STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER: Envive of Indianapolis		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect a resident's right to be free from verbal abuse by a Certified Nursing Assistant (CNA 6) who engaged in a verbal altercation with the resident that included profane language for 1 of 3 residents reviewed for abuse (Resident C). This deficient practice was corrected by 2/16/26 prior to the start of the survey and was therefore Past Noncompliance. Findings include:A Facility Reported Incident (FRI), dated 2/14/26 at 11:01 a.m., indicated Resident C and CNA 6 had a verbal altercation. CNA 6 stated the resident had hit her in the face and called her several names, and in return CNA 6 became upset and called Resident C names. CNA 6 was initially sent to another part of the building, then suspended pending investigation. The investigation was completed and CNA 6 subsequently terminated on 2/16/26. Resident C's clinical record was reviewed on 3/2/26 at 12:45 p.m. Diagnoses on Resident C's profile included hemiplegia (severe paralysis of one side) and hemiparesis (mild paralysis of one side) following a cerebral infarction affecting the left non-dominant side, intermittent explosive disorder, post-traumatic stress disorder (PTSD), and adjustment disorder with mixed anxiety and depressed mood. A quarterly MDS (Minimum Data Set) assessment, completed on 12/13/25, indicated Resident C was cognitively intact, and was documented during the assessment period as having both physical and verbal behaviors towards others. The resident was dependent on staff for transfers for toileting and shower/bathing. Resident C was wheelchair dependent. A current care plan for Resident C indicated he had an ADL (activities of daily living) self-care deficit related to decreased mobility secondary to hemiplegia, and a right above the knee amputation. He was dependent on staff for tub/shower transfers and bathing/showering. The resident used an electric wheelchair for mobility. A current care plan for Resident C indicated he had extensive behaviors of attention seeking and making false statements and accusations towards staff and others. Interventions included staff providing care in pairs. A current care plan for Resident C indicated he was at risk for falls/injury due to hemiplegia, a right above the knee amputation, and a history of non-compliance with self-transfers. Interventions included anticipate and meet the resident's needs, and call light was to be within reach. Resident C's clinical record lacked documentation on 2/14/26 regarding an altercation with a staff member. A witness statement from Nurse Supervisor 8, dated 2/14/26, indicated she had been walking towards A-Wing from the connecting hallway. As she got closer to the unit, she heard yelling and cursing from CNA 6 and Resident C. CNA 6 ran out of the shower room stating Resident C hit her in the face. Nurse Supervisor 8 asked CNA 6 to explain to the charge nurse what was going on as she went to check on the resident. CNA 6 stated she was going home and did not want to give any statements. Nurse Supervisor 8 indicated she had called the Director of Nursing (DON) after separating the resident and aide and gave report on what had happened as she saw at the time. This supervisor along with the charge nurse took patient in confidence, and made sure he had no immediate needs, and asked him what happened in the shower room. Resident stated that he was cursing at the CNA and that she was cursing back at him as they were both yelling, and she lunged at him in a threatening manner like a boxer, saying no one got hit. We asked him if he hit her and he denied touching her. At this time CNA 6 refused to give the supervisor or charge nurse report stating she would e-mail her statement. CNA 6 (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was relieved of her assignment and sent home for the safety of the residents pending further investigation. A witness statement from Registered Nurse (RN) 9, dated 2/14/26, indicated she had heard both Resident C and CNA 6 cursing each other out from the hallway. The voices were coming out of the A-hall shower room. The writer tried to understand what triggered the noise, but the only thing she could hear at that time was the two cursing each other back and forth. A nurse witness statement (signature illegible), dated 2/14/26, indicated the nurse had been coming from B-hall and heard CNA 6 yelling and cursing along with Resident C. CNA 6 then ran out of the shower room saying Resident C had hit her in the face. CNA 6 would not calm down enough to explain what happened in detail and refused to write a statement when asked. Review of CNA 6's staff file, indicated she was hired on 1/30/25, and had signed as having received education on abuse, resident rights, and dementia training. An Employee Termination Form, dated 2/16/26, indicated CNA 6 had been suspended on 2/14/26 at 11:30 a.m., and then involuntarily terminated for verbal abuse, after positive conclusion to an investigation on 2/14/26. A FRI follow-up, dated 2/20/26, indicated the investigation was completed and substantiated.CNA 5 and CNA 6 had been providing a shower to Resident C. When the shower was completed, CNA 5 went to get a male staff member to assist with the transfer of the resident. While CNA 5 was gone, CNA 6 stepped out of the shower room and stood by the door. Resident C, who was care planned for care in pairs, became upset and began banging and yelling. When CNA 6 and other staff members responded to the noise, Resident C started cussing and allegedly called CNA 6 the N word. CNA 6 was sent away from the area, then instructed to clock out by the weekend supervisor. CNA 6's employment with the company was subsequently terminated. During an interview on 3/2/26 at 2:01 p.m., the DON indicated on the morning of Saturday 2/14/26, female CNA 5 and male CNA 10 had lifted Resident C in the shower room, as it took 2 persons to safely transfer him. CNA 10 then left and CNA 5 proceeded to give the resident his shower. When the shower was finished, CNA 5 left the shower room to get assistance to again lift the resident. At some point, Resident C started banging on things, and CNA 6, who had been standing outside of the shower room to provide oversight and privacy, entered the shower room, and Resident C and CNA 6 got into a verbal confrontation. Staff nurses 9 and 12 overheard the resident and aide cursing each other but did not witness any physical altercation. The DON indicated after that the calls and messages between her and staff happened quickly and some simultaneously. Around 11:05 a.m., before the nurses could call her, CNA 6 called her to report Resident C had hit her. The DON instructed CNA 6 to get off the hallway and to provide a written statement. The DON then spoke to the weekend supervisor, who had been attempting to contact her, and was told there was more to the story. After hearing there had been a verbal altercation to include the use of profane language from both the resident and aide, the DON gave instructions for CNA 6 to be clocked out and sent home, and the aide was suspended after she left the facility. The weekend supervisor started gathering statements from the staff who had overheard the altercation. At 11:22 a.m., CNA 6 texted the DON asking if she was fired. The DON responded by again requesting a written statement, the aide responded, yes ma'am, but never provided a statement. The DON notified the Executive Director (ED) and all necessary parties of the incident. Abuse education to staff was initiated by Weekend Supervisor 8 on 2/14/26. On Monday, 2/16/26, the DON called CNA 6 and terminated her employment. During an interview on 3/3/26 at 11:55 a.m., CNA 5 indicated one weekend Resident C had been complaining about not getting showers and she told him she would give him one. CNA 5 had left the shower room while the resident washed himself and to get the male CNA 10 to help lift the resident into his chair. When coming back down the hall, CNA 5 heard a lot of screaming, and Resident C repeated yelling for CNA 6 to get out. There had not been anyone in the shower room with Resident C, and when CNA 5 heard him yelling, she thought he had fallen and she began to run. When she rounded the hall, she saw CNA 6 at the door threshold and heard her say, OMG I thought you fell. Resident C began yelling at CNA 6, asking why she did not get in there and put him in his chair. Why don't you get your fat black African ass over here and put me in my chair. When CNA 5 told the resident that CNA 10 was on his way because he could lift him, (continued on next page)

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