PRINTED: 11/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3) D.		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
155		155859	B. WING		10/27/2023
		<u>I</u>	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	3	17TH AVE		
ENVIVE	OF BEECH GROVE	≣		H GROVE, IN 46107	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
F 0000					
Bldg. 00					
Diag. 00			F 0000	This Plan of Correction is the	
	This was an offsite	Licensure Investigation	1 0000	Providers credible allegation of	of .
	Survey	Election investigation		compliance. Preparation and/o	
	Survey			execution of this plan of corre	
	Survey Date: Octo	ber 27, 2023		does not constitute admission	
				agreement by the provider of	
	Facility: #000391			truth of the facts alleged or	
	Provider: #155859			conclusions set forth in the	
	AIM: #100274990			statement of deficiencies. The	
				plan of correction is prepared	
	This state finding is	s cited in accordance with 410		and/or executed solely because	se it
	IAC 16.2.			is required by the provisions of	
				federal and state law.	
	Quality review com	npleted October 27, 2023			
F 9999					
Bldg. 00					
i biug. 00			E 0000	What corrective action will be	10/21/2022
			F 9999	What corrective action will be accomplished for those reside	10/31/2023
	16.2-3.1-2(h)(1) - Licenses (h) For the renewal of a license, the director may			found to have been affected b	
				alleged deficient practice;	y trie
				It is the consistent practice of	thic
		for any period up to one (1)		Provider to ensure that the fac	
				license is kept up to date and	•
	year, issue a probationary license, or deny a license application upon receipt and review of the			submitted timely. This Provide	
	following requirem	-		provided the IDOH with applic	
		all submit a renewal application		renewal and payment for curre	
		ast forty-five (45) days prior to		facility license. Facility license	
	the expiration of the			has been received and is curr	
				and in good standing.	
	This state rule was	not met as evidenced by:		9	
		Ž		How other residents having th	e
	Based on document	t review, the facility failed to		potential to be affected by the	
		renewed their license to		same alleged deficient practic	
	operate as a health	care facility before their		will be identified and what	
	current license expi	ired on September 30, 2023		corrective action will be taken	;
	<u> </u>				
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
David Ben	son		Ex		11/05/2023

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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	
		155859	B. WING		10/27/2023	
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER				I7TH AVE		
ENVIVE OF BEECH GROVE				I GROVE, IN 46107		
	C. DELONGOVE	-		T	1	
(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		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	TEI	. 14 6 32 1		All residents residing at this		
		ceived the facility's renewal		facility have the potential to be	• • • • • • • • • • • • • • • • • • •	
		ment post marked October 21,		affected by the alleged deficie	nt	
		ot at least 45 days of the current		practice.	OU	
	incense expiration d	ate of September 30, 2023.		This Provider provided the ID0	JH	
				with application renewal and		
				payment for current facility	oon	
				license. Facility license has b received and is current and in		
				good standing.		
			1	good standing.		
				What measures will be put into	_	
				place and what systematic		
				changes will be made to ensu	re	
				that the alleged deficient pract		
				does not recur;		
				The Executive Director has ac	lded	
				electronic calendar notification		
				be notified 60 day prior to facil		
				licensure expiration to ensure	<b>´</b>	
				renewal application has been		
				received, completed and		
				processed prior to 45 days of		
				expiration of current facility		
				license.		
				How will the corrective actions	s be	
				monitored or QA will be put in	to	
				place to ensure the alleged		
				deficient practice will not recu	ır;	
				The IDT team will review the		
				current standing of the facility		
				licensure at the QA monthly		
				meeting to ensure facility		
				licensure is active, in good		
				standing and status of any		
				upcoming expiration date. Th	e	
				Executive Director will be		
		1	responsible for monitoring and	4 I		

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

Event ID:

HFD511

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ensuring compliance with the

If continuation sheet

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155859	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	(X3) DATE SURVEY  COMPLETED  10/27/2023		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BEECH GROVE			STREET ADDRESS, CITY, STATE, ZIP COD 501 N 17TH AVE BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	DEFICIENCY)	OULD BE COMPLETION		
R 0000 Bldg. 00				facility license.			
Didg. 00	This was an offsite Licensure Investigation Survey  Survey Date: October 27, 2023  Facility: #000391  This State Residential Finding is cited in accordance with 410 IAC 16.2-5.  Quality review completed October 27, 2023		R 0000  This Plan of Correction is to Providers credible allegation compliance. Preparation and execution of this plan of conduction of this plan of conduction of the provider truth of the facts alleged or conclusions set forth in the statement of deficiencies. In plan of correction is preparand/or executed solely begins required by the provision federal and state law.		ation of an and/or correction der of the l or the s. The pared pecause it		
R 9999							
Bldg. 00	to the director at least the expiration of the This state rule was a Based on document ensure it had timely operate as a resident current license expiration and paying application and paying 2023, which was no	Il submit a renewal application st forty-five (45) days prior to	R 9999	What corrective action was accomplished for those found to have been affer alleged deficient practice. It is the consistent practice. It is the consistent practice is kept up to date submitted timely. This provided the IDOH with renewal and payment for facility license. Facility I has been received and it and in good standing.  How other residents have potential to be affected by same alleged deficient provided and which is the same alleged deficient provided to have accomplished and which is the same alleged deficient provided to have accomplished and which is the same alleged deficient provided to have accomplished and which is the same alleged deficient provided to have accomplished and which is the same alleged deficient provided to have accomplished and which is the same alleged deficient provided to have a same alleged deficient provided to the same alleged deficient provided	residents cted by the e; ice of this the facility e and Provider application or current icense is current ving the by the practice		

State Form Event ID: HFD511 Facility ID: 000391 If continuation sheet Page 3 of 5

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

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155859	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/27/2023			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BEECH GROVE			STREET ADDRESS, CITY, STATE, ZIP COD 501 N 17TH AVE BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DPRIATE DATE			
				corrective action will be tal All residents residing at the facility have the potential to affected by the alleged despractice.  This Provider provided the with application renewal an payment for current facility license. Facility license has received and is current and good standing.  What measures will be put place and what systematic changes will be made to e that the alleged deficient place and what systematic changes will be made to e that the alleged deficient place and recur;  The Executive Director has electronic calendar notificate be notified 60 day prior to licensure expiration to ensure expiration to ensure expiration of current facility license.  How will the corrective act monitored or QA will be puplace to ensure the alleged deficient practice will not a the IDT team will review the current standing of the facility licensure at the QA month meeting to ensure facility licensure is active, in good standing and status of any upcoming expiration date. Executive Director will be responsible for monitoring	ken; is o be ficient  a IDOH and as been d in  t into ansure bractice s added ation to facility aure een s of y  ions be at into d recur; he ility ly			

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155859	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/27/2023	
NAME OF PROVIDER OR SUPPLIER ENVIVE OF BEECH GROVE			STREET ADDRESS, CITY, STATE, ZIP COD 501 N 17TH AVE BEECH GROVE, IN 46107				
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					ensuring compliance with the facility license.		

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