STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37982 Based on interview, and record review, the facility failed to ensure information regarding a facility initiated discharge to the hospital was provided to the receiving facility for 2 of 3 residents reviewed for transfer discharge (Resident D and Resident G). Findings include: 1. On 1/3/22 at 11:00, the closed medical record was reviewed for Resident D. The diagnoses included, but were not limited to Parkinson's disease, schizoaffective disorder, bipolar type, psychotic disorder with delusions, diabetes, and anxiety disorder. On 12/2/22 at 3:10 p.m., an Interdisciplinary Care Team (IDT) note indicated Resident D was sent out to a local hospital for a Psychiatric (psych) evaluation and placement due to agitation and aggressive behavior. The rounding providers and psych physician discussed safety concerns with Resident D's continued residing at the facility. IDT and the facility's corporate leaders discussed the rounding providers and psych physician's recommendations regarding safety concerns with Resident D's returning to the facility and discussed the recommendation to not accept Resident D back at facility per MD (doctor) order due to safety concerns. This decision was communicated in full detail to all parties involved at the local hospital. On 12/2/22 at 11:15 a.m., a nurses' note indicated Resident D was sent to the local hospital for psychiatric evaluation. On 12/2/22 at 6:18 a.m., a nurses' note indicated Resident D was up for the entire night shift, was agitated and verbally aggressive all-night shift. He attempted to attack other residents, threatening to kill them. Staff maintained safety of other residents. No discharge assessment or transfer documents were found in the resident's record. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/22 at 1:47 p.m., the hospital's emergency room record indicated Resident D was a [AGE] year old male who presented to the emergency room for a psych evaluation. The patient had no complaints, and no paperwork was sent with him. A history was unobtainable from the patient due to his mental status. His work-up was unremarkable. The hospital had limited information related to the resident's medications, other than discharge summaries from outside hospitals found in the electronic record history. The patient was in no distress, alert, and voiced no complaints. Upon contact, the nursing home facility indicated they would not take the resident back under any circumstances. On 1/4/23 at 9:45 a.m., during an interview with the Executive Director (ED) and the Regional VP of Clinical Services (RVPSN), the RVPSN indicated Resident D had been given a 30 day notice to move out previously, when the facility had sent him to the local mission, back in April. No notices were provided on his return. The plan was for him to remain in the facility. The facility had a copy of his bed hold but no other paperwork. They were attempting to reach the Social Service Director (SSD), but she was not in the facility. The ED indicated she did not know what happened to the resident after he left the facility, maybe he was still at the hospital. They had not done any follow-up. She did not know what happened to his belongings. On 1/4/23 at 10:09 a.m., during an interview, the RVPSN indicated the facility had done everything they could do for this resident. Their physician refused to accept him back because he had homicidal tendencies. He was too dangerous to be around other residents. He had multiple incidents with other residents. They had to send him out to the hospital. There was no other choice. She had checked and his belongings were packed up. On 1/4/22 at 11:29 a.m., during an interview, the ED indicated the day after transferring it was identified the transfer/discharge assessment form had not been completed in the computer prior to sending the resident out because the nurse was in a hurry. She printed it off, blank, and manually marked it the next day. They should have given a history and diagnoses on the phone when they called report, to the emergency room . On 1/4/23 at 11:43 a.m., during an interview the RVPSN indicated the nurse said the next day they realized, during an IDT meeting, the assessment had not been completed. The nurse knew she could not document on a closed record, so she printed the form out and marked it with ink. It was not sent with the resident to the hospital. 2. On 1/5/22 at 10:30 a.m., the medical record was reviewed for Resident G. The diagnoses included, but were not limited to end stage renal disease, peripheral vascular disease and diabetes. On 11/16/22 Resident G was sent out to the hospital for evaluation from a previous fall, on 11/3/22. There was no documentation in the progress notes at that time, related to having been sent out. On 11/16/22 at 8:08 a.m., a Nurse Practitioner's note, date of visit 11/16/2022, indicated follow-up to hospitalization . Resident was seen today for follow-up to hospitalization . Patient discharge diagnosis was fluid overload and a commuted fracture involving the distal femoral metadiaphysis. The Assessment and Plan related to the fracture was to refer the resident to an Orthopedic specialist within 1 to 2 weeks and administer Oxycodone (pain medication). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) assessment indicated Resident G had discharged to the hospital on 11/11/23 with return anticipated. She returned on 11/15/23. The medical record lacked documentation of the resident's discharge to the hospital. Documentation was requested. On 11/22/23 the resident again went to the hospital with return anticipated. She returned on 11/26/22. On 1/5/23 at 3:37 p.m., the Director of Nursing (DON), in the presence of the RVPSN, indicated the bed hold policy was sent with the resident but the interact transfer discharge summaries had not been completed in the computer system. The required documents were not sent to the hospital with the resident. Cross Reference F689. On 1/4/23 at 11:56 a.m., the RVPSN provided a current policy, dated 8/2022, titled Hospital Discharge/Transfer. This policy indicated, It is the policy of this facility to make the transition for residents transferring from one facility to another safe and to provide for continuity of care and services in a manner that minimizes resident anxiety as much as possible. Residents will be discharged /transferred from the facility as per physician order, and that a review of the resident's acute needs, brief plan of care, and medications are completed and communicated to the acute care hospital .Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record: Face Sheet, H&P [history and physical]/physician's notes, Current orders, CCD (Continuity of Care) document: medication list, diagnoses codes, allergies, most recent vital signs, advanced directives, and vaccination records. Advanced directive form as applicable, comprehensive care plan, pertinent labs, notice of transfer/discharge, bed hold policy, Nursing notes/social service notes pertinent to behavior issues may be warranted for psychiatric hospitalization s .Nursing will provide a thorough report to the receiving hospital .the resident must be permitted to return to the facility unless the facility determines that circumstances outlined in the Involuntary Discharge policy exist. In that case the procedures in the policy must be followed This Federal tag relates to Complaints IN00396127 and IN00397568. 3.1-12(a)(3) 3.1-12(a)(4) 3.1-12(a)(5)(a) 3.1-12(a)(5)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37982 Based on interview, and record review, the facility failed to ensure a resident in the locked behavioral unit received proper notice of discharge for a facility initiated discharge for 1 of 3 residents reviewed for discharge (Resident D). Findings include: On 1/3/22 at 11:00, the closed medical record was reviewed for Resident D. The diagnoses included, but were not limited to Parkinson's disease, schizoaffective disorder, bipolar type, psychotic disorder with delusions, diabetes, and anxiety disorder. On 10/19/22 at 12:03 p.m., a nurses' note indicated Staff witnessed Resident D get into a disagreement with another resident. The resident became verbally and physically aggressive and made contact with the other resident. Both residents were immediately separated. Resident D was redirected with non-pharmacological interventions. On 10/19/22 at 6:29 p.m., a nurses' note indicated Resident D was sent to Neuropsychic facility (Neuropsych) for in-patient care per recommendation. Report was given to the RN who would be receiving the resident. Vital Signs were stable per baseline at time of discharging resident. Management was aware. A State Reportable #415, dated 10/19/22, indicated Resident D got upset with another Resident over their shared bathroom not being clean. No injuries were noted to either resident and Resident D's room was changed. He was sent out for a neuropsych evaluation. On 10/28/22 at 10:20 a.m., a nurses' note indicated Resident D returned from neuropsych hospital readmitted to room on the C Hall. On 11/13/22 at 00:42 a.m., a nurses' note indicated Resident D was verbally aggressive towards another resident threatening them as well as staff. Tried to redirect was unsuccessful. Resident was sent out to hospital for psychiatric (psych) eval. On 11/26/22 at 12:30 p.m., a nurses' note indicated Resident D had increased agitation and aggressiveness towards other residents. The Nurse Practitioner (NP) was notified and an order for PRN (as needed) Lorazepam (anti-anxiety medication) obtained. Order was given to send resident out for Psych evaluation. Management notified. A state reportable #421, dated 11/26/22, indicated Resident D got upset with another resident who refused to give him money. There were no negative outcomes identified to either resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/26/22 at 2:15 p.m., a nurses' note indicated Paramedics came to the facility to take Resident D to the emergency room (ER) for a Psych evaluation. Resident refused to go to the hospital. 911 for police department called to come help but resident continued refusing to go to the ER. Resident was his own responsible party. Management notified and aware of the situation. NP notified and aware of the situation. One on one care provided started at 2:00 p.m. by management. Resident continued being compliant with one-on-one care. On 11/30/22 11:05 Plan of Care Note: IDT Clan plan meeting was held with Social Services, Activity Director, Dietary Manager, Administrator, Director of Nursing, State Ombudsman in person, and Resident D. Resident voiced there was no family and preferred for only himself to be present. Activity Director discussed current activities of bingo, games, outdoors when weather permits, smoke break, discussed Resident's funds, discussed his choice to spend most of his funds on cigarettes then he would become upset/angry when staff did not provide him more cigarettes or give him money. Educated resident and recommended he manage/budget funds for cigarettes should he choose to continue to purchase cigarettes. Activity Director informed resident of current funds in account. Resident expressed understanding of cigarettes and budgeting funds, voiced no issues/concerns. Dietary Manager discussed current diet, meals, regular texture, thin liquid consistency, no issues/concerns were voiced. Discussed recent behaviors, agitation, threatening behaviors towards others, yelling out, physical behaviors towards others. Discussed these inappropriate behaviors towards others. Resident D expressed understanding of his behaviors and stated he would be good. Discussed options for alternate placement to better meet his needs. Discussed resident had toured a group home which he was interested in, then declined placement at group home due to not having a room to himself. Discussed a less restrictive environment for resident at group home. Resident stated he would think about the group home but still wanted a room to himself. Discussed the potential for Assisted Living Facility depending on meeting criteria, discussed CICOA. Resident agreed to apply for Medicaid Waiver. Discussed various methods of interventions, Resident continued to say he wanted a family and a woman, said people were jealous of him for what he had. Discussed interventions of setting personal goals for himself, discussed assisting Resident D with personal goals in a positive manner, resident expressed understanding of his behaviors, stated he was willing to be open minded with starting fresh with his behaviors and will work on his personal goals. Resident D stated he wants a good friend by his side, discussed appropriate ways of interacting with others. Resident expressed understanding of everything discussed, expressed understanding and recognition of his behaviors, expressed understanding of recommendations and agreed with these. Ombudsman also discussed his appropriate behaviors towards others in a positive environment. Offered to review medications, Resident D declined. Discussed recent discontinuing of psych medications, being followed by Rounding Providers medication management as well as new psychologist through Rounding Providers. Staff will continue to monitor behaviors, mood, and psychosocial well-being. No issues/concerns/questions voiced from Resident D. Staff will continue to encourage and support Resident D. On 12/2/22 at 3:10 p.m., an Interdisciplinary Care Team (IDT) note indicated Resident D was sent out to a local hospital for a Psych evaluation and placement due to agitation and aggressive behavior. The rounding providers and psychiatric physician discussed safety concerns with Resident D's continued residence at the facility. IDT and the facility's corporate leaders discussed the rounding providers and psych physician's recommendations regarding safety concerns with Resident D's returning to the facility, discussed recommendation to not accept Resident D back at facility per MD (doctor) order due to safety concerns. This decision was communicated in full detail to all parties involved at the local hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/22 at 11:15 a.m., a nurses' note indicated sent to (name of local hospital) for psych evaluation. On 12/2/22 at 6:18 a.m., a nurses' note indicated Resident D was up for the entire night shift, was agitated and verbally aggressive all-night shift. He attempted to attack other residents, threatening to kill them. Staff maintained safety of other residents. State reportable #424, dated 12/2/22, indicated Resident D had been up all night, came to the common area and made contact with another resident's hand. No abnormalities to the resident's hand were identified. No sign of symptoms or emotional distress. State reportable #425, dated 12/2/22, indicated Resident D made verbal threats to another resident. There was no signs or symptoms of distress. Resident D was sent to the emergency room for evaluation. No discharge assessment or transfer documents were found in the resident's record. On 12/2/22 at 1:47 p.m., the hospital's emergency room record indicated Resident D was a [AGE] year old male who presented to the emergency room for a psych evaluation. The patient had no complaints, and no paperwork was sent with him. A history was unobtainable from the patient due to his mental status. His work-up was unremarkable. The hospital had limited information related to the resident's medications, other than discharge summaries from outside hospitals found in the electronic record history. The patient was in no distress, alert and voiced no complaints. Upon contact, the nursing home facility indicated they would not take the resident back, under any circumstances. On 1/4/23 at 9:45 a.m., during an interview with the Executive Director (ED) and the Regional VP of Clinical Services (RVPSN), the RVPSN indicated Resident D had been given a 30 day notice to move out previously, when the facility had sent him to the local mission, back in April. No notices were provided on his return. The plan was for him to remain in the facility. The facility had a copy of his bed hold but no other paperwork. They were attempting to reach the Social Service Director (SSD), she was not in the facility. The ED indicated she did not know what happened to the resident after he left the facility, maybe he was still at the hospital. They had not done any follow-up. She did not know what happened to his belongings. On 1/4/23 at 10:09 a.m., during an interview, the RVPSN indicated the facility had done everything they could do for this resident. Their physician refused to accept him back because he had homicidal tendencies. He was too dangerous to be around other residents. He had multiple incidents with other residents. They had to send him out to the hospital, there was no other choice. She had checked and his belongings were packed up. On 1/4/22 at 11:29 a.m., during an interview, the ED indicated the day after transferring it was identified the transfer/discharge assessment form had not been completed in the computer prior to sending the resident out because the nurse was in a hurry. She printed it off, blank, and manually marked it the next day. They should have given a history and diagnoses on the phone when they called report, to the emergency room . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/4/23 at 11:43 a.m., during an interview the RVPSN indicated the nurse said the next day they realized, during an IDT meeting, the assessment had not been completed. The nurse knew she could not document on a closed record, so she printed the form out and marked it with ink. It was not sent with the resident to the hospital. On 1/4/23 at 11:56 a.m., the RVPSN provided a current policy, dated 8/2022, titled, Hospital Discharge/Transfer. This policy indicated, .It is the policy of this facility to make the transition for residents transferring from one facility to another safe and to provide for continuity of care and services in a manner that minimizes resident anxiety as much as possible. Residents will be discharged /transferred from the facility as per physician order, and that a review of the resident's acute needs, brief plan of care, and medications are completed and communicated to the acute care hospital .Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record: Face Sheet, H&P [history and physical]/physician's notes, Current orders, CCD (Continuity of Care) document: medication list, diagnoses codes, allergies, most recent vital signs, advanced directives, and vaccination records. Advanced directive form as applicable, comprehensive care plan, pertinent labs, notice of transfer/discharge, bed hold policy, Nursing notes/social service notes pertinent to behavior issues may be warranted for psychiatric hospitalization s .Nursing will provide a thorough report to the receiving hospital .the resident must be permitted to return to the facility unless the facility determines that circumstances outlined in the Involuntary Discharge policy exist. In that case the procedures in the policy must be followed This Federal tag relates to Complaints IN00396127 and IN00397568. 3.1-12(a)(3) 3.1-12(a)(4) 3.1-12(a)(5)(a) 3.1-12(a)(5)(b) 3.1-12(a)(6)(A)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37982 Based on observation, interview, and record review, the facility failed to ensure a resident was oriented and prepared for discharge, with no plan with the receiving facility, the resident was not in possession of his belongings, and the hospital did not have a record of his current medications, for 1 of 3 residents reviewed for discharge (Resident D). Findings include: On 1/3/22 at 11:00, the closed medical record was reviewed for Resident D. The diagnoses included, but were not limited to Parkinson's disease, schizoaffective disorder, bipolar type, psychotic disorder with delusions, diabetes and anxiety disorder. On 4/22/22 12:21 a.m., the Nurse Practitioner (NP) indicated in a late entry that she had a discharge visit with Resident D. She indicated he was being seen for discharge planning to the Local homeless shelter per the facility. He had a past medical history of psychotic disorder, Alzheimer's disease, Schizoaffective disorder, Parkinson's disease, diabetes mellitus type 2, age-related cognitive decline, anxiety disorder, tremor, muscle weakness, difficulty in walking, and insomnia. He did not appear to be in any acute distress at this time or during this visit. He was resting quietly in a chair. He was oriented to person and place with periods of confusion. He was pleasant and cooperative. Medications were sent with Resident D upon his discharge. On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per the NP. He was alert and oriented x3. He ambulated on own without assistive device. His gait was steady. On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was admitted from Local homeless shelter. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. On 4/25/22 at 5:56 p.m., the Staffing Coordinator/Unit Manager indicated Resident D returned to facility at 5:15 p.m. today. Resident returned with medications and his belongings. He was placed in a room on the locked behavior unit. Physician's orders were received to give him his 9:00 a.m. medication now per NP 40. He was alert and oriented x 3. He ambulated on own without assistive device. His gait was steady. On 4/25/22 at 6:00 p.m., Resident D's Admission/Readmission form indicated he was admitted from Local homeless shelter. He was oriented to person, place, time, and situation. He had a diagnosis of dementia and used 9 or more medication. His cognition was intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/26/22 with no time noted, the SSD (Social Service Director) indicated she spoke with the Local homeless shelter Director. He indicated the facility send Resident D back to the facility as no one contacted them to inform them of Resident D being dropped off. SSD informed Local homeless shelter Director that she was unaware of needing to inform them of residents' arrival because they took walk-ins. The Local homeless shelter Director indicated that was no longer the case. On 10/19/22 at 12:03 p.m., a nurses' note indicated Staff witnessed Resident D get into a disagreement with another resident. Resident D became verbally and physically aggressive and made contact with the other resident. Both residents were immediately separated. Resident D was redirected with non-pharmacological interventions. On 10/19/22 at 6:29 p.m., a nurses' note indicated Resident D was sent to Neuropsychiatry for in-patient care per recommendation. Report given to (Name) RN who would be receiving the resident. Vital Signs stable per baseline at time of discharging resident. Management aware. A State Reportable #415 indicated Resident D got upset with another Resident over their shared bathroom not being clean. No injuries were noted to either resident and Resident D's room was changed. He was sent out for a neuropsychiatry evaluation. On 10/28/22 at 10:20 a.m., a nurses' note indicated Resident D returned from neuropsychiatry hospital readmitted to room on the C Hall. On 11/13/22 at 00:42 a.m., a nurses' note indicated Resident D was verbally aggressive towards another resident threatening them as well as staff. Tried to redirect was unsuccessful. Resident was sent out to hospital for psych eval. On 11/26/22 at 12:30 p.m., a nurses' note indicated Resident D had increased agitation and aggressiveness towards other residents. The Nurse Practitioner (NP) was notified and an order for PRN (as needed) Lorazepam (anti-anxiety medication) obtained. Order given to send resident out for Psych evaluation obtained. Management notified. On 11/26/22 at 2:15 p.m., a nurses' note indicated Paramedics came to the facility to take Resident D to the emergency room (ER) for a Psych evaluation. Resident refused to go to the hospital. 911 for police department called to come help but resident continue refusing to go to the ER. Resident self POA (own responsible party). Management notified and aware of the situation. NP notified and aware of the situation. One on one care provided from 2:00 p.m. today by management. Resident continued being compliant with one-on-one care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/22 11:05 Plan of Care Note: IDT Clan plan meeting was held with Social Services, Activity Director, Dietary Manager, Administrator, Director of Nursing, State Ombudsman in person, and Resident D. Resident voiced there was no family and preferred for only himself to be present. Activity Director discussed current activities of bingo, games, outdoors when weather permits, smoke break, discussed Resident's funds, discussed his choice to spend most of his funds on cigarettes then he would become upset/angry when staff did not provide him more cigarettes or give him money. Educated resident and recommended he manage/budget funds for cigarettes should he choose to continue to purchase cigarettes. Activity Director informed resident of current funds in account. Resident expressed understanding of cigarettes and budgeting funds, voiced no issues/concerns. Dietary Manager discussed current diet, meals, regular texture, thin liquid consistency, no issues/concerns were voiced. Discussed recent behaviors, agitation, threatening behaviors towards others, yelling out, physical behaviors towards others. Discussed these inappropriate behaviors towards others. Resident D expressed understanding of his behaviors and stated he would be good. Discussed options for alternate placement to better meet his needs. Discussed resident had toured a group home which he was interested in, then declined placement at group home due to not having a room to himself. Discussed a less restrictive environment for resident at group home. Resident stated he would think about the group home but still wanted a room to himself. Discussed the potential for Assisted Living Facility depending on meeting criteria, discussed CICOA. Resident agreed to apply for Medicaid Waiver. Discussed various methods of interventions, Resident continued to say he wanted a family and a woman, said people were jealous of him for what he had. Discussed interventions of setting personal goals for himself, discussed assisting Resident D with personal goals in a positive manner, resident expressed understanding of his behaviors, stated he was willing to be open minded with starting fresh with his behaviors and will work on his personal goals. Resident D stated he wants a good friend by his side, discussed appropriate ways of interacting with others. Resident expressed understanding of everything discussed, expressed understanding and recognition of his behaviors, expressed understanding of recommendations and agreed with these. Ombudsman also discussed his appropriate behaviors towards others in a positive environment. Offered to review medications, Resident D declined. Discussed recent discontinuing of psych medications, being followed by Rounding Providers medication management as well as new psychologist through Rounding Providers. Staff will continue to monitor behaviors, mood, and psychosocial well-being. No issues/concerns/questions voiced from Resident D. Staff will continue to encourage and support Resident D. On 12/2/22 at 3:10 p.m., an Interdisciplinary Care Team (IDT) note indicated Resident D was sent out to a local hospital for a Psych evaluation and placement due to agitation and aggressive behavior. The rounding providers and psych physician discussed safety concerns with Resident D's continued residing at the facility. IDT and the facility's corporate leaders discussed the rounding providers and psych physician's recommendations regarding safety concerns with Resident D's returning to the facility, discussed recommendation to not accept Resident D back at facility per MD (doctor) order due to safety concerns. This decision was communicated in full detail to all parties involved at the local hospital. On 12/2/22 at 11:15 a.m., a nurses' note indicated sent to (name of local hospital) for psych evaluation. On 12/2/22 at 6:18 a.m., a nurses' note indicated Resident D was up for the entire night shift, was agitated and verbally aggressive all-night shift. He attempted to attack other residents, threatening to kill them. Staff maintained safety of other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No discharge assessment or transfer documents were found in the resident's record. On 12/2/22 at 1:47 p.m., the hospital's emergency room record indicated Resident D was a [AGE] year old male who presented to the emergency room for a psych evaluation. The patient had no complaints, and no paperwork was sent with him. A history was unobtainable from the patient due to his mental status. His work-up was unremarkable. The hospital had limited information related to the resident's medications, other than discharge summaries from outside hospitals found in the electronic record history. The patient was in no distress, alert and voiced no complaints. Upon contact, the nursing home facility indicated they would not take the resident back, under any circumstances. As such patient placed on emergency detention. Given his known neurocognitive issues, inability to care for himself, potential to harm others, I am worried that he is gravely disabled and would not do well if we discharge to the street or the shelter. A hospital note, dated 12/2/22 at 4:34 p.m., indicated the Hospital Social Worker (HSS) 17 met with Resident D in his room. The patient wanted to call the facility about his belongings. HSS 17 explained to him the nursing staff had been directed by the facility not to call or allow him to call due to them refusing to take him back and wanting to avoid any miscommunication or escalation of the current situation. In a hospital physician note, also dated 12/2/22, the resident expressed he wanted to go back to the facility to attend a Christmas party and be with other residents there and BINGO. A hospital note, dated 12/5/22 at 11:16 a.m., Resident D was standing in the doorway of his hospital room requesting access to a washing machine for the sweatpants. He was upset he can't wash the pants he wore into the hospital 3 days ago. A hospital note, dated 12/29/22, indicated Resident D had no acute events over night. He asked if he could obtain glasses somehow, since he left his glasses at (Name of Facility). A hospital note, dated 1/2/23, indicated Resident D was asking when he will be leaving, asking if it will be today. He needed all of his stuff that was at the facility. A hospital note, dated 1/6/23, indicated no acute events over night. No report of agitation. Asking about his money that he left at his facility. He had acquired a collection of Lays baked potato chips on his couch. On 1/3/23 at 3:50 p.m., during an email exchange with Hospital Social Worker (HSS) 16, she indicated she was no longer following Resident D's case. She was assigned to the emergency room , crisis and psych patients. The physicians had determined Resident was not in need of a crisis psychiatric intervention. He had been transferred up to the medical surgical unit for housing until they could find placement for him. The facility refused him back when they had tried to call report. HSS 17 had been assigned to his case on the medical /surgical unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/23 at 10:00 a.m., during an interview, on the locked behavior care unit, Registered Nurse (RN) 10 indicated he had worked at the facility for 4 years and was familiar with Resident D. Resident D had outbursts a lot. He would go from calm and fine to screaming and yelling. If he respected you, he would listen and calm down. RN 10 would take him to his room and talk to him. He would deescalate. He was just loud. No one was afraid of him. He just made a lot of disruption. Most of his outbursts had to do with his girlfriend. He had identified a female resident as his girlfriend and would become very worked up when talking about her. He did not know what happened to the resident's belongings. They had moved his room to the other hall when he returned from the mission. On 1/6/23 at 10:30 a.m., Residents J and K were observed seated in a common area having a snack. They were both interviewed regarding Resident D, at that time. Resident J indicated she had been at the facility about 9 months. Resident D was not at the facility anymore they had kicked him out. He would yell and scream all the time. One time he threatened to kick my ass. She chuckled and indicated she wasn't afraid of him That's just the way he was when he got loud. The staff would take him to his room, then he would be okay. Resident K indicated she remembered Resident D. He always wanted that girl (name of another resident) to be his girlfriend. He was always talking about her being his girlfriend. He never hurt anybody, he would just get loud and yell a lot. Resident K wasn't afraid of him. On 1/4/23 at 9:45 a.m., during an interview with the Executive Director (ED) and the Regional VP of Clinical Services (RVPSN), the RVPSN indicated Resident D had been given a 30 day notice to move out previously, when the facility had sent him to the local mission, back in April. No notices were provided on his return. The plan was for him to remain in the facility. The facility had a copy of his bed hold but no other paperwork. They were attempting to reach the Social Service Director (SSD), she was not in the facility. The ED indicated she did not know what happened to the resident after he left the facility, maybe he was still at the hospital. They had not done any follow-up. She did not know what happened to his belongings. On 1/4/23 at 10:09 a.m., during an interview, the RVPSN indicated the facility had done everything they could do for this resident- their physician refused to accept him back because he had homicidal tendencies. He was too dangerous to be around other residents. He had multiple incidents with other residents. They had to send him out to the hospital, there was no other choice. She had checked and his belongings were back there packed up. On 1/4/22 at 11:29 a.m., during an interview, the ED indicated the day after transferring it was identified the transfer/discharge assessment form had not been completed in the computer prior to sending the resident out because the nurse was in a hurry. She printed it off, blank, and manually marked it the next day. They should have given a history and diagnoses on the phone when they called report, to the emergency room . On 1/4/23 at 11:43 a.m., during an interview the RVPSN indicated the nurse said the next day they realized, during an IDT meeting, the assessment had not been completed. The nurse knew she could not document on a closed record, so she printed the form out and marked it with ink. It was not sent with the resident to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/23 at 11:46 a.m., during a telephone interview from his hospital room, Resident D indicated while at the facility he had got into a verbal confrontation with another man there. If they would let him come back and stay there he would just have to mind his own business. He wanted to go back there, to his home. That was his home. There was a lady who worked there that did not like him. She was always trying to make him leave. The facility had all his belongings. He had nothing at the hospital. On 1/4/23 at 11:56 a.m., the RVPSN provided a current policy, dated 8/2022, titled Hospital Discharge/Transfer. This policy indicated, It is the policy of this facility to make the transition for residents transferring from one facility to another safe and to provide for continuity of care and services in a manner that minimizes resident anxiety as much as possible. Residents will be discharged /transferred from the facility as per physician order, and that a review of the resident's acute needs, brief plan of care, and medications are completed and communicated to the acute care hospital .Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record: Face Sheet, H&P [history and physical]/physician's notes, Current orders, CCD (Continuity of Care) document: medication list, diagnoses codes, allergies, most recent vital signs, advanced directives, and vaccination records. Advanced directive form as applicable, comprehensive care plan, pertinent labs, notice of transfer/discharge, bed hold policy, Nursing notes/social service notes pertinent to behavior issues may be warranted for psychiatric hospitalization s. Nursing will provide a thorough report to the receiving hospital .the resident must be permitted to return to the facility unless the facility determines that circumstances outlined in the Involuntary Discharge policy exist. In that case the procedures in the policy must be followed This Federal tag relates to Complaints IN00396127 and IN00397568. 3.1-12(a)(3) 3.1-12(a)(4) 3.1-12(a)(5)(a) 3.1-12(a)(5)(b) 3.1-12(a)(6)(A)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on observation, interview, and record review, the facility failed to ensure a resident received treatment that was in accordance with professional standards of practice when they failed to assess, document, provide timely diagnostic testing after a fall with severe injury, withhold blood thinning medication, and update the care plan with individualized interventions, for 1 of 2 residents reviewed for falls with severe injury (Resident B). Findings include, On 1/3/23 at 2:33 p.m., Resident B's responsible party indicated, on 12/25/22, she came to take the resident home for the holiday and found the resident to have a black and blue eye and a white bandage beside her right eye. Staff told her Resident B had fallen the night before, but staff had not contacted her about the fall, and she had doubts about the date and time of the fall due to the extent of the injury. The Responsible Party called the Executive Director (ED) at home and demanded details of the fall and why staff had not contacted her. The ED indicated she was unaware of the fall but would contact the facility immediately. Resident B told her staff would not answer her call light, and she fell out of bed while attempting to self-transfer hitting her head and side on an oxygen concentrator. Complainant did not know at that time but later found out the resident had a large and to her disturbing bruise on her right side. To her knowledge the physician was not immediately notified of the fall or injuries, and there were no immediate orders for x-rays or a CT scan to rule out a concussion or broken ribs until after the holidays. The resident did not have a CT scan scheduled until 1/5/23 almost 2 weeks after her fall. A Report of Concern/Grievance Log, dated 12/26/22, indicated documentation Resident B's daughter was concerned the resident's call light was not being answered or not being answered timely. On 1/3/23 at 3:40 p.m., Resident B was observed sitting in a wheelchair at bedside receiving oxygen per nasal cannula from a soft sided pack on the back of the wheelchair. An oxygen concentrator was sitting near the top of the bed turned off. The resident was alert, talkative and soft spoken. A bandaid was positioned vertically beside the right eye, dark discoloration and edema was observed around the top and bottom of the right eye. Resident B indicated she had attempted to get up alone and fell hitting the oxygen concentrator. They don't pay any attention to me. They don't answer my call light when I call. When asked if she had any other injury, pointed down to the right side of her torso and indicated, somewhere down there. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation of Resident B with the Regional [NAME] President of Nursing Services, on 1/4/23 at 2:45 p.m., resident was sitting in her wheelchair near the nurse's desk with her coat on preparing to leave for an outside nephrology appointment unrelated to her fall and injuries. The Regional VP of Nursing Services observed a bandaid on right side of resident's face near the eye extending across and stuck to the eyebrow, and with permission from the resident removed the bandaid revealing a half inch horizonal scab at the outer end of the eyebrow. When questioned by the Regional VP of Nursing Services, Resident B indicated she had fallen due to waiting on staff to answer her call light and they kept walking by and ignoring her, so she attempted to self-transfer and fell . She got a black eye and hurt her side, and staff immediately put a bandaid on her eye so her daughter would not get mad. She had blurred right eye vision since the fall. When the Regional VP of Nursing Services asked Resident B if it would be okay with her to move up the CT scan by a day, Resident B got visibly upset and indicated what made her mad was nobody did anything when she fell and now they were asking to treat her. Resident B's record was reviewed on 1/4/23 at 10:54 a.m. Diagnoses on Resident B's profile included, but were not limited to, end stage renal disease, vascular dementia moderate with agitation and anxiety, restlessness and agitation, repeated falls, and dependence on supplemental oxygen. A quarterly Minimum Data Set (MDS) assessment, completed on 10/26/22, assessed Resident B as having the ability to make herself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 9 indicated moderately impaired cognition. Extensive assistance of one person physical assist for bed mobility, transfers, dressing, and eating. No physical help from staff for walking in room. Limited assistance of one person physical assist for locomotion on or off the unit, and personal hygiene. Supervision of one person physical assist for toilet use. 1 fall since admission/readmission or prior assessment with no injury. A care plan for Resident B dated 3/29/22 indicated, the resident was at risk for falls/injury due to a history of falls, impaired cognition/safety awareness, incontinence, and weakness/disability. The goal was for the resident to not sustain serious injuries. Interventions included dycem to the wheelchair, maintenance to elevate refrigerator to safer height to prevent resident from bending over, re-educate resident to use call light and request assistance for transfers, anticipate and meet the resident needs, call light within reach, keep personal items in reach, anti-rollbacks to wheelchair, and non-skid/gripper socks. 12/28/22 revision: PT/OT/ST to evaluate and treat. A care plan for Resident B dated 10/20/22 indicated, resident is on anticoagulant therapy related to blood clot prevention. The goal was for the resident to be free from discomfort or adverse reactions related to anticoagulant use. Interventions included administer anticoagulant medications as ordered by physician and monitor for side effects and effectiveness every shift. Daily skin inspection and report abnormalities to the nurse. Labs as ordered and report abnormal labs to the physician. Monitor/document/report adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden change in mental status, significant or sudden changes in vital signs. A Physician's order, dated 5/10/22, indicated oxygen at 2 liters (L) via nasal cannula, resident may remove at times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A Physician's order, dated 5/10/22, indicated Clopidogrel Bisulfate Tablet (Plavix a blood thinner) 75 milligrams (MG) give 1 tablet by mouth one time a day for blood clot. A Physician's order, dated 12/27/22 at 9:51 a.m., indicated obtain facial/skull x-ray. A physician's script, dated 12/29/22, indicated no contrast CT of the head, recent fall, hit head, patient on Plavix. Radiology Report Results, dated 12/28/22 at 9:30 a.m., indicated no acute findings considering the inherent limitations of skull radiology. If there was persistent clinical concern, consider CT. The resident record lacked documentation staff timely alerted the physician to Plavix use after the resident fell on [DATE] and developed extensive facial and torso bruising, or held the medication related to the extensive bruising or potential for internal bleeding. Pictures of Resident B, dated 12/25/22, indicated varying shades of purple and black discoloration and swelling to the right eye and eyebrow extending from top of the eyebrow, around the entire eye, down past the right cheekbone, and towards the right ear, white gauze taped on the right side of the face near the eye and over part of the eyebrow. Varying shades of dark to lighter purple bruising on the right side/flank area extending from bottom of the bra line down past the waistline, on the back and around towards the front of the torso. A skin assessment, dated 1/24/22, indicated some new discoloration or impaired skin integrity. Face small bruising on side of head. A fall risk assessment, dated 12/24/2022, indicated low risk for falls. Alert and oriented, 1-2 falls in the past 3 months. Ambulatory, continent, and gait normal. The resident record lacked documentation to describe the extent of Resident B's injures, treatment of the injuries, on-going monitoring of the injuries, or resident tolerance of injuries. Additional pain medication was documented in December as administered 1 time on 12/26/22. A Nurse's Note, dated 12/24/22 at 7:34 a.m., indicated Resident B had an unwitnessed fall. The nurse found the resident on the floor in room during hourly rounding, resident stated I was trying to get my robe. Full head to toe assessment done, resident had small bruising to head. Called family but no answer. Resident educated on the importance of the use of call light for anything. A Nurse's Note, dated 12/24/22 at 8:15 a.m., indicated no injures noted. A Nurse's Note, dated 12/26/22 at 12:01 a.m., indicated noticed right side of patients face and black eye bruised from recent fall. A Nurse's Note, dated 12/26/22 at 8:51 a.m., indicated observed pinpoint laceration to eyebrow and bruising to right eye and to right side. MD aware and was to put in a new order for X-ray, will notify family. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	A Nurse Practitioner's Note, dated 12/26/22 at 11:36 a.m., indicated resident seen today for follow up to a fall with injury. Resident complaint of right eye being sore. Resident reports she fell over the oxygen tank in her room trying to go to the bathroom. Resident reports hitting her head on the oxygen tank and hitting her side. Will order a stat chest X ray. Bruise around the right eye and right flank. An Interdisciplinary Note, dated 12/27/2022 at 10:41 a.m., indicated review of fall on 12/24/22. Patient reported fall while attempting to dress self, sustaining minor injuries. Nursing staff provided care for the resident upon notification and notified provider, family, and updated plan of care accordingly. Occupational Therapy/Physical Therapy/Speech Therapy (OT/PT/ST) will screen patient for any deficits and treat accordingly as intervention. A Psychotherapy Note, dated 12/27/22 at 3:55 p.m., indicated resident presented as fatigued, tearful, and depressed. She had a black eye and cut above her eye, which she reported that she fell and hit her oxygen tank. Speech rate slow and less talkative than usual. A Nurse Practitioner progress note, dated 12/28/22 at 11:58 a.m., indicated resident seen today for follow up to diagnostics. Resident denies any pain to the right eye, reports that the right eye was sore. Resident reported that her right flank continued to be sore, no fracture noted, bruise remains. On 12/28/22 a chest x-ray conclusion indicated modest cardiomegaly with mild congestive heart failure worse than 9/19/2022, fluid noted in minor fissure. Plan: repeated falls, continue to monitor. A Nurse's Note, dated 12/29/22 at 8:30 a.m., indicated small laceration remains to right brow area and bruising remains to right eye and right side. Discomfort noted with some movement but normal for baseline. A note on a calendar at nurse's desk indicated 1/6/23 at 10:10 a.m., Resident B had an appointment at a nearby radiology center for a CT scan of the head due to complaint of a fall. A Risk Management Report, dated 12/24/22 at 4:30 a.m., indicated Resident B was found on the floor by nurse during hourly rounding. Resident stated she was trying to go get her robe. Head to toe assessment completed. Resident educated on importance of using the call light whenever she needed anything. Bruise and laceration to face, bruise to right trochanter (hip). Resident alert and oriented to person, place, and time. Injury observed post fall. Notes: pinpoint 2 centimeter (cm) x 2 cm laceration right eyebrow. 5.5 cm x 8 cm dark purple bruising around eye. 7 cm x 9 cm dark purple bruising to right side. Director of Nursing (DON) notified 12/24/22 at 4:45 a.m., on-call MD notified 12/24/22 at 7:30 a.m. A radiology electronic ordering system report indicated, on 12/26/22 at 8:49 a.m., the DON ordered skull x-rays, and on 12/26/22 at 11:40 a.m. ordered chest x-rays. Reason for portability: patient weak/non-ambulatory (altered mental status/behavior issues). MRI results for Resident B, dated 1/4/23, indicated, there were compression fractures at thoracic (T)11, lumbar (L)3, L4, L5, age of these compression fractures was indeterminate. During an interview on 1/4/23 at 9:54 a.m., Qualified Medication Aide (QMA) 7 indicated, Resident B had skin discoloration due to a fall about a week ago. The resident required assistance for transfers, would put on her call light most of the time, but would get up alone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/4/23 at 9:57 a.m., Registered Nurse (RN) 5 indicated, Resident B was fairly proficient in transfers, needed assist with dressing due to limited range of motion in her shoulders, and was one of the few that would use the bathroom call light. During an interview on 1/4/23 at 10:26 a.m., Certified Nursing Assistant (CNA) 6 indicated, he could not say when Resident B fell , he worked Christmas Eve and when he came back, she had bruises. The resident had told him she was reaching for a robe on her chair and fell out of bed. During an interview on 1/5/23 at 10:08 a.m., Licensed Practical Nurse (LPN) 18 indicated, on 12/24/22 when she arrived to work at 7:00 a.m., she was informed Resident B had fallen around 4:00 a.m. When the resident was assessed and left the facility that morning for dialysis, the resident had no injury to her face or dressing to her eye. When LPN 18 returned to work on 12/26/22 Resident B was observed to have extensive dark purple bruising on her right eyebrow with edema and bruising around the eye. LPN 18 asked the NP to exam the resident. LPN 18 indicated, there was no documentation of the resident's condition in the medical record on 12/25/22. Indicated, she could not answer if Resident B had another fall between 12/24 and 12/26 but knew there had been no injury found on 12/24/22. LPN 18 indicated, Resident B's right eye looked to have dark deep purple bruising in a circle approximately 1-2 inches around the entire eye, with edema. The right eyebrow was raised and sticking out due to edema with a white dressing. A pinpoint open area on outer right brow area, all swollen. During the eye exam Resident B was grimacing, moaning, and guarding her right side as she was being moved around, and her right side was found to have dark deep purple bruising raised with edema from under her right arm extending to torso and around her back, down towards her waistline. Measurements at the time for her right eye started above brow down to cheek bone then over toward ear. Her right side/rib area darker bruising approx. 8 in diameter x 3 length, and purple bruising fading around it. The NP was supposed to put in orders for skull and chest x-rays. During an interview on 1/6/23 at 12:33 p.m., CNA 14 indicated, she had worked on 12/23 and 12/24 7:00 a. m. - 7:00 p.m. and Resident B was not injured. When she arrived at work on 12/25/22 at 7:00 a.m., the resident was observed to have injuries on her face. On 1/5/23 at 1:01 p.m., the Executive Director (ED) provided a Fall Program Guidelines, dated 12/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, To screen all residents to identify possible risk factors that could place a resident at risk for falls, evaluate those risks, implement interventions to reduce the risk and monitor the interventions for effectiveness .1. The resident will be assessed for fall risk upon admission and quarterly. 2. Interventions will be implemented if resident is determined to be at risk. 3. Should a fall occur, the nurse shall complete an assessment of the resident and circumstances surrounding the fall incident. The interdisciplinary team [IDT] should determine root cause and evaluate to ensure appropriate interventions are implemented. 4. The attending physician or medical director in the absence of the attending physician and the responsible party should be notified. 5. The resident care plan should be revised to reflect any new or change in interventions. 6. Effectiveness of interventions will be monitored through the Clinically At-Risk program . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/5/23 at 1:01 p.m., the ED provided a Call Lights policy and indicated the policy was the one currently being used by the facility. The policy indicated, Purpose: To respond to resident's requests and needs in a timely manner .All staff should assist in answering call lights. Nursing staff members shall go to resident's room to respond to call system and promptly cancel the call light when the room is entered . This Federal tag relates to Complaint IN00393356. 3.1-37(a) 3.1-37(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38767 Based on observation, interview, and record review, the facility failed to follow professional standards of practice to prevent potential for accidents while using a mechanical lift, resulting in a fall with fracture, delay of diagnosis of a fracture despite resident continued complaints of severe pain, and ensuring individualized care plan interventions were implemented for 1 of 3 residents reviewed for accidents (Resident G). Findings include: An Indiana State Department of Health Survey Report System report, dated 11/16/22 at 5:01 p.m., indicated Resident G had a change in condition/shortness of breath so was transferred to the emergency room where they found a fracture of the distal femoral metadiaphysis (end of the bone near the growth plate, commonly caused by a fall from a height). On 1/5/23 at 10:30 a.m., Resident G indicated, on 11/3/22 around 7:00 p.m., Certified Nursing Assistants (CNA) 8 and 9 had come into her room with the Hoyer (a mechanical lift) to transfer her from the bed to a shower chair. She was placed on a lift pad, the pad hooked to the lift, and as they swung her around in front of the TV, she suddenly fell from the lift pad and landed on the metal feet of the Hoyer lift and bounced onto the floor. Resident G indicated, she was approximately 4 - 5 feet in the air at the time of the fall as her bed was in high position when they lifted her off it, and it happened so fast she only started to yell out when she hit the floor. It was her opinion the aides did not check the Hoyer pad to make sure it was in good working order before transferring her, and upon inspection the broken strap was dry rotted, the pad ripped, and it came apart causing the strap to break. Resident G indicated the lift pad should never have been in use since it was rotten. Observation of Resident G's Hoyer pad showed it to have frayed and missing binding around the perimeter, the strap material was frayed, and there was one broken strap the resident indicated had caused her fall. Resident G indicated, when she was dropped, she instantly felt pain from her mid upper right arm down through her right leg stump. Initially staff only gave her a mild pain medicine which did nothing for the pain and they ordered an x-ray of her upper body but not her lower body. The resident indicated, she would scream out every time staff touched her for care and refused dialysis due to not being about to stand the pain of being transferred. They let me suffer for 2 weeks, kept telling me nothing was wrong. Resident G indicated, she finally saw the Nurse Practitioner (NP) walking past her door one day and asked to be seen at the hospital, where she was diagnosed with a hairline fracture and kept for several days. The resident indicated, the NP said she was not told the resident had fallen from a Hoyer lift. Resident G indicated, she reported to the hospital staff the nursing home had ignored her complaints that something was wrong. Resident G's record was reviewed on 1/5/23 at 11:01 a.m. Diagnoses on Resident G's profile included, but were not limited to, acquired absence of right and left leg below the knee (amputation), end stage renal disease with dependence on renal dialysis, hemiplegia and hemiparesis (paralysis) following cerebral infarction affecting left non-dominant side, and chronic pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Physician's order, dated 11/4/22, indicated Ibuprofen tablet (anti-inflammatory/analgesic) 600 milligrams (mg) give 600 mg by mouth one time only for pain. A Physician's order, dated 11/4/22, indicated Hydrocodone -Acetaminophen (narcotic pain medication) tablet 5-325 mg give 1 tablet by mouth three times a day for 7 days related to pain to right leg. A Physician's order from the hospital, dated 11/15/22, indicated oxycodone HCl (narcotic pain medication) tablet 5 mg give 0.5 tablet by mouth three times a day for pain. A fall assessment for Resident G, dated 11/3/22, indicate the resident was a low risk for falls. She was alert and oriented and required assistive devices with transfers. A Nurse's Note, dated 11/3/22 at 8:29 p.m., indicated Resident G had a witnessed fall. Resident fell while aides were in the process of transferring her from the bed to the shower chair via Hoyer lift. No injury, denied hitting head, complained of right-side pain, took PRN (as needed or requested) Tylenol (analgesic). New X-ray order per the NP for right upper extremities, hip, and pelvis. Director of Nursing (DON) notified. A Nurse's Note, dated 11/4/22 at 6:11 a.m., indicated resident complained of right hip pain due to earlier fall, she refused hospital visit and requested for stronger pain medication than Tylenol. NP gave order for ibuprofen 600 mg one (1) time now then follow up by NP in the morning. An Interdisciplinary (IDT) note, dated 11/4/22 at 9:21 a.m., indicated recent fall on 11/3/22. Resident was being transferred from bed to shower chair and fell . No injuries noted. X-rays ordered. Discussed intervention of staff education on safe transfers. Family/MD notified. Assessments and care plans updated. A late entry NP note, dated 11/4/22 at 12:42 p.m., indicated the resident was seen today for follow up fall without injury, reports fall during transfer from bed to chair. Right lower extremity slightly swollen related to fall. A NP note, dated 11/7/22 at 3: 35 p.m., indicated patient being seen today to follow-up to right hip, arm and knee pain after a fall. Resident receiving Norco (narcotic) 5/325 mg. Resident is having breakthrough pain. Norco will be increased and Tylenol for breakthrough pain. Resident is crying today and stated, I am really hurting, and I need something stronger for the pain. Resident encouraged to move in bed as she is complaining on being stiff. Patient will be referred to Physical Therapy (PT). A NP note, dated 11/9/22 at 11:08 a.m., indicated resident seen today for follow-up to a fall without injury. Right lower extremity swelling resolving. Assessment/Plan for pain, Biofreeze (topical pain relief) to right hip, knee and arm. A Nurse's Note, dated 11/10/22 at 1:03 p.m., indicated slight edema to face and arm. Refused blood pressure and has been refusing dialysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurse's Note, dated 11/16/22 at 8:08 a.m., indicated resident seen today for follow-up to hospitalization . Patient discharge diagnosis was fluid overload and a commuted fracture involving the distal femoral metadiaphysis. Refer to Ortho within 1 to 2 weeks. Oxycodone (narcotic pain medication) discussed with nursing. The resident record lacks documentation of the resident being sent to the hospital on 11/11/22 or reason for the transfer. A hospital History and Physical, dated 11/14/22, indicated resident resented to the emergency department with over one (1) week of right and hip pain, being admitted for hyperkalemia and a right distal femur fracture. Right hip/leg pain due to a distal femur fracture. Complaining that current pain regimen ineffective. Orthopedic surgery was consulted and recommended posterior splint and clinic follow up. Patient will need outpatient with follow up and supportive care for pain control and bowel regimen. Pain control with scheduled low dose Percocet (narcotic) 2.5 mg three times daily (TID) and PRN, oxycodone 5-325 mg for breakthrough pain. Hospital In-Patent Discharge Summary indicated, in house 1-11-22 - 11/15/22, diagnosis fracture of distal end of right femur. A hospital instructions for care x-ray report, dated 11/11/22 at 10:40 a.m., indicated fell out of Hoyer lift 9 days ago, via emergency medical service (EMS) from facility, was dropped out of Hoyer lift last week. X-rays done by facility last week were unremarkable. Bilateral below the knee (BTK) amputee. On 1/6/23 at 10:45 a.m., the ED provided documentation of education she indicated was presented to the nursing staff due to prior citation related to Hoyer use to include, a. On 1/20/22 mechanical lift education. The policy was presented and verbal direction on use. CNA 9 signed as having received the education. b. On 5/9/22 mechanical lift education. Use of the Hoyer lift was presented. CNA's 8 and 9 signed as having received the education. A quarterly Minimum Data Set (MDS) assessment completed 10/21/22, assessed Resident G as having the ability to make herself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 15/15 indicated cognitively intact. Extensive assistance of 2+ persons physical assistance for bed mobility. Total dependence of 2+ persons physical assist for transfers. Mobility devices included a wheelchair. No history of falls. A care plan for Resident G indicated the resident had an assistance with daily living (ADL) deficit related to diabetes mellitus, osteoarthritis, and hemiplegia or hemiparesis of the left side. The goal was for the resident to remain clean and well groomed. Interventions included, but were not limited to, the resident required a mechanical lift with 2 staff assistance for transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A care plan for Resident G, dated 10/21/22, indicated the resident was at risk for falls/injury due to bilateral amputee, diabetes mellitus, and hemiplegia or hemiparesis of the left side. The goal was for the resident to be free from falls. Interventions included, anticipate and meet the resident's needs, call light within reach, and ensure pathways were free of clutter. Revision dated 11/4/22 staff education provided related to safe transfer techniques. Resident record lacked documentation the care plan was updated with individualized interventions to include, but not limited to, use of a right leg splint. During an interview on 1/4/23 at 10:05 a.m., Qualified Medication Aide (QMA) 7 indicated, staff would go in every morning at 7:00 a.m. to set the resident up for am care, she required ADL assistance for bathing, dressing, and transfers due to being a double amputee. During an interview on 1/5/22 at 12:02 p.m., the DON and Regional VP of Nursing Services indicted, Resident G had fell during a transfer with staff and a Hoyer (mechanical lift).The Regional VP of Nursing Services indicated, during her investigation the resident had told them she fell from the Hoyer due to a frayed Hoyer pad but would not give staff the pad or show it to them. On-going staff education on Hoyer lift use was presented on 11/5/22 to include how to use the lift, only keeping the Hoyer pads for one (1) year and dating the pad when they were put out for use. Indicated, the housekeeping/laundry supervisor was responsible for the monitoring and replacing of Hoyer pads. During an interview on 1/5/23 at 12:18 p.m., the housekeeping/laundry supervisor indicated, she ordered Hoyer pads when told to by the DON or when the pads were outdated. When new Hoyer pads were received they were initially kept in her office, where she dated them before they went to the floor for resident use. Laundry staff checked the dates on the pads when laundering, and at 12 months threw them away. She was hired in February 2022, from that date she knew she dated new Hoyer pads and the 2 or 3 that had been in the laundry room, she was not sure about the pads that were already in use on the floor. Indicated she could guess the number of Hoyer pads in use on the wings, but there was no system currently in place to track the Hoyer pads. Ultimately laundry and nursing were responsible for the residents having usable, safe Hoyer pads. During an interview on 1/5/23 at 12:25 p.m., CNA 8 indicated, she had worked in the facility for a year. On 11/3/22 she and CNA 9 had gone to give Resident G a shower. They placed a Hoyer pad under the resident, hooked her up to the mechanical lift, and when they went the lift without warning the pad broke and the resident fell hitting the metal feet of the lift. At the time of the fall the resident was about four (4) feet off the floor. Observation of the Hoyer pad indicated it had a broken strap. CNA 8 indicated, she did not remember paying an attention to the condition of the Hoyer pad prior to the fall. As for prior education on mechanical lift transfers, she had been told to always use 2 persons for transfers per Hoyer but thought the actual training for Hoyer use and examining pads started after the fall on 11/3/22 during an in-service. When Resident G fell , she complained of her legs/hips being sore, but she did not want to go out to the doctor. It was the responsibility of laundry to make sure Hoyer pads were inspected and someone went in there and got rid of those that were not safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/5/23 at 2:30 p.m., the Executive Director (ED) indicated, her understanding was that Resident G fell from the Hoyer pad onto the bed, so she had not questioned staff regarding the incident. The housekeeping supervisor was responsible for ordering and monitoring Hoyer pads and replacing them. The ED indicated she had followed up with the resident the day after the fall due to being told it involved a fall from a Hoyer, but she was not told the resident fell to the floor. Resident G had not shown or given the ED the Hoyer pad that supposedly broke. The ED indicated, she was not sure how long Hoyer pads were to be kept, but she approved to replace them anytime needed. On 11/5/22 the ED presented a staff in-service regarding customer service and phone use, and the DON added Hoyer use to the in-service. The DON told her she had spoken to the aides, but she was not sure which ones. Checking the Hoyer pad should be the first thing the aides did before using the mechanical lift, safety should always come first. It was the responsibility of the CNA's using the Hoyer lifts to report when the lift pads were ripped or no longer safe. During an interview on 1/6/23 at 12:07 p.m., the DON indicated on 11/3/22 a nurse (she did not remember the name) called and reported Resident G had fallen from a Hoyer lift due to a problem with the sling (Hoyer pad). CNA 8 had told her the sling broke. Resident G indicated the staff turned her when up in the lift going towards the shower chair and the sling broke. On 11/4/22 she and Resident G spoke with the Regional VP of Nursing Services on the phone, and the resident told them the same story about the sling breaking and how she fell on the floor. The resident would not show the sling to the staff. Upon inspection of the Hoyer slings currently in use on the floor some had been dated and some not. Nurse documentation of a fall was to be entered in the electronic medical record to include in a risk management form, fall assessment, and Skin assessment. Once the risk management form was done, the IDT notes were made and populates into the progress notes for others to see. The MDS nurse was responsible for updates to the care plan. During an interview on 1/6/23 at 12:12 p.m., the ED indicated, the details of Resident G's fall from a Hoyer lift had not been put on the state reportable incident as she was not aware she had to put all detail on the report. Reportable incidents were sent to corporate for approval before being sent. On 1/5/23 at 1:01 p.m., the ED provided a Fall Program Guidelines, dated 12/2022, and indicated the policy was the one currently being used by the facility. The policy indicated, To screen all residents to identify possible risk factors that could place a resident at risk for falls, evaluate those risks, implement interventions to reduce the risk and monitor the interventions for effectiveness .1. The resident will be assessed for fall risk upon admission and quarterly. 2. Interventions will be implemented if resident is determined to be at risk. 3. Should a fall occur, the nurse shall complete an assessment of the resident and circumstances surrounding the fall incident. The interdisciplinary team [IDT] should determine root cause and evaluate to ensure appropriate interventions are implemented. 4. The attending physician or medical director in the absence of the attending physician and the responsible party should be notified. 5. The resident care plan should be revised to reflect any new or change in interventions. 6. Effectiveness of interventions will be monitored through the Clinically At-Risk program . On 1/6/22 at 11:30 a.m., ED provided Invacare Patient Sling Owner's Manual, revised 7/99, and indicated this was the Hoyer manual currently being used in the facility. The manual indicated, warning: after each laundering, inspect sling(s) for wear, tears, and loose stitching. Warranty 1 year. Dawn Regional indicated to her this meant to replace after one year. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/6/23 at 11:55 p.m., the ED provided a Mechanical Lift Policy, dated 8/2022, and indicated it was the policy currently being used by the facility. The policy indicated, A mechanical lift is to be utilized for residents who are too heavy to be moved by one person, or who are disabled to the point of inability to assist with transfers. Two [2] personnel members must be present when a mechanical lift is utilized .1. Inspect the mechanical lift before each use . The policy lacked documentation for mechanical lift sling monitoring and maintenance. This Federal tag relates to Complaint IN00393356. 3.1-45(a)(2)