STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Berne	1065 Parkway St Berne, IN 46711

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure recipes were followed for therapeutic diets. This had the potential to affect 6 residents that were on puree diets. (Resident 2, Resident 5, Resident 7, Resident 8, Resident 12, Resident 33)Findings include: An observation, on 08/10/25 at 10:59 AM, [NAME] 4 began puree preparation. In an interview, on 08/10/25 at 10:59 AM, [NAME] 4 indicated there was no recipe book for purees and was told just to add water and bread. She indicated she would eyeball consistency and would just open the lid of the puree to see how thick or thin it was. [NAME] 4 indicated she did not know how the nutritional value was maintained since she had just started with the facility. [NAME] 4 indicated she did not know the fork or spoon method for testing appropriate puree thickness. In an interview, on 08/10/25 at 10:59 AM, the Dietary Manager indicated there was no testing method for puree diets. There was a recipe book, however the cooks typically knew what to add, the menu was a 4 week rotation so the cooks knew how to prepare meals. For puree there were 6 slices of bread, a total of 6 puree diets. The Dietary Manger indicated pretty much everything the facility served was 4 ounces. 1. Resident 2's record review on 8/13/25 at 11:30 AM, indicated diagnoses included dysphagia, oropharyngeal phase. A physician order, dated 5/16/25, indicated to give a controlled carbohydrate diet, pureed texture. Nectar/mildly thick consistency to be given for aspiration prevention. 2. Resident 5's record review on 8/13/25 at 11:35 AM, indicated medical diagnoses included dysphagia, oropharyngeal phase. A physician order, 7/11/25, indicated to give a large portion diet, pureed texture, Nectar/mildly thick consistency, pudding as desired. May have comfort foods of any consistency as desired for dysphagia. 3. Resident 7's record review, on 8/13/25 at 11:40 AM, indicated medical diagnoses included dysphagia, pharyngoesophageal phase. A physician order, dated 7/30/25, indicated to give a regular diet, mechanical soft texture, regular/thin consistency. Resident requested food be pureed for diet. 4. Resident 8's record review, on 8/13/25 at 11:45 AM, indicated medical diagnoses included dysphagia, oropharyngeal phase. A physician order, dated 7/23/25, indicated to give a regular diet, pureed texture, regular/thin consistency. 5. Resident 12's record review, on 8/13/25 at 11:50 AM, indicated medical diagnoses included dysphagia, oropharyngeal phase. A physician order, dated 9/25/24, indicated to give a controlled carbohydrate diet, pureed texture, regular/thin consistency. 6. Resident 33's record reviewed on 8/13/25 at 11:55 AM, indicated medical diagnoses included dysphagia, oropharyngeal phase. A physician order, dated 3/18/25, indicated to give a regular diet, pureed texture, nectar/mildly thick consistency. A record review of pureed recipes-beef patty indicated cook temperature was 375.0 F, cook method was bake, serving size was 4 ounces, and total estimated prep time was 20 minutes. Preparation steps were: Measure desired number of servings into food processor. Blend until smooth. Use fork drip test and spook tilt. Test to confirm texture was specifications. Add small amounts of gravy, sauce, vegetable juice, water, fruit juice, milk, or half & half to meet desired consistency. Drain and discard excess liquid that has separated from the solid food pieces. Add commercial thickener if necessary. Based on liquid/thickener added, nutrition may vary. A current facility policy, titled Therapeutic Diets, dated 10/17, was provided by the Administrator on 8/11/25 at 10:35 AM. The policy indicated . Therapeutic diets are prescribed by the (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences 1.3-21(a)(3)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure sanitization was completed of the ice machine/chest. This had the potential to affect 28 residents that receive ice from facility. Finding include: Based on observation, interview, and record review the facility failed to ensure the ice machine was maintained. 28 of 42 residents residing in the facility received ice from the ice machine.During an observation of the ice machine located in the main dining room, on 08/10/25 at 10:30 AM, the Director of Nursing (DON), the ice machine lid was opened, there were black and orange substances on the rubber surface. Ice cubes were located below. The DON indicated this was the only ice machine in the building and they would shut down the machine. In an interview, on 8/10/25 at 10:59 AM, the Dietary Manager indicated maintenance was responsible for the ice machine. Dietary staff did not clean or have anything to do with the ice machine. In an interview, on 08/10/25 at 11:52 AM, the DON indicated staff took all residents' mugs, emptied them and filled them with fresh ice water. In an interview, on 08/11/25 at 11:43 AM, the Maintenance Director indicated he did not internally clean the ice machine. He would just thaw and clean the inner workings of the ice machine. The Maintenance Director indicated he cleaned the water reservoir but did not clean where the ice sits. The Maintenance Director indicated they clean the machine once a year. In an interview, on 08/13/225 10:08 AM, the Administrator indicated the ice machine was back on and now clean. A repair technician came and looked at it before turning it back on. In an interview, on 08/14/25 at 10:14 AM, the Administrator indicated 28 of 42 residents residing in the facility receive ice from the ice machine water. A current facility policy, titled Infection Control: cleaning ice machine and scoop, dated 1/23, was provided by the Administrator on 8/11/25 at 10:35 AM. The policy indicated . The ice machine and equipment (scoop) will be cleaned on a regular basis to maintain a clean, sanitary condition .Unplug machine and remove ice .Wash interior thoroughly using detergent solution. Rinse and drain with clean hot tap water .sanitize .air-dry .turn machine on .clean exterior of machine with detergent solution. Rinse and allow to dry .Ice scoop will be washed and sanitized at least weekly in the dish machine and allowed to dry .Store ice scoop beside or on top of the ice machine in a clean non-porous container that allows water to drain off(and not pool around scoop) .If self-dispensing ice machine, wash and clean only the outside of the machine. Sanitize the ice dispensing mechanism and drain area. Maintenance will clean and maintain interior 3.1-21(i)(1) and (3)

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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. Based on observation, interview, and record review, the facility failed to follow physicians orders for tube feeding for 1 of 1 residents reviewed (Resident 43). Findings include:During an observation, on August 11, 2025 at 11:24 AM, Resident 43 was observed to be alone in his room and sitting in his wheel chair to the left of the bed. An enteral pole was observed to be located to the right of the bed and the enteral feeding pump was turned off.During an observation, on August 11, 2025 at 1:03 PM, Resident 43 was observed to be alone in is room and sitting in his wheel chair to the left side of the bed in the same position as at 11:24 AM. An enteral feeding pole was observed to be located to the right of the bed in the same position as observed at 11:24 AM and the enteral pump was turned off. In an interview, on August 11, 2025 at 1:11 PM, Licensed Practical Nurse (LPN) 8 indicated she was unsure why Resident 43's enteral feeding pump was turned off. LPN 8 indicated she is aware that there is a hold feeding order for activities. LPN 8 indicated Resident 43 was by himself in his room and not participating in an activity. LPN 8 indicated Residents 43's enteral pump was usually restarted after an activity. LPN 8 indicated she was not Residents 43's nurse and was unsure why the pump was not restarted. LPN 8 indicated Resident 43's nurse was unavailable. In an interview, on August 11, 2025 at 1:52 PM, Registered Nurse (RN) 9 indicated she was Resident 43's nurse. RN 9 indicated Resident 43's enteral feeding pump had been on and Resident 43 had been receiving continuous tube feeding all day. RN 9 indicated Resident 43's enteral pump was off, however Resident 43 was now receiving the feeding as ordered. RN 9 indicated Resident 43 has a physician's order allowing the facility to stop the continuous feed when Resident 43 was participating in activities. During an observation, on August 13, 2025 at 12:06 PM, Resident 43 was observed to be alone in is room, eyes closed and sitting in his wheel chair to the left side of the bed. An enteral pole was observed to be located to the right side of the bed and the enteral feeding pump was turned off. In an interview, on August 13, 2025 at 12:08PM, RN 10 indicated she was unsure why Resident 43's enteral pump was turned off. RN 10 indicated she knew Resident 43 had a shower the morning of August 13, the enteral feeding was turned off and disconnected for showers. RN 10 indicated she was unsure how long Resident 43 had been back in his room from the shower. In an interview, on August 13, 2025 at 12:30 PM, the Director of Nursing (DON) indicated she was unable to provide a reason for Resident 43's enteral feeding pump being turned off. The DON indicated Resident 43 was technically always in activities because of the portable TV attached to his chair, however, indicated Resident 43 was alone in his room. The DON indicated she was unsure where the break down in communication was with the nurses being notified Resident 43 was back in his room after activities or a shower. The DON indicated they could provide CNA education on alerting nursing when residents requiring enteral feeding were back in their room after being engaged in an activity, therapy or shower so that the resident could return to receiving the feeding. Resident 43's record was reviewed on August 11, 2025 at 10:53 AM. Diagnoses included other specified disorder of brain, unspecified convulsions, disturbances of salivary secretion, dysphagia oropharyngeal phase and progressive multifocal leukoencephalopathy. Physicians Orders included NPO diet, Enteral Feed Order every shift Jevity 1.2 via G Tube at 65ml/hr continuous with 30 ml H2O Flush hourly and may stop feeding for activities, therapy, showers, etc. A review of Resident 43's current Care plan titled The resident requires tube feeding G-Tube r/t dysphagia secondary to PML, indicated the resident would maintain adequate nutritional and hydration status evidenced by a stable weight, no s/sx of malnutrition or dehydration through review date. Interventions included the resident was dependent with tube feeding and water flushes. Follow MD orders for current feeding orders and continue tube feeding as ordered. A current policy titled Medication and Treatment Orders dated 8/2024 was provided by the DON on August 13, 2025 at 1:50PM. The policy indicated Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state .A current policy (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Enteral Nutrition dated 8/2024 was provided by the DON on August 13, 2025 at 1:50PM. The policy indicated The dietitian monitors resident who are receiving enteral nutrition, and make appropriate recommendations for interventions to enhance tolerance and nutritional adequacy of enteral feedings .3.1-44(a)(2)