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	09/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observation, and record review, the facility failed to protect a resident's dignity by failing to provide necessary assistive mechanical lift slings for the transfer process resulting in a resident having to remain in bed despite her preferences for daily activities for 1 of 3 residents reviewed for dignity. (Resident 26)Finding includes: During an interview, on 9/22/25 at 10:34 a.m., Resident 26 indicated she required a mechanical lift for transferring from bed to her wheelchair and back to the bed. She was informed by facility staff there was a limited supply of mechanical lift slings, and she had to stay in bed over the previous weekend due to a mechanical lift sling not being available. She had soiled her sling due to incontinence and then had to wait for two days for the sling to be washed, air dried, and returned to the floor. Resident 26's clinical record was reviewed on 9/25/25 at 4:02 p.m. Diagnoses included muscle wasting and atrophy (shrink), fracture of the lower end of the femur (thigh bone that extends from hip to knee), morbid obesity, muscle weakness, and anxiety.A 9/2/25, admission, Minimum Data Set (MDS) assessment indicated Resident 26' was cognitively intact. She was dependent for toileting, hygiene, and needed substantial/maximal assistance for lower body dressing. Mobility activities were not attempted due to medical condition or safety concerns.A 9/2/25, state optional, MDS assessment indicated Resident 26 was totally dependent on two plus persons' physical assistance for transfers.A current care plan, revised on 9/3/25, indicated Resident 26 had an activity of daily living (ADL) self-care performance deficit related to impaired mobility, a recent femur fracture, and an extensive medical history. Interventions included Resident 26 required a mechanical lift with two staff assistance for transfers (08/27/25), she was dependent for toileting hygiene (9/3/25), and she did not walk (8/27/25).A current care plan, revised on 9/3/25, indicated that Resident 26 had bladder incontinence related to impaired mobility and diuretics. Interventions included Resident 26 was to be supplied with toileting devices, including bedpan, as appropriate (8/27/25).A current care plan, revised on 8/29/25, indicated Resident 26 had personal preferences in regard to her care that were important to her. She really enjoyed arts and crafts and was extremely social and liked being around other people. The goals indicated Resident 26 would attend the activities of her choice throughout her stay and her desires and personal preferences would be honored within the parameters of safe care through the next review. Interventions included to ensure Resident 26's dignity was maintained.During an interview, on 9/25/25 at 11:48 a.m., CNA 11 indicated the facility had a limited supply of full body slings for the mechanical lift. Residents had to be left in bed due to the lack of mechanical lift slings available due to quantity or slings being laundered.During an interview, on 9/26/25 at 1:26 p.m., CNA 5 indicated residents had informed her they had to stay in bed due to mechanical lift slings being unavailable. Soiled mechanical lift slings were sent to laundry to get washed and air dried. The turnaround time after a mechanical sling was sent to laundry was usually the next day.During an interview, on 9/26/25 at 2:13 p.m., the DON indicated mechanical lift slings were overseen by housekeeping, and they maintained a list of facility slings. She was unsure if the list contained the types and sizes of the slings. Slings were numbered when purchased. Slings were replaced if one was disposed of. Once slings were sent to laundry, the turnaround time was the same day or the next day. During an (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview, on 9/26/25 at 2:35 p.m., the Administrator indicated that the mechanical lift sling list could not be located. The slings were numbered on their tags once received at the facility. She thought the facility had 21 slings in total. She was not aware that mechanical lift slings were not available. She purchased three new slings earlier this year. During an observation, on 9/26/25 at 2:45 p.m., the Administrator opened the linen closet. The linen closet contained three split slings and one shower sling. One of the four slings was numbered.During an interview, on 9/26/25 at 2:58 p.m., the DON indicated she was not aware of residents being left in bed due to lack of mechanical lift slings. She expected staff to notify her if residents were unable to get out of bed. She was not aware of any concerns regarding the lack of slings.During an interview, on 9/26/25 at 3:55 p.m., RN 12 indicated she was not aware Resident 26 was left in bed between 9/20/25 and 9/21/25 due to a mechanical lift sling being unavailable. She recalled Resident 26 had remained in bed one of the days over the past weekend, but was unable to recall which day. During a phone interview, on 9/26/25 at 3:56 p.m., CNA 13, indicated Resident 26 had to stay in bed after supper on 9/21/25 due to the lift sling being soiled. Another sling that would fit her properly and without digging into her skin was unavailable. Resident 26 did not want to use the split sling due to it going underneath her knees and she had knee pain. Resident 26 did not like the type of sling that had straps which crisscrossed under the legs. During a phone interview, on 9/26/25 at 4:00 p.m., CNA 11 indicated Resident 26 was left in bed on Saturday 9/20/25. Staff provided personal care to Resident 26 and had gotten her dressed. Staff went to the linen closet to obtain a lift sling, and a full body sling was unavailable. Resident 26 stayed in bed due to the full body sling being laundered. Resident 26 did not get out of bed until 9/21/25.During a phone interview, on 9/26/25 at 4:09 p.m., CNA 3 indicated Resident 26 was left in bed on 9/20/25 due to the lack of availability of a full body sling. Resident 26 preferred full body slings due to split slings not being comfortable for her and because she has knee pain. Resident 26 was informed of a full body sling being unavailable and the inability to get her out of bed. CNA 3 initially checked laundry, and the sling was in the wash and again a couple hours later and it was hanging and air-drying. CNA 3 informed the weekend nurse that slings were not available. This was not the first incident that a resident had to be left in bed due to lack of lift slings. Previously, staff had informed the prior housekeeping supervisor. During an interview, on 9/2625 at 4:18 p.m., Resident 26 indicated that staff were unable to get her out of bed the previous weekend due to the lack of mechanical lift slings. She became very stiff due to being in bed for a prolonged period of time. This was not the first time this had occurred. A previous time caused her to miss playing BINGO, which was one of her favorite activities that she participated in. This past weekend, staff had gotten her dressed and ready for the day and then informed her they couldn't get her up due to the mechanical lift sling being in the laundry. Slings were usually in laundry for 24-48 hours. Most days, it had come to feel like first come first serve for lift slings. Sling shortage appeared to be on all shifts, all days of the week. She preferred full body slings due to safety and anxiety. Due to her size and physical problems, she felt she would fall out of a split sling. The CNAs were aware she preferred full body slings.A current facility policy, dated 8/2024 and titled SUBJECT: Dignity, provided by the Administrator on 9/26/25 at 3:51 p.m., indicated the following: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation: 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals choices preferences values and beliefs.5. When assisting with care residents are supported in exercising their rights for example residents are: b. encouraged to attend the activities of their choice, including religious, political, civic, recreational, or social activities;.d. allowed to choose when to sleep, eat, and conduct activities of daily living .12. Demeaning practices and standards of care that compromise dignity or prohibited. Staff are expected to promote dignity and assist residents; for example: f. promptly responding to a residence request for toileting assistance.A current facility policy, dated 8/2024, titled SUBJECT: Activities of Daily Living (ADLs), (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supporting, provided by the Administrator on 9/26/25 at 4:43 p.m., indicated the following: Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: b. mobility (transfer and ambulation, including walking); c. elimination (toileting);.7. The resident's response to interventions will be monitored evaluated and revised as appropriate.3.1-3(t)3.1-3(u)(1)3.1-3(v)(1)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review, and interview, the facility failed to ensure ordered adaptive equipment for eating was provided for 1 of 3 residents reviewed for activities of daily living (ADLs) (Resident 29). Finding includes: During an observation, on 9/22/25 at 11:40 a.m., Resident 29 was served lunch. His meal was served on a regular plate, regular bowl, and regular utensils. No adaptive utensils, plateware, or cups were observed in the dining room. During an observation, on 9/23/25 at 11:44 a.m., Resident 29 used regular utensils, cups, and plates during lunch. Resident 29's clinical record was reviewed on 9/24/25 at 3:04 p.m. Diagnoses included unspecified intellectual disabilities, vascular dementia, muscle weakness (generalized), and dysphagia (difficulty/discomfort swallowing) oropharyngeal phase. Current orders included resident to use built up handled utensils, one handled cup with spout, scoop bowl, and plate with suction base at all meals (9/27/24). An annual Minimum Data Set (MDS) assessment, dated 7/11/25, indicated the resident was severely cognitively impaired. He was independent with eating. A current nutritional care plan indicated the resident was at risk for malnutrition related to body mass index greater than 25 and chronic disease (9/14/14). Interventions included built up handled utensils (7/21/25), handled cup with spout (7/21/25), plate with suction base (7/21/25), provide built up utensils, one handled cup with spout, scoop bowl and plate with base at all meals (11/5/24), and scoop bowl with suction cup (7/21/25). During an interview, on 9/25/25 at 11:48 a.m., CNA 11 indicated the resident fed himself and did not use specialty items during dining service. She looked around the dining room and indicated everyone in the main dining room utilized regular cups, plates, and bowls. Adaptive dining equipment needs were communicated verbally or on the Kardex (care needs summary) in the resident's electronic chart. During an interview, on 9/25/25 at 12:08 p.m., CNA 11 accessed the resident's information on an electronic tablet and indicated the adaptive dining equipment was listed. She did not recall the resident ever using the listed adaptive dining equipment and was unaware he was supposed to use it. The resident managed well without the listed adaptive equipment, though he experienced minimal difficulty at times. During an interview, on 9/25/25 at 3:44 p.m., the DON indicated the adaptive dining equipment was listed on the resident's Kardex in the resident's clinical record. Once an order was received, the nursing staff completed a dietary communication slip. The dietary staff was responsible for the provision of the adaptive dining equipment at meals. The resident's care plan and orders should be followed. During an interview, on 9/25/25 at 3:59 p.m., the Administrator reviewed the resident's dietary slip for dinner. She indicated that adaptive dining equipment was not listed on the slip, although it should have been. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, dated 12/2022, titled SUBJECT: Kitchen Operations: Meal Service and Distribution, provided by the DON on 9/26/25 at 3:06 p.m., indicated the following: POLICY .Effective equipment will be provided .PROCEDURE: 2. All residents will be orivided with the proper assistive devices as identified by the care plan A current facility policy, dated 8/2024, titled SUBJECT: Assistance with Meals, provided by the DON on 9/26/25 at 4:05 p.m., indicated the following: .Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipement and utensils) will be provided for residents who need or request them. Thes may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups 3.1-38(a)(2)(D)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview, observation, and record review, the facility failed to provide transfer assistance to a dependent resident for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident 26)Finding includes:During an interview, on 9/22/25 at 10:34 a.m., Resident 26 indicated she required a mechanical lift for transferring from bed to her wheelchair and back to the bed. She was informed by facility staff there was a limited supply of mechanical lift slings, and she had to stay in bed over the previous weekend due to a mechanical lift sling not being available. She had soiled her sling due to incontinence and then had to wait for two days for the sling to be washed, air dried, and returned to the floor. Resident 26's clinical record was reviewed on 9/25/25 at 4:02 p.m. Diagnoses included muscle wasting and atrophy (shrink), fracture of the lower end of the femur (thigh bone that extends from hip to knee), morbid obesity, muscle weakness, and anxiety.A 9/2/25, admission, Minimum Data Set (MDS) assessment indicated Resident 26' was cognitively intact. She was dependent for toileting, hygiene, and needed substantial/maximal assistance for lower body dressing. Mobility activities were not attempted due to medical condition or safety concerns.A 9/2/25, state optional, MDS assessment indicated Resident 26 was totally dependent on two plus persons' physical assistance for transfers.A current care plan, revised on 9/3/25, indicated Resident 26 had an activity of daily living (ADL) self-care performance deficit related to impaired mobility, a recent femur fracture, and an extensive medical history. Interventions included Resident 26 required a mechanical lift with two staff assistance for transfers (08/27/25), she was dependent for toileting hygiene (9/3/25), and she did not walk (8/27/25).A current care plan, revised on 9/3/25, indicated that Resident 26 had bladder incontinence related to impaired mobility and diuretics. Interventions included Resident 26 was to be supplied with toileting devices, including bedpan, as appropriate (8/27/25).During an interview, on 9/25/25 at 11:48 a.m., CNA 11 indicated the facility had a limited supply of full body slings for the mechanical lift. Residents had to be left in bed due to the lack of mechanical lift slings available due to quantity or slings being laundered.During an interview, on 9/26/25 at 1:26 p.m., CNA 5 indicated residents had informed her they had to stay in bed due to mechanical lift slings being unavailable. Soiled mechanical lift slings were sent to laundry to get washed and air dried. The turnaround time after a mechanical sling was sent to laundry was usually the next day.During an interview, on 9/26/25 at 2:13 p.m., the DON indicated mechanical lift slings were overseen by housekeeping, and they maintained a list of facility slings. She was unsure if the list contained the types and sizes of the slings. Slings were numbered when purchased. Slings were replaced if one was disposed of. Once slings were sent to laundry, the turnaround time was the same day or the next day.During an interview, on 9/26/25 at 2:35 p.m., the Administrator indicated that the mechanical lift sling list could not be located. The slings were numbered on their tags once received at the facility. She thought the facility had 21 slings in total. She was not aware that mechanical lift slings were not available. She purchased three new slings earlier this year.During an observation, on 9/26/25 at 2:45 p.m., the Administrator opened the linen closet. The linen closet contained three split slings and one shower sling. One of the four slings was numbered.During an interview, on 9/26/25 at 2:58 p.m., the DON indicated she was not aware of residents being left in bed due to lack of mechanical lift slings. She expected staff to notify her if residents were unable to get out of bed. She was not aware of any concerns regarding the lack of slings.During an interview, on 9/26/25 at 3:55 p.m., RN 12 indicated she was not aware Resident 26 was left in bed between 9/20/25 and 9/21/25 due to a mechanical lift sling being unavailable. She recalled Resident 26 had remained in bed one of the days over the past weekend, but was unable to recall which day.During a phone interview, on 9/26/25 at 3:56 p.m., CNA 13, indicated Resident 26 had to stay in bed after supper on 9/21/25 due to the lift sling being soiled. Another sling that would fit her properly and without digging into her skin was unavailable. Resident 26 did not want to use the split sling due to it going underneath her knees and she had knee pain. Resident 26 did not like the type of sling that had straps which crisscrossed under the legs. During a (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone interview, on 9/26/25 at 4:00 p.m., CNA 11 indicated Resident 26 was left in bed on Saturday 9/20/25. Staff provided personal care to Resident 26 and had gotten her dressed. Staff went to the linen closet to obtain a lift sling, and a full body sling was unavailable. Resident 26 stayed in bed due to the full body sling being laundered. Resident 26 did not get out of bed until 9/21/25.During a phone interview, on 9/26/25 at 4:09 p.m., CNA 3 indicated Resident 26 was left in bed on 9/20/25 due to the lack of availability of a full body sling. Resident 26 preferred full body slings due to split slings not being comfortable for her and because she has knee pain. Resident 26 was informed of a full body sling being unavailable and the inability to get her out of bed. CNA 3 initially checked laundry, and the sling was in the wash and again a couple hours later and it was hanging and air-drying. CNA 3 informed the weekend nurse that slings were not available. This was not the first incident that a resident had to be left in bed due to lack of lift slings. Previously, staff had informed the prior housekeeping supervisor.During an interview, on 9/2625 at 4:18 p.m., Resident 26 indicated that staff were unable to get her out of bed the previous weekend due to the lack of mechanical lift slings. She became very stiff due to being in bed for a prolonged period of time. This was not the first time this had occurred. A previous time caused her to miss playing BINGO, which was one of her favorite activities that she participated in. This past weekend, staff had gotten her dressed and ready for the day and then informed her they couldn't get her up due to the mechanical lift sling being in the laundry. Slings were usually in laundry for 24-48 hours. Most days, it had come to feel like first come first serve for lift slings. Sling shortage appeared to be on all shifts, all days of the week. She preferred full body slings due to safety and anxiety. Due to her size and physical problems, she felt she would fall out of a split sling. The CNAs were aware she preferred full body slings.A current facility policy, dated 8/2024, titled SUBJECT: Activities of Daily Living (ADLs), Supporting, provided by the Administrator on 9/26/25 at 4:43 p.m., indicated the following: Policy Statement: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL's). Policy Interpretation and Implementation: 2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: b. mobility (transfer and ambulation, including walking); c. elimination (toileting);.7. The resident's response to interventions will be monitored evaluated and revised as appropriate.3.1-38(a)(3)

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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 observation, record review, and interview, the facility failed to ensure the physician ordered diet was followed for 1 of 3 residents reviewed for nutrition (Resident 16). Finding includes:Resident 16's clinical record was reviewed on 9/24/25 at 3:47 p.m. Diagnoses included type 2 diabetes mellitus without complications, vitamin B12 deficiency anemia, and dementia.Current orders included regular diet with mechanical soft texture, no mashed potatoes, straws with liquids and given on right side of mouth, small sips (5/2/25), sitagliptin phosphate (for diabetes) 50 mg daily (9/24/25), and insulin glargine 100 units/mL - inject 15 units twice a day (5/10/25). A quarterly Minimum Data Set (MDS) assessment, dated 7/21/25, indicated the resident was severely cognitively impaired. He required supervision and cueing with eating. A current nutritional care plan (revised on 5/21/25) indicated the resident was at risk for malnutrition related to chronic disease, a body mass index greater than 25, and altered carbohydrate metabolism from diabetes. Interventions included provide and serve diet as ordered (2/10/25) and registered dietitian (RD) to evaluate and make diet change recommendations as needed (2/10/25). A nutritional risk assessment, completed by the dietitian, dated 7/16/25, indicated the resident received a regular diet with mechanical soft textures, thin liquids, no mashed potatoes, and straws with liquids and given in small sips on right side of mouth. During a dining observation on 9/25/25 at 11:34 a.m., the resident fed himself bites of meatloaf, mashed potatoes and gravy, carrots, and vanilla ice cream. He indicated that he was eating bananas and pointed to the carrots. During a dining observation on 9/25/25 at 12:09 p.m., CNA 3 assisted the resident with eating all his mashed potatoes and meat loaf. Resident 16's 9/25/25 lunch meal ticket, provided by CNA 3, listed mashed potatoes for the resident's starch for the meal. During an interview, on 9/25/25 at 12:20 p.m., CNA 3 indicated she assisted Resident 16 to eat his mashed potatoes, and he seemed to do okay with them. He had received mashed potatoes on his meal trays other times she had worked. During an interview, on 9/26/25 at 11:40 a.m., the Dietary Manager indicated when a resident's diet order changed, she was supposed to get a form with the diet change. She was not always given the form with diet changes. She had been unaware of Resident 16's order for no mashed potatoes. The diet card had listed mashed potatoes for serving. During an interview, on 9/26/25 at 1:14 p.m., the Speech Therapist (ST) indicated she did not know how the no mashed potatoes got put on the order she had put in for the resident on 5/21/25. She had not limited mashed potatoes in the past as there would not be a reason to do so. n The dietary manager had asked her if she knew about the resident having an order for no mashed potatoes about a month ago. She thought it might have been a dislike put in by the nursing department, but she did not know. The resident had not been on her caseload at that time, so she did not investigate it any further. During an interview, on 9/26/25 at 2:14 p.m., RN 7 indicated she had only put in a diet order one time. The ST put the order into the resident's electronic record, then the nurse filled out a form with the diet change and gave the form to dietary. During an interview, on 9/26/25 at 2:56 p.m., the DON indicated when the ST recommended a diet, the ST put the order in the resident's electronic record, the nurse confirmed the order, then a form was given to dietary with the diet change. The resident's diet orders should have been followed, and the resident should not have received mashed potatoes. A current facility policy, revised 8/2024, provided by the DON on 9/26/25 at 3:45 p.m., titled Medication, Diet, and Treatment Orders, indicated the following: .Dietary orders will be communicated to the dietary department using the dietary communication form and will be added to the meal ticket. 3.1-46(a)(2)