro psych decline (reduction in cognitive ability such as unit. Care plan interventions memory, awareness, judgment and/or mental implemented and will be further acuity), and Schizoaffective disorder, bipolar type updated on resident's return to (includes features of both schizophrenia, affects a facility. person's thinking, sense of self, and perceptions, and a mood disorder such as bipolar disorder How other residents

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which includes mania and depression). He resided

On 9/15/22 at 11:54 a.m., a review of Resident D's

care plans was completed. They were created on

on the locked behavior unit.

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taken?

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having the potential to be

affected by the same deficient practice will be identified and

what corrective action will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLE	ETED
		155077	B. W	ING		09/20/2	2022
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
END /// /E	OF INIDIANIA DOLLO				CHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.16	DATE
	5/4/22. The care pla	ans lacked documentation of no			All residents on Behavior	r unit	
		esident's 2 psychiatric hospital			have the potential to be affect	ed	
		22 and 7/20 to 7/29/22, and 5			by this alleged deficient practi		
		r residents. The care plan		All residents on Behavior unit			
	problems were:	1			are monitored and all resident		
	1 ^	diagnosis of homicidal			plans were audited and updat		
	behavior.	S			with individualized intervention		
		s anti-anxiety medication			prevent resident to resident		
	related to anxiety disorder.				altercations.		
	3. The resident uses anti-psychotic medications				alteroations.		
		ective disorder, bipolar type.			3. What measures will be j	nut	
		ent, Potential for injury to self			in place or what systemic	, at	
	or others.				changes will be made to		
	4. Resident D exhibits restlessness, nervousness				ensure that the deficient		
		y symptoms related to a			practice does not occur?		
	diagnosis of anxiety				All licensed clinical staff		
	5. Resident D had in				were educated on:		
		hought process related to			o "Behavior		
	_	mer's and is at risk for decline.			Assessment/Monitoring"		
	_	t processes/altered mental			Assessment/worldoning		
		gnoses of schizoaffective			4. How the corrective action		
		pe and Psychotic disorder with			will be monitored to ensure t	-	
		own physiological condition.			deficient practice will not red		
	defusions due to kin	own physiological condition.			i.e., what quality assurance	,ui	
	A core plan revised	d on 9/22/22, indicated the			program will be put into place		
	_	ent D had (Auditory, Visual)			program will be put into place	,e :	
	1 ~	ception of something not			DNS/designee will audit	5	
	•	episodes, talking to himself in			residents on the behavior unit		
		coom, he had a history of			three times a week x4 weeks,		
		ors towards others, history of			then twice a week x8 weeks, t		
	_	owards others, abusive					
	00	f throwing items, making			weekly x3 months to ensure a	.11	
		males and wanting a girlfriend.			behavior residents are being	ro in	
		we towards others, lunging at			monitored and interventions a	16 111	
	1				place to prevent resident to resident altercations.		
		s, and making threatening					
		and interventions had not	The results of these audits will be				
	_	the care plan was created on			reviewed by the QAPI commit		
	5/4/22.				overseen by the Executive Dir		
	D 11 (D)	11 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			for no less than six months. The	ne	
	Resident D's report	able incidents to the Indiana			results will be reviewed for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		155077	B. W	'ING		09/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
(X4) ID	CIDANADA	STATEMENT OF DEFICIENCIE	1	ID	·	ı	(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		th for the last 8 months were		1710	patterns, trends and continued	١	DATE
	as follows:	101 1110 11101 0 1110111110 11 11 12 1			recommendations for process		
		s reported that Resident D		monitoring and improvement until			
		esident 16's cell phone. She					
	denied him and he called her a b***h. b. On 5/10/22, it was reported that Resident D made contact with Resident 17. Resident 17 was				100% compliance is achieved		
					5. Date of completion:		
					10/21/2022		
		hallucinating and was sent to the hospital.					
	c. On 5/17/22, it was reported that Resident 83						
		nts to Resident D, and Resident					
	D made contact with Resident 83.						
	d. On 6/2/22, it was reported that Resident 17						
	made racial comments to Resident D, and Resident D pushed Resident 17. It was known that Resident						
	17 was in need of p						
	_	s reported that Resident 83					
		Resident D for no reason.					
		s reported that Resident D					
		Resident C fell and fractured					
	his wrist.						
		a.m., Resident D's "soft file"					
		e SSD. These were dated					
		nation regarding Resident D					
		discharge. No times were					
	noted.						
	On 2/22/22 *******	a time noted the Conicl					
		o time noted, the Social SSD) indicated the resident had					
	,	ents, verbal and physical					
		staff and peers, but was					
	00	l ADLs, scored high on BIMS					
		mental status) and inquired					
	1	he local homeless shelter.					
	-On 3/11/22 with no	time noted, a care plan					
	meeting was held with SSD, Assistant Director of						
		nd Resident D. SSD discussed					
		mitted to facility this morning					
	from an inpatient ps	sychiatric (psych) stay. SSD					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		î ´	JILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/20	LETED		
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	asked Resident D i psych stay, Resider fight. SSD agreed a becoming very low yelling and scream (activity of daily lirindependent with a management., disconotice to Local hor concerns of other revery agitated and be SSD and ADON, see wanted to stay at the speaking to Reside out. SSD educated behavior and disrupt continued to yell are redirect him but was SSD and ADON to a symptom of Reside staff regarding the jacket on the chair Resident D this after behaviors. He denied staff regarding the jacket on the chair Resident D this after behaviors. He denied system of the system of the system of the system of psychosoconic Social Service Direct Resident D who was symptoms of psychoconcerns, or behavior, or behavior of the state of the system of the syste	f he recalled the reason for the at D indicated he got into a and discussed behaviors of d with threatening behavior ing out. We discussed his ADL ving) status of being a second his potential 30-day meless shelter due to safety esidents. Resident D became egan yelling and screaming at tated he's not leaving, and he are facility. SSD had difficulty and D due to yelling, screaming Resident D on current verbal potion to other peers. Resident and scream. SSD attempted to as unsuccessful. He screamed at a leave his room. 3 p.m., the SSD was notified by and become agitated with semoking time. He slammed his in hallway. SSD spoke with ernoon regarding his ed having these behaviors. The standing. No behaviors noted set on a spropriate behaviors of the sum on appropriate behaviors of the sector (SSD) also visited with the spleasant. No signs or the social well-being, mood						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		•	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	notified Resident D and told her she car SSD and ADON sp having this behavior SSD educated Resistence conversation of him potential for a 30-d understanding that 30-day notice. He astated she would sp Director (ED). They week. - On 3/23/22 at 1:32 the SSD visited wit spirits. He showed symptoms of psych concerns. - On 3/24/2022 at 2 the SSD and ADON discussed threatening with yelling and second threatening with yelling and second to him on the agitated and began continued to ask for educated Resident 1 decurrently the Interir scored at a high risk	was upset with a female peer mot have another boyfriend. oke with him. He admitted to or and state he was jealous.					
	40 indicated in a lat	a.m., the Nurse Practitioner (NP) te entry that she had a Resident D. She indicated he					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		 JILDING	00	COMPL 09/20/	ETED
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD		
ENVIVE	OF INDIANAPOLIS			APOLIS, IN 46224		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION y for discharge planning to	TAG	DEFICIENCY)		DATE
	the local homeless sa past medical histor Alzheimer's disease Parkinson's disease, age-related cognitive tremor, muscle wear and insomnia. He disease action active distress at this was resting quietly in person and place with was pleasant and consent with Resident I active times through the several times through upcoming discharged Resident D of the classification of 4/22 appointment on 4/22.	helter per the facility. He had ry of psychotic disorder, schizoaffective disorder, diabetes mellitus type 2, e decline, anxiety disorder, kness, difficulty in walking, d not appear to be in any time or during this visit. He in a chair. He was oriented to th periods of confusion. He operative. Medications were D upon his discharge. The p.m., the Discharge Summary ad spoken with Resident D shout this week regarding his to on 4/22/22. She informed inic providing transportation their clinic for an initial 2/22, then would be				
	transported to the local Resident D became visits and asked on another chance. SSI Resident D by education due to him yelling a with Resident D on discharge to the local the 30-day discharge leave facility. He was threatening behavious way he was leaving Non-emergency policy with escorting Residuella. The police and into van. He was	cal homeless shelter. agitated throughout these different occasions for D attempted to redirect ating him but was unable to t writer. Staff members visited this day regarding his al homeless shelter related to e notice. Resident refused to as yelling and screaming, with rs. He told the staff the only was if the cops were called. ice were contacted to assist dent D to an outpatient clinic's escorted Resident D outside				

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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 09/20/2022 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 - On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented times 3. He ambulated on own without an assistive device. His gait was steady. - On 5/26/22 SSD was notified of Resident D "smacking" a Certified Nursing Aide (CNA) on the buttocks. SSD asked Resident D why he did it, educated him on appropriate behaviors and explained this behavior was inappropriate. Resident D apologized. - On 6/1/22 with no time noted, SSD was notified of Resident D becoming agitated and verbally aggressive as he stated he was jealous of the other peers wanting a girlfriend. SSD was able to redirect him with conversation, walking on the unit and offered activities of interest. He appeared in a better mood with no further behaviors noted. - On 7/20/22 with no time noted, the SSD, DON and the Rounding Psych physician denied him for inpatient psych stating medications would not help his behaviors. This was his personality and medication would not change or help him. - On 9/19/22 at 2:35 p.m., the ED indicated Resident D did not have a behavioral contract with the facility. On 9/19/22 at 2:36 p.m., the April MAR

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medications indicated Resident D took the

by mouth once daily for schizophrenia.

1. Aripiprazole tab 20 mg (milligram), take 1 tablet

following medications:

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077		ì í	ILDING	NSTRUCTION 00	(X3) DATE COMPL 09/20 /	ETED		
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	2. Quetiapine fuma take 1 tablet by mo 3. Quetiapine fuma mouth every night 4. Buspirone Hel (a by mouth 3 times a 5. Lactulose (laxati mL by mouth once (high ammonia). 6. Trazodone Hel (a mg, take 1 tablet by for insomnia. 7. Carbidopa/Levoc Parkinson's disease by mouth once dail 8. Amantadine Hel mg, take 100 mg by for Parkinson's. 9. Amlodipine Best for high blood prest by mouth once dail 10. Donepezil Hel to mouth at bedtime for 11. Gabapentin cap mouth three times of 12. Hydrochlorothi mouth daily for hyp 13. Lamotrigine tabonce daily for bipol 14. Vitamin D cap capsule by mouth edeficiency. 15. Acetaminophem mouth every 6 hour On 9/19/22 at 3:13 indicated Activity 2.	rate (anti-psychotic) tab 50 mg, at the every morning. rate tab 300 mg, take 1 tablet by at bedtime. Inti-anxiety) tab 5 mg, take 5 mg day for anxiety. ve) 10 gr (grams)/15 mL, take 30 daily for hyperammonemia antidepressant/sedative) tab 50 mouth every night at bedtime dopa (dopamine promotor for of tab 25-100 mg, take 1 tablet tabl						
	redirect him. Resid	esident D and was able to ent D liked to do crafts, loved tivity staff talked to him. She						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		, ,	LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/20/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	shift or weekends h but they did know was kept so they co supplies for his leis him cigarettes when personnel were in the 7:00 p.m.	ot know if the evening/night ad special activities for him, where the activity room key uld have had access to ure. The facility also bought in he was out. Activity the building 7 days a week until						
	Resident D loved cl in his room. The sta He liked to talk abo prices. The AD indi computer to him to	p.m., the SSD indicated leaning and organizing things off knew the resident very well. But cars. He liked to compare licated she would take a look at ads. The SSD indicated to making a binder of activities						
	Coordinator was trabehavior health uniwas a dedicated staunit. The ED provides Staff Coordinator dehavior unit. She with totally 62.5 minutes behavioral health stavideos. The YouTu online by BJC Behavioral Patients with 1. The video to edu 9:09 minutes long. 2. The video to edu	p.m., the ED indicated the Staff timed to run the locked t and for the most part there if on the behavioral health led the specific training the id to be over the locked watched 6 YouTube videos, s. Then, she educated the aff, who also watched the 6 be videos were provided avioral Health. They were that: Providing Care for ith Psychiatric Issues. cate about anxiety issues was cate about anger and as 11:57 minutes long.						
	was 9:37 minutes lo 4. The video to edu was 11:52 minutes	cate about suicide risk issues						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SU COMPLET 09/20/20	TED
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		45 BE	T ADDRESS, CITY, STATE, ZIP COD EACHWAY DR ANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was 10:15 minutes 6. The video to edu was 9:47 minutes lo	cate about hallucination issues				
	Resident D indicate came in from outside he needed to go to to no reason. He indicated that were a 30 day a provided the documbegan shaking badle conversation was used the notice of dischameant. On the day of room at the facility time to go. He had indicated he was seshelter and the staff	w, on 9/20/22 at 10:11 a.m., and the SSD did not like him. He de and the SSD indicated to him the local homeless shelter for ated he was given documents notice and a right to appeal. He ments to review. Resident D y and indicated this posetting to him. He said he but did not understand what arge or request for a hearing of his discharge, he was in his and the SSD indicated it was just been laying down. He not to the local homeless fat local homeless shelter y had no right to send him				
	send him to the local threat" to get him to local homeless shell faced the wall. The to the front door. To the local homeless in the police car. He and medications. He how to take medical local homeless shell dispense medication. One resident at local	al homeless shelter tried to				
	walked away. Resid	th him," he just turned and lent D indicated with his haking he was unable to read.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155077	B. WI	NG		09/20/	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
	Г				- , -		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		not try to read the medication		IAG			DATE
		not know how to take the					
		not know what kind of					
		es now, so he left them alone.					
	incurentials he takes now, so he tert them alone.						
	He indicated sometimes he thought about killing						
	people. He had nev	er killed anyone or tried to kill					
		ought about killing his brother					
		hey took his money and threw					
		ed he was mad at the SSD but					
		out killing her. Sometimes he					
	felt like fighting, bu	at not fighting to kill them.					
	During an interviev	v on 9/20/22 at 10:47 a.m., the					
	_	ted they were trying to					
		D from the facility because of					
	_	psych physician indicated he					
		isorder, not behaviors. His					
		very high level compared to					
	the other residents.	The facility was trying to care					
	for his needs. They	were able to care for his					
		a personality disorder. He did					
	not "need to be aro	und other people."					
	On 9/20/22 at 10.53	3 a.m., the SSD indicated the					
		licated to the facility to send					
		ocal mental health outpatient					
		oom and not accept him back.					
	They did not follow						
		nterviewed on 9/13/22 at 11:35					
	a.m. He wanted to s	speak in private about a					
		red in the facility. He					
	indicated that Resid	lent D had gotten in his face.					
		lent D to get out of his					
		n Resident D pushed him					
		s wrist. The police came and					
		t they could not arrest					
		licated that it happened in the					
		e his room. The nursing staff					
	arrived and told hin	n to stay on the ground. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	LETED
		155077	B. WING			09/20/	/2022
	PROVIDER OR SUPPLIER		4	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	ambulance was notice emergency room for his left wrist. Resident C pointed indicated that he musheal. He indicated on him. Since the ir except play his vide. The staff gave him On 9/13/22 at 3:00 was completed. Rediagnoses but not libipolar disorder, an and GERD (gastroed A progress note, da Resident C and Res 7/16/22 resulting in down. Resident C lemergency room for A note, dated 7/16/2 Resident C returned with a new diagnose distal radius, and a supplementation of the commitmental recomminuted fracture of the supplementation of the supplemen	to a splint on his arm and ust wear it to help the fracture that incident had had no effect neident, he did not do anything to game system and smoke.			CROSS-REFERENCED TO THE APPROPRIA	ATE	
	Resident C had order immobilizer to be of (Occupational Ther for 60 days for ADI retraining, therapeu	ers, dated 7/21/22, for a left arm n except for skin checks, OT apy) services 5 days per week L (Activities of Daily Living) tic exercise, therapeutic egiver education, and group					

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Event ID:

0Z2N11

Facility ID: 000032

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PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155077		î ´	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/20	ETED		
	PROVIDER OR SUPPLIER OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)			(X5) COMPLETION DATE	
		ine in function following a fall						
	indicated that reside	plan, dated 7/19/22. It ent had a wrist fracture with a his prior level of function after itation.						
	with a date of 8/202 9/19/22 at 3:45 p.m provide, and reside health services as n highest practicable psychosocial well-tecomprehensive asses Behavioral sympton facility-approved by the comprehensive interdisciplinary ter symptoms in reside severity, distress, arresident and develo Safety strategies with in necessary to protefrom harm. Interves and part of an overside.	avior Assessment/Monitoring" 22 provided by the ED on a indicated, "The facility will ants will receive behavioral eeded to attain or maintain the physical, mental, and being in accordance with the essment and plan of care. ms will be identified using ehavioral screening tools and assessment. The am will evaluate behavioral ants to determine the degree of and potential safety risk to the p a plan of care accordingly. Ill be implemented immediately eet the resident and others entions will be individualized all care environment that functional and psychosocial						
		o understand, prevent or 's distress or loss of abilities						
F 0756 SS=D Bldg. 00	On §483.45(c) Drug F §483.45(c)(1) The	eview, Report Irregular, Act						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

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If continuation sheet Page 129 of 154

DENTIFICATION NUMBER 155077 NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS (X3) ID SUMMARY STATEMENT OF DEFICIENCE PREERY (EACH DEPCIENCY MUST BE PRECEDED BY PILL TAG ROUGHARD AS LED ENTIFIVATION NORMATION month by a licensed pharmacist. \$483.45(c)(2) This review must include a review of the resident's medical chart. \$483.45(c)(4) The pharmacist must report any irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (iii) The attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. \$483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, limit from the pharmacist unstake when he or she identifies an irregularity that requires unstate when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record reviews and interviews, the	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
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medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.		-						
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§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			iei fationale in the resident's					
maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.		medical record.						
maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.		8483 45(c)(5) The	e facility must develop and					
monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.		- , , , ,	-					
are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.		•	•					
steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.								
pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.								
identifies an irregularity that requires urgent action to protect the resident.		1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '						
action to protect the resident.								
		_						
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		· ·		F 0'	756	F756 – Drug Regimen Review	v,	10/21/2022

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			JILDING	ONSTRUCTION 00	(X3) DATE COMPL 09/20/	LETED	
	PROVIDER OR SUPPLIEF		<u> </u>	45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR IAPOLIS, IN 46224	<u>I</u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	,IE	DATE
	facility failed to tim	nely respond to the pharmacist's			Report Irregular, Act On		
	monthly drug regimen review recommendations				SS=D		
	for 2 of 5 residents reviewed for unnecessary				"Based on record reviews and	1	
	medications (Reside	•			interviews, the facility failed to)	
	`	,			timely respond to the pharmac		
	Findings include:				monthly drug regimen review		
					recommendations for 2 of 5		
	1. On 9/15/22 at 2:0	01 p.m., Resident 57's record was			residents reviewed for		
	reviewed. He had t	he following diagnoses but not			unnecessary medications		
	limited to type 2 dia	abetes, schizoaffective			(Residents 57 and 36)."		
	disorder, seizures, d	lepression, hyperlipidemia,			1. What corrective action(s	s)	
	hypotension, anemi	a, and gastro-esophageal			will be accomplished for tho	-	
	reflux disease.				residents found to have been	n	
					affected by the deficient		
	On 1/31/22 the phar	rmacist recommended to			practice?		
	consider decreasing	Lexapro to 5 milligrams (mg)					
	from 10g due to du	plicate therapy. Resident was			· Residents 57 and 36 hav	/e	
	also prescribed Zolo	oft. Both medications were			had all pharmacy monthly dru	g	
	used to treat depres	sion.			regimen review recommendat	ions	
					reviewed with MD and any ne	W	
		(interdisciplinary team) met, scontinued on 3/4/22.			order implemented per MD.		
					2. How other residents		
	2. On 9/15/22 at 2:5	53 p.m., Resident 36's record was			having the potential to be		
	reviewed. He had t	he following diagnoses but not			affected by the same deficie	nt	
	limited to tremors,	vascular dementia, delirium,			practice will be identified an	d	
	chronic kidney dise	ase, anorexia, anemia,			what corrective action will be	е	
	unspecified psychos	sis, insomnia, and			taken?		
	hyperlipidemia.						
					· All residents with monthly	y	
	_	armacist recommended to			pharmacy recommendations h	nave	
	consider an increase in Aricept (a medication used				the potential to be affected by		
	to treat dementia) from 5 mg to 10 mg for a				deficient practice.		
	maintenance dose for his diagnosis of vascular						
	dementia.				· All Pharmacy		
					recommendations over last 6		
	During an interview on 9/16/22 at 10:00 a.m., the				months have been reviewed f	or all	
	VP of Clinical Operations indicated that the		current residents and any				
		d to the recommendation on			outstanding issues will be		
	2/9/22 and denied the	he request to increase the			addressed immediately with N	1D.	

PRINTED: 08/28/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MUL A. BUII B. WIN	DING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/20/2022	
	PROVIDER OR SUPPLIEF			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR IAPOLIS, IN 46224		
ENVIVE (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF dosage. During an interview DON indicated that were expected to be On 9/19/22 at 3:45 provided a copy of policy was titled, "I dated 9/2022. The physician does not response, or the cor that no action has b medical director or	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION of on 9/16/22 at 2:05 p.m., the repharmacy recommendations repharmacy recommendations repharmacy recommendations repharmacy recommendations repharmacy recommendations responded to within 7 days. p.m., the Administrator the current facility policy. The Medication Regimen Review" policy indicated "if the provide a timely or adequate resultant pharmacist identifies reen taken, he/she contacts the (if the medical director is the) the Administrator"	PI		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 3. What measures will be pin place or what systemic changes will be made to ensure that the deficient practice does not occur? DNS will be in-serviced to "Medication Regimen Reviewed by the put into place" How the corrective action will be monitored to ensure the deficient practice will not recipie, what quality assurance program will be put into place. DNS/designee will audit outstanding pharmacy recommendations weekly x6 months and ongoing to ensure recommendations are reviewed MD/NP and completed timely. The results of these audits will reviewed by the QAPI commit overseen by the Executive Direction for no less than six months. The results will be reviewed for patterns, trends and continued.	on: ew" on the cur all ed by I be tee rector he	(X5) COMPLETION DATE
F 0761	483.45(g)(h)(1)(2)				recommendations for process monitoring and improvement to 100% compliance is achieved 5. Date of completion: 10/21/2022	until	
SS=E Blda. 00	Label/Store Drugs	s and Biologicals ng of Drugs and Biologicals					

Drugs and biologicals used in the facility must be labeled in accordance with currently

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		155077	B. WI	NG		09/20/	2022
	PROVIDER OR SUPPLIER		•	45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTIO		DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTI FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	accepted professis the appropriate accinstructions, and to applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper tempermit only author access to the keys §483.45(h)(2) The separately locked compartments for listed in Schedule Drug Abuse Preventage and other dreacept when the fipackage drug districted the quantity stored dose can be reading and monitor the tento store medications units with medications units with medications units with medications units with medications units medications units with m	onal principles, and include ocessory and cautionary the expiration date when the expiration date with the expiration date with the expiration date of the expiration and date of the expiration and control and expiration and control and expiration	F 07		F761 – Label/Store Drugs and Biologicals SS=E "Based on observation, interview and record review, the facility failed to label medications, destroy expired vials and solut of medications, and monitor the temperature of refrigerators us to store medications and vaccinations for 3 of 4 units will medication storage. (Resident 71, 33, 52, 5, and 64)."	ew, tion e sed th s	10/21/2022
	B wing front medic	ation cart was observed to			 What corrective action(s will be accomplished for those 	-	
	have the following	unlabeled medications:			residents found to have been		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

If continuation sheet Page 133 of 154

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155077	B. Wl	ING		09/20/	/2022
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ACHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS				IAPOLIS, IN 46224		
CINVIVE	OF INDIANAFOLIS			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
					affected by the deficient		
		uterol inhaler that was opened			practice?		
		read 2 puffs inhale orally every					
	6 hours as needed for	or shortness of			· Residents 71, 33, 52, 5 a	ınd	
	breath/wheezing.				64 have had all medications		
					audited for appropriate labels	and	
	Resident 71 had dorzolamide eye drops with no				expirations dates, any issues		
	date to indicate when the bottle was opened.				noted were immediately		
					addressed. If medications nee	eded	
	Resident 71 had late	anoprost solution 0.005%			replaced, they were replaced	at no	
	solution with no dat	te to indicate when the bottle			cost to resident. Medication		
	was opened.				storage rooms/carts were aud	ited	
					for appropriate labels and exp	ired	
	2 . Resident 33 had	an open bottle of tears eye			medications were destroyed.		
	drops with no date	opened on the bottle. She had			Refrigerator temperature		
	another bottle of tea	ars eye drops with no date			monitoring is in place.		
	open on the bottle.						
					2. How other residents		
	A bottle of ciproflo	xacin eye drops was in the cart			having the potential to be		
	for Resident 33. Th	ne order was times and ended			affected by the same deficien	nt	
	on 7/20/22.				practice will be identified and	d	
					what corrective action will be	e	
	3. Resident 52 had	a bottle of artificial tears in the			taken?		
	medication cart with	h no label to indicate when the					
	bottle was opened.			· All residents have the			
					potential to be affected be		
		ottle of pilocarpine solution			deficient practice.		
	4% in the cart with	no date to indicate when it was					
	opened.				· Medications rooms,		
					medication carts and medicati	on	
		ombivent inhaler with no date			refrigerators have had 100% a	audit	
	to indicate when it	was opened.			and any issues were immedia	tely	
					addressed.		
	4. Observed a container of breo in the medication						
	cart. There was no label on the medication to				3. What measures will be p	out	
	indicate who the container belonged to.				in place or what systemic		
					changes will be made to		
	The C wing medication cart contained his artificial				ensure that the deficient		
	tears in its original	box along with another bottle			practice does not occur?		
	of artificial tears. C	One was opened and lacked a			All licensed staff will be		

0Z2N11

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 09/20/2022					
		155077	B. W	ING		09/20/202	22
	PROVIDER OR SUPPLIER			45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO	(X5) MPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re	DATE
	date to indicate whe				in-serviced on: o "Medication Storage"		
	_	tion room observed. The imperature log with the date of			4. How the corrective action	on	
	June 2022. It contained tuberculin serum sent				will be monitored to ensure t		
		on 7/29/22. The bottle lacked a			deficient practice will not red	ur	
	date when it was op	ened and had expired.			i.e., what quality assurance		
	The Daving medica	tion room was observed to			program will be put into place	e?	
	have no temperature				DNS/Designee will comp	lete	
		the refrigerator contained			5 random audits weekly in		
		s B vaccination) that expired on			medications rooms and		
	4/3/20.				medications carts for 6 month	s to	
	D 11 . (41 10	0.1			ensure medications have		
		ontainers of clorpactin			appropriate labels, are destroy	red	
		gerator. One bottle was and another bottle was opened			timely and refrigerator temperatures are monitored a	nd	
	on 8/18/22.	and another bottle was opened			within range.	iu	
					The results of these audits wil	be	
	On 9/20/22 at 3:00	p.m., a policy for medication			reviewed by the QAPI commit	tee	
		ed. It was not provided by			overseen by the Executive Dir		
	exit on 9/20/22 at 4	:00 p.m.			for no less than six months. The	те	
	3.1-25(j)				results will be reviewed for	,	
	3.1-25(m)				patterns, trends and continued recommendations for process		
	3.1-25(n)				monitoring and improvement		
					100% compliance is achieved		
					5. Date of completion: 10/21/2022		
F 0802 SS=F Bldg. 00	§483.60(a) Staffin The facility must e the appropriate co to carry out the fur nutrition service, to resident assessment	Support Personnel g employ sufficient staff with empetencies and skills sets nctions of the food and aking into consideration ents, individual plans of oper, acuity and diagnoses					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155077	B. WI	NG		09/20/	2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	of the facility's res accordance with the required at §483.7 §483.60(a)(3) Support of the facility must personnel to safel the functions of the functions of the safel the functions of the functions of the safel the functions of the functions of the safel the facility staff were knowledgresponsibilities requal a clean and safe open the potential to effer from the kitchen. Findings include: 1. Upon entrance in subsequent kitchen facility's industrial observed to only redegrees Fahrenheit staff were unaware low temperature mashould test the chen dishwasher water to attained. The kitchen towels were used to they came out of the serving-ware took to cool water temperat sink was observed to the safe	ident population in he facility assessment '0(e).	F 08		F802 – Sufficient Dietary Support Personnel SS=F "Based on observation, interviand record review, the facility failed to ensure the kitchen stawere knowledgeable of the datasks and responsibilities requito maintain the kitchen in a cleand safe operating condition whad the potential to effect 82 oresidents served from the kitchen." 1. What corrective action(swill be accomplished for tho residents found to have been affected by the deficient practice? All Dietary Staff have been serviced about the daily tasks responsibilities required to maintain the kitchen in a clear and safe operating condition wincludes cleaning dishes and	iew, aff hilly uired ean which of 83 se n en in and which	10/21/2022
		uld connect to a pump to			maintaining the dish machine.		

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r /	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155077	B. WING		09/20/2022
NAME OF 1	PROVIDER OR SUPPLIEI	R		ET ADDRESS, CITY, STATE, ZIP COD	•
ENI\/I\/E	OF INDIANAPOLIS	•		EACHWAY DR	
CINVIVE	OF INDIANAPOLIS	9	INDI	ANAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF	BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	dispense the sanitiz	_		2. How other residents	
	3-compartment sin	k was not observed to be		having the potential to be	
	utilized, despite the	e dishwasher being too cold. A		affected by the same defic	cient
	blank dishwashing	monitor log was observed		practice will be identified a	and
	posted on the front	of the machine for the month		what corrective action will	be
	of September. Dish	washing logs from		taken?	
	June-August were	reviewed and lacked			
	documentation that	the chemical concentration		· All residents have the	
	had been monitored	d and there were multiple days		potential to be affected by t	he
	with low temperatu	re readings. Large serving		alleged deficient practice.	
	trays were observed	d to be in use in			
	transmission-based	precaution (TBP) isolation		· All Dietary Staff have I	been in
	rooms which were	returned to the kitchen to be		serviced about the daily tas	ks and
	cleaned in the dish	washer. During a follow up		responsibilities required to	
	observation on 9/13	3/22, the dishwashing machine		maintain the kitchen in a cle	ean
	was observed to no	t reach the required		and safe operating condition	n which
	•	-compartment sink was		includes cleaning dishes an	nd
	observed to be fille	ed and in use with dishes		maintaining the dish machir	ne.
	soaking but was no	t at the proper concentration			
	of sanitizing solution	on.		3. What measures will b	e put
				in place or what systemic	
	These deficient pra	ctices resulted in an immediate		changes will be made to	
	jeopardy which wa	s removed during the survey		ensure that the deficient	
	period.			practice does not occur?	
				· All dietary employees	will be
	Cross Reference F8	312.		in-serviced on:	
				o "Food Receiving and Sto	orage
	_	nto the facility for the annual		Policy"	
		ey, an initial kitchen tour was		o "Preventing Foodborne I	Illness –
		Dietary Manager (DM). the		Food Handling Policy"	
		out of soap, and the paper			
	_	f the soap dispenser. The DM		4. How the corrective ac	
		sometimes and she needed to		will be monitored to ensur	
		to restock the soap. In the		deficient practice will not	
		her staff were observed to use		i.e., what quality assuranc	
	an alcohol-based ha	and gel instead of soap and		program will be put into p	
	water.			· BOM/Designee will au	
				new dietary employee files	•
	Three bulk storage	bins were observed in use for		2 weeks of hire for 6 month	s to

flour, sugar and thickener. The bins were not

ensure job specific orientation has

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED
		155077	B. W	ING		09/20/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	3			IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		at substances could be easily			been completed including dail	ly	
		DM was unaware why the			task and responsibilities to		
	scoops should not b	be left in the bins.			maintain a clean and safe		
					operating condition. This will		
	Cross reference F8	12.			include the "Food Receiving a		
	12.0	0/12/22 + 0.46 - 1			Storage Policy" and "Preventi	_	
	_	iew on 9/13/22 at 9:46 a.m., the			Foodborne Illness – Food Hai	ndling	
		and her staff were still on a big			Policy".		
	_	e almost everyone was pretty			Dietary Director/ Designed and distant and distan		
		at herself a lot of things, most googled" research about			will audit/quiz 2 random dietal employees weekly x6months	•	
		(parts per million- a					
	_	of sanitizer in water). She			ensure staff are knowledgeab the daily tasks and responsible		
		what she knew. Upon hire,			required to maintain the kitche		
		t a checklist they signed, then			a clean and safe operating	511 111	
	learned as they wer				condition.		
	learned as they wer				Condition.		
	On 9/12/22 at 4:54	p.m., the Administrator (ADM)			The results of these audits will	ll be	
	provided copies of	the kitchen staff's job-specific			reviewed by the QAPI commit	ttee	
	orientations and the	ey were reviewed at this time.			overseen by the Executive Di		
	The document was	titled, "Dietary			for no less than six months. T		
	Aid/Server/Cook Jo	ob Specific Orientation." The			results will be reviewed for		
	orientation was 6-p	age packet with a 90-day			patterns, trends and continue	d	
		e date of employment) to			recommendations for process	;	
	_	check off. The packet was			monitoring and improvement	until	
		ections: 1. Facility Orientation,			100% compliance is achieved	l.	
		rvice and 3., Dining Room. At					
		tion, there was a place for the			5. Date of completion:		
		of the supervisor confirming			10/21/2022		
		as and the date those items					
	were reviewed.						
	Dietary aid 12 was	hired on 3/15/22. His					
		tion was dated and signed as					
		e day as his hire on 3/15/22.					
	_	for supervisor/trainer initials					
	and dates of comple						
	Dietary Aid 16 was	s hired on 5/20/22. Her					
		tion was dated and signed as					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILE		00		COMPLETED	
		155077	B. WING			09/20/	2022	
	PROVIDER OR SUPPLIEF		4	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	DROVIDEDIC DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE	
	completed the same	e day as her hire on 5/20/22.						
		for supervisor/trainer initials						
	and dates of comple	etion were blank.						
	D' / A'110	1: 1 2/14/22 H						
	1	hired on 3/14/22. Her tion was dated and signed as						
		e day as her hire on 3/14/22.						
	_	For supervisor/trainer initials						
	and dates of comple	-						
	Dietary Aid 20 was	hired on 8/15/22. Her						
	job-specific orienta	tion was dated and signed as						
	completed the same	e day as her hire on 8/15/22.						
	The three sections f	for supervisor/trainer initials						
	and dates of comple	etion were blank.						
	1	hired on 5/11/22. Her						
		tion was dated and signed as						
	_	e day as her hire on 5/11/22.						
		For supervisor/trainer initials						
	and dates of comple	etion were blank.						
	On 9/17/22 at 3:45	p.m., the Administrator						
		current facility policy titled,						
		nd Storage," dated 8/2022. The						
		Foods shall be received and						
		that complies with safe food						
		Dry foods that are stored in						
	bins will be remove	ed from original packaging,						
	labeled and dated ('	'use by" date). Such foods will						
	be rotated using a "	first in - first out" system"						
	0.0/17/00 : 0.15	4 4 1 1 1 1						
		p.m., the Administrator						
		current facility policy titled,						
	_	orne Illness - Food Handling,"						
	_	policy indicated, "Food and						
		mployees will follow and sanitary procedures to						
		of foodborne illness						
		gel CANNOT be used in place						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPI A. BUILDIN B. WING		ISTRUCTION 00	(X3) DATE S COMPLI 09/20/2	ETED	
	PROVIDER OR SUPPLIER		45	BEAC	DDRESS, CITY, STATE, ZIP COD CHWAY DR POLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE .	(X5) COMPLETION DATE
	service employees of utensils such as t paper and spatulas a illness All emplo serve food will be transfood handling and p Employees will den competency in these	food service areas food will be trained in the proper use tongs, [scoops], gloves, deli as tools to prevent foodborne byees who handle, prepare or rained in the practices of safe preventing foodborne illness. monstrate knowledge and e practices prior to working g food to residents"					
F 0812 SS=K Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.					
	approved or consifederal, state or lo (i) This may included incetly from local applicable State a regulations. (ii) This provision of facilities from usin gardens, subject that applicable safe graphicable. (iii) This provision	de food items obtained producers, subject to					
	- ,,,,	ore, prepare, distribute and ordance with professional diservice safety.	F 0812		F812 – Food Procurement,		10/21/2022
	A. Based on observ	ration, interview, and record			Store/Prepare/Serve-Sanitary	,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0Z2N11

Facility ID: 000032

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022	
NAME OF I	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
			45 BEACHWAY DR				
ENVIVE	OF INDIANAPOLIS	3		INDIAN	NAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	failed to ensure dishes, trays,			SS=K		
		serving- ware) were cleaned			"A. Based on observation,		
		ected by the dishwasher			interview, and record review,		
		ed according to regulation			facility failed to ensure dishes		
		2 of 83 residents who received			trays, and pots and pans (ser	_	
	food from the kitchen being at risk of				ware) were cleaned and sani		
		n improperly cleaned			as directed by the dishwashe		
	_	ding the potential of exposure			instructions and dried accord	-	
		ng trays being cleaned from			regulation which resulted in 8		
	isolation rooms.				83 residents who received for		
					from the kitchen being at risk		
		pardy began on 9/12/22 when			contamination from improper	-	
		rial dishwashing machine was			cleaned serving-ware includir	-	
		ach a wash temperature of 80			potential of exposure from kit		
		(F). When asked, the kitchen			serving trays being cleaned fi		
		if the machine was a high or			isolation rooms. The immedia		
	_	achine and were unaware they			jeopardy began on 9/12/22 w		
		mical concentration of the			the facility's industrial dishwa	_	
		o ensure proper sanitation was en staff indicated cloth dish			machine was observed to only	•	
					reach a wash temperature of		
		wipe off and dry dishes as e dishwasher because the			degrees Fahrenheit (F). Whe	п	
		too long to air dry due to the			asked, the kitchen staff were unaware if the machine was a	hiah	
	_	tures. The 3-compartment wash			or low temperature machine a	•	
	_	to be missing the chemical			were unaware, they should te		
		n and lacked the tubing			chemical concentration of the		
		uld connect to a pump to			dishwasher water to ensure p		
	dispense the sanitiz				sanitation was attained. The	υρει	
		k was not observed to be			kitchen staff indicated cloth d	ich	
	_	e dishwasher being too cold. A			towels were used to wipe off		
	_	monitor log was observed			dry dishes as they came out of		
		of the machine for the month			dishwasher because the		
	of September. Dish				serving-ware took too long to	air	
		reviewed and lacked			dry due to the cool water	~	
	1	the chemical concentration			temperatures. The 3-compart	ment	
		d and there were multiple days			wash sink was observed to be		
		re readings. Large serving			missing the chemical disinfec		
	trays were observed				solution and lacked the tubing		
		precaution (TBP) isolation			hook-up which should connec		
		returned to the kitchen to be			a pump to dispense the sanit		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	ED
		155077	B. W	ING		09/20/20	22
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ACHWAY DR		
ENVIVE	OF INDIANAPOLIS			INDIANAPOLIS, IN 46224			
	- -				T	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	. , 	DATE
		vasher. During a follow up			solution. The 3-compartment		
		3/22, the dishwashing machine			was not observed to be utilize		
	was observed to not reach the required temperature. The 3-compartment sink was				despite the dishwasher being		
	-	-			cold. A blank dishwashing mo		
		d and in use with dishes			log was observed posted on the		
	_	t at the proper concentration on. The Administrator,			front of the machine for the m		
					of September. Dishwashing Ic		
	-	of Clinical Operations, and Chief			from June-August were review		
	-	vere notified of the immediate			and lacked documentation the		
		m. on 9/13/22. The immediate			the chemical concentration ha	-	
	jeopardy was remov				been monitored and there we		
	-	nained at a lower scope and			multiple days with low temper		
		no actual harm with potential nal harm that is not immediate			readings. Large serving trays	were	
		nai nafin mai is not immediate			observed to be in use in	_	
	jeopardy.				transmission-based precautio		
	D Dagad an abar	ation intomious and researd			(TBP) isolation rooms which v	vere	
		ation, interview, and record			returned to the kitchen to be	urin a	
		failed to ensure the employee			cleaned in the dishwasher. Du	iring	
	_	n the kitchen was supplied			a follow up observation on	hina	
	-	ns in food storage were labeled			9/13/22, the dishwashing mad		
		lly identified and failed to			was observed to not reach the	;	
		d scoops were not left in bulk had the potential to effect 82			required temperature. The	n rod	
	_	were served from the kitchen.			3-compartment sink was obse		
	of 65 residents who	were served from the kitchen.			to be filled and in use with dis		
	Finding include:				soaking but was not at the pro	pper	
	rinding include:				concentration of sanitizing		
	A During on initial	kitchen tour on 9/12/22 from			solution. The Administrator,		
	_				Regional Director of Clinical	iono	
	observed:	5 a.m., the following was			Operations, and Chief Operat Office were notified of the	IUIIS	
	ooseived.					m	
	There was a standin	ng puddle of water near the			immediate jeopardy at 2:33 p. on 9/13/22. The immediate	111.	
		The Dietary Manager (DM)				1/22	
		was leaking from the			jeopardy was removed on 9/1		
		_			but noncompliance remained	aı a	
	dishwasher, which had been giving them				lower scope and severity of		
	problems on and off again for several months.				pattern, no actual harm with		
	A dishwasher monitoring log for the month of				potential for more than minima harm that is not immediate	ai	
	_	ted on the front of the machine be blank. The DM indicated			jeopardy. B. Based on observation		
1	i but was observed to	DE DIANK. THE DIVI MUICALEO	1		L B Based on observation	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155077	B. W	ING		09/20/	/2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			CHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS				IAPOLIS, IN 46224		
CINVIVE	OF INDIANAFOLIS	•		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n filled out because the			interview, and record review,	the	
	dishwasher had not				facility failed to ensure the		
	temperature and the temperatures varied too				employee handwashing sink i		
	widely. She was unsure if the dishwasher was a				kitchen was supplied with soa		
	high or low temper	ature machine.			bulk items in food storage wei		
					labeled and dated to be easily		
		l wash cycles back-to-back.			identified and failed to ensure		
	-	ure was monitored by an			long-handled scoops were no		
		ter that never read more than 80			in bulk storage bins which had	d the	
		(F). No dishes were in the			potential to effect 82 of 83		
		observation, so the water			residents who were served fro)m	
		ouch was lukewarm. The water			the kitchen."		
		gent, or disinfectant was			1. What corrective action(s		
	_	ensed from the tubing into the			will be accomplished for tho		
	_	tment which allowed it to be			residents found to have been	n	
		machine. When asked how the			affected by the deficient		
		ed if the dish machine did not			practice?		
		are, the DM indicated the			Dishwashing machine is		
	_	k was rarely used and the			low temperature machine and	İS	
		ven hooked up. She did not			operating properly at correct		
	know what parts pe				temperature.		
		e mass of a chemical or			· Chemical concentration		
	_	it volume of water) was or how			the dishwasher water is within		
	to check the concer	itration.			normal range. The 3-comparti	ment	
	TI DM' 1' / 1'				wash sink is repaired and		
		because the water was too cold			operating properly.	4	
		cle the dishes took too long to used cloth towels to wipe off			· Employees educated on	HOL	
		nent out of the machine as			using large serving trays in	_	
	needed.	nent out of the machine as			transmission based precaution	n	
	needed.				isolation rooms.		
	After the dishwesh	er cycles were observed, Cook			Dishwashing log is up to		
		vasher with serving-ware to			date. The employee handwash	nina	
		king pot and several burgundy			sink has full supply of soap.	mig	
					Bulk food storage items	are	
	trays. As he ran the dishes through the cycle, the				l labeled and dated with no	ai €	
	machine did not reach temperature. Cook 12 indicated the dish machine had been having				long-handled scoops left in bir	ne	
	problems since he started in March, specifically				l long-nandied scoops left in bil	13.	
	_	always cold, and they had to			2. How other residents		
		dry the serving-ware. He did			2. How other residents having the potential to be		
	ase crour towers to	ary are serving-ware. He did	1		i naving the potential to be		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155077	B. W	ING		09/20/2	2022
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ACHWAY DR		
ENI\/I\/E	OF INDIANAPOLIS						
CINVIVE	OF INDIANAPOLIS			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	not know what PPN	A was or how to check the			affected by the same deficie	nt	
	concentration.				practice will be identified and	b	
					what corrective action will be	e	
	On 9/12/22 at 9:50 a.m., a rolling cart with breakfast				taken?		
	trays was observed on the A-hall. All food items						
	and beverages were observed to be plated on				· All residents have the		
		rving-ware and set on top of			potential to be affected by this		
	large plastic burgundy food trays. Meal tickets				alleged deficient practice.		
	which remained on the trays included the names				The Following were evaluated	,	
		tion as new admission for			repaired and monitored.		
	COVID-19 precauti	ions.			· Dishwashing machine is		
					low temperature machine and	is	
	_	v on 9/12/22 at 9:50 a.m.,			operating properly at correct		
		on Aide (QMA) 14 indicated			temperature.		
		ent who had admitted and was			· Chemical concentration	of	
	_	e (Resident 286) but he was out			the dishwasher water is within		
		t time for Dialysis. When			normal range. The 3-compartr	nent	
		served meals, she indicated all			wash sink is repaired and		
		red and served in Styrofoam			operating properly.		
		ght in on a burgundy tray.			· Dishwashing log is up to		
	_	ed to the kitchen like all the			date.		
	others.				· The employee handwash	ning	
					sink has full supply of soap.		
	_	v on 9/12/22 at 9:55 a.m., QMA			Bulk food storage items	are	
		vas one resident who was			labeled and dated with no		
	_	e on the D-hall (Resident 4). Her			long-handled scoops left in bir	ns.	
		all paper containers but taken					
		regular tray. At this time, she			3. What measures will be p	out	
		iate PPE (personal protective			in place or what systemic		
		ered the room. Through the			changes will be made to		
	_	t 4 was observed sitting in a			ensure that the deficient		
		e-bed table in front of here			practice does not occur?		
		reakfast off a Styrofoam plate			All dietary staff will be		
	that rested on one o	f the burgundy food trays.			educated on:		
					o "Cleaning Dishes and Dish		
	During a follow up visit to the kitchen on 9/12/22				Machine"		
		ntil 12:15 p.m., the following was			o "Kitchen Culinary Sanitatio	n	
	observed:				Facts"	.	
	Dist., A11 (D.1)	16			o "American Dish Service (A	· ·	
	Dietary Aide (DA)	16 was observed at the	1		LLow Temperature Dishwasher		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLET	ED
		155077	B. WI	NG		09/20/20)22
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	L			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	equipment and serving-ware			Manual"		
	_	ted the dishwasher had been			o "American Dish Service,		
		and because it did not dry the			Installation Instructions"	,,	
		f used cloth towels to wipe off			o "Food Receiving and Stora	-	
	and dry dishes after	the wash.			o "Preventing Foodborne Illn	ess –	
	The dishwasher was	s observed for several more			Food Handling"		
		n instructional panel on the			4. How the corrective action	,	
	l -	he machine which indicated			4. How the corrective action will be monitored to ensure to		
		s a low temperature machine					
		minimum of 120 degrees F for			deficient practice will not red i.e., what quality assurance	,ui	
		inse cycles. Additionally, the			program will be put into place	202	
		be tested to ensure a minimum			Dietary Manager /Design		
		ine sanitizer was concentrated			will audit the following twice a	ice	
	into the water.	me samuzer was concentrated			week x8 weeks then weekly x	, l	
	into the water.				months and monthly ongoing		
	The DM indicated s	she had not been testing for			ensure residents are not at ris		
		rved to get a small container			contamination:	K OI	
		the strip into the water			o Dishwashing machine will	he	
		vasher was running. She			audited for proper operation a		
		nd compared it to the guide on			temperature per manufacturer		
	_	container. The side of the			guidelines.		
		PM concentrations to match			o Chemical concentration of	the	
		h, but 50 PPM was not listed			dishwashing water will be aud		
		ottle. The strip was not			to ensure concentration is with		
		colors. The DM indicated she			normal range and the	•	
		the tubing and she held the			3-compartment wash sink is		
		ine to prime the tubing. No			functioning properly.		
		I to be dispensed into the			o Dishwashing log will be au	dited	
	1 ^	eservoir. The DM attempted to			to ensure the log is up to date		
		ine multiple times without			o The employee handwashir		
		sed. She retested the			sink will be audited for full sup	-	
		water, and the strip did not			of soap.	•	
	change colors.	-			o Bulk food storage items wil	ll be	
					audited for labels and dates w		
	During an interview	on 9/12/22 at 12:05 p.m., the			no long-handled scoops left in		
	dish washing machi	ne logs from June through			bins.		
	_	re reviewed with the DM. At			o Employees not using large		
	_	ated the logs were temperature			serving trays in TBP isolation		
		ough the log was for PPM			rooms		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155077	B. WI	NG		09/20/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			CHWAY DR		
ENIVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
LINVIVE	OI INDIANAFOLIS			INDIAN	AI OLIO, III 40224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	I -	I not know the staff should be					
	_	so she has instructed them to			The results of these audits will		
	_	s only. Upon review of the			reviewed by the QAPI commit		
		days were recorded below the			overseen by the Executive Dir		
	required minimum				for no less than six months. Th	ne	
		6, 18, 19, 21, 22, 23 and 31, 2022.			results will be reviewed for		
		11, 12, 17, 18, 24, 25, 26, 27, 29			patterns, trends and continued		
	and 30, 2022.	7 0 10 16 17 10 20 20 1			recommendations for process		
		7, 8, 10, 16, 17, 18, 20, 28 and			monitoring and improvement u		
	29, 2022.				100% compliance is achieved.	•	
	During on interview	on 9/12/22 at 12:09 p.m., the			5. Date of completion:		
	1	for indicated the kitchen staff			5. Date of completion: 10/21/2022		
		nat the dishwasher was not			10/21/2022		
		rature. He suspected the hot			Reason for IDR request:		
		e problem. They had			There was no resident harm d	ue to	
		r issues with the dishwasher			this alleged deficiency. There		
		and leaking so they had a			precedent of F812 ever being		
		come out for repairs. Other			at a K level. While we do not	onou	
		echnical repairs, the			dispute the citation, we do disp	oute	
	_	for was not qualified or			the scope and severity.	paro	
		the dishwasher when it broke					
		needed to call someone else to					
		en he went to assess the					
	machine after the D	M let him know it was not up					
		erature, he observed that the					
	temperature did not	get over 80 degrees F.					
	During an interview	on 9/12/22 at 12:17 p.m., the					
	Administrator indic	ated she had been informed of					
		ishwasher from earlier that					
		vasher had issues that "come					
	and go," and were r	epaired as needed.					
	During an interview on 9/12/22 at 12:33 p.m., the						
	DM indicated she had repeatedly reported						
	concerns about the disrepair of the dishwasher to						
	the Administrator a						
		contacted cooperate about the					
I	Licenses She had ever	n witnessed the Administrator	1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMPL	(X3) DATE SURVEY COMPLETED 09/20/2022		
	NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION	
TAG	_	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	answer on repairs. burgundy trays servout on, the DM ind	and had not been given a final When asked about the Ving trays that meals were sent icated every room received thereving trays except the two expressions.					
	trays was observed and beverages were Styrofoam or plasti were placed on top trays. Meal tickets included the names	6 p.m., a rolling cart with lunch on the A-hall. All food items cobserved to be plated on c disposable serving-ware but of large plastic burgundy food which remained on the trays of residents in isolation as COVID-19 precautions.					
	Nursing Assistant (lunch box to Reside positive. After she she entered the roo she was observed to	p.m., an unidentified Certified CNA) delivered a Styrofoam ent 4, who was COVID-19 donned the appropriate PPE, m, and through the open door, o set the lunch box on top of a ray that was on Resident 4's					
	Administrator indicate to wipe off the burg	y on 9/12/22 at 1:25 p.m., the cated staff had been instructed gundy serving trays before the COVID-19 positive rooms.					
	Maintenance Direct determined that the turned off a switch that turned the hot called and gotten so water heater which Additionally, he idemachine was not proposed to the control of the	v on 9/12/22 at 3:07 p.m., the tor indicated he had kitchen staff had accidently under the dishwashing sink, water off. He had already omeone out to check the hot was being repaired as well. entified the tubing on the dish roperly dispensing chemicals needed to contact someone					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPLETED	
155077		155077	B. WING			09/20/	2022
			STI	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	{	45	BEAC	CHWAY DR		
ENVIVE OF INDIANAPOLIS		INI	DIANA	APOLIS, IN 46224			
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCE		DATE
	_	et that fixed. There was no way					
	to determine how long the tubing had been compromised and not properly dispensing the dishwashing chemicals.						
	During a follow-up	observation of the dish					
		n 9/12/22 at 4:47 p.m., a					
	Contracted Technic	ian was observed as he put					
		air on the dishwashing					
		ne, he indicated the "squeeze					
		ide and rinse solutions had					
	_	nd needed to be replaced.					
		the dish washer cycle was					
	~	that water poured into the					
		bbles gathered on the top of					
		licated soapy water was cian had tested the water and					
	1 ~	o the correct PPM. He					
	_	ed the pump and chemical					
	_	n for the 3 compartment sink					
		en missing. The DM who was					
		, indicated she had no idea the					
	1 ~	able to be replaced, who, or					
	how often they show	-					
	On 9/13/22 from 9:	14 a.m., until 9:40 a.m., a return					
		in the kitchen to observe the					
	dishwashing machin	ne.					
	The DM indicated s	she had been instructed to let					
	the machine run 5-6	times to ensure it got up to					
	temperature before	running dishes through it. She					
	began the machine.	After 10 back-to-back cycles,					
		eached 112 degrees F. The DM					
	indicated she did not know why it was "acting						
	up" again. It had be	en fixed the previous night.					
	While the dish mac	hine ran, the DM used a purple					
		p in the wash water. The test					
	strip turned to indicate the appropriate amount of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/20/2022			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		en dispensed into the dish						
		er and it was 50 PPM. The DM						
		from corporate had come in						
	_	epairs, but she had gone home						
	_	e research" on PPM testing and						
		r own. She had used the						
	incorrect test strips	on 9/12/22.						
	While still weiting	for the dish machine to get un						
		for the dish machine to get up vas requested to test the PPM						
	•	ent sink, as dishes were						
	observed in the wash sink soaking. The DM used several of the same purple test strips she had							
		sher. The strip did not turn						
		licated she needed to add the						
		plained that two new hoses						
		stalled last night to hook the						
		erly. She pressed a button						
		ump to dispense the chemical						
	sanitizer. She dippe	ed a purple strip in the water						
	several more times,	, but the strip did not turn						
	colors. When prom	pted to test the water with a						
	different type of tes	st strip that the PPM strip						
		ged color to indicate the water						
	was 100 PPM. The	e Dietary Manager was unaware						
	this PPM was not a	ppropriate for the 3						
	compartment sink.							
	During an interview	v on 9/13/22 at 9:29 a.m., DA 18						
	-	ot received any new education						
		y before. The DM added at						
		n the process of getting her						
		The DM indicated she had not						
		ce material either, but she had						
	,	e repairs and had been told by						
	the technicians wha	-						
	On 9/13/22 at 9·46	a.m., the Administrator was						
		hwashing machine was still						
		orrect temperature. Copies of						

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	T OF PERIODE				ONID NO. 0936-039	
ľ		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
155077		155077	B. WING		09/20/2022	
			CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹		CHWAY DR		
ENVIVE	OF INDIANAPOLIS	•	INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	٧
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	the in-service and/o	or education that was provided				
		e requested at this time.				
	j					
	During an interview	v on 9/13/22 at 10:11 a.m., the				
	_	Administrator had just asked				
		hen staff sign an in-service				
		e education on the dishwasher				
	_	e had called all her kitchen				
	_	receive the education.				
	starr to come in to r	eceive the education.				
	0 0/12/22 / 10 25					
		7 a.m., the DM provided a copy				
	_	n-in and a current policy titled,				
	_	nd Dish Machine." She was in				
		ating her staff. A corporate				
		t night and educated her and				
	the staff that were p	present.				
		a.m., the above policy was				
	reviewed [and detai	iled below] and lacked				
	information/instruc	tion on low versus high				
	temperature dish ma	achines, PPM sanitizing				
	procedure, and refe	rred to the dish washing				
	manufacture's recor	nmendations, but no				
		nmendations were included.				
	On 9/13/22 at 11:12	2 a.m., the dish washer was				
		DM, the Regional Director of				
		I) and two other technicians.				
	,	d rinse cycle the internal				
	_	ered 130 degrees F. The RDM				
	_	c valve to the hot water tank				
	_	vas replaced, which was				
		epair the Maintenance Director				
	had completed the p	previous day.				
	0.0/10/20 110/10					
		3 p.m., the previously mentioned				
	l * *	d with the Administrator. She				
		time, that the policy lacked				
		tion related to the sanitation				
	intent/specifications	s/requirements. Additionally,				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTII A. BUILDI B. WING		nstruction 00	(X3) DATE (COMPL 09/20/	ETED	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	as the provided pol- machine manufactur dish washing manu requested at this tini indicated she had lo machine was "so of repairs, they did no she would look only On 9/13/22 at 1:50 provided typed inst have been copied o "Kitchen Culinary of Administrator also dishwashing manua printed a copy from Sanitation Facts," of test a sanitation bud 3-compartment sinf Peel off a strip and tested for ten (10) s the key on the outsi wet. Sanitizer conce million (ppm). Idea concentration is acc low temperature chemical chlorine of	icy referred to the dish are's recommendations and the al, those documents were he as well. The Administrator boked for the manual, but the d," and had had so many thave a copy of the manual so tine. p.m., the Administrator ructions, which were noted to note a policy template, titled, Sanitation Facts." The provided a copy of the all and indicated she had a online. The "Kitchen Culinary ated 8/2021, indicated,"to	TA	G	DEFICIENCY)		DATE	
	Temperature Dishw Manual," dated 7/2 NOTICE: before instructions for futu	vish Service [ADS] Low vasher Model: 5-AG-S Parts 013. The manual indicated, " you begin keep all ure reference should you						
	up-to-date informat appropriate docume www.americadish.c	that you have the most ion, we would direct you to the ent on our website: com it is your obligation as ure that the replacement parts						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPLETED	
155077		B. WING 09/20/2022			2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				CHWAY DR		
ENVIVE OF INDIANAPOLIS			INDIAN	APOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		installed safely and properly,					
	1	d, the machine is left in proper					
	_	der failure to provide					
	adequate water quar						
		nachine will cause the machine					
	to function imprope	rly					
	On 9/14/22 at 7:50 a	a.m., additional					
		or the 5-AG-S dish machine					
		ed on the manufactures'					
	website at:						
	https://www.americ	andish.com/WhatsNew/Install					
		205-AGS.pdf. A document					
	titled, "American D	ish Service, "INSTALLATION					
	INSTRUCTIONS N	Model 5-AGS or 5-AG," dated					
	5/2017 indicated, "	Water heaters or boilers must					
	provide the minimu	m temperature of 120F for this					
	model of machine,	which demands an hourly					
	minimum of 118.4	GPH. Temperatures above 150F					
	degrees exceed the	operational design limits for					
	this model. While th	ne supply water must have a					
		legrees, 130/140F degrees is					
		est results CHEMICAL					
		ADS provides three (3)					
		dispense liquid chemicals					
		are color coded "Red"					
	_	Sanitizer, "Blue" Rinse aid					
		provided for chemical product					
		(chlorine) concentrations					
		parts per million. Inspect the					
	_	ny cuts or holes, keep them					
	1 ~	ed CHEMICAL LINES -					
	Squeeze tubes shou six months"	ld be replaced at least every					
	six months"						
	On 9/13/22 at 10:35	a.m., the DM provided a copy					
		terial and sign-in sheet she					
		staff. A current facility policy					
	1 -	shes and Dish Machines,"					
	_	olicy indicated, "Dishes and					
	auteu 6/2022. The p	one, marcacca, Disnes and					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155077	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/20/2022		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	cookware will be we meal make sure of properly loaded of pressure. Follow means air dry all items and machine in good regular to the immediate jeogwas removed on 9/2 water heater and discompanies, the Diewere educated on heater the air and the compartment sink dishwasher and the compartment sink dishwasher was improncompliance remseverity of pattern, for more than mining jeopardy because the monitoring of dishwasher. B. Upon entrance in kitchen tour on 9/12 handwashing station dispenser was out of were set horizontall dispensing box. The over and indicated station was out of steplacement and we replace it. Instead, the alcohol-based hand it, and placed it on the station was out of steplaced it.	rashed and sanitized after each detergent and sanitizers are check temperatures and anufactures' recommendations Keep your ware washing pair" pardy that began on 9/12/22 14/22 when the facility had the shwasher repaired by outside tary Manager and dietary staff ow to use and monitor the emical concentration of the chemical concentration of the chemical concentration of the plemented, but the mained at a lower scope and no actual harm with potential mal harm that is not immediate the need for additional washer temperatures, chemical					
	The dry storage are	a was observed. There were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMP	(X3) DATE SURVEY COMPLETED 09/20/2022			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
	SUMMARY: (EACH DEFICIEN REGULATORY OR three extra-large, stewere not labeled or inside could not easindicated there was and thickener. Ther scoops laying on to each tub. When ask bulk storage, the DI that should not be a explained, the scoop source of contamina several different kit On 9/17/22 at 3:45 provided a copy of "Food Receiving an policy indicated," stored in a manner thandling practices bins will be remove labeled and dated (" be rotated using a "fo On 9/17/22 at 3:45 provided a copy of "Preventing Foodbot dated 8/2022. The provided 8/2022. The provided a copy of the provided a copy of the provided and the service of the prevent the spread of Antimicrobial hand of handwashing in the service employees to of utensils such as the service of the provided as the service of the provided as the provided thand of the provided than the provided the provided the provided the provided the provided the provided the provided the provided the provided the provided than the provided than the provided than the provided than the provided than the provided than the provided than the provided than the provided than the provided than the provided than the provided than th		45 BI	EACHWAY DR	CTION ULD BE	(X5) COMPLETION DATE		
	3.1-21(i)(1) 3.1.21(i)(3)							

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