STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	02/19/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00453734. Complaint IN00453734- Federal/State deficiencies related to the allegations are cited at F622 and F626. Survey dates: February 18 and 19, 2025 Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 4 Medicaid: 94 Other: 5 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2025.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted February 18-19, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 21, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to ensure a resident was able to appeal a facility initiated discharge and failed to document why the facility was discharging the resident instead of allowing them to return to the facility after a hospital stay for 1 of 3 residents reviewed	F 0622	**F 622 – Transfer and Discharge Requirements** *"Facility failed to ensure a resident was able to appeal a facility initiated discharge and failed to document why the facility was*	03/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Levi Back	VP of Clinical Services	03/24/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	for discharges (Resident D). Findings include: On 2/18/25 at 11:32 a.m., a record review was completed for Resident D. He had the following diagnoses which included but were not limited to antisocial personality disorder (a mental health condition characterized by a persistent pattern of disregard for and violation of the rights of others, often leading to problems in relationships, work, and legal issues), bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and behavior, alternating between periods of mania and depression), pseudobulbar affect (a neurological disorder characterized by uncontrollable episodes of laughing or crying that are often inappropriate or exaggerated), insomnia, attention-hyperactivity disorder (a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and/or impulsivity that interfere with daily functioning in multiple areas), and traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, bump, fall, or car accident). During a review of his hospital note, dated 10/27/24, prior to admission to the Skilled Nursing Facility, indicated Resident D became aggressive in the emergency department and threw his colostomy bag. Also, he had spent time at another hospital and had some issues with social work and placement issues. He was banned from that hospital due to bad behaviors and history of being abusive to staff. A Brief Interview for Mental Status (BIMS) assessment score, completed on 12/10/24, indicated he scored 15 out of 15, and was		*discharging the resident instead of allowing them to return to the facility after a hospital stay for 1 of 3 residents reviewed for discharges (Resident D).”* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D was affected by the alleged deficient practice. Resident D was sent to hospital for an acute change in condition. Based on residents' needs at time of discharge from hospital, the facility was not equipped to meet resident needs. Resident D had discharged paperwork immediately reviewed. It was determined the facility is currently unable to care for resident needs. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** (How to protect *like* residents). - All Residents being sent to hospital for acute medical changes have the potential to be affected by the alleged deficient practice. All residents that are being sent to hospital for acute changes will be assessed for return and resident will be notified of returning	

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	cognitively intact. A care plan, dated 11/20/24, indicated Resident D had a diagnosis of anti-social personality disorder (ASHD). A care plan, dated 11/21/24, indicated Resident D had a diagnosis of bipolar disorder. A care plan, dated 11/21/24, indicated Resident D had a diagnosis of mild intellectual disabilities. A care plan, dated 11/20/24, indicated Resident D had a mood problem related to diagnosis of paranoid schizophrenia. A care plan, dated 12/5/24, indicated Resident D had made sexually inappropriate behaviors such as asking staff to have sex with him. A care plan, dated 12/5/24, indicated Resident D was physically aggressive as evidenced by throwing his colostomy bag at staff, throwing the remote control at staff related to poor impulse control, antisocial personality disorder, schizophrenia, autism, cursing at staff, places himself on the floor, spitting at staff, throwing bowls and plates on the floor causing them to shatter, and manipulative behaviors towards staff. A care plan, dated 12/5/24, indicated Resident D was verbally aggressive as evidenced by yelling out frequently when he wants something related to mental, emotional illness, poor impulse control and had made false allegations toward staff. A care plan, dated 12/11/24, indicated Resident D had behaviors of refusal of care, medications, wound treatment, non-compliant with wound treatment, digging and picking into his wound		process. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DHS and ADHS were educated on the Envive Admission Policy, Envive Transfer or Discharge, Facility-Initiated Policy, and Envive Bed Hold and Return Policy and procedure. - Education and training were provided to DHS and ADHS on 2/25/25 by the clinical support consultant. Education provided: Envive Admission Policy Envive Transfer or Discharge, Facility-Initiated Policy Envive Bed Hold and Return Policy **4: 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?** DHS/designee will complete daily monitoring through the clinical care meeting for all residents that are sent to hospital for acute changes and make sure proper procedure was followed and monitor 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6	

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	repetitively removing his dressing. Resident D was observed poking a fork into his wound and a straw to his stoma. He was non-compliant with the smoking policy and was found smoking cigarettes in his room. A care plan, dated 12/24/24, indicated Resident D had a history of making false allegations against staff. A care plan, dated 12/26/24, indicated Resident D exhibited restlessness, nervousness, and/or anxiety symptoms, agitation, attention and concentration deficit due to diagnosis of ASHD. A progress note, dated 2/2/25, indicated Resident D used another resident's cell phone to call 911, paramedics arrived and stated resident want to be transferred to a local hospital, and it was his right to transfer. There was no indication of why Resident D wanted to transfer as his needs were being met at the facility. A progress note, dated 2/3/25, indicated a nurse from the local hospital call and indicated Resident D had been admitted with swollen testicles. A hospital progress note, dated 2/3/25, indicated Resident D had numerous hospitalizations at multiple systems over the last 6 months. He was seen in the emergency room. The resident's record lacked documentation of a reason for the discharge of the resident by the physician. The resident's record lacked documentation of how the resident was a danger to other residents or himself. The resident's record lacked documentation of why the facility was not honoring the resident's right to return to the facility pending an appeal of any facility-initiated		months. DHS/designee will be responsible for monitoring compliance of the line list procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 3/21/2025	

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	discharge. During an interview with the Social Services Director (SSD) on 2/18/25 at 10:53 a.m., she indicated Resident D did not have a discharge assessment completed because he was leaving 911. She indicated the company decided not to take him back because of his behaviors. They were worried about the overall safety of other residents and staff. On 2/18/25 at 10:55 a.m., during an interview with the Executive Director (ED), he indicated they admitted Resident D to administer some antibiotics. He was aware that residents would not always be accepting to care. He threw his colostomy bag at the staff. He hit a staff member in the face. He called the police around 36 times. Resident D finally handed his phone off to management to lock up. The police did not want to arrest him due to the wounds he had on his buttocks. He dug in his wounds with silver ware. He destroyed his room and pulled a handrail off the wall. They attempted 1 on 1 supervision because he was consuming so much time with his call light and hollering at staff. It took 2 to 3 staff members to care for him at a time due to safety concerns. He indicated when he reviewed Resident D's admission documentation prior to admission at the facility, it did not indicate the resident had these behaviors. There were no specific incidents causing a denial to readmit Resident D. The ED was unaware of the resident's current condition at the hospital. On 2/18/25 at 12:40 p.m., during an interview with the ombudsman, she indicated she witnessed Resident D's behaviors herself. He dug in his colostomy bag and acted like he was going to throw feces on her. She told the facility they			

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	would have to give a 30-day notice of intent to discharge. On 2/18/25 at 1:03 p.m., an interview by phone was attempted but Resident D did not answer his phone. On 2/18/25 at 1:03 p.m., during an interview, Resident D's mother indicated she was unaware of the reason why Resident D was not allowed to return to the facility. She worried about his belongings and cell phone. On 2/19/25 at 10:31 a.m., a policy titled, "Transfer or Discharge, Facility Initiated" was provided by the Special Projects and Interim Administrator. It indicated, " ...Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy ...." This deficiency relates to Complaint IN00453734.			
F 0626 SS=D Bldg. 00	483.15(e)(1)(2) Permitting Residents to Return to Facility Based on interview and record review, the facility failed to follow the policy by not allowing the resident to return to the facility after a hospitalization for 1 of 3 resident reviewed for discharged (Resident D). Findings include: On 2/18/25 at 11:32 a.m., a record review was completed for Resident D. He had the following diagnoses which included but were not limited to	F 0626	**F 626 – Permitting Resident to Return to Facility** *"Facility failed to follow the policy by not allowing the resident to return to the facility after a hospitalization for 1 of 3 resident reviewed for discharged (Resident D)."* **1: What corrective action(s) will be accomplished for those residents found to have been**	03/21/2025

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	antisocial personality disorder (a mental health condition characterized by a persistent pattern of disregard for and violation of the rights of others, often leading to problems in relationships, work, and legal issues), bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood, energy, and behavior, alternating between periods of mania and depression), pseudobulbar affect (a neurological disorder characterized by uncontrollable episodes of laughing or crying that are often inappropriate or exaggerated), insomnia, attention-hyperactivity disorder (a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and/or impulsivity that interfere with daily functioning in multiple areas), and traumatic brain injury (an injury to the brain caused by an external physical force, such as a blow, bump, fall, or car accident). . A progress note, dated 2/2/25, indicated Resident D used another resident's cell phone to call 911, paramedics arrived, stated resident want to be transferred to a local hospital, and it was his right to transfer. There was no indication of why Resident D wanted to transfer as his needs were being met at the facility. A progress note, dated 2/3/25, indicated a nurse from the local hospital call and indicated Resident D had been admitted with swollen testicles. A hospital progress note, dated 2/3/25, indicated Resident D had numerous hospitalizations at multiple systems over the last 6 months. The resident's record lacked documentation of how the resident was a danger to other residents or himself. The resident's record lacked documentation of why the facility was not		**affected by the deficient practice?** Resident D was affected by the alleged deficient practice. Resident D was sent to hospital for an acute change in condition. Based on residents' needs at time of discharge from hospital, the facility was not equipped to meet resident needs. Resident D had discharged paperwork immediately reviewed. It was determined the facility is currently unable to care for resident needs. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** (How to protect *like* residents). - All Residents being sent to hospital for acute medical changes have the potential to be affected by the alleged deficient practice. All residents that are being sent to hospital for acute changes will be assessed for return and resident will be notified of returning process. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DHS and ADHS were	

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	honoring the resident's right to return to the facility pending an appeal of any facility-initiated discharge. During an interview with the Social Services Director (SSD) on 2/18/25 at 10:53 a.m., she indicated Resident D did not have a discharge assessment completed because he was leaving 911. She indicated the company decided not to take him back because of his behaviors. They were worried about the overall safety of other residents and staff. On 2/18/25 at 10:55 a.m., during an interview, the Executive Director (ED) indicated they admitted Resident D to administer some antibiotics. He was aware that the resident would not always be accepting to care. He threw his colostomy bag at the staff. He hit a staff member in the face. He called the police around 36 times. Resident D finally handed his phone off to management to lock up. The police did not want to arrest him due to the wounds he had on his buttocks. He dug in his wounds with silver ware. He destroyed his room and pulled a handrail off the wall. They attempted 1 on 1 supervision because he was consuming so much time with his call light and hollering at staff. It took 2 to 3 staff members to care for him at a time due to safety concerns. He indicated when he reviewed Resident D's admission documentation prior to his admission at the facility, it did not indicate the resident had these behaviors. There were no specific incidents causing a denial to readmit Resident D. The ED was unaware of the resident's condition at the hospital. On 2/18/25 at 12:40 p.m., during an interview, the ombudsman indicated she witnessed his behavior herself. He dug in his bag and acted like he was		educated on the Envive Admission Policy, Envive Transfer or Discharge, Facility-Initiated Policy, and Envive Bed Hold and Return Policy and procedure. - Education and training were provided to DHS and ADHS on 2/25/25 by the clinical support consultant. Education provided: Envive Admission Policy Envive Transfer or Discharge, Facility-Initiated Policy Envive Bed Hold and Return Policy **4: 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?** DHS/designee will complete daily monitoring through the clinical care meeting for all residents that are sent to hospital for acute changes and make sure proper procedure was followed including but not limited to, reviewing resident needs for return and monitor 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DHS/designee will be responsible for monitoring compliance of the line list procedure for 6 months. The results of these audits will be	

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	going to throw feces on her. She told the facility they would have to give a 30-day notice of intent to discharge. On 2/18/25 at 1:03 p.m., an interview by phone was attempted but Resident D did not answer his phone. On 2/18/25 at 1:03 p.m., during an interview, Resident D's mother indicated she was unaware of the reason why Resident D was not allowed to return to the facility. She worried about his belongings and cell phone. On 2/19/25 at 10:31 a.m., a policy titled, "Transfer or Discharge, Facility Initiated" was provided by the Special Projects and Interim Administrator. It indicated, " ...Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy ...." This deficiency relates to Complaint IN00453734.		reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 3/21/2025	