STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155859	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Beech Grove	501 N 17th Ave Beech Grove, IN 46107

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed follow the menus prepared in advance for 1 of 1 dining observations. Findings include: On 12/10/25 at 1:00 p.m., observed posted menu on the wall, outside of the main dining room. The menu indicated scalloped potatoes were to be served on 12/10/25 during lunch time. During a dining observation on 12/10/25 at 1:10 p.m., the following was observed: - Resident 44, Resident 24, Resident 29, and Resident 42's lunch plate was observed to include mashed potatoes, the plate did not include the listed scalloped potatoes as indicated on the posted menu. - At that time, Resident 42's a family member indicated the meals Resident 42 received on his meal tray did not match the posted menu. During an interview on 12/19/25 at 1:00 p.m., the Administrator indicated he was not aware of the discrepancy and indicated the posted menu should match the served meal. On 12/12/25 at 9:12 a.m., the Executive Director provided a policy titled Kitchen operations: Meal Service and Distribution, dated December 2022, and indicated it was the current policy being used by the facility. A review of the policy indicated Procedures .3. Residents' meals are distributed promptly with supervision provided as needed. Staff should check resident name and room number to verify correct information, and check items on the tray against the tray ticket to assure all necessary items are provided. 3.1-20(i)(2)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 1 of 3 kitchen observations. A refrigerator food item was not covered, and a perishable food item was not discarded by the use-by-date. Findings include: During the initial facility tour with the Executive Director (ED) on 12/9/25 at 9:45 a.m., the resident snack pantry, located near the resident dining room area, was observed. The following was observed inside the resident snack pantry refrigerator:-One plastic gallon container of Country Fresh white milk was located on the shelf of the refrigerator door. The milk container contained a grayish colored thick substance that covered the bottom of the container. Similar substances were observed inside the container that was adhered to the sides of the container. Near the top of the milk container, the manufacturer's pre-printed Use By Date: 11/30/25 was observed.-One medium sized plastic pan was observed on the top shelf of the refrigerator unit. The pan was approximately ten percent full of applesauce. The pan was partially covered with a loose fitted plastic wrap. The plastic wrap was torn in half which resulted in the majority of the pan to be un-covered. During an interview on 12/9/25 at 9:50 a.m., the ED indicated the milk container should have been discarded by the use by date and the applesauce pan should have been completely covered.On 12/12/25 at 9:31 a.m., the Director of Nursing provided a copy of the Kitchen Operations: Food Storage policy, dated 1/1/23, and indicated it was the current policy in use by the facility. A review of the document indicated, .all foods shall be covered or wrapped tightly .may not exceed the manufacturer's use-by-date .On 12/10/25 at 2:55 p.m., a review of the retail Food Establishment Sanitation Requirements Title 410 IAC 7-26, effective April 16, 2025, indicated: .refrigerated, ready to eat, potentially hazardous food prepared .discarded .covered containers, or wrappings .wrap food tightly to prevent cross contamination . 3.1-21(i)(2)3.1-21(i)(3)

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide special eating utensils for 1 of 2 residents reviewed for restorative services. (Resident 42) Finding included: On 12/10/25 at 1:39 p.m., the clinical record for Resident 42 was reviewed. The diagnoses included, but were not limited to, hemiplegia (loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing). The current Physician's orders, dated 11/9/25 indicated the following: - Regular diet, pureed texture, nectar/mildly thick consistency fluids. - An Occupational Therapy clarification Order, dated 11/17/25 with no end date, indicated Resident 42 was to use a Kennedy cup (a lightweight, easy to grip adapted drinking cup designed to prevent spills) and scoop plate (a scoop plate is a type of dish specifically designed to help individuals with limited motor skills or disabilities that makes eating challenging) during all meals. During a dining observation on 12/10/25 at 12:30 p.m., observed Resident 42 consuming lunch in the main dining room. Resident 42's plate was observed to be a regular plate and not the required scoop plate. The resident was using a regular cup for liquids. The Kennedy cup was not visible or accessible to the resident. During a dining observation on 12/11/15 at 12:45 p.m., observed the same. During a dining observation on 12/15/25 at 12:44 p.m., observed Resident 42 in his room consuming lunch. The required scoop plate was not observed. During an interview at that time a family member indicated the resident began using the Kennedy cup 3 days ago. An Occupational Therapy note, dated December 2025, indicated Goal: Resident 42 would safely perform self-feeding tasks with minimal assist with use of built-up utensils and a scoop dish with a plate guard and a Kennedy cup. During an interview on 12/11/25 at 11:25 a.m., Physical Therapist (PTA 4), indicated the facility was to provide the proper feeding utensils. During an interview on 12/12/25 at 10:20 a.m., the Director of Nursing indicated she was not aware of the order for the eating utensils. On 12/12/25 at 9:12 a.m., the Executive Director provided a policy titled, Meal Service and Distribution and indicated it was the current policy being used by the facility. A review of the policy indicated .2. All residents will be provided with the proper assistive devices when consuming meals and snacks. 3.1-21(h)

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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, interview, and record review, the facility failed to implement infection control practices for 1 of 1 residents with urinary catheters observed. A urinary catheter drainage bag was touching the floor. (Resident 26)Finding includes: On 12/9/2025 from 12:10 p.m., until 12:30 p.m., observed Resident 26 sitting in the dining room. The resident's catheter drainage bag was observed to be hanging from the wheel chair and the drainage bag was touching the floor. During an interview on 12/9/25 at 12:33 p.m., Certified Nursing Assistant (CNA) 2, indicated the catheter drainage bag was not supposed to touch the floor. On 12/9/25 at 12:35 p.m., observed the Assistant Director Nursing adjust the catheter drainage bag so that it was not touching the floor. On 12/12/25 at 8:37 a.m., the Director of Nursing provided a policy titled Catheter Care, dated August, 2024, and indicated it was the current policy being used by the facility. A review of the policy indicated .11. Be sure the catheter tubing and drainage bag are kept off the floor. 3.1-18(b)(1)