STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to provide written notice to the residents and/or their representatives pertaining to transfer/discharge rights and the facility's bed hold policy for 3 of 3 residents reviewed for hospitalizations. (Resident's 4, 27, and 45). Findings include: 1. Resident 4's clinical record was reviewed on 3/30/26 at 12:59 p.m. Diagnoses included cerebral infarction (stroke), atrial fibrillation (irregular heart rhythm), and vascular dementia.A progress note, dated 8/13/25 at 7:45 p.m., indicated Resident 4 was lethargic and had to be fed for dinner. Her speech was garbled. She intermittently responded to verbal or tactile stimuli. Resident 4's family was at bedside and requested the resident to be sent to the emergency room (ER) for evaluation. The on-call provider, DON, and ambulance to transport were notified. Hospital called and was given report. Emergency Medical Technicians (EMTs) transported the resident to the hospital.Resident 4's clinical record lacked documentation indicating if the Notice of Transfer rights and bed hold policy was provided to the resident and/or provided to her representative.2. Resident 27's clinical record was reviewed on 3/30/26 at 10:54 a.m. Diagnoses included hyperosmolality (high solute concentration in the blood) and hypernatremia (high sodium level), tonsillar cancer, and nontraumatic subarachnoid hemorrhage (spontaneous bleeding into the space surrounding the brain).A progress note, dated 2/8/26 at 6:57 a.m., indicated Resident 27 had moist respirations and had difficulty breathing. Respirations were labored at 46. oxygen saturation reading was 55-62 % on room air. Provider was notified and a new order was received to send the resident to the ER and oxygen was to be applied at 15 L. A message left for Resident 27's representative. The DON was notified and 911 was called at 6:29 a.m. The resident was transferred to the local hospital and report was called to ER.A progress note, dated 2/8/26 at 12:49 p.m. indicated Resident 27's brother notified the facility that the resident was admitted to ICU with a diagnosis of severe pneumonia.Resident 27's clinical record lacked documentation indicating if the Notice of Transfer rights and bed hold policy was provided to the resident and/or his representative. A progress note, dated 2/23/26, indicated Resident 27 had an unresponsive episode in the dining room. Oxygen was placed on the resident. Oxygen saturation was 89%. Vital rechecked 15 minutes later. Heart rate was 38 and oxygen saturation was 74% with decreased responsiveness. Provider notified and received orders for ER evaluation. EMS contacted and provided transport to local hospital. Report called to local hospital. Family was notified.A progress note, dated 2/23/26 at 3:02 p.m., indicated Resident 27 was admitted to the hospital.Resident 27's clinical record lacked documentation indicating if the Notice of Transfer rights and bed hold policy was provided to the resident and/or his representative.3. Resident 45's clinical record was reviewed on 3/27/26 at 3:15 p.m. Diagnoses included anemia, hypertension (high blood pressure) and dementia. A progress note, dated 3/10/26 at 10:05 p.m., indicated Resident 45 had gray, heavy sediment in his urine with very foul odor. Resident's baseline was alert and orientated x3, and he asked the nurse where he was. The resident indicated that he did not feel good. On call provider and family were notified. The resident's family wanted the resident to be sent to ER. Family was concerned about him when they visited as he was not acting like himself.A progress note, dated 3/10/26 10:34 p.m., indicated an order was received for ER evaluation. 911 was notified and report (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 - Some	was called to the hospital.A progress note, dated 3/10/26 10:58 p.m., indicated EMS was at facility to provide transport to the ER.A progress note, dated 3/11/26 4:00 a.m., indicated Resident 45 was admitted to the hospital for urosepsis.Resident 45's clinical record lacked documentation indicating if the Notice of Transfer rights and bed hold policy was provided to the resident and/or his representative.During an interview, on 3/30/26 at 1:30 p.m., the Social Services Director (SSD) indicated Resident 27 had a guardian who was notified when he went to the hospital. Resident 45 was his own representative; however, the facility usually notified his wife if he went to the hospital. Notice of Transfer forms and bed hold policies were not mailed out or given directly to residents or their family members. Forms were only sent to the ER at the time of the transfer.During an interview on 3/30/26 at 1:30 p.m., the DON indicated bed hold paperwork was sent to the hospital in a packet given to the EMTs at the time of the transfer.During an interview, on 3/31/26 at 9:43 a.m., RN 2 indicated if a resident had a change in their condition and needed to be sent out for an evaluation, the nurse was to notify the provider to get an order. The DON and family were to be notified of the transfer. All notifications were to be documented. The nurse was to complete a change in condition assessment, which consisted of step-by-step instructions and indicated what documentation needed to be completed. A progress note was to be entered, and a transfer form was to be completed. Upon notification of the EMS, report was to be called to the receiving facility. Paperwork was usually sent with EMTs and included the face sheet, medication list, the resident's code status, and a bed hold policy. The packet was sent with EMTs. No paperwork was given to residents. The bed hold was for the hospital to know the facility would take the resident back when discharged from the hospital.During an interview, on 3/31/26 at 1:45 p.m., the SSD indicated the nursing staff filled out a bed hold policy at the time of a resident's transfer to the hospital and she was given a copy. She then typed it out to make it more legible and placed it in a binder. She believed all bed holds went with the resident to the hospital and upon the family notifying the family of resident's transfer, they would tell them that the bed hold was sent to the hospital.During an interview, on 3/31/26 at 1:59 p.m., the DON indicated a transfer form was to be completed when a resident was transferred to the hospital. There was no documentation of what information, including the Notice of Transfer rights and bed hold policy, was sent to the hospital at the times of Resident 4, 27, and 45's hospitalizations. There was no documentation of Resident 4, 27, and 45 representatives having received the Notice of Transfer rights and bed hold policy at the time of each hospitalization. A current facility policy, dated 8/2024, titled Transfer or Discharge, Facility -Initiated, provided by the DON on 3/31/26 at 2:39 p.m., indicated the following: .20. Notice of Facility Bed-Hold and Return policies are provided to the residents and representatives within 24 hours of emergency transfer. 21. Notices are provided in a form and manner that the resident can understand, taking into account the resident's education level, language, communication barriers, and physical or mental impairments.Documentation of Facility-Initiated Transfer or Discharge. 1. When a resident is transferred or discharged from the facility the following information is documented in the medical record: 1.b. That an appropriate notice was provided to the resident and/or legal representative.410 IAC (Indiana Administrative Code) 16.2-3.1-3.1-12(a)(25)410 IAC 16.2-3.1-3.1-12(a)(26)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident and/or the resident representative received a copy of the resident's baseline care plan following admission for 1of 3 residents reviewed for care plans. (Resident 8) Finding includes:Resident 8's clinical record was reviewed on 3/30/26 at 10:30 a.m.Census information indicated the resident was admitted to the facility on [DATE].The clinical record lacked documentation that the resident and/or the resident's representative was provided with a copy of the baseline care plan.During an interview, on 3/30/26 at 1:30 p.m., the Social Services Director (SSD) indicated she had not completed a baseline care plan conference review note for Resident 8 due to him not having had a care plan conference since his admission. As a result, no baseline care plan information was provided to Resident 8 or to his resident representative.During an interview, on 3/31/26 at 1:28 p.m., the SSD indicated baseline care plan information was to be conveyed to residents or their representative within 72 hours after a resident's admission to the facility. Baseline care plan information was permitted to be relayed over the phone. No phone contact was made with Resident 8's representative regarding baseline care plan information. Resident 8's cognitive status was intact, but cognitive functions fluctuated at times. She did not provide base line care plan information, verbally or written, to Resident 8. A current policy, dated 8/2024, titled Care Plans, Baseline, provided by the DON, on 3/31/26 at 2:39 p.m., indicated the following: Policy Statement: A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation.4. The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan as necessary. 5. Provision of the summary to the resident and/or resident representatives is documented in the medical record.410 IAC (Indiana Administrative Code)16.2-3.1-30(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to offer and administer appropriate pneumococcal vaccinations per the Center for Disease and Control (CDC) guidance for 2 of 5 residents reviewed for vaccinations. (Resident 27 and 45)Findings include: 1. Resident 27's clinical record was reviewed on 3/27/26 at 10:54 a.m. Diagnoses included tonsillar cancer, traumatic brain injury, and diabetes (high blood sugar).A review of the resident's vaccinations included the following:The resident had a historical administration, dated 12/19/11, of Pneumovax 23 pneumococcal vaccination (PPSV 23). This was prior to the resident's admission to the facility.The clinical record lacked a Pneumococcal Vaccine Consent or Declination Form.The clinical record lacked any offering of the pneumococcal vaccines PCV 15, 20, or 21 as recommended by the CDC.2. Resident 45's clinical record was reviewed on 3/27/26 at 3:15 p.m. Diagnoses included aortic valve insufficiency, heart disease, and muscle weakness.A review of the resident's vaccinations indicated the resident had not received a pneumococcal vaccination.A Pneumococcal Vaccine Consent was signed on 12/6/24. The record lacked an updated consent or declination.The clinical record lacked any offerings of a pneumococcal vaccine. During an interview, on 3/30/26 at 1:30 p.m., the DON indicated she was unable to locate current pneumococcal vaccination forms for Resident 27 and 45. The facility did not administer any vaccinations, and an off-site company was utilized to administer vaccinations to the residents. She was aware that another vaccine clinic needed to be scheduled but had not done it yet.During an interview, on 3/31/26 at 2:06 p.m., the DON indicated pneumonia vaccinations were offered per guidelines.During an interview, on 3/31/26 at 2:24 p.m., the Infection Preventionist indicated residents were offered pneumococcal vaccinations.The Center for Disease and Control (CDC) website, accessed on 4/1/26 at 2:30 PM, indicated the following: Pneumococcal Vaccine Recommendations.Adults 50 years or older. Routine vaccination recommendations: Administer PCV (pneumococcal conjugate vaccines) 15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccine history is unknown. PCV15: Additional vaccination recommended. If PCV15 is used, administer a dose of PPSV23 one year later. Only one dose of PPSV (pneumococcal polysaccharide vaccine) 23 is indicated. If PPSV23 was previously administered, another dose isn't needed. The patient's pneumococcal vaccinations are complete. PCV20 or PCV21: Additional vaccination not recommended. If PCV20 or PCV21 is used, a dose of PPSV23 isn't indicated. Regardless of which vaccine is used (PCV20 or PCV21), the patient's pneumococcal vaccinations are complete. Recommendation for shared clinical decision-making. Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old.A current facility policy, dated 8/2024, titled Pneumococcal Vaccine, provided by the DON on 3/31/26 at 2:39 p.m., indicated the following: Policy Statement: All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation: 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series and when indicated are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident was completed the current recommended vaccine series. 2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of their resident's admission if not conducted prior to admission.7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.410 IAC (Indiana Administrative Code) 16.2-3.1-18(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 administer the appropriate COVID-19 vaccinations per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for infection control. (Resident 45)Finding includes:Resident 45's clinical record was reviewed on 3/27/26 at 3:15 p.m. Diagnoses included aortic valve insufficiency, heart disease, and muscle weakness.A quarterly Minimum Data Set (MDS) assessment, dated 3/9/26, indicated the resident's cognitive status was moderately impaired.A COVID-19 vaccine consent and a COVID-19 booster consent was signed by Resident 45's representative on 12/6/24.A review of the resident's vaccinations indicated the resident had not received a COVID-19 vaccination and the family representative had refused the vaccination in December 2024.The record lacked an updated or yearly COVID-19 vaccination consent or declination.During an interview, on 3/30/26 at 1:30 p.m., the DON indicated she was unable to locate current COVID-19 vaccination forms for Resident 45. The facility did not administer any vaccinations, and an off-site company was utilized to administer vaccinations to the residents. She was aware that another vaccine clinic needed to be scheduled but had not done it yet.During an interview, on 3/31/26 at 2:06 p.m., the DON indicated COVID-19 vaccinations were to be offered yearly.During an interview, on 3/31/26 at 2:24 p.m., the Infection Preventionist indicated residents were offered COVID-19 vaccinations.The Center for Disease and Control (CDC) website, accessed on 4/1/26 at 2:30 PM, indicated the following: COVID-19 Vaccination for Long-term Care Residents.Vaccine recommendations: CDC recommends an updated COVID-19 vaccine for most adults ages 18 years and older, including people who live and work in long-term care (LTC) settings, get 1 dose of an updated COVID-19 vaccine. CDC recommends everyone ages 65 and older including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart.Reminder: People who live in LTC settings must give consent or agree to getting a COVID-19 vaccine.410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)(5)