STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155531	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Huntington	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)
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 interviews and record reviews, the facility failed to protect a resident's (Resident B) right to be treated with dignity and respect by CNA 6 when the resident requested their assistance for 1 of 3 residents reviewed for dignity. Findings include:Findings include:Resident B's clinical record was reviewed on 1/30/26 at 8:54 a.m. Diagnoses included vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and need for assistance with personal care. Her quarterly Minimum Data Set (MDS) assessment, dated 11/21/25, indicated she was cognitively intact. She used a walker and a manual wheelchair for mobility. She required substantial to maximal assistance with lower body dressing and sitting to standing. She required partial to moderate assistance with upper body dressing and personal hygiene. She was dependent with transfers. Her current care plan for risk for impaired communication, revised on 1/12/26, indicated that she was hard of hearing. Her interventions initiated on 11/14/24 included allow adequate time for her response, minimize environmental stimuli, observe effectiveness of communication strategies and provide clear, simple instructions. She had a current care plan, initiated on 1/7/26, that indicated that she had a psychosocial wellbeing problem potential related to negative interactions with others. A progress note, dated 1/8/26 at 4:10 p.m., indicated the resident's representative was notified regarding an incident with a CNA. A progress note dated 1/8/26 at 4:29 p.m., indicated the resident denied any issues and was not experiencing any signs or symptoms of distress. The facility investigation, provided by the Administrator on 1/30/26 at 9:23 a.m., included the following information: A 1/7/26, typed statement signed by the Activity Director indicated she reported to the Administrator that she heard someone yelling loudly while she was putting things away in the activity room. She heard the person state You can't keep pushing your call light unless you need something, there are other people I need to take care of. When the Activity Director stepped out of the Activity room, she saw CNA 6 coming out of Resident B's room. A 1/7/26 typed statement signed by the Administrator and the Director of Nursing (DON) indicated that upon entering Resident B's room, the DON and Administrator applied Personal Protective Equipment (PPE) due to Resident B being in isolation related to COVID-19. Resident B was asked if she had experienced any trouble with staff. The Administrator raised her voice because Resident B could not hear through the PPE mask. Resident B indicated that CNA 6 told her she could not turn on her call light because staff were busy and she did not feel abused. The Administrator and DON informed Resident B that staff should not tell her that she could not use her call light. In an interview, CNA 6 indicated that Resident B turned on her call light, and she responded after applying PPE. Resident B asked who was going to complete her menus. CNA 6 indicated that Resident B could not hear her, so she raised her voice and told her that she would help her later. Resident B indicated that she still could not hear her and CNA 6 left the room. Resident B then turned on her call light again. The Administrator indicated to CNA 6 that it was unprofessional, and the residents had the right to turn on their call light. The Administrator (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encouraged CNA 6 to get help if she was feeling frustrated with a certain resident. A typed statement, dated 1/8/26 and signed by the Activity Assistant, indicated, on January 7th, she and the Activity Director were cleaning out the storage room, as the Activity Assistant walked back into the activity room, she heard an aide using a very loud and angry tone. The Activity Director stepped out of the activity room, and they both looked to see where it was coming from, however, the doors were closed. The Activity Director heard an aide tell the resident that she could not keep pushing her call light if she didn't need something, because there were other people she needed to take care of and she didn't have time to keep coming into her room. At that point, they saw CNA 6 coming out of Resident B's room. A typed statement, dated 1/8/26, signed by the Social Service Director and the Administrator, indicated that a staff member made the Administrator aware that CNA 6 also told the resident that she would not change her because she was too busy. Upon being told the information, an investigation was immediately initiated, and CNA 6 was suspended. When Resident B was interviewed, she denied the need to use the restroom, and indicated she did not feel abused. Resident B's roommate was interviewed and denied that Resident B needed to use the restroom. Resident B's roommate indicated CNA 6 indicated to Resident B not to turn on her call light on unless she needed something. CNA 6 received education related to Resident Rights 12/2024 and Abuse 1/2025. CNA 6 could not be reached for an interview during the survey date. During an interview on 1/30/26 at 8:41 a.m., Resident B indicated that she did not have concerns with staff. During an interview on 1/30/26 at 11:36 a.m., the Administrator indicated that CNA 6 was not suspended on 1/7/26 because the incident was just unprofessionalism. CNA 6 was suspended on 1/8/26 due to the additional statement on 1/8/26 that CNA 6 refused to toilet Resident B. During an interview on 1/30/26 at 12:05 p.m. QMA 5 indicated at times you needed to speak loudly to Resident B, but the volume and tone used were different. Resident B had confusion and repeated herself and turned on her call light a lot. QMA 5 considered abuse as telling a resident they couldn't turn on their light and refusing to take a resident to the bathroom. During an interview on 1/30/26 at 1:35 p.m., CNA 7 indicated she was standing outside of Resident B's closed door and heard CNA 6 tell Resident B to stop putting her call light on and she wasn't going to take her to the bathroom. Resident B turned on her call light again and CNA 7 assisted her to the bathroom. CNA 7 reported to the Administrator on 1/7/26 that CNA 6 told Resident B to stop putting her call light on. The next day, on 1/8/26, in a following up interview with the Administrator, CNA 7 reported that CNA 6 also told Resident B that she would not take her to the bathroom. A 9/2022 facility policy, titled Resident Abuse, Neglect and Exploitation Procedural Guidelines, provided in the facility's investigation by the Administrator on 1/30/26 at 9:23 a.m., indicated the following: .Envive Healthcare (EHC) has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect .3. Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being .c. Deprivation of goods and services by staff: staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s) This citation relates to Intake 2712215. 3.1-3(a)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of verbal abuse and neglect timely and with accurate information to the State Agency for 1 of 3 residents reviewed for abuse. (CNA 6 and Resident B)Findings include:The facility's investigation was provided by the Administrator, on 1/30/26 at 9:23 a.m., and included the following information: A 1/8/26 Facility Reported Incident indicated on 1/8/26 it was reported to the Administrator that CNA 6 had allegedly yelled at Resident B. The 1/11/26 follow up indicated it was found that CNA 6 had raised her voice as she was in full PPE and Resident B could not hear her through her mask. CNA 6 indicated that she did indicate to the resident not to turn on her call light unless she needed something. CNA 6 was educated on professionalism.The incident report lacked indication of an allegation of threat to withhold services from the resident. A 1/7/26, typed statement signed by the Activity Director indicated she reported to the Administrator that she heard someone yelling loudly while she was putting things away in the activity room. She heard the person state You can't keep pushing your call light unless you need something, there are other people I need to take care of. When the Activity Director stepped out of the Activity room, she saw CNA 6 coming out of Resident B's room. A 1/7/26 typed statement signed by the Administrator and the Director of Nursing (DON) indicated that upon entering Resident B's room, the DON and Administrator applied Personal Protective Equipment (PPE) due to Resident B being in isolation related to COVID-19. Resident B was asked if she had experienced any trouble with staff. The Administrator raised her voice because Resident B could not hear through the PPE mask. Resident B indicated that CNA 6 told her she could not turn on her call light because staff were busy and she did not feel abused. The Administrator and DON informed Resident B that staff should not tell her that she could not use her call light. In an interview, CNA 6 indicated that Resident B turned on her call light, and she responded after applying PPE. Resident B asked who was going to complete her menus. CNA 6 indicated that Resident B could not hear her, so she raised her voice and told her that she would help her later. Resident B indicated that she still could not hear her and CNA 6 left the room. Resident B then turned on her call light again. The Administrator indicated to CNA 6 that it was unprofessional, and the residents had the right to turn on their call light. The Administrator encouraged CNA 6 to get help if she was feeling frustrated with a certain resident. A typed statement, dated 1/8/26, signed by the Activity Assistant indicated on January 7th, she and the Activity Director were cleaning out the storage room, as the Activity Assistant walked back into the activity room, she heard an aide using a very loud and angry tone. The Activity Director stepped out of the activity room, and they both looked to see where it was coming from, however, the doors were closed. The Activity Director heard an aide tell the resident that she could not keep pushing her call light if she didn't need something, because there were other people she needed to take care of and she didn't have time to keep coming into her room. At that point, they saw CNA 6 coming out of Resident B's room. A typed statement, dated 1/8/26, signed by the Social Service Director and the Administrator, indicated that a staff member made the Administrator aware that CNA 6 also told the resident that she would not change her because she was too busy. Upon being told the information, an investigation was immediately initiated, and CNA 6 was suspended. When Resident B was interviewed, she denied the need to use the restroom, and she did not feel abused. Resident B's roommate was interviewed and denied that Resident B needed to use the restroom. Resident B's roommate indicated CNA 6 indicated to Resident B not to turn on her call light on unless she needed something. CNA 6's Employee Corrective Action form, dated 1/7/26, indicated she received education on speaking properly to residents and to talk with leadership regarding ways to talk with residents when frustrated. The (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form was signed by CNA 6. CNA 6's Employee Corrective Action form, dated 1/8/26, indicated she was suspended for two days and would report to her supervisor to resume duties on 1/10/26 at 6:00 p.m. The form was signed by CNA 6. CNA 6 was educated on the facility's policy and procedure for Harassment and Standards of Behaviors on 1/17/26. An undated in-service titled Abuse for all staff included CNA 6's signature. CNA 6's timecard indicated she worked on 1/7/26 from 1:54 p.m. to 9:57 p.m., on 1/8/26 from 5:53 a.m. to 2:00 p.m. and on 1/10/26 from 5:54 p.m. to 6:03 a.m.During an interview on 1/30/26 at 11:36 a.m., the Administrator indicated that CNA 6 was not suspended on the 1/7/26 because the incident was considered unprofessional. CNA 6 was suspended on 1/8/26 due to an additional statement received on 1/8/26 that CNA 6 refused to toilet Resident B. During an interview on 1/30/26 at 1:35 p.m., CNA 7 indicated she was standing outside of Resident B's closed door and heard CNA 6 tell Resident B to stop putting her call light on and she wasn't going to take her to the bathroom. Resident B turned on her call light again and CNA 7 assisted her to the bathroom. CNA 7 reported to the Administrator on 1/7/26 that CNA 6 told Resident B to stop putting her call light on. The next day, on 1/8/26, in a following up interview with the Administrator, CNA 7 reported that CNA 6 also told Resident B that she would not take her to the bathroom. A current facility policy, titled Abuse, Neglect, Exploitation and Misappropriation, Reporting, and Investigating, provided by the Administrator on 1/30/26 at 2:37 p.m. indicated the following: .Reporting Allegations to the Administrator and Authorities .1 .the suspicion must be reported immediately to the administrator and to other officials according to state law .3. Immediately is defined as: h. within two hours of an allegation involving abuse .Investigating Allegations .1. All allegations are thoroughly investigated .6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete Cross reference F550. This citation relates to Intake 2712215. 3.1-28(c)