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	09/05/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	09/05/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to complete a thorough investigation of a resident-to-resident allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident D)Findings include:Review of a facility reported incident, dated 8/24/25, indicated Resident D and Resident E were outside in the smoking area. There was a disagreement between them, and Resident E made contact with Resident D's cheek. The two residents were separated. Resident D was assessed with no injuries observed by the nurse. Resident D indicated he had moderate pain to the area and was treated for pain management. Both residents returned to their rooms. The physician, Director of Nursing, Administrator and resident's representatives were notified. A follow-up report was added on 8/19/25 and indicated Resident E and Resident D were doing well. During the interview process, Resident E indicated he had been upset with Resident D because he felt he was making fun of another resident. Resident D believed he had not said anything and did not know why it happened. Resident E indicated he was wrong to behave that way. Both residents had made up their differences and have interacted with each other. No other issues between residents had occurred and no psychosocial concerns had been noted.1. The clinical record for Resident D was reviewed on 9/5/25 at 10:28 a.m. Diagnoses included left-sided hemiplegia and hemiparesis following a stroke, anxiety disorder, and right above knee amputation. A quarterly Minimum Data Set (MDS) assessment, dated 6/19/25, indicated the resident was cognitively intact. The resident had no hallucinations or delusions, rejection of care, and had no physical or verbal behaviors. A nursing progress note, dated 8/23/25 at 10:15 p.m., indicated Resident D reported that another resident had punched him with a closed fist on the left cheek while not facing him, after having a small disagreement. The resident reported pain to his left cheek where he was punched. The resident was assessed for pain, skin injury and vital signs. He reported his pain as 5 out of 10. No injuries were noted. Vitals signs were within normal limits. The residents were separated and reminded to maintain distance. The Administrator was notified immediately.During an interview on 9/5/25 at 10:28 p.m., Resident D indicated the incident was embarrassing for him, to be hit over a misunderstanding. He was left with swelling on the left side of his face and felt like he could not see as well out of his left eye. He felt the staff were unconcerned about his feelings following the incident. The Administrator and Social Services Director had asked him how he was doing, but only in common areas where there was no privacy. He had been smoking in his truck following the incident because he was concerned the resident might misunderstand him again. He was just not comfortable. Resident E had apologized to him, but he remains uncomfortable around him.2. The clinical record for Resident E was reviewed on 9/5/25 at 10:25 a.m. Diagnoses included paranoid schizophrenia, antisocial personality disorder, and hypertensive heart disease with heart failure. A quarterly MDS assessment, dated 7/2/25, indicated the resident was cognitively intact. The resident had no hallucinations or delusions, rejection of care, and had no physical or verbal behaviors.A nursing progress note, dated 8/23/25 at 6:38 p.m., indicated Resident E was observed walking back to his room from the smoking area when a few seconds later, Resident D was observed coming down the hallway on his electric wheelchair, yelling, and accusing Resident E to have bashed me in my face. Resident E exited his room into the hallway and started to argue with Resident D. Staff members intervened and de-escalated the incident, directing residents to their rooms.During an interview on 9/5/25 at 10:25 a.m., Resident E indicated he made a mistake during the incident and apologized to Resident D. He had misunderstood what Resident D had said and had hit him. He felt the two were fine to be around each other now.During an interview on 9/5/25 at 11:45 a.m., the Nurse Practitioner (NP) indicated she had seen Resident D on 8/25/25 and observed no swelling, redness or bruising to the left side of his face. He had not mentioned he was fearful or concerned about Resident E or feeling in danger. She had observed him in the common areas and outside smoking with residents. She was confident Resident D would have talked to her about any discomfort in being around Resident E.During an interview on 9/5/25 at 10:52 a.m., the Administrator indicated Resident E was protective of other residents and staff. He indicated Resident E had heard Resident D say something inappropriate about someone and had slapped Resident D on the left side of his face. He was on the phone with the nurse when Resident D was at the nurses' station and had requested to call the police. He had instructed the nurse to call the police if that was what Resident D requested. However, Resident D changed his mind and indicated to the nurse he did not want the police called. He observed Resident D the following day and could not see any redness or swelling to the left side of his face.The Administrator provided the incident investigation information on 9/5/25 at 11:15