STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155077	B. WING			02/19/2025	
				CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD CHWAY DR		
ENIVIVE (OE INDIANADOLIS						
ENVIVE OF INDIANAPOLIS				INDIANAPOLIS, IN 46224			
(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	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
F 0000							
Bldg. 00							
		e Investigation of Complaint	F 00	000	Preparation or execution of this		
	IN00453734.				plan of correction does not		
					constitute admission or agreer		
	_	734- Federal/State deficiencies			of provider of the truth of the facts		
	_	tions are cited at F622 and			alleged or conclusions set fort		
	F626.				the Statement of Deficiencies. The		
					Plan of Correction is prepared	and	
	Survey dates: Febru	ary 18 and 19, 2025			executed solely because it is		
	T 11. 1 00	0022			required by the position of Fed	leral	
	Facility number: 00				and State Law. The Plan of		
	Provider number: 1				Correction is submitted to resp		
	AIM number: 1002	2/3330		to the allegation of noncompli			
	C DIT				cited during the Complaint Sur	-	
	Census Bed Type: SNF/NF: 103				conducted February 18-19, 20	25.	
	Total: 103				Please accept this Plan of		
	10141. 103				Correction as the provider's credible allegation of complian	00	
	Census Payor Type:				as of March 21, 2025. The pro		
	Medicare: 4	•			respectfully requests desk rev		
	Medicaid: 94				with paper compliance to be	<u>CW</u>	
	Other: 5				considered in establishing that	the	
	Total: 103				provider is in substantial	· tilo	
	100011				compliance.		
	These deficiencies r	reflect State Findings cited in					
	accordance with 410	_					
	Quality review com	pleted on February 27, 2025.					
		•					
F 0622	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements						
SS=D							
Bldg. 00							
		and record review, the facility	F 06	522	F 622 – Transfer and Dischar	ge	03/21/2025
		sident was able to appeal a			Requirements "Facility failed to ensure a resident		
		charge and failed to document					
		s discharging the resident			was able to appeal a facility		
	_	them to return to the facility			initiated discharge and failed to		
	atter a hospital stay	for 1 of 3 residents reviewed			document why the facility was		

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

TITLE

(X6) DATE 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

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

continued program participation.

Brandon Levi Back

KTX811

VP of Clinical Services

000032

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 02/19/2025 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 for discharges (Resident D). discharging the resident instead of allowing them to return to the Findings include: facility after a hospital stay for 1 of 3 residents reviewed for On 2/18/25 at 11:32 a.m., a record review was discharges (Resident D)." completed for Resident D. He had the following diagnoses which included but were not limited to 1: What corrective action(s) will antisocial personality disorder (a mental health be accomplished for those condition characterized by a persistent pattern of residents found to have been disregard for and violation of the rights of others, affected by the deficient often leading to problems in relationships, work, practice? and legal issues), bipolar disorder (a chronic Resident D was affected by mental health condition characterized by extreme the alleged deficient practice. shifts in mood, energy, and behavior, alternating Resident D was sent to between periods of mania and depression), hospital for an acute change in pseudobulbar affect (a neurological disorder condition. Based on residents' characterized by uncontrollable episodes of needs at time of discharge from laughing or crying that are often inappropriate or hospital, the facility was not exaggerated), insomnia, attention-hyperactivity equipped to meet resident needs. disorder (a neurodevelopmental disorder Resident D had discharged characterized by persistent patterns of inattention, paperwork immediately reviewed. hyperactivity, and/or impulsivity that interfere It was determined the facility is with daily functioning in multiple areas), and currently unable to care for traumatic brain injury (an injury to the brain resident needs. caused by an external physical force, such as a blow, bump, fall, or car accident). 2: How other residents having the potential to be affected by During a review of his hospital note, dated the same deficient practice will 10/27/24, prior to admission to the Skilled Nursing be identified and what Facility, indicated Resident D became aggressive corrective action will be taken. in the emergency department and threw his (How to protect *like* residents). colostomy bag. Also, he had spent time at All Residents being sent to another hospital and had some issues with social hospital for acute medical work and placement issues. He was banned from changes have the potential to be that hospital due to bad behaviors and history of affected by the alleged deficient being abusive to staff. All residents that are being A Brief Interview for Mental Status (BIMS) sent to hospital for acute changes assessment score, completed on 12/10/24, will be assessed for return and indicated he scored 15 out of 15, and was resident will be notified of returning

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

Event ID:

KTX811

Facility ID: 000032

If continuation sheet

Page 2 of 9

PRINTED: 04/03/2025 VED 039

EPARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>00</u>	COMPLETED			
	155077	B. WI	NG	02/19/2025			
NAME OF PROVIDER OR SURDI IER		STREET ADDRESS, CITY, STATE, ZIP COD					

	100077	<u></u>	02/13/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD	
		45 BEACHWAY DR	
ENVIVE	OF INDIANAPOLIS	INDIANAPOLIS, IN 46224	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTIO	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPROP	DATE
	cognitively intact.	process.	
	A care plan, dated 11/20/24, indicated Resident D		
	had a diagnosis of anti-social personality disorder	3: What measures will be p	
	(ASHD).	into place or what systemi	ic
		changes will be made to	
	A care plan, dated 11/21/24, indicated Resident D	ensure that the deficient	
	had a diagnosis of bipolar disorder.	practice does not recur?	
		The DHS and ADHS	
	A care plan, dated 11/21/24, indicated Resident D	educated on the Envive Adı	mission
	had a diagnosis of mild intellectual disabilities.	Policy, Envive Transfer or	
		Discharge, Facility-Initiated	
	A care plan, dated 11/20/24, indicated Resident D	Policy, and Envive Bed Hole	
	had a mood problem related to diagnosis of	Return Policy and procedur	e.
	paranoid schizophrenia.	- Education and tra	ining
		were provided to DHS and	ADHS
	A care plan, dated 12/5/24, indicated Resident D	on 2/25/25 by the clinical su	Jpport Jpport
	had made sexually inappropriate behaviors such	consultant.	
	as asking staff to have sex with him.	Education provided:	
		Envive Admission Policy	
	A care plan, dated 12/5/24, indicated Resident D	Envive Transfer or Discha	arge,
	was physically aggressive as evidenced by	Facility-Initiated Policy	
	throwing his colostomy bag at staff, throwing the	Envive Bed Hold and Ret	urn
	remote control at staff related to poor impulse	Policy	
	control, antisocial personality disorder,		
	schizophrenia, autism, cursing at staff, places	4: How the corrective action	on
	himself on the floor, spitting at staff, throwing	will be monitored to ensur	e the
	bowls and plates on the floor causing them to	deficient practice will not i	recur
	shatter, and manipulative behaviors towards staff.	i.e., what quality assuranc	e e
		program will be put into pl	lace?
	A care plan, dated 12/5/24, indicated Resident D	DHS/designee will	
	was verbally aggressive as evidenced by yelling	complete daily monitoring the	nrough
	out frequently when he wants something related	the clinical care meeting for	all
	to mental, emotional illness, poor impulse control	residents that are sent to ho	
	and had made false allegations toward staff.	for acute changes and mak	•
	_	proper procedure was follow	
	A care plan, dated 12/11/24, indicated Resident D	monitor 5 days a week for 4	•
	had behaviors of refusal of care, medications,	weeks, 3 days a week for 4	
	wound treatment, non-compliant with wound	and 2 days a week for 4 we	
	treatment, digging and picking into his wound	then monthly in QAPI for 6	,
	, , , , , , , , , , , , , , , , , , , ,	1	l

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED		(X3) DATE SURVEY COMPLETED 02/19/2025				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			45 BE	STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
LINVIVL	OI INDIANAI OLIO		INDIA					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI				
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
		ng his dressing. Resident D		months.				
		g a fork into his wound and a						
		He was non-compliant with the		DHS/designee	I			
		was found smoking cigarettes		be responsible for monitoring				
	in his room.			compliance of the line list				
		0/04/04 : 1: 1		procedure for 6 months. The				
		2/24/24, indicated Resident D		results of these audits will be				
		king false allegations against		reviewed by the QA committee	ee			
	staff.			overseen by the Executive	, .			
	A agra mlam dat- 1 1	2/26/24 indicated Desident D		Director. If a threshold of 95%				
	-	2/26/24, indicated Resident D ss, nervousness, and/or		not achieved, an action plan				
		agitation, attention and		be developed. The facility the	•			
		it due to diagnosis of ASHD.		the QAPI program, will review				
	concentration defici	it due to diagnosis of ASTID.		update, and make changes to DPOC as needed for sustain				
	A progress note do	ted 2/2/25, indicated Resident		substantial compliance for no	•			
		dent's cell phone to call 911,		than 6 months.	1622			
		and stated resident want to be		than o months.				
	-	and stated resident want to be		E Data of completions				
		as no indication of why		5. Date of completion: 3/21/2025				
		to transfer as his needs were		3/21/2023				
	being met at the fac							
	A progress note da	ted 2/3/25, indicated a nurse						
		ital call and indicated Resident						
	-	d with swollen testicles.						
	A hospital progress	note, dated 2/3/25, indicated						
		nerous hospitalizations at						
	multiple systems ov	ver the last 6 months. He was						
	seen in the emergen	ncy room.						
	The resident's recor	d lacked documentation of a						
		arge of the resident by the						
	physician. The resid	lent's record lacked						
	documentation of h	ow the resident was a danger						
	to other residents or	himself. The resident's record						
	lacked documentati	on of why the facility was not						
		nt's right to return to the						
	facility pending an appeal of any facility-initiated							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077			A. BUILDING 00 B. WING		COMPLETED 02/19/2025		
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 CY MUST BE PRECEDED BY FULL A 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		
	Director (SSD) on a indicated Resident I assessment complet 911. She indicated take him back becar were worried about residents and staff. On 2/18/25 at 10:55 the Executive Direct admitted Resident I antibiotics. He was not always be accept colostomy bag at the in the face. He call Resident D finally I management to lock to arrest him due to buttocks. He dug in He destroyed his rotthe wall. They attembecause he was concall light and holler members to care for concerns. He indicates admission at the fact resident D's admission at the fact resident D. The Electron at Concerns and Conc	with the Social Services 2/18/25 at 10:53 a.m., she D did not have a discharge red because he was leaving the company decided not to use of his behaviors. They the overall safety of other 5 a.m., during an interview with exter (ED), he indicated they D to administer some aware that residents would oting to care. He threw his e staff. He hit a staff member red the police around 36 times. He had on his an his wounds with silver ware. On and pulled a handrail off mpted 1 on 1 supervision suming so much time with his ing at staff. It took 2 to 3 staff or him at a time due to safety atted when he reviewed sion documentation prior to be selitive, it did not indicate the rehaviors. There were no ausing a denial to readmit D was unaware of the resident's the hospital. 10 p.m., during an interview with the indicated she witnessed for herself. He dug in his acted like he was going to She told the facility they					

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

Event ID:

KTX811

Facility ID: 000032

If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		155077	B. WING 02/19/2025			
NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS			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	
	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 rela	tes to Complaint IN00453734.				
F 0626 SS=D Bldg. 00	483.15(e)(1)(2) Permitting Reside	nts to Return to Facility				
	failed to follow the resident to return to hospitalization for 1 discharged (Resider Findings include: On 2/18/25 at 11:32 completed for Resider	of 3 resident reviewed for	F 0626	F 626 – Permitting Resident of Return to Facility "Facility failed to follow the policy not allowing the resident to return to the facility after a hospitalization for 1 of 3 resider reviewed for discharged (Residu)." 1: What corrective action(s) be accomplished for those residents found to have been	licy ent dent will	

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

Event ID:

KTX811

Facility ID: 000032

If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		155077	B. WING 02/19/2025			025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					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 APPROPRIAT		TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
	_	ty disorder (a mental health			affected by the deficient		
		ized by a persistent pattern of			practice?		
	_	olation of the rights of others,			Resident D was affected	d by	
		blems in relationships, work,			the alleged deficient practice.		
	-	polar disorder (a chronic			Resident D was sent to		
		tion characterized by extreme			hospital for an acute change i		
		rgy, and behavior, alternating			condition. Based on residents		
	_	mania and depression),			needs at time of discharge fro	m	
	_	t (a neurological disorder			hospital, the facility was not	.	
	-	controllable episodes of			equipped to meet resident nee		
		that are often inappropriate or			Resident D had dischar	-	
	/-	nnia, attention-hyperactivity			paperwork immediately review		
	· ·	velopmental disorder			It was determined the facility i	S	
		rsistent patterns of inattention,			currently unable to care for		
		or impulsivity that interfere			resident needs.		
	_	ing in multiple areas), and					
	_	rry (an injury to the brain			2: How other residents havir	_	
		al physical force, such as a			the potential to be affected b	-	
	blow, bump, fall, or	car accident).			the same deficient practice v	vill	
					be identified and what		
		ted 2/2/25, indicated Resident			corrective action will be take		
		dent's cell phone to call 911,			(How to protect <u>like</u> residents)		
		, stated resident want to be			- All Residents being sent	to	
		al hospital, and it was his right			hospital for acute medical	.	
		vas no indication of why			changes have the potential to		
		to transfer as his needs were			affected by the alleged deficie	nt	
	being met at the fac	unty.			practice.		
		. 12/2/25 : 1: 1			All residents that are be	-	
		ted 2/3/25, indicated a nurse			sent to hospital for acute char	_	
	•	ital call and indicated Resident			will be assessed for return and		
	D nad been admitte	d with swollen testicles.			resident will be notified of return process.	irning	
	A hospital progress	note, dated 2/3/25, indicated			ριούσου.		
		nerous hospitalizations at					
		ver the last 6 months.			3: What measures will be pu	,	
					into place or what systemic	•	
	The resident's recor	d lacked documentation of			changes will be made to		
		as a danger to other residents			ensure that the deficient		
					practice does not recur?		
	or himself. The resident's record lacked documentation of why the facility was not				The DHS and ADHS we	ere	

04/03/2025 PRINTED: FORM APPROVED 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 B. WING 02/19/2025 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 honoring the resident's right to return to the educated on the Envive Admission facility pending an appeal of any facility-initiated Policy, Envive Transfer or discharge. Discharge, Facility-Initiated Policy, and Envive Bed Hold and During an interview with the Social Services Return Policy and procedure. Director (SSD) on 2/18/25 at 10:53 a.m., she Education and training indicated Resident D did not have a discharge were provided to DHS and ADHS assessment completed because he was leaving on 2/25/25 by the clinical support 911. She indicated the company decided not to consultant. take him back because of his behaviors. They Education provided: were worried about the overall safety of other **Envive Admission Policy** residents and staff. Envive Transfer or Discharge, Facility-Initiated Policy On 2/18/25 at 10:55 a.m., during an interview, the Envive Bed Hold and Return Executive Director (ED) indicated they admitted Policy Resident D to administer some antibiotics. He was aware that the resident would not always be 4: How the corrective action accepting to care. He threw his colostomy bag at will be monitored to ensure the the staff. He hit a staff member in the face. He deficient practice will not recur called the police around 36 times. Resident D i.e., what quality assurance finally handed his phone off to management to program will be put into place? lock up. The police did not want to arrest him due DHS/designee will to the wounds he had on his buttocks. He dug in complete daily monitoring through his wounds with silver ware. He destroyed his the clinical care meeting for all room and pulled a handrail off the wall. They residents that are sent to hospital attempted 1 on 1 supervision because he was for acute changes and make sure consuming so much time with his call light and proper procedure was followed hollering at staff. It took 2 to 3 staff members to including but not limited to, care for him at a time due to safety concerns. He reviewing resident needs for return indicated when he reviewed Resident D's and monitor 5 days a week for 4 admission documentation prior to his admission at weeks, 3 days a week for 4 weeks the facility, it did not indicate the resident had and 2 days a week for 4 weeks, these behaviors. There were no specific incidents then monthly in QAPI for 6 causing a denial to readmit Resident D. The ED months. was unaware of the resident's condition at the hospital. DHS/designee will be responsible for monitoring On 2/18/25 at 12:40 p.m., during an interview, the compliance of the line list ombudsman indicated she witnessed his behavior procedure for 6 months. The herself. He dug in his bag and acted like he was results of these audits will be

KTX811

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

PRINTED: 04/03/2025 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER ENVIVE OF INDIANAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE STREET ADDRESS, CITY, STATE, ZIP COD 45 BEACHWAY DR INDIANAPOLIS, IN 46224 (X4) ID PROVIDERS PLAN OF CORRECTION (C4) ID PROVIDERS PLAN OF CORRECTION (C4) ID PROVIDERS PLAN OF CORRECTION (C5) ID PROVIDERS PLAN OF CORRECTION (C5) ID PROVIDERS PLAN OF CORRECTION (C5) ID PROVIDERS PLAN OF CORRECTION (C6) ID PROVIDERS PLAN OF CORRECTION (C6) ID PROVIDERS PLAN OF CORRECTION (C6) ID PROVIDERS PLAN OF CORRECTION (C7) ID PROVIDERS PLAN OF CORRECTION (STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155077		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 02/19			ETED	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (X4)				45 BEA	ACHWAY DR		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPI	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE
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, 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.		going to throw fece they would have to to discharge. On 2/18/25 at 1:03 attempted but Resid phone. On 2/18/25 at 1:03 Resident D's mothe the reason why Res return to the facility belongings and cell On 2/19/25 at 10:31 or Discharge, Facilithe Special Projects indicated, "Once residents have the resident/representation; and doct this policy"	s on her. She told the facility give a 30-day notice of intent p.m., an interview by phone was dent D did not answer his p.m., during an interview, r indicated she was unaware of ident D was not allowed to r. She worried about his phone. I a.m., a policy titled, "Transfer ity Initiated" was provided by and Interim Administrator. It admitted to the facility, ight to remain in the facility. Insfers and discharges, when the et specific criteria and require ive notification and return as specified in		overseen by the Executive Director. If a threshold of 95% not achieved, an action plan w be developed. The facility the the QAPI program, will review update, and make changes to DPOC as needed for sustaining substantial compliance for no than 6 months. 5. Date of completion:	is vill rough , the	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KTX811 Facility ID: 000032 If continuation sheet Page 9 of 9