STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Muncie	7524 E Jackson Street Muncie, IN 47302

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to mitigate the risk of accidents and injury by failing to ensure safety razors were securely stored in two shared bathrooms of 4 cognitively impaired residents (Resident C, Resident H, Resident N and Resident P) on the dementia unit. Findings include:1. During an observation of Resident C's bathroom (shared with Resident H), on 1/7/26 at 9:49 a.m., the unlocked tri-fold mirrored vanity above the sink contained a disposable razor. At the same time, the Memory Care Director entered the bathroom after speaking with Resident C and indicated that the razor should not be left in the residents' bathrooms.Resident C's clinical record was reviewed on 1/7/26 at 3:27 p.m. Diagnoses included hallucinations, cognitive communication deficit, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.A quarterly MDS (Minimum Data Set) assessment, dated 10/10/25, indicated he had severe cognitive impairment.Resident H's clinical record was reviewed on 1/8/26 at 1:13 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care. A quarterly MDS assessment, dated 1/8/26, indicated he had moderate cognitive impairment.2. During an observation of Resident N and Resident P's bathroom, accompanied by the Memory Care Director, on 1/7/26 at 9:53 a.m., the unlocked tri-fold mirrored vanity above the sink contained two disposable razors. Resident N and P's bathroom was accessible from the memory care unit's main dining room. The Memory Care Director indicated that Resident N and P's family brought the razors into the facility, and they should not have been left in the residents' bathrooms.Resident N's clinical record was reviewed on 1/8/26 at 12:33 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, and need for assistance with personal care.A quarterly MDS assessment, dated 12/30/25, indicated he had severe cognitive impairment.Resident P's clinical record was reviewed on 1/8/26 at 12:44 p.m. Diagnoses included unspecified dementia, moderate, with agitation and unspecified dementia, moderate, with anxiety.Her admission MDS assessment, dated 11/20/25, indicated she had moderate cognitive impairment.During an interview with CNA 12, on 1/8/26 at 10:17 a.m., she indicated Resident C was able to brush his own teeth, could walk but used a wheelchair and was able to take himself to the bathroom. Resident H needed some assistance but could take himself to the bathroom. Resident N and Resident P could toilet themselves and stood at the bathroom sink independently. She further indicated that she did not normally keep disposable razors in the residents' bathrooms. During an interview with the Administrator, on 1/8/26 at 1:56 p.m., he indicated he was unable to locate a policy for storage of disposable razors.This citation relates to Intakes 2700504 and 2706579. 3.1-45(a)(1)

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure a resident, who had not been deemed able to self-administer medications, received supervision during a nebulizer medication administration for 1 of 1 resident (Resident E) randomly observed receiving a nebulizer treatment.Findings include:During a random observation on 1/7/26 at 10:12 a.m., Resident E was observed lying in bed with a nebulizer machine running. At the same time, RN 8 was seated at the [NAME] hall nurses' station.At 10:14 a.m., RN 8 entered Resident E's room, turned off the nebulizer, assessed the resident's lung sounds, and exited the room. RN 8 indicated that she did not normally remain with residents during their nebulizer treatments.Resident E's clinical record was reviewed on 1/7/26 at 10:36 a.m. Diagnoses included cognitive communication deficit, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other schizophrenia, acute bronchitis, chronic obstructive pulmonary disease with (acute) exacerbation, acute cough, dyspnea, other specified symptoms and signs involving the circulatory and respiratory systems and chronic obstructive pulmonary disease.A quarterly MDS (Minimum Data Set) assessment, dated 11/25/25, indicated she was moderately cognitively impaired.Her medication orders included ipratropium-albuterol inhalation solution (breathing treatment medication) 0.5 mg (milligram) - 2.5 mg 3 mg/3 ml (milliliter) inhale one vial orally four times a day for shortness of breath and wheezing. The medication was to be administered by the clinician.Her current care plan, initiated on 3/3/25, indicated she had a potential for impaired gas exchange related to diagnoses of COPD (Chronic Obstructive Pulmonary Disease), dyspnea, rhinitis, shortness of breath and wheezing. Interventions included to administer medications as ordered.The clinical record lacked indication of Resident E being assessed as able to self-administer medications. During an interview with RN 5 on 1/8/26 at 11:15 a.m., she indicated she did not remain with the residents during their nebulizer treatments, but did go back to check on the residents during the treatment.A current facility policy titled Administering Medications through a Small Volume Nebulizer provided by the DON on 1/8/26 at 11:00 a.m. indicated the following: .Steps in the Procedure.24. Remain with the resident for the treatment.3.1-47(a)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' personal care items were labeled and not cohorted with other resident's personal care items during observations for 3 shared bathrooms of 6 cognitively impaired residents (Resident C, Resident H, Resident F, Resident G, Resident J, Resident N and Resident P) on the dementia unit.Findings include:1.During an observation of Resident C's bathroom (shared with Resident H), on 1/7/26 at 9:49 a.m., the unlocked tri-fold mirrored vanity above the sink contained the following personal care items without resident identifiers:a. An empty bottle of Vashe Wound Cleanser.b. One partially used bottle of after shave gel.c. One open can of shaving cream.d. One partially used tube of perfumed body cream.e. Two denture brushes.f. One toothbrush.During the observation, the Memory Care Director entered the bathroom after speaking with Resident C and indicated that no one had wounds and they were not sure why the Vashe Wound Cleanser was in the bathroom.Resident C's clinical record was reviewed on 1/7/26 at 3:27 p.m. Diagnoses included hallucinations, cognitive communication deficit, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.His quarterly MDS (Minimum Data Set) assessment, dated 10/10/25, indicated he had severe cognitive impairment.Resident H's clinical record was reviewed on 1/8/26 at 1:13 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care. His quarterly MDS assessment dated [DATE] indicated he had moderate cognitive impairment.2. During an observation of Resident F and Resident G's bathroom (shared with Resident J), accompanied by the Memory Care Director, on 1/7/26 at 9:51 a.m., the unlocked tri-fold mirrored vanity above the sink contained the following personal care items without resident identifiers:a. One roll-on deodorant.b. One partially used tube of toothpaste.c. One partially used bottle of lotion.d. One toothbrush in a foam cup.Resident F's clinical record was reviewed on 1/8/25 at 12:56 p.m. Diagnoses included schizoaffective disorder, cognitive communication deficit, psychotic disorder with delusions due to known physiological condition, paranoidschizophrenia, dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, delusional disorders and Alzheimer's disease with late onset.Her quarterly MDS assessment, dated 11/8/25, indicated she had moderate cognitive impairment.3. During an observation of Resident N and Resident P's bathroom, accessible from the memory care unit's main dining room, accompanied by the Memory Care Director, on 1/7/26 at 9:51 a.m., the unlocked tri-fold mirrored vanity above the sink contained the following personal care items without resident identifiers:a. One partially used tube of skin repair cream.b. One toothbrush.c. One bottle of baby lotion.d. One container of cornstarch powder.e. Four incontinence briefs.Resident N's clinical record was reviewed on 1/8/26 at 12:33 p.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, and need for assistance with personal care.His quarterly MDS assessment, dated 12/30/25, indicated he had severe cognitive impairment.Resident P's clinical record was reviewed on 1/8/26 at 12:44 p.m. Diagnoses included unspecified dementia, moderate, with agitation and unspecified dementia, moderate, with anxiety.Her admission MDS assessment, dated 11/20/25, indicated she had moderate cognitive impairment.During the observations, the Memory Care Director indicated the residents' personal care items should have had resident identifiers on them.During an interview with CNA 12, on 1/8/26 at 10:17 a.m., she indicated Resident C was able to brush his own teeth, could walk but used a wheelchair and was able to take himself to the bathroom. Resident H needed some assistance but could take himself to the bathroom. Resident F could stand and ambulate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in her wheelchair independently. She let staff know when she needed to use the bathroom and needed assistance pulling her pants up and down. Resident G and J were dependent on staff for mobility and toileting. Resident N and Resident P could toilet themselves and stood at the bathroom sink independently. She indicated that the personal care items should have resident identifiers on them and the facility would normally keep the items in the shower room, the residents' drawers, or in the residents' closets.During an interview with the Administrator, on 1/8/26 at 1:56 p.m., he indicated he was unable to locate a policy for the storage of residents' personal care items.This citation relates to Intake 2700504. 3.1-18(a)