STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Hartford City	715 N Mill St Hartford City, IN 47348

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 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 record review and interview, the facility failed to report an allegation of abuse to the State Agency within the required time frame. (Resident B) Findings include A facility reported incident, dated 10/27/25 at 4:19 p.m., submitted to the Indiana Department of Health indicated an incident occurred on 10/27/25 at 3:01 p.m. The reported incident indicated the following: On 10/27/25 Resident B reported to the Administrator that CNAs yelled at her on 10/26/25. On 10/27/25 an investigation was initiated, and the CNAs were suspended pending the investigation outcome. Review of the facility's abuse investigation file, provided on 11/6/25 at 11:49 a.m., included the following: RN 9's statement indicated Resident B's representative approached the nurses station on 10/26/25 at approximately 1:00 p.m. and asked to talk to someone about a concern she had regarding the resident. Resident B had reported to her that Resident B had overheard, at lunch, the CNAs say from around a corner that she was old enough and should not be peeing herself, and that they were not going to continue to get her up and down like a yo-yo. During an interview, on 11/7/25 at 2:13 p.m., RN 9 indicated on 10/26/25, after lunch, the CNAs were taking residents from the dining room to their rooms. Resident B's representative asked to speak to the Administrator. The resident's representative indicated Resident B had told her the CNAs had said Resident B was old enough to hold her urine, and they had to keep getting her up and down like a yo-yo to go to the bathroom. During an interview, on 11/7/25 at 2:24 p.m. , RN 9 indicated she had let the Administrator know about the incident on 10/26/25 at 1:26 p.m., according to the date and time on her phone. During an interview, on 11/7/25 at 3:30 p.m., the Administrator indicated she had received a text from RN 9 about the incident with Resident B on 10/26/25. She had spoken to RN 9 and the Resident B's representative on 10/26/25. RN 9 indicated Resident B was not overly upset. The Administrator had not believed this was abuse, but more of a customer service issue since Resident B had overheard something. Once she spoke to Resident B on 10/27/25 at 3:00 p.m., and Resident B indicated the CNAs yelled at her, cried, and indicated she did not want the CNAs to be fired, the Administrator decided the situation was possible abuse. She began the investigation and notified the State Agency at that time. A current facility policy, dated 8/2024, titled Abuse, Neglect, Exploitation and Misappropriate, Reporting, and Investigating, provided by the Administrator on 11/6/25 at 4:23 p.m., indicated the following: .All reports of resident abuse (including injuries of unknow origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulation) and thoroughly investigation by facility management. Findings of all investigation are documented and reported.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 'Immediately' is defined as: h. within two hours of an allegation involving abuse. Cross Reference F610. This citation relates to Intake 2657526. 3.1-28(c)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to conduct a thorough investigation of an allegation of abuse and failed to implement immediate interventions to prevent potential abuse while the investigation was in progress. (Resident B) Findings include: A facility reported incident, dated 10/27/25 at 4:19 p.m., submitted to the Indiana Department of Health indicated an incident occurred on 10/27/25 at 3:01 p.m. The reported incident indicated the following: On 10/27/25 Resident B reported to the Administrator that CNAs yelled at her on 10/26/25. On 10/27/25 an investigation was initiated, and the CNAs were suspended pending the investigation outcome. CNA 3 and CNA 5 were the CNAs mentioned in the report. The clinical record for Resident B was reviewed on 11/6/25 at 10:30 a.m. Diagnoses included fracture of lower end of left femur, chronic kidney disease, stage 4, type 2 diabetes mellitus with diabetic polyneuropathy, morbid obesity due to excess calories, anxiety disorder, and muscle weakness. Current orders included torsemide (diuretic) 20 mg daily and resident uses a mechanical lift with the assistance of two staff members. An admission Minimum Data Set (MDS) assessment, dated 9/2/25, indicated the resident was cognitively intact. She was dependent on staff assistance for toileting. She required substantial/maximal staff assistance with bathing and lower body dressing. She was frequently incontinent of bowel and bladder. A care plan, initiated 8/27/25 and revised 9/3/25, indicated that the resident had an ADL (activities of daily living) self-care performance deficit related to impaired mobility, recent femur fracture, and extensive medical history. Interventions included the following: The resident required a mechanical lift for transfers with two staff assistance (8/27/25) and the resident required extensive assistance of one or two staff assistance with toileting (9/3/25). A care plan, initiated 8/27/25 and revised 9/3/25, indicated the resident had bladder incontinence related to impaired mobility and diuretics. Interventions included the following: Clean the resident's perineal area with each incontinence episode (8/27/25) and supply the resident with toileting devices as appropriate (8/27/25). A care plan, initiated on 10/3/25 and revised on 10/29/25, indicated the resident had made false statements and accusations. She had stated she had to stay in bed all weekend because there were no clean mechanical lift pads when she had in reality stated she did not want to get up when the aides attempted to assist her. She said no one wanted to lay her down and put her on the bedpan because they cannot ever find a bedpan when in reality her bedpan was sitting right beside her bed. She said she did not receive a dessert when she had taken hers off her tray and put in her pocket prior to asking for another dessert. Interventions included the following: Care in pairs (10/3/25). A progress note, dated 10/27/25 at 4:21 p.m., indicated the physician and family were aware of the resident's concern. The resident's clinical record lacked additional information on the resident's allegation of abuse and subsequent actions by the facility. Review of the facility's grievance log for September 2025 and October 2025, provided by the Administrator on 11/6/25 at 10:12 a.m., indicated one grievance was filed on 10/26/25 at 3:00 p.m. The grievance indicated Resident B's resident representative wanted to be notified about the resident's medication changes and upcoming appointments. She was concerned about resident's heel wound progression with the resident's future discharge home. Review of the facility's abuse investigation file, provided on 11/6/25 at 11:49 a.m., included the following: CNA 5's statement on 10/28/25 indicated Resident B was in the dining room for lunch on 10/26/25. CNA 5 was informed by CNA 3 that Resident B needed changed. CNA 5 and CNA 3 laid the resident down and performed care. The nurse called the CNAs into the doorway of Resident B's room and asked if CNA 5 and CNA 3 were the two. Resident B said they were not, and the situation had not even happened that day. CNA 5 explained to the resident's representative that CNA 5 and CNA 3 had assisted the resident to lay down and performed care. RN 9's statement indicated Resident B's representative approached the nurses station on 10/26/25 at approximately 1:00 p.m. and asked to talk to someone about a concern she had regarding the resident. Resident B had reported to her that Resident B had overheard, at lunch, the CNAs say from around a corner that she was old enough and should not be peeing herself, and that they were not going to continue to get her up and down like a yo-yo. The nurse went down to the resident's room with the representative to talk to Resident B. The resident could not or would not say who the staff were that had said those things. RN 9 called the two CNAs into the resident's room and asked Resident B if they were the ones who said those things about her. She said it was not them, it was something she overheard as the aides were walking away from her on a different day. CNA 5 explained to the resident representative that the aides had laid Resident B down, provided care, and left. The Social Services soft file notes indicated the resident had been checked on 10/28/25 and 10/29/25 for any continuing concerns. The abuse investigation file lacked a statement from