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	03/27/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the implementation of adequate and consistent nutritional interventions for a dependent resident (Resident 10) which resulted in actual harm related to significant weight loss and compromised nutritional status for 1 of 2 residents reviewed for tube feeding (TF) and the facility failed to ensure a Resident, (Resident 8) who was at high risk for malnutrition was appropriately monitored for weight loss for 1 of 8 residents reviewed for nutrition monitoring.Findings include:1. On 3/23/26 at 10:28 a.m., Resident 10 was initially observed. He was reclined in a high back wheelchair in his room. His left leg was contracted and pulled tight to his chest, his left arm was also contracted and tucked to his chest. He appeared very thin and frail. A tube feeding (TF) was hung and running at a rate of 60 milliliters (ml) and was just under 600 ml from a total of 1,000 ml. His lips were dry and cracked with a thick yellowish pasty film at the corners of his lips. On 3/24/26 at 12:50 p.m. Resident 10 was not in his room and an unidentified nursing staff member indicated he was getting a shower at that time. On 3/24/26 at 1:37 p.m., Resident 10 was observed back in his room, reclined in his wheelchair with his eyes closed. His TF was not hooked up and a lunch tray of pureed food was left untouched on the bedside table just behind his wheelchair. During an interview on 3/24/26 at 1:40 p.m., Certified Nursing Aide (CNA) 16 indicated she did not know if he was NPO (nothing by mouth) but if he was, he would probably not eat his lunch tray. He used to eat some but then started just holding the food in his mouth, so his TF was his only source of food. On 3/25/26 at 10:00 a.m., a wound treatment observation was conducted. Resident 10 was disconnected from the TF to be laid in bed for the wound treatment. On 3/25/26 at 11:14 a.m., Resident 10 remained in bed after his wound dressing, and his TF was unhooked. The TF pump alarmed and flashed inactive, has been [NAME] for 10 minutes. At that time, the feeding hung was at 700 ml and the fluids hung were at just under 600 ml. On 3/25/26 at 1:33 p.m., Resident 10 remained in bed. His TF remained unhooked. The TF pump continued to alarm and flashed inactive, has been [NAME] for 10 minutes. The feeding hung remained at 700 ml and the fluids hung were at just under 600mls. On 3/25/26 at 2:03 p.m., the Facility Social Service Director (SSD) facilitated a video phone call with Resident 10's family member. The family member expressed concern for the resident's appearance, and did not realize he had lost so much weight, or that his legs were so contracted. (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
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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/24/26 at 1:14 p.m., Resident 10's record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, history of a stroke which affected his left, non-dominate side and severe-protein calorie malnutrition. A quarterly Minimum Data Set (MDS) assessment, dated 3/18/26, indicated he was totally dependent on staff to meet all activity of daily living (ADL) needs including, feeding/nutrition. Before Resident 10's hospitalization on 1/21/26 he weighed 138 lbs. Upon his return from the hospital on 1/30/26 he weighed 128.4 lbs. The record lacked documentation of Interdisciplinary Team (IDT) and/or Registered Dietician (RD) follow up after his hospitalization to address this weight loss and prevent further weight loss. Upon his return from the hospital, his TF orders were discontinued from 1/29/26 – 2/2/26 with no clear alternative nutrition plan. A NP progress note, dated 1/30/26, indicated the resident had returned from the hospital and staff were requesting he be seen for pocketing of food. Evaluated to address swallowing safety and current Nothing by Mouth (NPO) status. Swallowing difficulty had been persistent and provoked by attempts at oral intake. Symptoms relieved by NPO status. Receiving enteral nutrition per G-Tube per existing feeding orders. On 2/2/26 the physician ordered for the resident to have TF at 90 ml over 12 hours daily. A Nutrition/Dietary Note, dated 2/6/26, indicated a weight warning with a weight of 128 lbs. Dietitian note indicated aware of significant weight loss and the resident was added to clinically at risk (CAR) monitoring. A Nutrition/Dietary Note, dated 2/22/26, indicated a weight warning with a weight of 128 lbs. Dietitian note indicated aware of significant weight loss and the resident was followed weekly. On 2/24/26 he was weighed at 127.8 lbs, then on 3/2/26 he was down to 117 lbs, an 8.59% loss in one week. The record lacked documentation of a re-weight following the 3/2/26 weight, and/or that nursing notified the RD of the weight loss in writing per facility policy. On 3/5/26 the tube feed order was switched from an isosorb formula to Jevity 1.5 formula at 60 ml on continuous. The record lacked documentation of rational, gradual titration, or dietician-driven plan associated with this transition. A NP progress note, dated 3/10/26, indicated the resident was seen today per nursing request for decreased appetite. Resident was observed lying in bed with meal tray at bedside and had not consumed any food or fluids. Nursing reported resident was offered assistance with feeding but did not open his mouth. On questioning, resident stated he did not like the food provided and preferred pancakes, French toast, or meatloaf. He denied nausea, vomiting, abdominal pain, choking, or odynophagia (painful swallowing). Appetite had been decreased over the past several days per (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	nursing. Symptoms occur with each meal and were aggravated by dissatisfaction with current pureed diet. Resident remained on pureed diet due to prior aspiration noted on previous swallowing study. Recent weights show 117 lbs on 3/2/26 and 127.8 lbs on 2/24/26, indicating significant weight loss. Body Mass Index (BMI) was 15.9, consistent with severe malnutrition. Resident was currently receiving Jevity 1.5 via G-tube continuously at 60 mL/hr over 24 hours (total volume 1440 mL/day) with free water flushes at 50 mL/hr (total 1200mL/day). Given continuous enteral feeding regimen, patient may be experiencing satiety contributing to poor oral intake. He reported willingness to undergo repeat swallowing evaluation in hopes of diet advancement and agreed to consume ice cream and nutritional supplements while awaiting reassessment. Speech therapy reconsulted for repeat swallowing study. Registered Dietitian notified of significant weight loss and current tube feeding regimen for reassessment and caloric evaluation. Abdomen was soft, non-tender, nondistended. G-tube in place without erythema or drainage. Significant weight loss despite enteral nutrition raises concern for increased metabolic demand, inadequate caloric provision, malabsorption, or fluid shifts. High risk for further clinical decline.RD notified to reassess caloric needs, tube feeding rate, and timing (consider adjustment to promote oral intake if appropriate). Initiated oral supplementation (Magic Cups TID and ice cream with meals) per patient preference. Close interdisciplinary monitoring required. On 3/23/26 a new comprehensive care plan was initiated which indicated, Resident 10 had a terminal prognosis related to protein calorie malnutrition and was placed on Hospice as a result. During an interview on 3/26/26 at 1:40 p.m., with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) present, the above concerns were reviewed and discussed. The RNC indicated, Resident 10 was discussed weekly during CAR. When he first came back from the hospital, he was eating but then started to decline, so the TF were re-started. Shortly after, he started pocketing food, so he was put back to NPO and TF dependent. The dietician participated in the weekly CAR discussion over the phone, and the DON or RNC were uncertain when the last time the Dietician had been in to physically assess the resident. On 3/27/26 at 9:53 a.m., the Administrator provided a copy of current facility policy titled, Weight Assessment and Intervention, dated 8/2024. The policy indicated, Residents are weighed upon admission and at intervals established by the interdisciplinary team. any weight change of 5% or more since the last weight assessment is re-taken the next day for confirmation, if the weight is verified, nursing will immediately notify the dietician in writing. undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes. the residents target weight range. whether and to what extent weight stabilization or improvement can be anticipated. On 3/27/26 at 9:53 a.m., the Administrator provided a copy of current facility policy titled, Enteral Nutrition, dated 8/2024. The policy indicated, Adequate nutritional support through enteral nutrition is provided to residents as ordered. the dietician monitors residents who are receiving enteral nutrition, and makes appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings. the nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor he resident for worsening of condition that place the resident at risk for the above. 2. On 3/23/2026 at 10:03 a.m. Resident 8 was observed as she lay in bed resting with her eyes closed. She appeared to be thin and petite but not to the point of frailty. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/24/26 at 12:54 p.m. Resident 8's medical record was reviewed. She was a memory care Resident whose diagnoses included but were not limited to dementia and malnutrition. Resident 8 was admitted to the facility on [DATE]. A Nurse Practitioners (NP) note, dated 2/17/26, indicated Resident 8 was being admitted to the facility for nutritional monitoring, among other things. That note indicated the NP wanted the clinical staff to obtain weights weekly. The record lacked an order for weekly weights at that time. Resident 8 had a recorded weight of 79 pounds on 2/17/26. An NP note dated 2/20/26 indicated they wanted the clinical staff to continue to obtain weights weekly for Resident 8. The record lacked an order for weekly weights at that time. A Clinical at Risk (CAR) (predictive models or assessment tools used in medicine to identify patients with a higher likelihood of adverse outcomes) assessment dated [DATE] indicated the dietician added fortified foods and would follow up with a full nutritional assessment. On 2/24/26 a nutritional risk assessment was done for Resident 8. That assessment indicated Resident 8 weighed 91 pounds at the hospital on 2/5/26, which meant she had a significant weight loss of 12 pounds or 13% in less than one month. In the dietician note section the dietician indicated the plan for Resident 8 was to start offering 4-ounce mighty shakes (a nutritional supplement) once a day, clinical staff will monitor weights weekly and she would be followed weekly in CAR. The dietician considered Resident 8 to be at high risk for malnutrition. A CAR assessment, dated 2/27/26, indicated Resident 8's Body Mass Index (BMI) was very low and no weekly weights had been obtained yet. The record lacked an order for weekly weights at that time. Resident 8 had a recorded weight of 104.2 pounds on 3/5/26. A CAR assessment, dated 3/6/26, indicated the dietician had requested clinical staff reweigh Resident 8 due to a significant weight gain of 31.9% in two weeks. The note indicated the resident's eating habits had not changed since the previous assessment. A CAR assessment, dated 3/13/26, indicated there were no new weights obtained since the last assessment. The dietician requested the clinical staff reweigh Resident 8 to confirm or deny the significant weight gain. A CAR assessment, dated 3/20/26, indicated there were no new weights obtained since the last assessment. The dietician requested the clinical staff reweigh Resident 8 to confirm or deny the significant weight gain. Resident 8 had a recorded weight of 192.8 pounds on 3/22/26. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident 8 discharged to her home from the facility on 3/26/26. The record lacked evidence of oversight and appropriate monitoring of Resident 8's weight and nutritional status. Appropriate weekly weights were never ordered, reweights to confirm or deny significant weight changes were not obtained, and discrepancies in nutritional and weight status were not resolved prior to Resident 8 discharging to her home from the facility. On 3/27/26 at 11:18 a.m. the Director of Nursing (DON) indicated she was unaware Resident 8's weights were so off. She indicated had she known she would have had the staff get a reweight immediately and reevaluate the plan for the Residents nutritional status with the dietician and provider. On 3/27/26 at 9:53 a.m., the Administrator provided a copy of current facility policy titled, Weight Assessment and Intervention, dated 8/2024. The policy indicated, Residents are weighed upon admission and at intervals established by the interdisciplinary team. any weight change of 5% or more since the last weight assessment is re-taken the next day for confirmation, if the weight is verified, nursing will immediately notify the dietician in writing. undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation includes. the residents target weight range. whether and to what extent weight stabilization or improvement can be anticipated. 410 IAC (Indiana Administrative Code) 16.2-3.1-46

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure dependent residents were provided with assistance to maintain their necessary activities of daily living (ADLs) for 5 of 6 residents reviewed for ADLs (Residents 70, 73, 78, 97, and 10). Findings include:1. During an observation, on 3/23/26 at 10:22 a.m., Resident 70 was observed lying in bed. The fingernails on the resident's left hand were long and untrimmed, with dark debris underneath them. The resident had a full beard and mustache with food debris observed in the beard. During an observation, on 3/24/26 at 12:09 p.m., Resident 70 was observed lying in bed. The resident's fingernails on the left hand remained long and untrimmed, with dark debris underneath them. During an observation, on 3/25/26 at 9:18 a.m., the Resident 70 was observed lying in bed with food debris observed in his beard. During an observation, on 3/25/26 at 9:50 a.m., the Resident 70 was observed lying in bed with food debris in his beard. The resident's fingernails on the left hand remained long and untrimmed, with dark debris underneath them. Resident 70's record was reviewed on 3/25/26 at 2:26 p.m. Diagnoses on the resident's profile included, but were not limited to, personal history of traumatic brain injury. An annual Minimum Data Set (MDS) assessment, dated 2/5/26, indicated the resident had a severe cognitive impairment, required partial/moderate staff assistance for eating, substantial/maximal assistance from staff for personal hygiene, and lacked documentation the resident exhibited behaviors during the look back period, including rejection of care. A care plan, last revised on 2/9/26, indicated the resident had an ADL self-care performance deficit related to impaired mobility. Interventions included, but were not limited to, the resident required substantial/maximal staff assistance with personal hygiene and dependent on staff assistance for bathing. Progress notes, dated 2/23/26 to 3/25/26, lacked documentation the resident was offered, provided, or refused fingernail care. The progress notes lacked documentation the resident refused to have food debris removed from his beard. A treatment administration record (TAR), dated March 2026, indicated the resident was monitored for a behavior of care refusal. The TAR indicated the resident had zero occurrences of the monitored behavior. A bathing schedule was observed in the task section of the electronic record. The schedule indicated the resident was scheduled for bathing on Mondays and Thursdays on night shift. The log indicated the resident received eight baths during the last 30 days as scheduled and lacked documentation the resident refused bathing. Shower sheets indicated the resident received a bath or a shower on 3/2/26, 3/5/26, 3/9/26, 3/12/26, 3/16/26, 3/19/26, and 3/23/26. The shower sheets lacked documentation fingernail care was offered, provided, or refused with the bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation, on 3/23/26 at 1:10 p.m., Resident 73 was observed up in the wheelchair, waiting in line to go outside to smoke. There was a large puddle of urine observed under the resident's wheelchair, and a foul body odor was noted. During an observation, on 3/24/26 at 12:13 p.m., Resident 73 was observed up in his wheelchair. The resident's fingernails on both hands were long and untrimmed, with dark debris underneath them. During an observation, on 3/24/26 at 1:37 p.m., Resident 73 was observed up in his wheelchair. The resident's fingernails on both hands were long and untrimmed, with dark debris underneath them. During an observation, on 3/25/26 at 9:11 a.m., Resident 73 was observed up in his wheelchair. The resident's fingernails on both hands were long and untrimmed, with dark debris underneath them. Resident 73's record was reviewed on 3/26/26 at 10:09 a.m. Diagnoses on the resident's profile included, but were not limited to, unspecified schizophrenia (a chronic, severe brain disorder that distorts how a person thinks, feels, acts, and perceives reality). A care plan, last revised on 1/16/26, indicated the resident had an ADL self-care performance deficit related to activity intolerance. Interventions included, but were not limited to, the resident was dependent on staff assistance for personal hygiene and bathing/showering. Progress notes, dated March 2026, lacked documentation the resident was offered, provided, or refused fingernail care. A behavior log, included in the task section of the electronic record, indicated the resident had not refused care during the last 30 days. A bathing log, included in the task section of the electronic record, indicated the resident was scheduled for bathing on Mondays and Thursdays on night shift. The log indicated the resident received 7 baths, and refused 1 bath, during the last 30 days. Shower sheets indicated the resident was bathed on 3/2/26, 3/5/26, 3/9/26, 3/12/26, 3/16/26, 3/19/26, and 3/23/26. The shower sheets lacked documentation the resident was offered, provided, or refused fingernail care with the baths. 3. During an observation, on 3/23/26 at 11:28 a.m., Resident 78 was observed lying in bed. The resident's fingernails on her right hand were long and untrimmed with dark debris underneath them. During an interview, on 3/23/26 at 1:55 p.m., Resident 78's family member indicated they had observed the resident's fingernails to be long and dirty at times. During an observation, on 3/24/26 at 11:43 a.m., Resident 78 was observed lying in bed. The resident's fingernails on her right hand remained long and untrimmed with dark debris underneath them. During an observation, on 3/24/26 at 1:39 p.m., Resident 78 was observed up in her wheelchair. The resident's fingernails on her right hand remained long and untrimmed with dark debris underneath them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 3/25/26 at 8:59 a.m., Resident 78 was observed lying in bed. The resident's fingernails on her right hand remained long and untrimmed with dark debris underneath them. Resident 78's record was reviewed on 3/26/26 at 12:15 p.m. Diagnoses on the resident's profile included, but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain tissue of oxygen and nutrients) unspecified severity with other behavioral disturbance. An admission Minimum Data Set (MDS) assessment, dated 1/30/26, indicated the resident had a moderate cognitive impairment, was dependent on staff assistance for showering/bathing and personal hygiene, and lacked documentation the resident refused care. A care plan, last revised on 2/2/26, indicated the resident had an ADL self-care performance deficit related to activity intolerance. Interventions included, but were not limited to, the resident was dependent on staff assistance for personal hygiene and bathing/showering. Progress notes, dated March 2026, lacked documentation the resident was offered, refused, or provided fingernail care. A shower schedule, dated 3/26/26, indicated the resident was scheduled for bathing on Tuesdays and Saturdays on night shift. Shower sheets indicated the resident was bathed on 3/3/26, 3/7/36, 3/10/26, 3/14/26, 3/17/26, 3/21/26, and 3/24/26. The shower sheets lacked documentation fingernail care was offered, provided, or refused with the baths. 4. During an observation, on 3/23/26 at 10:54 a.m., Resident 97's fingernails on both hands had dark debris underneath them. During an observation, on 3/24/26 at 12:14 p.m., Resident 97's fingernails on both hands had dark debris underneath them. During an observation, on 3/25/26 at 9:10 a.m., Resident 97's fingernails on both hands had dark debris underneath them. Resident 97's record was reviewed on 3/26/26 at 1:53 p.m. Diagnoses on the resident's profile included, but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain tissue of oxygen and nutrients) mild with other behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 3/7/26, indicated the resident was cognitively intact, was dependent on staff assistance for showering/bathing and personal hygiene, and lacked documentation the resident refused care. A care plan, last revised on 12/9/25, indicated the resident had an ADL self-care performance deficit related to decreased mobility. Progress notes, dated March 2026, lacked documentation the resident was offered, provided, or refused fingernail care. Interventions included, but were not limited to, the resident was dependent for (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal hygiene and showering/bathing. A shower log, included in the task section of the electronic record, indicated the resident was scheduled for bathing on Tuesdays and Fridays on night shift. The log indicated the resident received 8 baths in the last 30 days and lacked documentation the resident refused bathing. During an interview, on 3/26/26 at 10:46 a.m., the Director of Nursing (DON) indicated fingernail care should have been done with showers and as needed. Food should have been cleaned from a resident's beard after they were done eating. If a resident refused care, the aides should have notified the nurse, and the nurse should have documented it in the notes. During an interview, on 3/26/26 at 1:30 p.m., Qualified Medication Aide (QMA) 9 indicated fingernail care should have been provided with showers and as needed. If a resident was diabetic, the nurse had to do fingernail care, but it still should have been done on scheduled shower days. If a resident refused care they re-attempted three times and notified the nurse. The aides were able to document refusals in the task section, and the nurse should have documented refusals in their notes. 5. On 3/23/26 at 10:28 a.m., Resident 10 was initially observed. He was reclined in a high back wheelchair in his room. His left leg was contracted and pulled tight to his chest, his left arm was also contracted and tucked to his chest. He appeared very thin and frail. He was unable to answer questions and just stared blankly. He was dressed in only a hospital gown, he had a bushy beard, and long thick fingernails with debris under them. On 3/24/26 at 12:58 p.m., Resident 10 received a shower. On 3/24/26 at 1:37 p.m., Resident 10 was observed back in his room after his shower. His bear remained overgrown and bushy, his fingernails remained long and had debris under them. On 3/25/26 at 2:03 p.m., the Facility Social Service Director (SSD) facilitated a video phone call with Resident 10's family member. She expressed concern for his appearance, and did not realize he had lost so much weight, or that his legs were so contracted. On 3/24/26 at 1:14 p.m., Resident 10's record was reviewed. He was a long-term care resident with diagnoses which included, history of a stroke that affected his left non-dominate side. A quarterly Minimum Data Set (MDS) assessment, dated 3/18/26, indicated he was totally dependent on staff for all ADLs, including personal hygiene and grooming. He had a comprehensive care plan, revised 3/6/26, which indicated he had an ADL self-care performance deficit related to his diagnoses and was dependent on staff for all ADL care. On 3/26/26 at 2:50 p.m., the Administrator provided a copy of current facility policy titled, Activities of Daily Living (ADLs), Supporting, dated 8/2024. The policy indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observations, interviews, and record reviews, the facility failed to complete a side rail assessment for 4 of 7 residents reviewed for the potential for accidents (Residents 29, 52, 54, and 20). B. Based on observations and interviews, the facility failed to ensure sliding glass doors were appropriately bolted shut in the memory care unit. This deficient practice had the potential to affect 29 of 29 Residents who resided in the memory care unit. Findings include:A1. On 3/23/26 at 10:00 a.m., Resident 29 was observed lying in bed with quarter (1/4) side rails on both sides of his bed. Resident 29 indicated he used the rails to move about in bed. On 3/26/26 at 12:17 a.m., a record review was completed for Resident 29. He had the following diagnoses which included, but were not limited to, chronic respiratory failure, low back pain, and obesity. He had a side rail assessment, dated 1/25/25, which indicated he did not have side rails on his bed. On 3/26/26 the Director of Nursing (DON) was made aware and she placed an order in his record, .per resident request, resident prefers to have the upper siderails in the up position for convenience of positioning and hanging his remote. On 3/27/26 at 10:13 a.m., the DON indicated he probably changed his mind at some point to have the rails and they just added them. 2. On 3/23/26 at 10:15 a.m., Resident 52 was observed lying in bed with 1/4 side rails on both sides of his bed. On 3/27/26 at 9:51 a.m. a record review was completed for Resident 52. He had the following diagnoses which included, but were not limited to, hypothyroidism, vitamin D deficiency, and age-related cataract. His record had an overdue side rail assessment dated [DATE]. 3. On 3/23/26 at 10:30 a.m., Resident 54 was sitting up in his bed. His bed linens were soiled with a red substance. He had 1/4 side rails on his bed. On 3/24/26 at 12:19 a.m., a record review was completed for Resident 54. He had the following diagnoses which included, but were not limited to, post-traumatic stress disorder, hypertension, seizures, and heart failure. His record had an overdue side rail assessment dated [DATE]. 4. On 3/23/26 at 10:00 a.m. Resident 20 was observed as he lay in bed resting with his eyes closed. He appeared to have limited range of motion due to contracted extremities (permanent or severe tightening of muscles, tendons, ligaments, or skin, causing rigid, bent joints and limited movement). Resident 20 had a quarter side rail on the left side of the bed. On 3/25/26 at 3:08 p.m. Resident 20's medical record was reviewed. He was a memory care resident (continued on next page)

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Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whose diagnoses included, but were not limited to, dementia and traumatic brain injury. As part of the most recent quarterly nursing evaluation a side rail assessment was done on 3/17/26. That assessment indicated Resident 20 did not have any side rails on his bed. As part of a quarterly nursing evaluation a side rail assessment was done on 3/1/26. That assessment indicated it was recommended Resident 20 have bilateral side rails on his bed. On 3/27/26 at 10:21 a.m., the [NAME] President of Clinical Operations (VPCO) indicated they did side rail assessments quarterly. They would have done an assessment at the end of the month. The bedside nurses complete the quarterly assessments. On 3/26/26 at 2:42 p.m., a policy titled, Bed Safety and Bed Rails, was provided by the Executive Director (ED). It indicated, .Prior to the installation or the use of a side or bed rail, alternatives to the use of side or bed rails are attempted.If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the used of bed rails. B. On 3/23/26 at 11:30 a.m. the sliding glass door in room [ROOM NUMBER] on the memory care unit was observed. Upon pulling on the door handle the top of the door opened approximately 1 to 2 inches, wide enough to stick a hand or small arm through. There were multiple rooms that had sliding glass doors like the one in room [ROOM NUMBER], but they did not budge when pulled on. On 3/27/26 at 10:04 a.m. the sliding glass door in room [ROOM NUMBER] of the memory care unit was observed again. No apparent change had been made to the door. Maintenance had been observed going on and off the unit several different times across several different days. On 3/27/26 at 10:11 a.m. Licensed Practical Nurse (LPN) 10 indicated clinical staff check the main locked doors regularly but they didn't do any checks of the sliding glass doors. She believed maintenance handled checking those doors. On 3/27/26 at 10:20 a.m. the memory care Unit Manager (UM) indicated during their angel rounds they went around and looked at the doors and checked for broken blinds of cracks, but they did not check to see if they could be opened or not. She indicated the opening was wide enough for someone to get a hand in it and potentially smash it, this concerned her greatly and she immediately had clinical staff go around to check all of the doors. She indicated she planned to speak with maintenance about this issue and came up with a plan to ensure they will be checked routinely from now on. On 3/27/26 at 10:37 a.m. the Maintenance Director indicated he added a screw to the top of the door in room [ROOM NUMBER] to prevent the top corner of the door from moving. He indicated there was supposed to be a screw at the top and bottom of all the sliding glass doors to prevent them from opening, he wasn't sure what happened to the screw in the top of the door in room [ROOM NUMBER]. He also indicated because of the issue with that door they will be implementing annual checks of all sliding glass doors in the memory care unit, he indicated before this issue came up they did not have regular checks in place they only fixed things as the need arose. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity during interactions with staff and dining for 2 of 2 residents reviewed for dignity (Resident 87 and 112). Findings include: 1. During an observation, on 3/23/26 at 11:34 a.m., Resident 87 was repetitively and loudly yelling in the hallway. Licensed Practical Nurse (LPN) 6 sternly told the resident, I'm going to assist you, but you're still yelling in the hallway for no reason. Resident 87 continued to yell. The staff was not observed to attempt to find out why the resident was yelling or provide a targeted intervention. During an observation, on 3/23/26 at 11:50 a.m., Resident 87 was observed repeatedly calling out for help for several minutes. The Administrator had approached the resident, and then indicated the resident had been incontinent and was wet. Two nurse aides were present at the nurses' station but did not approach the resident or address the resident's calls for help. At the same time, the resident indicated he was upset, kicked a soiled shirt, and indicated he was wet. The resident was observed to have a wet spot on the front of his sweatpants. During an interview, on 3/23/26 at 1:04 p.m., Resident 87 indicated the staff did not treat him with respect and dignity, and they did not follow his instructions. The resident indicated earlier, when he started yelling, he needed assistance to get to his urinal, but the staff was not helping. He was frustrated because they were not helping him. When he was unable to access his urinal, he peed his pants, because he was not able to wait. He was then yelling because he wanted to get help getting changed. The resident indicated the nurse was not nice to him when he was yelling, and this was not unusual. The resident indicated it made him feel bad when the staff spoke to him that way. Resident 87's record was reviewed on 3/27/26 at 9:27 a.m. Diagnoses on the resident's profile included, but were not limited to, dementia (progressive decline in memory, thinking, and cognitive skills severe enough to interfere with daily life). A quarterly Minimum Data Set (MDS) assessment, dated 2/12/26, indicated the resident was cognitively intact, dependent on staff assistance for personal hygiene, and frequently incontinent of bladder. A care plan, last revised on 11/4/25, indicated the resident had behaviors of becoming physically and verbally aggressive, urinating on the floor, and verbal aggression towards staff. Interventions included, but were not limited to, assess and anticipate the resident's needs including toileting and redirect the resident with non-pharmacological interventions to enhance his quality of life including offering to converse about him working in a hotel, used to play tennis, ride bikes, going outdoors, chess, offering the resident to watch television, attend church services, and socialization. A care plan, last revised on 2/13/26, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to decreased mobility. Interventions included, but were not limited to, dependent for toileting hygiene and personal hygiene. A care plan, last revised on 2/13/26, indicated the resident had bladder incontinence related to decreased mobility. Interventions included, but were not limited to, supply resident with toileting devices as appropriate including a urinal and check routinely for incontinence and change clothing as needed after incontinence episodes. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/27/26 at 11:04 a.m., the Social Services Director (SSD) indicated if a resident was approached by the staff in a negative manner, the resident was more likely to respond in a negative way. The approaches used by staff affected the resident's response. The SSD indicated for this resident, the nurse speaking to him in the way she did was not likely to help the resident calm down or de-escalate the situation. The staff should have used interventions included on the resident's care plans when he was yelling. The SSD indicated the resident was very religious and talking with him about his religion was helpful. The resident could also be re-approached at a later time, or the Director of Nursing (DON) or SSD could have been asked to help with the resident if needed. On 3/27/26 at 12:15 p.m., the Administrator provided a document titled, .Dignity, last revised in August 2024, and indicated it was the policy currently being used by the facility. The policy indicated, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times. 2. On 3/23/26 from 12:00 p.m. until 12:30 p.m. the following was observed during a dining observation. At 12:00 p.m. staff began to pass lunch trays in random order to the residents gathered in the dining room, so that some residents were left waiting while their tablemates ate. At one table, where four residents sat, two residents were served, while the other two waited. By the time they were served their other two tablemates had already eaten and left the table. At 12:09 p.m., Resident 112's lunch plate was set in front of her. She was reclined in a Broda chair, had slid down, was leaning to her left side, and her head nearly resting on the armrest of the chair. Two unidentified staff members, pulled her away from the table, and attempted to reposition her by using the hoyer pad that was under her. The Assistant Director of Nursing and one of the nursing aides, removed her from the dining room, leaving her lunch plate at the table. At 12:18 p.m., Resident 112 was returned to the dining room at her place at the table where her plate remained. When staff attempted to help feed her, she refused to take bites. No one offered to warm the plate up, or offer her an alternative. An unidentified nursing aide, attempted to help Resident 112 eat, by standing and leaning over her and resting her forearms on the table. She talked to another aide and did not engage or look at the Resident. She did not make meaningful attempts to encourage Resident 112 to eat. After a few quick attempts, she left the resident to gather discarded meal tickets. At 12:30 p.m., Resident 112 was removed from the dining room, after not eating or being offered alternatives. On 3/24/26 at 10:13 a.m., Resident 112's record was briefly reviewed. She had diagnoses which included, but were not limited to, cerebral palsy. She had a quarterly Minimum Data Set (MDS) assessment, dated 3/13/26, indicated she was totally dependent on staff for all activities of daily living (ADLs) including nutrition and eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/26 at 12:15 p.m., the Administrator provided a copy of current facility policy titled, Dignity, dated 8/2024. The policy indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. allowed to choose when to sleep, eat and conduct activities of daily living; and. provided with a dignified dining experience. 410 IAC (Indiana Administrative Code) 16.2-3.1-3.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure call lights were kept within the residents' reach for 3 of 3 residents reviewed for call lights (Residents 70, 78, and 6). Findings include:1. During an observation, on 3/23/26 at 10:24 a.m., Resident 70 was observed lying in bed. The resident's call light was on the floor behind the head of the bed. There was no call light within the resident's reach. Resident 70's record was reviewed on 3/25/26 at 2:26 p.m. Diagnoses on the resident's profile included, but were not limited to, personal history of traumatic brain injury and aphasia (a communication disorder resulting from brain damage that impairs a person's ability to speak, understand, read, and write). An annual Minimum Data Set (MDS) assessment, dated 2/5/26, indicated the resident had a severe cognitive impairment and was dependent on staff assistance for most activities of daily living (ADLs). A care plan, last revised on 11/20/25, indicated the resident had a communication speech/language deficit related to aphasia and spoke non-sensical sentences and statements. Interventions included, but were not limited to, ensure and provide a safe environment including the resident's call light being kept within reach. A care plan, last revised on 2/9/26, indicated the resident was at risk for falls related to impaired mobility. Interventions included, but were not limited to, keep the resident's call light within reach. 2. During an observation, on 3/23/26 at 11:28 a.m., Resident 78 was lying in bed. The resident's call light was on the floor, between the bed and the wall. At the same time, the resident indicated she was not sure how she would call for help if needed because she was not sure where her call light was. During an observation, on 3/24/26 at 11:43 a.m., Resident 78 was lying in bed. The resident's call light was draped across the foot of the bed, hanging over the side approximately eight inches, and was not within the resident's reach. At the same time, the resident indicated she did not know where her call light was and did not think the staff had given it to her yet. During an observation, on 3/25/26 at 8:59 a.m., Resident 78 was observed lying in bed. The resident's call light was hanging over the foot of the bed and not within the resident's reach. At the same time, the resident indicated she was not sure where her call light was, and no one had given her the call light today. The resident indicated it bothered her not to have her call light within reach because without it, she had to yell for help when she needed it. Resident 78's record was reviewed on 3/26/26 at 12:15 p.m. Diagnoses on the resident's profile included, but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain tissue of oxygen and nutrients) unspecified severity with other behavioral disturbance. An admission Minimum Data Set (MDS) assessment, dated 1/30/26, indicated the resident had a moderate cognitive impairment and was dependent on staff assistance for showering/bathing and personal hygiene. A care plan, last revised on 2/2/26, indicated the resident was at risk for falls and fall related injuries. Interventions included, but were not limited to, keep the resident's call light within reach and encourage the resident to use it. 3. During an observation, on 3/23/26 at 12:52 p.m., Resident 6 was observed lying on a mattress next to the bed. The resident's call light was between the bed and the wall, and not within the resident's reach. Resident 6's record was reviewed on 3/24/26 at 11:33 a.m. Diagnoses on the resident's profile included, but were not limited to, unspecified altered mental status. A quarterly Minimum Data Set (MDS) assessment, dated 3/11/26, indicated the resident was cognitively intact. A care plan, last revised on 1/16/26, indicated the resident was at risk for falls and injury related to decreased mobility. Interventions included, but were not limited to, keep the resident's call light within reach. During an interview, on 3/26/26 at 1:30 p.m., Qualified Medication Aide (QMA) 9 indicated residents should have always had their call lights within their reach in their rooms. Staff should have made sure the call lights were within the residents' reach before the staff left the residents' room. During an interview, on 3/26/26 at 2:04 p.m., the Director of Nursing (DON) indicated call lights should have been placed within the residents' reach before staff left their room. On 3/27/26 at 9:11 a.m., the Administrator provided a document titled, .Answering the Call Light, last (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised in August 2024, and indicated it was the policy currently being used by the facility. The policy indicated, .General Guidelines.5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interviews and record reviews, the facility failed to ensure residents had orders for desired advance directives for two residents (Residents 75 and 113) and failed to ensure a Physician Order for Scope of Treatment (POST) form was appropriately filled out for a resident (Resident 3) for 3 of 5 residents reviewed for advanced directives.Findings include:1. On 3/26/26 at 11:43 a.m., a record review was completed for Resident 75. He had the following diagnoses which included, but were not limited to, cerebral infarction (stroke), aphasia (difficulty speaking), dementia, major depressive disorder, anxiety disorder and insomnia. His record lacked an order indicating he desired to have a full code status in the event of a cardiac arrest. He had a care plan, dated 3/4/26, indicating he wished to be a full code. The goal, dated 3/4/26, indicated that his wishes would be honored. 2. On 3/23/26 at 11:57 a.m., a record review was completed for Resident 113. She had the following diagnoses which included, but were not limited to, multiple fractures of the ribs, essential hypertension (HTN), hyperlipidemia (high cholesterol), generalized anxiety disorder, depression, insomnia, and muscle weakness. Her record lacked an order indicating she desired to have a full code status in the event of a cardiac arrest. She had a care plan, dated 3/3/26, indicating she wished to be a full code. The goal, dated 3/4/26, indicated her wishes would be honored. On 3/27/26 at 10:05 a.m., the Director of Nursing (DON) indicated she added orders for the two residents. 3. On 3/26/26 at 10:39 a.m. Resident 3's medical record was reviewed. She was a memory care resident whose diagnoses included, but were not limited to, dementia. Resident 3's medical record indicated her daughter was her Power of Attorney (POA). Resident 3 had a POST form that had been uploaded to her medical record. Upon review of this form, it was found that the form was filled out incorrectly. At the top of the form in the section labeled Patient Last Name, Patient First Name and Middle Initial Resident 3's daughter's name had been written which would have indicated the POST form was for the Resident 3's daughter not the Resident. On 3/27/26 at 11:18 a.m. the Director of Nursing (DON) indicated the POST form was more than likely filled out in error by Resident 3's daughter and it wasn't caught before being uploaded. She indicated they would reach out to the Resident's daughter to have her sign a new POST form immediately. A policy titled, Advanced Directives revised on 8/24 was provided by the Executive Director (ED) on 3/26/26 at 2:42 p.m. It indicated, .The resident has the right to formulate an advance directive, including the right to accept of refuse medical or surgical treatment. Advanced directives are honored (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in accordance with state law and facility policy. 410 IAC (Indiana Administrative Code) 16.2-3.1-4(1)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a medication disposition for residents' medications when discharged from the facility for 2 of 2 records reviewed for discharge (Residents 120 and 119).Findings include:1. On 3/24/26 at 11:37 a.m., a record review was completed for Resident 120. She was discharged from the facility on 2/27/26. The resident's record lacked documentation upon discharge of the disposition of the following medications:magnesium oxide (a supplement) 400 milligram (mg)Trintellex (used to treat depression) 20 mgferrous sulfate (a supplement) 325 mgnaloxone (a lifesaving non-controlled opioid antagonist) 0.4 mgmethocarbamol (a muscle relaxer)1000 mgpantoprazole (used to treat acid reflux) 40 mgglycolax powder (use to treat constipation)acetaminophen (used to treat pain) 500 mgsenna-docusate (used to treat constipation) 8.6-50 mggabapentin (used to treat pain) 600 mgtorsemide (a diuretic)10 mgondansetron (used to treat nausea and vomiting) 4 mgloperamide (used to treat diarrhea) 2 mgdulcolax (used to treat constipation) 10 mgMilk of Magnesia (used to treat constipation) 30 ml2. On 3/24/26 at 12:36 a.m., a record review was completed for Resident 119. He was discharged from the facility on 2/28/26.The resident's record lacked documentation upon discharge of the disposition of the following medications:Risperdal (an antipsychotic) 0.5 milligram (mg)vitamin (a supplement) B12 1000mcg (microgram)metoprolol 12.5 mg (used for high blood pressure)lisinopril (used for high blood pressure) 10mgMilk of Magnesia 30 ml (used to treat constipation)methimazole (used to treat hypothyroidism) 5 mgfurosemide (a diuretic) 20 mgamlodipine (used to treat high blood pressure) 10 mgsennosides-docusate (used for constipation) 8.6 mg-50 mgacetaminophen (pain reliever) 325 mgEliquis (a blood thinner) 5 mgomega 3 [NAME] oil (a supplement) 500 mgcholecalciferol (a supplement)1000 u (unit)mirtazepine (an antidepressant) 7.5 mgDuring an interview with the [NAME] President of Clinical Services (VPCS) on 3/27/26 at 11:13 a.m., he indicated the resident's medications were sent back to the pharmacy and they were destroyed. He indicated he had no record of the destruction.On 3/26/26 at 9:51 a.m., the Director of Nursing (DON) received an email from the pharmacy indicating they could not find where the two residents had any of their medications returned to the pharmacy.A policy titled, Discarding and Destroying Medications, with a revision date of 8/24 was provided by the Executive Director (ED) on 3/26/26 at 2:14 p.m. It indicated, .non-controlled and schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guideline regarding disposition of non-hazardous medications.The medication disposition record contains, at a minimum, the following information: h. the resident's name, i. the name and strength of the medication, j. the prescription number, k. the name of the dispensing pharmacy, l. date medication destroyed, m. the quantity destroyed, n. the method destroyed, o. reason for destruction, p. signature of witnesses.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's Minimum Data Set (MDS) assessment was accurate for 1 of 18 residents' MDS assessments reviewed (Resident 78). Findings include:During an observation, on 3/23/26 at 11:28 a.m., Resident 78 was lying in bed. The resident's left hand was closed, and she was unable to open or move it. Resident 78's record was reviewed on 3/26/26 at 12:15 p.m. Diagnoses on the resident's profile included, but were not limited to, hemiplegia (near paralysis on one side) and hemiparesis (weakness or limitation in movement on one side) following a nontraumatic subarachnoid hemorrhage (a type of stroke caused by bleeding into the space surrounding the brain) affecting the left non-dominant side. An admission MDS assessment, dated 1/30/26, indicated the resident did not have a limitation in range of motion to the upper or lower extremities. During an interview, on 3/26/26 at 12:57 p.m., the MDS Coordinator indicated the resident's admission MDS assessment, dated 1/30/26, was not coded correctly. The assessment should have indicated the resident had an impairment on one side of the upper extremities. The MDS Coordinator indicated the facility used the Resident Assessment Instrument (RAI) manual as their facility policy for completing MDS assessments. The Centers for Medicare and Medicaid [NAME] (CMS) RAI manual 3.0, dated October 2025, indicated, .GG0115: Functional Limitation in Range of Motion.Coding Instructions for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand).Code 1, impairment on one side: if resident has an upper.extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(c)(4)

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	03/27/2026

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's Pre-admission Screening and Resident Review (PASRR) (a federal Medicaid requirement ensuring individuals with serious mental illness or intellectual disabilities are not inappropriately placed in nursing homes) was re-evaluated when a psychiatric diagnosis was added for 1 of 2 residents reviewed for PASRR (Residents 78 and 11). Findings include:1. Resident 78's record was reviewed on 3/26/26 at 12:15 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, psychotic disorder (a mental health condition characterized by a loss of contact with reality, where individuals struggle to distinguish what is real from what is not) with delusions (firm, fixed, and false beliefs that persist despite clear evidence to the contrary and are not explained by a person's cultural or religious background) due to a known physiological condition, dated 1/23/26, and psychotic disorder with hallucinations (a false perception of objects or events involving the senses) due to a known physiological condition, dated 1/30/26. A PASRR Level One Screening Outcome, dated 10/18/21, was completed at another nursing facility. The screening indicated the resident did not have a serious mental illness, and level two PASRR an in-depth, person-centered assessment required when a Level I screen indicates a person applying to a Medicaid-certified nursing facility may have a serious mental illness, intellectual disability, or related condition was not required). The resident's record lacked documentation the resident was referred for a new PASRR assessment when the psychotic disorder diagnoses were added. Physician's orders indicated the resident received psychotropic medications including Depakote (mood stabilizer), trazodone (antidepressant), and buspirone (anti-anxiety medication). During an interview, on 3/26/26 at 12:55 p.m., the [NAME] President (VP) of Life Enrichment indicated she reviewed the resident's record, and the resident needed reassessed for the consideration of a level two PASRR. The resident had a new psychotic disorder diagnosis which required reassessment. During an interview, on 3/27/26 at 11:04 a.m., the Social Services Director (SSD) indicated she thought the psychotic disorder diagnosis was on the resident's record when she was admitted to the facility from another nursing facility. The resident was on the list to be referred for a new PASRR assessment due to the diagnosis, but it had not been completed yet. The SSD was not sure how long from the time of admission they had to complete the referral.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review the facility failed to ensure a fall care plan was appropriately revised to reflect new fall interventions to be in place after several falls. This deficient practice had the potential to affect 1 of 7 Residents (Resident 12) reviewed for care plan revision.Findings include:On 3/25/26 at 12:01 p.m. Resident 12's medical record was reviewed. He was a memory care resident whose diagnoses included, but were not limited to, dementia and schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms with major mood episodes).An Interdisciplinary Team (IDT) note, dated 8/27/25, indicated on that day Resident 12 had fallen out of bed while he was changing positions. The new intervention to be put in place to prevent future falls was to refer the Resident to Occupational Therapy (OT) for an evaluation on his bed mobility. The note indicated Resident 12's care plan had been reviewed and updated.Resident 12's current fall care plan lacked the new fall intervention from his fall on 8/27/25.An IDT note, dated 10/13/25, indicated on 10/11/25 Resident 12 had fallen in the bathroom. The new intervention to be put in place to prevent future falls was to have Physical Therapy (PT) work with the Resident on dynamic functional transfers to improve safety awareness. The note indicated Resident 12's care plan had been reviewed and updated.Resident 12's current fall care plan lacked the new fall intervention from his fall on 10/11/25.An IDT note, dated 10/16/25, indicated on 10/15/25 Resident 12 had fallen in the activity room. The new intervention to be put in place to prevent future falls was to have PT work with the resident on lower extremity strength. The note indicated Resident 12's care plan had been reviewed and updated.Resident 12's current fall care plan lacked the new fall intervention from his fall on 10/15/25.An IDT note, dated 10/29/25, indicated on that day Resident 12 had fallen in his room trying to go to the bathroom. The new intervention to be put in place to prevent future falls was to have PT work with the Resident on bed mobility. The note indicated Resident 12's care plan had been reviewed and updated.Resident 12's current fall care plan lacked the new fall intervention from his fall on 10/29/25.On 3/27/26 at 12:00 p.m. a copy of a current facility policy titled, Care Plans, Comprehensive Person-Centered, dated 8/2024, was provided. That policy indicated, .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.410 IAC (Indiana Administrative Code) 16.2-3.1-35(c)(1)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure orders were in place and implemented to properly monitor, flush, and secure a resident's G-tube, for 1 of 2 residnets reviewed for tube feeding, (Residnet 95)Findings include:On 3/23/26 at 10:30 a.m. Resident 95 was observed in bed wearing a hospital gown. She indicated she had a G-tube but expressed a desire to have it removed due to irritation and pain. She reported the tube was no longer used.On 3/26/26 at 10:57 a.m., Resident 95's g-tube and incersion cite was observed with Licensed Practical Nurse (LPN) 17. Insertion site noted to have cut gauze; resident reported discomfort, bloating, and pain. LPN 17 indicated, the only order related to the g-tube was to put [NAME] Oxide at the insertion cite. She did not know why the tube was so long, and indicated nurses had not been flushing the tube because there were no orders. She observed the tube and indicated she was not sure why it was clouded, or what could be in the tube.On 3/26/26 at 11:15 a.m., Resident 95's G-tube was observed with the Regional Nurse Consultant. He indicated the tube was excessively long and he had to pull it out from between her thighs. He observed the insertion cite and acknowledged that the site appeared irritated and raw, likely from tugging and exposure to gastric contents. He indicated the need for orders for aspiration, flushing, and anchoring.On 3/26/26 at 9:59 a.m., Resident 95's record was reviewed.Her record lacked physician orders routine or as needed g-tube cite care such as, flushes, spirations, anchoring and monitoring for sign/symptoms of infection.Her comprehensive care plans lacked revision to indicated the g-tube was not longer in use, and or how to provide care for the equipment until it could be removed.During an interview on 3/26/26 at 12:00 p.m., The Director of Nursing indicated, nursing staff should review orders and recognize there were no standing orders for her g-tub after her return from the hospital, and called the physician to obtain appropriate orders to prevent the risk for complications and infections.On 3/27/26 at 9:53 a.m., the Administrator provided a copy of current facility policy, titled, Enteral Nutrition, dated 8/2024. The policy indicated, Staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as: aspiration, tube misplacement or migration, skin breakdown around insertion site, perforation of the stomach or small intestine leading to peritonitis, esophageal swelling, strictures, fistulas; and clogging of the tube. Staff caring for residents with feeding tubes are trained on how to recognize complications relating to the administration of enteral nutrition products, such as: nausea, vomiting, diarrhea and abdominal cramping, inadequate nutrition, metabolic abnormalities, interactions between feeding formula and medications; and aspiration. Residents receiving enteral nutrition are periodically reassessed for the continued appropriateness and necessity of the feeding tube. Results of these assessments are documented and any changes are made to the care plan. Input from the resident or legal representative is included in the assessment.410 IAC (Indiana Administrative Code) 16.2-3.1.44.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were properly stored and dated on medication carts for 2 of 2 medication carts observed for medication storage (Residents 58, 65, 64, 92, 51, 47, 63, and 83).Findings include:On 3/24/26 at 11:35 a.m. B hall medication cart was reviewed with Licensed Practical Nurse (LPN) 7. Findings were as follows:Resident 58 had an open Fluticasone inhaler that had no open date on the box or the inhaler itself.Resident 65 had an open Albuterol inhaler that had no open date on the box or the inhaler itself.Resident 65 had a second open Albuterol inhaler that had no open date on the box or the inhaler itself.Resident 64 had an open Albuterol inhaler that had no open date on the box or the inhaler itself.Resident 92 had an open Incruse Elipta inhaler that had no open date on the box or the inhaler itself.Resident 51 had an open Albuterol inhaler that had no open date on the box or the inhaler itself.Resident 47 had an Anoro Ellipta inhaler that had no open date on the box or the inhaler itself.Resident 63 had a bottle of Amoxicillin (an antibiotic) that indicated it should be taken for 7 days. The bottle indicated it was filled on 2/5/26. LPN 7 indicated Resident 63 stopped taking the Amoxicillin a while ago, it just hadn't been thrown out yet. The LPN indicated she did not know there was a separate expiration date for some medications, such as inhalers, once they were opened. On 3/24/26 at 12:15 a.m. A hall medication cart was reviewed with LPN 8. Findings were as follows:Resident 83 had a bottle of Moxifloxacin (an antibiotic) eye drops that indicated it should be given for only 7 days. The bottle indicated it had been filled on 2/10/26.Bisacodyl (a stool softener) suppositories were being stored in the same compartments as eye drops and nasal sprays.There was an open glass vial of lidocaine (a local numbing agent) in one of the compartments of the drawer. There was no bag or box for this medication and there was no prescription label on the bottle to indicate who the medication was for or what the order was.On 3/27/26 at 1:05 p.m. a copy of a current facility policy titled, Medication Storage in the Facility, dated 2020 was provided. That policy indicated .3. Orally administered medications are kept separate from externally used medications (e.g. suppositories, liquids, lotions and tablets. 13. Outdated. medications.are immediately removed from stock.On 3/27/26 at 1:05 p.m. a copy of a current, undated facility guideline titled, Expiration Dates, was provided. That policy indicated .Anoro Ellipta [expiration] 6 weeks after foil opened.Fluticisone [expiration] 6 weeks after foil opened.Incruse Ellipta [expiration] 6 weeks after foil opened.Albuterol [expiration] 3 months at room temperature.Symbicort [expiration] 3 months after foil opened.410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)410 IAC (Indiana Administrative Code) 16.2-3.1-25(m)410 IAC (Indiana Administrative Code) 16.2-3.1-25(n)