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	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Huntington	850 Ash St Huntington, IN 46750

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plans were reviewed and revised with appropriate and individualized fall prevention interventions to mitigate the risk for further falls for 4 of 4 residents reviewed for accidents. (Residents B, C, D and E)Findings include: 1.Resident B's clinical record was reviewed on 4/6/26 at 10:39 a.m. Diagnoses included essential (primary) hypertension, syncope and collapse, muscle weakness (generalized), unsteadiness on feet, need for assistance with personal care, and cognitive communication deficit. A 2/19/26, admission, Minimum Data Set (MDS) assessment indicated he had severe cognitive impairment. He used a wheelchair for mobility. He was dependent for toileting, lower body dressing, footwear, personal hygiene, bed mobility, sit to stand, and transfers. He had no falls at that time. His medications included muscle rub cream (pain reliever) twice daily, finasteride (treat benign prostatic hyperplasia) 5 mg daily, diclofenac sodium gel (topical) (pain reliever) twice daily, and amlodipine besylate (treat hypertension) 10 milligram (mg) daily. He had an order, dated 2/12/26, for quarter side rails for mobility, positioning, and to aid with bed mobility. A current fall care plan, initiated on 2/12/26, indicated he was at risk for falls and fall related injury due to history of falls, decline in mobility, and cognitive impairment. His intervention was to anticipate and meet his needs (2/12/26). A skilled charting note, dated 2/22/26 at 3:10 p.m., indicated he was alert and oriented to person. There was no change in cognitive status, and visual hallucinations were present. He was sitting in the hallway and concerned about the large truck that was going to back over him if he was not urgently removed from the area. A fall risk assessment, dated 3/2/26, indicated he was at risk for falls. A fall risk evaluation note, dated 3/2/26 at 11:00 a.m., indicated he had a fall. The immediate intervention was education to call for assistance before attempting to stand or transfer. An Interdisplinary (IDT) note, dated 3/2/26 at 11:43 a.m., indicated he fell due to confusion and attempted to stand and walk independently. He was educated and reminded to call for assistance prior to standing. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 3/8/26, indicated he was at risk for falls. A Situation, Background, Assessment, and Recommendation (SBAR) summary, dated 3/8/26 at 7:03 p.m., indicated he had a fall, he was observed standing up and taking several steps falling on to his bottom then lying on the floor. He remained stable and was assisted to his wheelchair. A fall risk evaluation note, dated 3/8/26 at 7:14 p.m., indicated the resident had a fall. The immediate intervention was education to ask for help when wanting to stand or transfer to a new location. An IDT note, dated 3/11/26 at 3:20 p.m., indicated he was confused at baseline with the diagnosis of cognition communication deficit. He thought he was walking back to his room at time of fall. He participated in physical and occupational therapy services. He was sitting at the nurses' station with proper footwear and was educated to call for assistance prior to attempting to stand. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 3/13/26, indicated he was at risk for falls. A fall risk evaluation note, dated 3/13/26 at 8:35 p.m., indicated he had a fall. The immediate interventions included assessing for injuries, obtaining vital signs, completing neurological checks, (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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He did not hit his head. The family was notified, came to the facility, and requested him to be sent to the emergency room. He had no new injuries. His neurological checks and vital signs were within normal limits. 2.Resident C's clinical record was reviewed on 4/6/26 at 12:07 p.m. Diagnoses included essential (primary) hypertension, type 2 diabetes mellitus without complications, restless legs syndrome, hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side, muscle weakness (generalized), other symptoms and signs involving the musculoskeletal system, need for assistance with personal care, other abnormalities of gait and mobility, chronic fatigue, and low back pain. A 1/5/26, quarterly, MDS assessment indicated he had severe cognitive impairment. He used a wheelchair for mobility. He required partial to moderate assistance with toileting hygiene, upper body dressing, sitting to stand, chair/bed-to-chair transfer, toilet transfer. He required substantial to maximal assistance with lower body dressing, footwear, and personal hygiene. He required supervision to touch assistance for bed mobility and walking 10 feet. His medications included furosemide (treat hypertension) 20 mg daily, levocetirizine dihydrochloride (treat allergies) 5 mg daily, lisinopril (treat hypertension) 40 mg daily, pramipexole dihydrochloride (treat restless leg syndrome) 0.25 mg daily, spironolactone (treat hypertension) 0.5 mg daily, trazodone (treat insomnia) 75 mg daily, venlafaxine 37.5 mg daily, ticagrelor (antiplatelet) 90 mg twice daily, and carvedilol (treat hypertension) 3.125 mg twice daily. A current care plan, revised on 8/13/25, indicated he was at risk for falls/injury due to decreased mobility secondary to hemiplegia/hemiparesis of the right nondominant side, chronic obstructive pulmonary disease (COPD), arthropathic psoriasis, history of falls, and use of high-risk medications. His interventions included non-skid strips in front of recliner (4/21/25), encouraging him to wear gripper socks/ shoes prior to transfers (8/4/25), and using a wheelchair for all locomotion/transfers (10/16/25). The CNA assignment sheet indicated he walked and the lacked documentation of fall interventions. A fall risk assessment, dated 12/31/25, indicated he was at risk for falls. A nurses note, dated 1/13/26 at 3:09 p.m., indicated he was found sitting on the floor and yelled for nursing. He indicated that he was walking without his walker in his room, fell on his left knee and landed on his bottom. He did not hit his head. The area on his left knee was cleaned and covered with a band aid. A fall risk evaluation note, dated 1/13/26 at 3:26 p.m., indicated he had a fall and was educated on calling for assistance. An IDT note, dated 1/16/26 at 10:14 a.m., indicated he fell while ambulating without walker in bedroom. He was on the physical therapy caseload. His intervention included educating him on fall precautions and the importance of utilizing an ambulation device. He verbalized understanding. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 2/8/26, indicated he was at risk for falls. An incident note, dated 2/8/26 at 3:19 p.m., indicated he activated his call light and was found sitting on the floor in front of his chair. His wheelchair was within reach with both brakes locked and had footwear on at the time of the fall, he had been attempting to move the laundry from plastic hangers to wooden hangers and placing them in the closet. He denied hitting his head and had slight redness on his lower back. A fall risk evaluation note, dated 2/8/26 at 3:32 p.m., indicated the immediate intervention were obtaining his vital signs and assessing his cognitive status. He was assisted to his chair, his clothes were moved to the wooden hangers and hung up for him. Environmental services was notified that his clothes needed to be placed on wooden hangers in the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	future so that he did not try to move them himself. An IDT note, dated 2/9/26 at 11:08 a.m., indicated that he fell while ambulating in bedroom and attempted to put his clothes away. He was educated to call for assistance for daily activities such as putting clothing away. He was receiving therapy services.The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment dated [DATE] indicated he was not at risk for falls. A nurses note, dated 3/24/26 at 11:46 a.m., indicated he was lying on the floor in front of his wheelchair. He indicated his wheelchair was not locked. He had pain to his head and bottom with a small bump noted on the back of his head. An IDT note, dated 3/30/26 at 9:17 a.m., indicated he fell from his wheelchair. Interventions included adding a non-slip pad to his wheelchair cushion. The intervention was not added to the resident's care plan. During an interview with Resident C, on 4/6/26 at 1:17 p.m., he was observed sitting in his wheelchair wearing flip-flops. He indicated he had several falls due to his legs giving out and to prevent further falls he sat in his wheelchair and used his call light. 3. Resident D's clinical record was reviewed on 4/6/26 at 12:35 p.m. Diagnoses included chronic obstructive pulmonary disease, primary generalized (osteo) arthritis, chronic pain syndrome, peripheral vascular disease, muscle weakness (generalized), unsteadiness on feet, and cognitive communication deficit. A 12/30/25, annual, MDS assessment indicated she had severe cognitive impairment. She used a wheelchair for mobility. She was dependent for toileting hygiene and footwear. She required partial to moderate assistance with upper body dressing, personal hygiene, bed mobility, and transfers. She required substantial to maximal assistance with lower body dressing. She had no falls at that time. Her medications included duloxetine (treat depression) 60 mg daily, Ozempic (weight loss) 0.25 mg subcutaneously weekly, buspirone 5 mg three times daily, gabapentin (treat neuropathy) 800 mg three times daily, methadone (narcotic)10 mg every six hours, and oxycodone (narcotic) 15 mg every six hours. A current care plan, revised on 8/19/25, indicated she was at risk for falls/injury due to impaired mobility, impaired cognition, fluctuating need for assist with Activities of Daily Living (ADL) care, and the use of high fall risk medications. Her interventions included ensuring assistive mobility device was within reach (2/24/22), non-skid/gripper socks (2/24/22), education to ask for assistance with transfers, ensuring assistive devices were within reach (6/22/23), nonskid strips to chair (7/29/24), and wearing Crocs during transfers (1/14/25). The CNA assignment sheet indicated she transferred herself and she had nonskid strips in front of her recliner. A fall risk assessment, dated 1/13/26, indicated she was at risk for falls. A late entry fall risk evaluation note, dated 1/22/26 at 4:50 a.m. and created on 1/23/26 at 6:49 a.m., indicated she had a fall. The immediate intervention were replacing the non-skid strips in front of her recliner that are no longer nonskid and agreeing to wear Crocs when sleeping so that if she falls asleep again with her electric recliner in the lifted position, she would have non-skid shoes on when she started to slide out of her recliner. An incident note, dated 1/22/26 at 4:50 a.m., indicated she was found on her back on the floor in front of her electric recliner which was in an elevated position. She indicated she did not know what happened, she woke up and was on the floor. She had soft, fuzzy, thick regular socks on her feet. A fall risk assessment, dated 1/22/26, indicated she was at risk for falls. An IDT note, dated 1/26/26 at 2:07 p.m., indicated she had fallen while in her recliner. She was not wearing proper footwear, only soft fuzzy socks with no grip. Interventions were educating her on the importance of wearing proper footwear, and maintenance to replace nonskid strips in front of her recliner. The intervention was not added to the resident's care plan. A fall risk evaluation note, dated 2/10/26 at 6:20 p.m., indicated she had a fall. Immediate interventions were monitoring and following facility flow sheet for neurological checks with full assessment. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 2/10/26, indicated she was not at risk for falls. A SBAR summary, dated 2/11/26 at 12:43 p.m., indicated she fell while attempting to sit down in recliner during transfer. She missed the recliner and slid onto her bottom. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. An IDT note, dated 2/17/26 at 2:47 p.m., indicated her fall interventions included reminding her to feel for the chair on the back of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her knees prior to sitting down to ensure that the chair is in fact behind her. She verbalized understanding. A late entry incident note, dated 3/6/26 at 5:30 p.m. and created on 3/7/26 at 5:48 p.m., indicated she used the restroom and attempted to stand to wash her hands. She leaned against the wall and landed on her bottom. She did not utilize her call light and her wheelchair in the locked position. A late entry fall risk evaluation note, dated 3/6/26 at 5:47 p.m. and created on 3/7/26 at 6:02 p.m., indicated she had a fall. The immediate interventions were notifying the nurse practitioner, reminding Resident D to call for assistance, and assessing her neurological status. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 3/6/26, indicated she was not at risk for falls. An IDT note, dated 3/11/26 at 3:16 p.m., indicated she fell while washing hands after using the bathroom by herself as she did not use her call light. Interventions included encouraging her to utilize her call light for assistance with any ADLs. She refused therapy services. A nurses note, dated 3/15/26 4:58 p.m., indicated yelling was heard and she found laying beside her wheelchair on the bathroom floor leaning against the wall. She indicated that she didn't know how she fell again, it was explained that there was urine on the floor. She was transferred back into her wheelchair. She complained of a headache and elbow pain with bruising noted. A fall risk assessment, dated 3/15/26, indicated she was at risk for falls. An IDT note, dated 3/16/26 at 1:55 p.m., indicated she had urine under her feet when she attempted to get up and fell. She had nonskid strips in front of her chair and was wearing nonskid socks. The CNAs were notified to check and change her frequently. The care plan lacked an updated individualized intervention to mitigate the risk for further falls.4.Resident E's clinical record was reviewed on 4/6/26 at 2:14 p.m. Diagnoses included pain in right hip, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bilateral primary osteoarthritis of knee, peripheral vascular disease, essential (primary) hypertension, muscle weakness (generalized), difficulty in walking, not elsewhere classified, unsteadiness on feet, need for assistance with personal care, and unspecified dementia, severe, with agitation. A 3/18/26, admission, MDS assessment indicated she had severe cognitive impairment. She had physical and verbal behavioral symptoms directed towards others and wandering. She used a wheelchair for mobility. She was dependent with toileting and footwear. She required partial to moderate assistance with upper body dressing and personal hygiene. She required substantial to maximal assistance for lower body dressing, bed mobility, and transfers. She had one fall with no injury. A current care plan, revised on 3/13/26, indicated she was at risk for falls/fall related injury due to history of falls, required assist with transfers cognitive impairment. Interventions included anticipating and meeting her needs (3/11/26), ensuring call light was within reach and encouraging use (3/11/26), ensuring pathways were free of clutter (3/11/26), keeping personal items within reach (3/11/26), and therapy screening, evaluation and treatment as indicated (3/11/26). The CNA assignment sheet indicated she walked and lacked the documentation for fall interventions. A nurses note, dated 3/18/26 at 4:10 a.m., indicated a resident was heard yelling out Help, Resident E was not in her room and in her bed where she had been. CNAs searched the 200 hall and found Resident E lying on her back on top of blankets and her wheelchair cushion in the 200-hall conference room. She was barefoot and indicated her feet were hot and she took her socks off. She fell and that the pillow under her was always slippery each time she was in the chair. Prior to falling she was scooting herself in her chair and the pillow scooted her to the floor. Resident E's nonskid socks were in her bed in her room. An IDT note, dated 3/23/26 at 12:35 p.m., indicated she had an unwitnessed fall from her chair while self-propelling in the conference room. She had dementia and increased confusion at night. Interventions included dycem under her cushion and the psychiatric nurse practitioner was notified and increased her Seroquel dosage. The care plan lacked an updated individualized intervention to mitigate the risk for further falls. A fall risk assessment, dated 3/23/26, indicated she was at risk for falls. During an interview, on 4/6/26 at 1:48 p.m., CNA 7 indicated they kept Resident B at the nurses' station in his wheelchair due to confusion. He required assistance (continued on next page)

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