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	06/09/2025

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

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. A. Based on record review and interview, the facility failed to provide bed hold policy and transfer/discharge notifications to the resident and/or their representative for 3 of 3 residents reviewed for hospitalizations. (Residents 31, 24, & 191) B. Based on record review and interview, the facility failed to ensure appropriate transfer information was communicated to the receiving provider for 1 of 1 residents reviewed for discharge. (Resident 38) Findings include: A1. Resident 31's clinical record was reviewed on 6/6/25 at 1:41 p.m. Diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and hypertension. A 5/7/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A 3/4/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. A 3/24/25 nurse's note indicated a new order to send the resident to the emergency room and all parties were aware. Review of a notice of transfer/discharge form, dated 3/4/25, indicated the resident was discharged to the hospital. The form indicated the facility must attach a copy of the facility's bed hold policy. The bed hold form was attached. The clinical record lacked indication to whom the transfer discharge form and the bed hold policy was provided. A2. Resident 24's clinical record was reviewed on 6/6/25 at 2:23 p.m. Diagnoses included frontal lobe and executive function deficit following a cerebral infarction, hypertension, and unspecified dementia. A 1/10/25, annual, MDS assessment indicated the resident was moderately cognitively impaired. A 4/2/25, discharge MDS assessment indicated the resident discharged with a return anticipated. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/2/25 nurse's note indicated the resident was in the hospital. Review of a notice of transfer/discharge form, dated 4/2/25, indicated the resident was discharged to the hospital. The form indicated the facility must attach a copy of the facility's bed hold policy. The bed hold form was attached. The clinical record lacked indication to whom the transfer discharge form and the bed hold policy was provided. A3. Resident 191's clinical record was reviewed on 6/6/25 at 2:32 p.m. Diagnoses included unspecified dementia, unspecified hypotension, and prediabetes. A 4/6/25, significant change, MDS assessment indicated the resident was moderately cognitively impaired. A 5/18/25, nurse's note indicated the resident was transferred to the hospital and the resident's daughter was informed. A 5/18/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. A 5/27/25, entry, MDS indicated the resident returned to the facility. A 5/28/25, nurse's note indicated the resident was not acting right or responding to staff and a new order to send to the hospital was received. The resident's daughter was informed. A 5/28/25, discharge, MDS assessment indicated the resident discharged with a return anticipated. Review of a notice of transfer/discharge forms, dated 5/18/25 and 5/28/25, indicated the resident was discharged to the hospital. The forms indicated the facility must attach a copy of the facility's bed hold policy. The bed hold forms were attached. The clinical record lacked indication to whom the transfer discharge form and the bed hold policy was provided. During an interview, on 6/9/25 at 10:18 a.m., LPN 5 indicated, when a resident was sent to the hospital, the floor nurse would ensure a physician's order was received. The nurse would print out the resident documents including orders, pertaining labs, code status, family contact information, and care plans. LPN 5 indicated she printed out two copies and provided one to the resident and the other set to the ambulance or transportation driver. The resident's family was to be contacted as soon as possible. The discharge was documented in the discharge form in the electronic medical record. During an interview, on 6/9/25 at 3:50 p.m., the Corporate Nurse Consultant indicated he was not able to find documentation to verify if the resident or resident representatives had received copies of the transfer/discharge form or bed hold policy for the residents reviewed. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy, dated 8/2024 and titled, Bed Holds and Returns, provided by the Corporate Nurse Consultant on 6/9/25 at 2:43 p.m., indicated the following: . A. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during a period of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided written notice about these policies at least twice .b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) 3. Multiple attempts to provide the resident representative with the notice 2 should be documented in cases where staff were unable to reach and notify the representative timely . B1. Resident 38's clinical record was reviewed 6/6/25 at 3:44 p.m. Diagnoses included right side hemiplegia, hypertension and unspecified heart failure. A 1/10/25, quarterly, MDS assessment indicated the resident was moderately cognitively impaired. A 3/31/25 nurse's note indicated the resident was going to be discharging to another long term care facility today. A 4/1/25, discharge, MDS assessment indicated the resident discharged without a return anticipated. A 4/1/25 nurse's note indicated the resident discharged to another facility. The resident's medications and paperwork were sent with the resident's daughter. Review of a notice of transfer/discharge form, dated 3/31/25, indicated the resident was discharged to another long term care facility. The forms indicated the facility must attach a copy of the facility's bed hold policy. The bed hold form was attached. The clinical record lacked indication of the resident's discharge information being communicated to the receiving facility. During an interview on 6/9/25 at 3:59 p.m., the SSD indicated Resident 38 had discharged to another facility. The resident's daughter was given the packet of resident information, along with the resident's medications. The facility provided the information to the transportation company or the family, if they provided the transportation. The staff would document in the clinical record who at the new facility received the verbal report on the resident and the resident's paper documentation. The SSD was unable to locate the documentation ensuring the new facility received the appropriate information for the resident's transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy, dated 8/2024 and titled, Discharge, Facility-Initiated, provided by the Corporate Nurse Consultant on 6/9/25 at 3:03 p.m., indicated the following: . b. discharge refers to the movement of a resident from a bed in one certified facility to another certified facility or other location in the community .Information Conveyed to Receiving Provider 1. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: a. The basis for the transfer or discharge .b. Contact information of the practitioner responsible for the care of the resident, c. Resident representative information . d. Advance directive information, e. All special instructions or precaution for ongoing care . f. Comprehensive care plan goals; and f. All other information necessary to meet the resident's needs, including but not limited to: resident status, baseline and current mental, behavioral, and functional status, recent vital signs, diagnoses and allergies, medications (including when last received), most recent relevant labs . a copy of the resident's discharge summary, and any other document, as applicable, to ensure a safe and effective transitions of care . 3.1-12(a)(6)(A)(i)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to follow registered dietician recommendations and to notify the physician for a resident experiencing a progressive, unplanned weight loss for 1 of 1 residents reviewed for nutrition. (Resident 18) Finding includes: Resident 18's clinical record was reviewed on 6/6/25 at 11:08 a.m. Diagnoses included schizoaffective disorder, muscle weakness, unspecified obesity, and type 2 diabetes mellitus. A current order, initiated 12/30/24, indicated a regular texture, no added salt, consistent carbohydrate diet. A 5/11/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident 18 was moderately cognitively impaired, required supervision by staff for eating, and had weight loss. Resident 18 weighed 157 pounds (lbs) on 5/3/25. Resident 18's weight record was reviewed and indicated the following: 175 pounds (lbs) on 12/1/24, 172.3 lbs on 1/2/25, 167.4 lbs on 2/3/25, 162.8 lbs on 3/27/25, 158.4 lbs on 4/18/25, and 157 lbs on 5/3/25. This reflected a 10.29% weight loss over a six-month period. Resident 18's meal consumption from 5/11/25 through 6/8/25 indicated the resident typically ate 51-75 % of her meals, occasionally 26-50 % of meals, and rarely 76-100 % of meals. A nutrition care plan, initiated on 2/21/25, indicated the resident would maintain their current weight through the next review. Interventions included weekly weights (2/21/25), serve diet as ordered (2/21/25), and the registered dietician to evaluate and make diet changes as needed (2/21/25). A 3/24/25 nutritional risk assessment indicated the resident's carbohydrate controlled diet be liberalized to a regular diet, to offer more calories and protein. A 3/24/25 nurse note indicated Resident 18's weight was down 4.8% in 30 days and 9% in 90 days, which was a significant weight loss. The resident received a carbohydrate controlled diet and the Registered Dietitian (RD) recommended to change this diet to a regular diet to offer more calories and protein. A 3/26/25 electronic mail (email) from the RD to the Interdisciplinary team (IDT) indicated to liberalize Resident 18's diet from carbohydrate controlled to a regular diet. A 3/26/25 nutritional risk assessment indicated the resident's carbohydrate controlled diet was to be liberalized to a regular diet, to offer more calories and protein. A 4/16/25 nutrition note indicated Resident 18's weight was without significant change in 30 days. The resident received a carbohydrate controlled diet and the RD recommended to change this diet to a regular diet which offers more calories and protein. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation indicating the physician was notified of the resident's significant weight loss. The clinical record lacked an order to change the resident's diet or indication that the physician declined the recommendation to change the resident's diet. During an interview, on 6/6/25 at 1:39 p.m., the Director of Nursing (DON) indicated the facility held hybrid nutritional meeting with some interdisciplinary team (IDT) members attending in person and others by phone. The RD recommendations were sent by email to the IDT team and he (the DON) followed up on those recommendations. The RD documented in the electronic medical record (eMar). During a telephone interview, on 6/9/25 at 2:55 p.m., the RD indicated she reviewed resident weights weekly and held a clinical meeting to discuss the results and her recommendations. The recommendations are also sent via email to the IDT group. The RD indicated she recommended to liberalize Resident 18's diet in March 2025 to prevent further weight loss. During a follow-up interview, on 6/9/25 at 3:48 p.m., the DON indicated he was not aware that Resident 18 remained on a carbohydrate controlled diet. He indicated the clinical team should notify the physician of weight loss and RD recommendations. Any IDT members with the proper credentials could change a resident's diet order in the clinical record. A facility policy, dated 8/2024 and titled, Nutritional Assessment, provided by the Corporate Nurse Consultant on 6/9/25 at 3:29 p.m., indicated the following: .1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within the current baseline assessment timeframes) and as indicated by change in condition that places the resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic multidisciplinary process that includes gathering and interpreting data and using the data to help define meaningful interventions for the resident at risk for or with impaired nutrition . 3.1-46(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure shift to shift narcotic reconciliation was completed for 3 of 4 medication carts reviewed for medication storage. (A Unit, Cottage Unit, and C Unit medication carts) This deficient practice had the potential to affect 18 out of 30 residents who resided in the facility and received controlled medications from A Unit, Cottage Unit, and C Unit medication carts. Findings include: 1. During a medication storage observation of A Unit medication cart, accompanied by LPN 9 on 6/5/25 at 9:55 a.m., the Shift To Shift Narcotic Count record was reviewed and was missing LPN 9's signature and count when she took over the cart at the beginning of her shift on 6/5/25. LPN 9 immediately signed her name to the blank and indicated she had not signed nor recorded her count at the beginning of her shift. The last recorded count of controlled medications indicated there were 9 sheets and 9 cards. Upon counting the cards and sheets, LPN 9 indicated there were 8 sheets and 8 cards, which was a discrepancy from the last recorded count. She had not recognized nor notified anyone of the discrepancy. She believed the discrepancy was due to a calculation error two shifts prior, but it was not her duty to determine why there was a discrepancy. She should have reported the discrepancy to the DON. LPN 9 indicated there were additional missing signatures and counts on multiple dates and shifts in May and June 2025 for the A Unit medication cart. Review of the Shift To Shift Narcotic Count records for A Unit medication cart, from 5/1/25 through 6/5/25, lacked shift to shift reconciliation of controlled substances on the following dates and shifts: 5/3/25 - day shift 5/5/25 - day shift 5/5/25 - night shift 5/10/25 - day shift 5/10/25 - night shift 5/11/25 - day shift 5/13/25 - night shift 5/15/25 - night shift 5/16/25 - day shift 5/21/25 - day shift 5/22/25 - day shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/22/25 - night shift 5/24/25 - night shift 5/28/25 - night shift 5/30/25 - day shift 5/30/25 - night shift 5/31/25 - day shift 6/1/25 - day shift 6/5/24 - day shift 2. During a medication storage observation of Cottage Unit medication cart, accompanied by LPN 9 on 6/5/25 at 10:23 a.m., the Shift To Shift Narcotic Count record was reviewed and was missing LPN 9's signature and count when she took over the cart at the beginning of her shift on 6/5/25. Upon counting the cards and sheets, no discrepancies were found. During an interview, LPN 9 indicated she had not signed nor recorded the count at the beginning of her shift on 6/5/25 for the Cottage Unit medication cart. There were additional missing signatures and counts on multiple dates and shifts in May and June 2025 for the Cottage Unit medication cart. With each exchange of the medication carts, both staff exchanging the carts were required to count and verify the number of cards and sheets to ensure no discrepancies. When discrepancies were found with controlled medications, they were required to notify the DON immediately. Keys to a cart with controlled medication discrepancies should not have been accepted without the DON investigation and a resolution to the discrepancy. This was an opportunity for drug diversion. Review of the Shift To Shift Narcotic Count records for Cottage Unit medication cart, from 5/1/25 through 6/5/25, lacked shift to shift reconciliation of controlled substances on the following dates and shifts: 5/5/25 - day shift 5/6/25 - day shift 5/6/25 - night shift 5/10/25 - night shift 5/11/25 - day shift 5/11/25 - night shift 5/15/25 - night shift 5/16/25 - day shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/16/25 - night shift 5/17/25 - day shift 5/20/25 - night shift 5/22/25 - day shift 5/22/25 - night shift 5/23/25 - day shift 5/23/25 - night shift 5/24/25 - day shift 5/28/25 - night shift 5/29/25 - day shift 5/29/25 - night shift 5/30/25 - night shift 5/31/25 - day shift 5/31/25 - night shift 6/1/25 - day shift 6/1/25 - night shift 6/4/25 - day shift 6/5/25 - day shift 3. During a medication storage observation of C Unit medication cart, accompanied by RN 4 on 6/5/25 at 11:30 a.m., the Shift To Shift Narcotic Count record was reviewed. During an interview, RN 4 indicated there were missing signatures and counts on multiple dates and shifts in May and June 2025 for the C Unit medication cart. A count should have been documented along with signatures of both staff members during an exchange of the medication cart. Incomplete signatures or counts were not acceptable. Review of the Shift To Shift Narcotic Count records for C Unit medication cart, from 5/1/25 through 6/5/25, lacked shift to shift reconciliation of controlled substances on the following dates and shifts: 5/2/25 - day shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/6/25 - night shift 5/7/25 - day shift 5/10/25 - day shift 5/10/25 - night shift 5/11/25 - day shift 5/13/25 - day shift 5/13/25 - night shift 5/15/25 - day shift 5/15/25 - night shift 5/20/25 - day shift 5/20/25 - night shift 5/23/25 - night shift 5/24/25 - day shift 5/25/25 - day shift 5/29/25 - day shift 5/31/25 - day shift 5/31/25 - night shift 6/1/25 - day shift During an interview on 6/5/25 at 2:36 p.m., the DON indicated both staff members exchanging a medication cart were required to count the medication sheets, medication cards, compare the count with the last medication reconciliation to ensure there were not any discrepancies, record the count and provide signatures of acknowledgement. One was not able to identify if the reconciliation was completed when the medication reconciliation record was incomplete. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current facility policy, dated 8/2024, titled Controlled Substances, provided by the DON on 6/5/25 at 5:27 p. m., indicated the following: Policy Statement . The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) . Dispensing and Reconciling Controlled Substances 4. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 5. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 6. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 7. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services 3.1-25(b)(3)

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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. Based on observation, record review, and interview, the facility failed to ensure staff were educated in, and implemented, Enhanced Barrier Precautions (EBP) during high-contact care. (Resident 37) Finding includes: During an interview on 6/2/25 at 4:49 p.m., Resident 37 was in bed, with a tube feeding running, and indicated she had a sacral pressure injury. Staff wore gloves when they provided her wound care and other cares, but they did not wear gowns. During a wound observation on 6/5/24 at 4:10 p.m., RN 4 performed hand hygiene and donned gloves after the resident consented to a wound observation. She leaned forward over the resident's bed, without donning a gown and her pants were against the resident's bed linens. RN 4 unsecured the resident's brief and removed the resident's old dressing that was rolled up at the bottom. An open pressure injury to the sacrum was approximately the size of a pencil eraser and contained slough. RN 4 doffed her gloves, performed hand hygiene, and left the room to get some supplies. On 6/5/24 at 4:18 p.m., RN 4 returned to the resident's room with wound care supplies, performed hand hygiene and donned gloves. Wound care was provided per physician order without the use of a gown. Resident 37's clinical record was reviewed on 6/5/25 at 4:50 p.m. Diagnoses included unspecified severe protein-calorie malnutrition, dysphagia, and a stage 3 pressure ulcer (full-thickness tissue loss, where the skin is damaged and subcutaneous fat is visible) of the sacral region. Current orders included the use of EBP to reduce the risk of transmission of multi-drug resistant organisms every shift and cleanse area to the coccyx with wound cleanser, pat dry, apply skin prep to the periwound, apply medical grade honey, and cover with a bordered gauze daily. A 5/20/25, admission, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. She required maximal assistance for toileting, bathing, personal hygiene, lower body dressing, sit to stand, and transfers. The resident was at risk for pressure injuries. A current care plan, dated 5/23/25, indicated the resident required the use of enhanced barrier precautions related to the presence of a wound to reduce the risk of multi-drug resistant organism transmission. Interventions included EBP per the Center for Disease Control (CDC) guidelines during high contact resident care and precautions to remain in place until the resolution of the wound. Review of an admission assessment, dated 5/13/25, indicated the resident had a stage 3 wound to her coccyx on admission from the hospital. During an interview on 6/5/25 at 4:36 p.m., RN 4 indicated the resident had EBP and she did not wear a gown as required during the wound care observation. She forgot about EBP because she did not typically perform the residents wound care since it was scheduled to be changed on night shift. Gowns were readily available in the resident's closet. EBPs were in place to protect the resident from wound contamination as a result of any contaminants that may have been on RN 4's clothing. It also prevented RN 4 from carrying anything into other residents' rooms. She should have worn a gown and gloves during the resident's wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/25 at 10:39 a.m., CNA 7 indicated she was familiar with the care of residents on Unit B. She did not know what EBP was. Her assignment was the B Unit and she also assisted on Unit A and Unit C. CNA 7 was unaware of any residents on the B Unit who required any specific precautions or additional personal protective equipment during high contact care. She was uncertain what needed to be worn for EBP. CNAs referenced the CNA assignment sheet to determine which residents required EBP. On 6/9/25 at 10:53 a.m., CNA 8 indicated she did not know what EBP was. She had worked on Unit A , Unit B, and Unit C in the last week and no one told her anyone required specific precautions on any of those units. When residents required specific precautions, she expected to find the information on the CNA assignment/report sheets. She also identified when residents required specific precautions because the residents' room doors were labeled with signage and personal protective equipment canisters were outside the residents' rooms. None of the CNA sheets for Unit A, Unit B, nor Unit C had any residents marked with EBP. She had not followed any specific precautions during high contact care for residents on Unit A, Unit B, nor Unit C over the last week. On 6/9/25 at 11:11 a.m., CNA 10 indicated EBP was utilized for residents with Clostridium difficile (an infectious bacteria) or other specific illnesses. A gown, gloves, and mask were required for EBP. She was assigned to Unit C and also assisted on Unit A and Unit B. She was made aware when residents required EBP by the sign on the resident's door, which explained which PPE was required. It was also included on the CNA report sheets if a resident required EBP. If PPE was necessary, she had to retrieve it from the clean utility room across from the nurses' station. She was unaware of any residents on Unit A, Unit B, nor Unit C who required EBP. During an observation on 6/9/25 from 11:39 a.m. to 11:50 a.m., CNA 10 answered Resident 37's call light. The resident indicated she was ready to get changed. CNA 10 went to the resident's closet and retrieved the resident's clothing and a clean incontinence brief and placed them on the resident's bed linens. The closet door contained signage for EBP and indicated everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for high contact resident care activities. The listed high-contact resident care activities included: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care. A note was hand written on the sign that gowns were located in the closet. Without hand hygiene, CNA 10 donned gloves, prepared wash cloths for incontinence care, and took the supplies to the bedside. The CNA removed the resident's pajama pants with gloved hands as she leaned against the resident's bed linens. With the same gloves, CNA 10 reached into her right pants pocket, removed three trash bags from a roll, and placed the roll back into her pocket. The CNA leaned forward against the bed linens, removed the resident's pajama shirt, and removed the resident's incontinence brief. Incontinence care and a clean brief were provided by CNA 10. As CNA 10 leaned against the bed to put on the resident's pants and shirt, her name badge draped against the resident's bare abdominal skin next to her feeding tube site. With the contaminated gloves, the CNA repositioned the feeding tubing out of the way as she pulled the resident's shirt down. CNA 10 then placed her right arm around the resident's back and directly against the resident's clothing as she assisted the resident to reposition from lying to sitting on the side of the bed. The CNA's gloves were doffed and placed into the bag. Without hand hygiene, CNA 10 picked up the call light and a box of tissues from the resident's bed and handed them to the resident. CNA 10 did not wear a gown, perform hand hygiene, nor change gloves throughout the observation. She exited the resident's room with bags of dirty linens in both hands. (continued on next page)

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	06/09/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/25 at 11:51 a.m., CNA 10 indicated she had not seen the EBP sign affixed to the resident's closet door during the resident care observation, nor had she seen it before. As a result, she did not don a gown for the resident care observation. She should have donned a gown, gloves, and a mask prior to the resident's high-contact care. On 6/9/25 at 12:40 p.m., the DON indicated EBP was required for residents with invasive lines, catheters, feeding tubes, wounds with broken skin, and those colonized with a multi-drug resistant organism. A gown and gloves were required during high contact care for residents in EBP to include: wound care, incontinence care, clothing changes, and manipulation of invasive devices. He had provided an in-service about EBP, but was uncertain when it occurred. On 6/9/25 at 2:50 p.m., the DON indicated he was unable to provide information to show when EBP education was provided for staff and which staff had received the education. Unit B had five residents who required EBP and Unit C had two residents who required EBP. On 6/9/25 at 5:44 p.m., LPN 12 indicated she was an agency staff member. The facility had not provided education regarding EBP before she provided care for the residents in the facility. A current facility policy, dated 8/2024, titled Enhanced Barrier Precautions, provided by the DON on 6/9/25 at 2:49 p.m., indicated the following: Policy Statement . Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation . 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. transferring; d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and h. wound care (any skin opening requiring a dressing) . 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk 3.1-18(b)(2) 3.1-18(l)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to offer, educate, and/or administer pneumococcal vaccines per the Center for Disease and Control (CDC) guidance for 2 of 5 residents reviewed for immunizations. (Residents 3 and 4) Findings include: 1. Resident 3's clinical record was reviewed on 6/6/25 at 3:19 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus with diabetic neuropathy, and a stage 4 pressure ulcer of the sacral region. The clinical record lacked an order for the pneumococcal vaccine. Review of the resident's vaccinations included the following: The resident had a historical administration of Pneumovax 23 on 5/9/17, prior to admission to the facility. A Pneumococcal Vaccine Consent Form, dated 1/29/25, indicated education was provided and the resident's representative consented to administration of the vaccine. The vaccine was not administered. During an interview on 6/9/25 at 1:00 p.m., the DON indicated a Pneumococcal Vaccine Consent Form for Resident 3 was completed on 1/29/25. The facility had not administered Resident 3's pneumococcal vaccine and she was due to receive the next dose. 2. Resident 4's clinical record was reviewed on 6/5/25 at 2:30 p.m. Diagnoses included chronic pain syndrome, hypertension, and type 2 diabetes mellitus. The admission dated was 2/12/25. Current orders included may have pneumococcal vaccine one time if over the age of 65 and may have Pneumococcal vaccine once every 5 years if under the age of 65 (2/12/25) and annual flu and Pneumonia vaccine orders unless contraindicated (2/12/25). Review of the resident's vaccinations included the following: The resident had a historical administration of Pneumovax 23 on 9/15/14 and Prevnar 13 on 1/31/18, prior to admission to the facility. The clinical record lacked education and a signed consent/declination form for the pneumococcal vaccination. During an interview on 6/9/25 at 1:00 p.m., the DON indicated the facility had administered the vaccines when they were due in the past. The new owners had a different process, in which an outside provider was utilized to administer vaccines. The facility had not held a vaccine clinic with the outside provider. He was uncertain how immunizations/vaccines were handled when they were due in between the clinics. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 6/9/25 at 4:26 p.m., the DON indicated he was unable to locate documentation or consents for Resident 4's pneumococcal vaccinations. A facility policy, dated 8/2022, titled, Influenza, Pneumococcal, and COVID-19 Immunizations, provided by the DON on 6/9/25 at 5:42 p.m., indicated the following: . Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of influenza, pneumococcal, and COVID-19 immunizations. A copy will be retained in the medical record. 2. Upon admission each resident/resident representative will sign an informed consent form indicating the acceptance/refusal of immunization. A copy will be retained in the medical record and results added to the preventative health record in EHR . 6. Each resident will be offered, unless medically contraindicated, or already vaccinated, a pneumococcal vaccine per the attending physician's orders . 12. CDC recommends pneumococcal vaccinations (PCV 13 or Prevnar 13*, PPSV 23 or Pneumovax 23*, PVC 20 or Prevnar 20, PCV 15 or Vaxneuvance) for all adults 65 years or older . 3.1-18(b)(5)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, the facility failed to offer, educate, and/or administer COVID-19 vaccines per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for immunizations. (Residents 4) Finding includes: Resident 4's clinical record was reviewed on 6/5/25 at 2:30 p.m. Diagnoses included chronic pain syndrome, hypertension, and type 2 diabetes mellitus. The admission dated was 2/12/25. The resident had a historical administration of COVID-19 vaccinations on 1/22/21, 2/19/21, 12/28/21, 7/7/22, and 11/29/22, all prior to admission to the facility. Current orders included may test for COVID-19 as needed (2/12/25). The clinical record lacked education and a signed consent/declination form for the COVID-19 vaccination. During an interview on 6/9/25 at 1:00 p.m., the DON indicated the facility had not had a vaccine clinic to administer vaccinations. The new owners had a different process in which an outside provider was utilized to administer vaccines. The facility had not held a vaccine clinic with the outside provider. He was uncertain how immunizations/vaccines were handled when they were due in between the clinics. During an interview, on 6/9/25 at 4:26 p.m., the DON indicated he was unable to locate documentation or consents for Resident 4's COVID-19 vaccinations. The vaccination consents were part of the admission packet. A facility policy, dated 8/2022, titled, Influenza, Pneumococcal, and COVID-19 Immunizations, provided by the DON on 6/9/25 at 5:42 p.m., indicated the following: . Upon admission each resident/resident representative will be provided with information regarding the risk and benefits of influenza, pneumococcal, and COVID-19 immunizations. A copy will be retained in the medical record. 2. Upon admission each resident/resident representative will sign an informed consent form indicating the acceptance/refusal of immunization. A copy will be retained in the medical record and results added to the preventative health record in EHR .13. COVID-19 boosters will be offered and given based on the CDC recommendations 3.1-18(b)(5)