Brandon

PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-039

07/07/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> </u>			
		155077	B. WING		06/03	/2025	
		<u> </u>	CTDEE	T ADDRESS, CITY, STATE, ZIP CO	- <u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R			עי		
ENVIVE	OF INDIANAPOLIS	3	45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
F 0000							
D14= 00							
Bldg. 00	IN00460578. Complaint IN00460 related to the allegal F684. Survey dates: June Facility number: 00 Provider number: 1 AIM number: 1002 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type Medicare: 2 Medicaid: 20 Other: 81 Total: 103 These deficiencies accordance with 41	200032 55077 273330 ::	F 0000	Preparation or execution plan of correction does a constitute admission or of provider of the truth of alleged or conclusions as the Statement of Deficient Plan of Correction is presexecuted solely because required by the position and State Law. The Plan Correction is an abatem respond to the allegation noncompliance for an indicated May 19, 2025. Please accept this Plan Correction as the provide credible allegation of coas of May 25, 2025. The respectfully requests dewith paper compliance to considered in establishing provider is in substantial compliance.	agreement agreement of the facts set forth on encies. The epared and e it is of Federal n of eent plan to n of icident of ler's mpliance e provider esk review to be ng that the		
SS=G	Quality of Care						
Bldg. 00							
-	failed to obtain tim of a full thickness be resulting in actual be required hospitaliza	and record review, the facility ely treatment and assessments ourn to a resident's left foot narm when the resident ation and surgical interventions spital for 1 of 4 reviewed for	F 0684	1: What corrective action be accomplished for the residents found to have affected by the deficient practice? 1 resident was affected by the deficient practice?	nose e been nt	06/04/2025	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	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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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 06/03/2025 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 timely care and treatment (Resident B). the alleged deficient practice of burning by hot water. Findings include: Upon incident notification and finding, resident was During an interview on 6/2/25 at 12:07 p.m., immediately assessed. NP was Resident B indicated on 5/19/25 his left foot was notified and new orders were burned when the nurse was providing wound received for infection, pain control. care. He indicated the nurse brought over a basin wound care treatment and orders of water for him to soak his foot in prior to to send resident to hospital for applying a treatment to the sore on the bottom of eval/treat. his left foot. When he put his foot into the water, he felt like it was too hot and pulled his foot out. 2: How other residents having The nurse told him she had felt the water, and it the potential to be affected by was not too hot, but to hold on and she would go the same deficient practice will get some supplies. She had been out of the room be identified and what for a couple of minutes when she passed by his corrective action will be taken. door and told him to go ahead and try again. She All residents have the had not checked the water temperature. When he potential to be affected by the returned his foot into the water, it felt hot but alleged deficient practice. tolerable. When she returned about five minutes All residents and staff later, she was surprised to see a blister on the top were instructed to notify MD/NP of his foot. His feet were numb a lot because of immediately during resident his diabetes, and he had not realized the water change of condition. was still hot. All like residents had skin assessments performed head to Cross reference F689. toe assessment for any injuries. Results of the questions A review of Resident B's clinical record was were compiled and reviewed by completed on 6/2/25 at 10:53 a.m. Diagnoses facility leadership. If actions included burn of unspecified degree of left foot, needed to be taken, action plans diabetes mellitus type II, and degenerative disease were created and implemented of the nervous system. immediately. A nurse practitioner progress note completed by 3: What measures will be put Nurse Practitioner (NP) 2, dated 5/19/25 at 3:30 into place or what systemic p.m. and created on 5/24/25 at 8:18 p.m., included changes will be made to Resident B was seen at the request of nursing for ensure that the deficient a blister to his left foot. The resident " ...was practice does not recur? found seated with both feet resting on a towel and Education and training a wash basin visibly placed in front of the patient. were provided to ED, DHS on

MC8T11

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 06/03/2025 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 Nursing indicated that foot washing was initiated 5/22/25 by the clinical support as a preparatory measure before the consultant and VP of Clinical administration of previous treatment...for an Services unrelated skin condition. Nurse reports that she Education provided: facilitated foot washing by preparing water and ISDH Incident Reporting Policy directing the patient to immerse his feet. Resident Change of Condition Subsequently, the patient raised concerns Policy regarding the water temperature. Nurse reports, Abuse, Neglect, Exploitation, 'the water temperature was found to be within an Misappropriation Policy acceptable range.' Following this, the nurse Accidents/Incidents advised the patient to 'hold on' while she retrieved Investigating and Reporting Policy treatment supplies. Nurse reports, upon her return to the room, the patient presented with a Staff and residents were fluid-filled blister on the top of left foot, after educated on the immediate and removing his foot from the water. Notable clinical timely reporting to facility findings included the presence of loose skin and personnel. mild erythema on the affected foot." 4: How the corrective action A Weekly Skin Assessment, dated 5/19/25 at 6:58 will be monitored to ensure the p.m., indicated the resident had a new impairment deficient practice will not recur of skin integrity. The description indicated a fluid i.e., what quality assurance filled blister to the top of the left foot. Wound program will be put into place? interventions indicated the NP/physician was DHS/designee will review notified, a treatment as ordered, and monitor for resident changes of condition signs or symptoms of infection. report daily and reviewed in QAPI for 6 months. A current physician's order, dated 5/19/25 at 7:00 p.m., indicated to cleanse left foot with sterile ED/Maintenance water, pat dry, and apply a non-adherent dressing. Director/DHS/designee will Staff were to wrap foot with gauze and secure with complete daily monitoring through tape. Treatment was to be completed every day clinical care meeting and then and night shift. monthly in QAPI for 6 months. A Weekly Skin Assessment, dated 5/20/25 at 6:01 ED/DHS/designee will be a.m., indicated the resident had a new impairment responsible for monitoring change of skin integrity. The description indicated "left of condition resident review for 6 toes." Wound interventions indicated the months. The results of these NP/physician was notified and treatment as audits will be reviewed by the QA ordered. committee overseen by the Executive Director. If a threshold

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155077	B. WI	NG		06/03/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2					
					CHWAY DR		
EINVIVE	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	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The clinical record	lacked documentation			of 100% is not achieved, an ac	ction	
		ment and description of the			plan will be developed. The		
	resident's burn wound on 5/20/25.				facility through the QAPI progr	am,	
					will review, update, and make		
	A nursing progress note by LPN 7, dated 5/21/25 at 5:06 p.m., indicated the dressing to Resident B's				changes to the DPOC as need	led	
					for sustaining substantial		
		get off and had blisters noted			compliance for no less than 6		
	_	es, sloughing, copious amount			months		
	•	skin peeling, and very painful					
		d NP was notified, and					
	treatment was comp	pleted as ordered.					
	4 ND						
	A NP progress note completed by NP 2, dated						
	5/21/25 at 7:46 p.m. and created on 5/25/25 at 9:15 p.m., included Resident B was seen at the request						
	_	to his left foot. "The patient					
		o visit concerning their left foot					
	-	ed with new symptoms during					
		tient has a significant history					
	-	uent cellulitis episodes,					
		Il management of skin integrity					
	_	eations. The patient reports					
	_	ne affected area (Left foot).					
	_	es the pain as moderate but					
	_	ecifically to the left foot					
	-	vious blisterThe treatment					
	plan includes contir	nued monitoring and					
		emphasis on prompt					
	notification of any a	acute changes, underscoring					
		ce given the patient's					
		omplications due to his					
		ons. Nursing staff have been					
	_	dates and are prepared to					
		evelopments promptlyDerm:					
	Dressing intact to le	eft foot"					
		note completed by RN 3,					
		:03 p.m., indicated the resident					
	_	excruciating pain to his left					
	100t. The resident if	ndicated his foot was					

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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		06/03/	2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			CHWAY DR		
ENI\/I\/E	OE INDIANADOLIS				APOLIS, IN 46224		
ENVIVE OF INDIANAPOLIS			INDIAN	APOLIS, IN 40224			
(X4) ID	SUMMARY	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	vater prior to the scheduled					
		5. RN 3 had changed the					
	_	ted the "foot appears to be a					
	1	llow slough, red, draining &					
		contacted 911 and the resident					
		te care burn unit for further					
	evaluation and treat	ment.					
	A CULL III A DUI	1 1 1 5/22/25 1 12 51					
	I -	report, dated 5/23/25 at 12:51					
	1 ~	reason for review was for a members in attendance were					
		nd registered dietician. The					
		that the resident had been					
	admitted to the hospital on 5/22/25 for a diabetic foot ulcer. Under the Skin/Wounds section of the						
		re listed regarding left foot					
	1 -	ot ulcer. Cleanse with wound					
	1 ~	rogel and bordered gauze. The					
		care plan had been updated					
	1 -	5/25/25. The report lacked					
	_	sident sustaining and being					
		a burn sustained during care					
	at the facility.	S					
	·						
	During an interview	v on 6/2/25 at 11:46 a.m., LPN 4					
	indicated she was p	reparing to complete Resident					
	B's wound care orde	ers, and she wanted to					
	complete foot care	prior to his left foot treatment.					
	As she was running	the water into the basin for					
	the resident to soak	his foot, she ran her hand					
		vater and felt it was warm and					
	1	basin. She had not checked the					
	_	water in the basin after it was					
		d the resident to put his left					
		esident B placed his foot in the					
		the water was hot and					
		he indicated to him that she					
	1	e water and told him to hang					
		o get his wound care supplies.					
	She was gone for al	bout five minutes and when					

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		LDING	00	COMPLETED	
		155077	B. WIN	IG		06/03/2025	
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	`	ICY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION room his foot was in the basin.		TAG	DEFICIENCE!		DATE
		n had developed a small lemon					
		top of his foot. She had not					
		ident to put his foot in the					
		the room. He indicated to her					
	his foot hurt and she	e administered an as needed					
	dose of pain medica	ation. She requested another					
		m NP 2, and she called the unit's					
	_	came to the resident's room.					
		ented in a progress note, as					
	the NP was going to	o document.					
	During on interview	v on 6/2/25 at 12:40 p.m., NP 2					
	1	een called to Resident B's					
		noticed a blister, but the					
		vas "sorta" red with a small					
		visualized the resident's foot					
	_	ent, but had not had staff					
	_	s's dressing during her					
		e had not examined the wound					
		visit with the resident for					
	increased pain. The	physician was completing					
	rounds the followin	g day (5/22/25), and she					
	wanted the physicia	nn to look at the left foot at					
	that time.						
	Duning a talanta	interview on 6/2/25 -+ 2:41					
		interview on 6/2/25 at 2:41 d Resident B had been in "so					
	_	wound looked "bad." He had					
		pain the night before. When					
		his wound treatment on					
		en unaware the resident had					
		his left foot. She had prepared					
		tment for his diabetic ulcer to					
	_	ft foot. The resident had a hard					
		reatment. She had called the					
		approval to send him to the					
	emergency room fo						
	A Burn Service Tea	am History and Physical Note,					

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f ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155077	A. BUILDING 00 COMPLETED B. WING 06/03/2025				
		133077	D. WI			00/03/	
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	dated 5/22/25, from indicated the reside burns to his left foo The Assessment/Plathree day old full the foot. An Inpatient Dischafrom the acute care resident had two surand 5/27/25 for deb graft application. A current facility por "Change in a Reside provided by the Corl 12:06 p.m., included Interpretation and Inwill record in the reinformation relative medical/mental con	the acute care provider, and had presented with scald to the the three days ago. In indicated the patient had a lickness scald burn to the left three scales arge Summary, dated 5/30/25, provider, indicated the regical procedures on 5/22/25 aridement of left foot and skin to blicy, dated 8/2024, titled, ent's Condition or Status," apporate Nurse on 6/3/25 at did the following: "Policy mplementation8. The nurse sident's medical record to changes in the resident's					
	3.1-37(a)						
F 0689 SS=G Bldg. 00	failed to protect a re actual harm when the thickness burn to his interventions for 1 of (Resident B). The of	and record review, the facility esident during care resulting in the resident sustained a full as left foot requiring surgical of 4 reviewed for accidents deficient practice was corrected the start of the survey, and	F 06	589	1: What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice? 1 resident was affected the alleged deficient practice oburning by hot water.	n by f	06/04/2025
	<i>G</i>				and finding resident was		

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 06/03/2025 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 A review of Resident B's clinical record was immediately assessed. NP was completed on 6/2/25 at 10:53 a.m. Diagnoses notified and new orders were included burn of unspecified degree of left foot, received for infection prevention, diabetes mellitus type II, and degenerative disease pain control, wound care treatment of the nervous system. and orders to send resident to hospital for eval/treat. A quarterly Minimum Data Set (MDS) assessment, dated 4/11/25, indicated the resident was cognitively intact, used a wheelchair for mobility, required partial to moderate assistance of 2: How other residents having the staff to put on and remove footwear, complete potential to be affected by the lower body dressing, transfer from chair to bed, same deficient practice will be and had a diabetic foot ulcer and received identified and what corrective dressings to his feet. action will be taken. A health care plan, initiated 2/4/25, indicated All residents have the Resident B had diabetes mellitus with neuropathy. potential to be affected by the Interventions included to avoid exposure to alleged deficient practice. extreme heat or cold. All residents and staff A nurse practitioner progress note completed by were instructed not to use hot Nurse Practitioner (NP) 2, dated 5/19/25 at 3:30 water until further testing was p.m., included Resident B was seen at the request completed. of nursing for a blister to his left foot. The resident "was found seated with both feet resting All water dispensing outlets on a towel and a wash basin visibly placed in were temperature tested per front of the patient. Nursing indicated that foot regulation. Temperature in washing was initiated as a preparatory measure resident bathroom sink where before the administration of previous alleged hot water came from, treatment...for an unrelated skin condition. Nurse tested at 119 degrees Fahrenheit, reports that she facilitated foot washing by as well as, the remaining rooms preparing water and directing the patient to on the hall. All water heaters were immerse his feet. Subsequently, the patient raised adjusted to range from 110 – 115 concerns regarding the water temperature. Nurse degrees Fahrenheit. Temperatures reports, the water temperature was found to be are being done daily for 3 months within an acceptable range.' Following this, the and appropriate action will be nurse advised the patient to 'hold on' while she made accordingly.

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retrieved treatment supplies. Nurse reports, upon her return to the room, the patient presented with

a fluid-filled blister on the top of left foot, after

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All like residents had skin

assessments performed from head

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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 155077		JILDING	ONSTRUCTION 00	(X3) DATE : COMPL 06/03/	LETED
	PROVIDER OR SUPPLIEF			45 BEA	ADDRESS, CITY, STATE, ZIP COD ACHWAY DR JAPOLIS, IN 46224		
ENVIVE (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF removing his foot fi findings included th mild erythema on th A nursing progress at 5:06 p.m., indica- left foot was hard to to top of all five toe of serous drainage, to touch. The woun treatment was comp A NP progress note 5/21/25 at 7:46 p.m. at the request of nur "The patient seen fo their left foot pain, symptoms during re significant history of cellulitis episodes, i management of skin complications. The in the affected area describes the pain a located specifically previous blisterTh continued monitorin emphasis on promp changes, underscori given the patient's p complications due to	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION From the water. Notable clinical the presence of loose skin and the affected foot" Intote by LPN 7, dated 5/21/25 ted the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted the state of the dressing to Resident B's to get off and had blisters noted to get off and had ble to get off the president B's to get off and had blisters noted to get off and had ble for all the get off and had ble for all the get of and had ble for all the get o		INDIAN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) to toe for any injuries that may suspected as burns. All like residents and stawere asked the following questions: Have you ever sustained a bidue to the water being too hot. How long has the water bee too hot? Have you told staff about the water being too hot? What was their response. Results of the questions were compiled and reviewed be facility leadership. If actions needed to be taken, action plawere created and implemented immediately. 3: What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not recommendately test.	r be aff ourn ? n e you ? soy ans d into es e cur?	(X5) COMPLETION DATE
	developments prom left foot"	note completed by RN 3,			water dispensing outlets rangi from closest to water heater a furthest from water heater. - Education and training	ng nd	

had complained of excruciating pain to his left

foot. The resident indicated his foot was

were provided to ED, DHS and

Maintenance Director on 5/22/25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155077	B. Wl	ING		06/03/2	025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			CHWAY DR		
ENVIVE	OF INDIANAPOLIS	3		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	ļ		DATE
	_	vater prior to the scheduled			by the clinical support consult	tant	
		25. RN 3 had changed the steel the "foot appears to be a			and VP of Clinical Services		
	_	ellow slough, red, draining &			Education provided:		
	toes matted." RN 3 contacted 911 and the resident was taken to an acute care burn unit for further				Education provided.		
					Envive Water Temperatures		
	evaluation and trea				Safety of Policy	5,	
	During an interview on 6/2/25 at 11:33 a.m., the DON indicated there was no order as part of Resident B's wound care to soak his foot. LPN 4 wanted to make sure the area was clean prior to completing the ordered treatment to the diabetic ulcer on the bottom of his left foot. She should not have soaked his foot as this was not part of				ISDH Incident Reporting Po	olicy	
					Resident Change of Conditi	ion	
					Policy		
					Abuse, Neglect, Exploitation	n,	
					Misappropriation Policy		
	his wound care trea	atment orders.					
					Wound Care Policy		
	_	w on 6/2/25 at 11:46 a.m., LPN 4					
	_	preparing to complete Resident			Accidents/Incidents		
		lers, and she wanted to			Investigating and Reporting P	Policy	
	_	prior to his left foot treatment.			,		
	1	g the water into the basin for			Burn Management		
		this foot, she ran her hand water, and it felt warm. She			Staff and residents wer		
	_				educated on the immediate a		
		basin. She had not checked the water in the basin after it was			timely reporting of water	IIU	
	^	ed the resident to put his left			temperatures to facility person	nnel	
		lesident B placed his foot in the			if water temperature is suspen		
		the water was hot and			to be out of range.		
		She indicated to him that she			15 25 5at 51 fally5.		
	had just checked th	e water and told him to hang					
		go get his wound care supplies.					
		bout five minutes and when			4: How the corrective action v	vill be	
		room his foot was in the basin.			monitored to ensure the defic	ient	
	She noticed his ski	n had developed a small lemon			practice will not recur i.e., who	at	
		top of his foot. She had not			quality assurance program wi		
	intended for the res	sident to put his foot in the			put into place?		
	basin when she left	the room. He indicated to her					
	his foot hurt and sh	e administered an as needed			DHS/designee will		
	dose of pain medic	ation. She informed NP2 and			randomly test 5 employee		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 00 COMPLETED			
		155077	B. W	'ING	06/03/2025		25
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			CHWAY DR		
ENVIVE	OF INDIANAPOLIS				APOLIS, IN 46224		
	Т		1		, - -	<u> </u>	77.0
(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 APPROPRIATE DEFICIENCY)		TE CC	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		d both came to the resident's			competencies regarding the		
	room.				previously stated education ar		
	Daning on internal	(/2/25 -+ 12.07			daily x2 weeks, 2x a week x2		
	1	on 6/2/25 at 12:07 p.m.,			weeks, weekly x2 weeks and		
		d his left foot was burned			monthly in QAPI for 6 months.		
	_	roviding wound care. He					
		brought over a basin of water					
		foot in prior to applying a e on the bottom of his left			ED/Moisterers		
		is foot into the water, he felt			ED/Maintenance		
		and he pulled his foot out. The			Director/DHS/designee will	ugh	
		•			complete daily monitoring throws water temperature checks to	ugn	
	nurse told him she had felt the water, and it was				ensure that water temperature		
	not too hot, but to hold on and she would go get some supplies. She had been out of the room for a				are maintained between state		
		when she passed by his door			regulation daily x3 months, the		
		shead and try again. She had			monthly in QAPI for 6 months.		
	_	ter temperature. He put his			I monthly in QAFT for 6 months.		
		it felt hot but tolerable. When					
		five minutes later, she was					
		lister on the top of his foot.					
	_	a lot because of his diabetes,			/p>		
		zed the water was still hot.			/p>		
	una ne naa not rean	zed the water was still het.			, p		
	During an interview	on 6/2/25 at 12:40 p.m., NP 2					
	_	een called to Resident B's					
		he had not noticed a blister, but					
		ot was "sorta" red with a small					
		visualized the resident's foot					
	_	ent, but had not had staff					
	_	's dressing during her follow					
		due to increased pain. The					
	_	oleting rounds the following					
	day (5/22/25), and s	she wanted the physician to					
	look at the left foot						
	During a telephone	interview on 6/2/25 at 2:41					
	_	d Resident B had been in "so					
	much pain" and his	wound looked "bad" on					
	5/21/25. He had not	been in a lot of pain the night					
	before. When she h	ad completed his wound					

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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 S COMPLE 06/03/2	ETED
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ACHWAY DR	-	
ENVIVE	OF INDIANAPOLIS			NAPOLIS, IN 46224		
(X4) ID PREFIX	(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 I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	treatment on 5/21/2 resident had sustain had prepared to con diabetic ulcer to the resident had a hard She had called the I send him to the eme A Burn Service Tea dated 5/22/25, from indicated the reside burns to his left foo The Assessment/Pla three day old full th foot. An Inpatient Discha from the acute burn resident had two sur and 5/27/25 for deb graft application. A current facility po "Change in a Reside provided by the Con 12:06 p.m., included Interpretation and In will record in the re information relative medical/mental con The deficient practi after the facility implication and most staff interviews, res	ce was corrected by 5/23/25 plemented a systemic plan that ing actions: water temperature onitoring, resident interviews, ident skin assessments, and continued monitoring."	TAG	DEFICIENCY		DATE

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Event ID:

 $MC8T11 \qquad {\tt Facility\ ID:} \quad 000032$

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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 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/03/2025	
	PROVIDER OR SUPPLIE			45 BEA	ADDRESS, CITY, STATE, ZIP COD CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF 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
	This citation relate 3.1-45(a)	s to Complaint IN00460578.					

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