

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155531	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2025
NAME OF PROVIDER OR SUPPLIER  Envive of Huntington		STREET ADDRESS, CITY, STATE, ZIP CODE  850 Ash St Huntington, IN 46750	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review, the facility failed to promote and protect resident dignity by ensuring residents' written consent was received per facility policy before posting photographs and videos on the facility's social media platforms for 2 of 8 residents reviewed. (Resident D and E) Findings include: A facility social media posting, on 7/28/25, showed a photograph of Resident D during an arts and crafts activity. A facility social media posting, on 8/13/25, showed photographs of some of the facility's residents at a lake during a meal. Resident E was pictured in the online photographs. Resident D's clinical record was reviewed on 9/19/25 at 10:34 a.m. Diagnoses included dementia, depression, and mild cognitive impairment. During an interview, on 9/19/25 at 11:45 a.m., the Administrator indicated Resident D did not have a signed photography/video release form in her admission packet. A consent record, provided by the Administrator, on 9/19/25 at 2:12 p.m., indicated Resident D signed consent for photographs intended for medical records and activities. The consent did not include social media release. Resident E's clinical record was reviewed on 9/19/25 at 10:40 a.m. Diagnoses included diabetes, bipolar disorder, and heart failure. A 8/7/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident E was cognitively intact. During an interview, on 9/19/25 at 11:12 a.m., the Administrator indicated Resident E did not have a signed photography/video consent release form in his admission packet. During an interview, on 9/19/25 at 1:09 p.m., Resident D indicated she was aware pictures were taken of her and were used within the facility and were on the facilities social media pages. She did not have a concern with the posted pictures. Resident E was unavailable for an interview during the survey on 9/19/25. On 9/19/25 at 1:23 p.m., the DON confirmed photography on the facilities social media posts included Resident D and Resident E. A current facility policy, titled Videotaping, Photographing, and other imaging of Residents, provided by the Administrator, on 9/19/25 at 2:32 p.m., indicated the following: .2. Staff may not take or release images or recordings of any resident without explicit written consent. Written consent must be obtained from the resident or representative prior to obtaining images or recordings of the resident for any purposes other than investigation of abuse, neglect, or emergencies, and photography obtained for personal/ family use at the verbal request of the resident or family This citation relates to Intake 2609206.3.1-3(t)</p>		

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation and interview, the facility failed to implement facility policy for assistive device use during a mobility transfer of a physically dependent resident for 1 of 1 residents reviewed for transfers. (Resident M) Findings include: Resident M's clinical record was reviewed on 9/19/25 at 11:43 a.m. Diagnoses included Parkinson's disease, muscle weakness, tremors and difficulty in walking. Current orders included weight bearing as tolerated with hip (protection) precautions. A 9/12/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Resident M had upper and lower extremity impairment on one side. Resident M was dependent on staff members for chair/bed to chair transfers. Resident M's current care plan included: I have an Activity of Daily Living (ADL) self-care performance deficit related to Parkinson's disease, tremors, and weakness initiated on 4/4/25 and reviewed on 8/7/25. Interventions included transfers required extensive assistance with two staff members. CNA may use mechanical lift as needed. During an observation, on 9/19/25 at 10:24 a.m., CNA 3 and CNA 5 transferred Resident M without the use of an assistive device or gait belt. Both CNAs placed their arms under Resident M's armpits before lifting resident up and out of his recliner. They both cued Resident M to move his feet while they transferred resident over to his bed. After foley catheter and incontinence care was completed, CNA 3 and CNA 5 transferred resident from his bed back into his recliner by grabbing Resident M under his armpits. Both CNAs cued Resident M to use his feet as they transferred him into his recliner. During an interview, on 9/19/25 at 10:41 a.m., CNA 3 and CNA 5 both indicated they should have used a gait belt to transfer Resident M. On 9/19/25 at 10:59 a.m., RN 4 indicated staff should have used a gait belt while Resident M was transferred. On 9/19/25 at 11:06 a.m., the DON indicated Resident M required a gait belt during transfers. A current policy, titled Safe lifting and Movement of Residents, provided by the Administrator, on 9/19/25 at 11:54 a.m., indicated the following: .1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/ transfer belts) and mechanical lifting devices This citation relates to Intake 2616293. 3.1-37(a)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation and interview, the facility failed to maintain appropriate infection control practices during urinary catheter and incontinence care for 1 of 3 residents reviewed for infection control. (Resident M) Findings include: Resident M's clinical record was reviewed on 9/19/25 at 11:43 a.m. Diagnoses included Parkinson's disease, diabetes, muscle weakness, and tremors. A 9/12/25, quarterly, Minimum Data Set (MDS) assessment indicated resident was cognitively intact. Resident M had upper and lower extremity impairment on one side. Resident M was dependent on staff members for toileting. Resident M's current care plan included: I have an Activity of Daily Living (ADL) self-care performance deficit related to Parkinson's disease, tremors, and weakness initiated on 4/4/25 and reviewed on 8/7/25. Interventions included toilet use: assistance with toileting needs, dependent on two staff members. During an incontinence care observation, on 9/19/25 at 10:24 a.m., CNA 3 washed her hands and put on gloves. Resident M had had a small bowel movement. After providing incontinence care and redressing the resident, CNA 3, still wearing the same gloves used to provide incontinence care, touched Resident M's call light and his bed controls before she walked over to the trash can and removed her gloves. After she removed her gloves, CNA 3 performed hand hygiene. During an interview, on 9/19/25 at 10:41 a.m., CNA 3 indicated she should have removed her gloves before she touched Resident M's call light and bed controls. On 9/19/25 at 10:59 a.m., RN 4 indicated staff should remove their gloves and perform hand hygiene before touching a residents call light or bed controls after providing incontinence care. On 9/19/25 at 11:06 a.m., the DON indicated she would expect staff to remove gloves and perform hand hygiene before touching anything as their gloves would be considered dirty. A current policy, titled Handwashing/ Hand Hygiene, provided by the Administrator, on 9/19/25 at 11:54 a.m., indicated the following: .All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors This citation relates to Intake 2616293. 3. 1-18(l)</p>		