STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155549	A. BUILDING 00 B. WING	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF MUNCIE	7524 E JACKSON STREET MUNCIE, IN 47302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457515, IN00456613, IN00456677, IN00456768, IN00457079. Complaint IN00457515 - No deficiencies related to the allegations are cited. Complaint IN00456613 - No deficiencies related to the allegations are cited. Complaint IN00456677 - No deficiencies related to the allegations are cited. Complaint IN00456768 - Federal/state deficiencies related to the allegations are cited at F880. Complaint IN00457079 - No deficiencies related to the allegations are cited. Survey dates: April 15 and 16, 2025 Facility number: 000681 Provider number: 155549 AIM number: 100286100 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 3 Medicaid: 30 Other: 3 Total: 36 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and/or execution of this plan of correctio in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 04/29/2025. The facility is respectfully requesting paper compliance for all deficiencies.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roberta A Shull	Executive Director	04/29/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Quality review completed April 21, 2025.			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure staff (LPN 1) followed the facility cleaning protocol for resident glucometers to reduce the risk of contamination and spread of infection for 5 of 5 residents reviewed for infection control during medication administration. (Resident B, H, J, K, and L) Findings include: During a medication administration observation on 4/15/25 at 5:02 a.m., the following infection control concerns were observed: LPN 1 removed the Resident B's glucometer from a plastic bag in the medication cart. The glucometer was placed directly on the medication cart while LPN 1 gathered supplies and medications. Upon entering the resident's room, LPN 1 placed the glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned to the medication cart and placed the glucometer directly on the cart. She then returned it to the plastic bag and secured it to the medication cart. The glucometer was not disinfected during the observation. The top of the medication cart was not cleaned/disinfected during the observation. The resident's over bed table was not cleaned prior to placing the glucometer on the table. LPN 1 removed the Resident H's glucometer from a plastic bag in the medication cart. The glucometer was placed directly on the medication cart while LPN 1 gathered supplies and	F 0880	F880 1. Residents B, H, J, K, and L were not negatively affected but all residents have the potential to be affected by this alleged deficient practice. RN's, LPNs, and QMA's, including LPN 1, have been educated on completing equipment and surface disinfecting with appropriate disinfectants prior to storing and use of equipment. 2. All residents who need glucometer checks have the potential to be affected by this alleged deficient practice. RN's, LPNs, and QMA's, have been educated on completing equipment and surface disinfecting with appropriate disinfectants prior to storing and use of equipment. 3. Education has been provided to all RN's, LPNs, and QMA's, and the return demonstration was completed. All RN's, LPNs, and QMA's, have been educated on equipment and surface disinfecting with appropriate disinfectants before storing and using equipment. Staff have completed a return demonstration of surface and equipment sanitation. A monitoring form has been implemented. 4. The Director of Nursing and or	04/29/2025

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	medications. Upon entering the resident's room, LPN 1 placed the glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned to the medication cart and placed the glucometer directly on the cart. She then returned it to the plastic bag and secured it to the medication cart. The glucometer was not disinfected during the observation. The top of the medication cart was not cleaned/disinfected during the observation. The resident's over bed table was not cleaned prior to placing the glucometer on the table. LPN 1 removed the Resident J's glucometer from a plastic bag in the medication cart. The glucometer was placed directly on the medication cart while LPN 1 gathered supplies and medications. Upon entering the resident's room, LPN 1 placed the glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned to the medication cart and placed the glucometer directly on the cart. She then returned it to the plastic bag and secured it to the medication cart. The glucometer was not disinfected during the observation. The top of the medication cart was not cleaned/disinfected during the observation. The resident's over bed table was not cleaned prior to placing the glucometer on the table. LPN 1 removed the Resident K's glucometer from a plastic bag in the medication cart. The glucometer was placed directly on the medication cart while LPN 1 gathered supplies and medications. Upon entering the resident's room, LPN 1 placed the glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned to the medication cart and placed the glucometer directly on the cart. She then returned it to the plastic bag and secured it to the medication cart. The glucometer was not		designee will be responsible for monitoring staff to ensure appropriate surface and equipment disinfection is completed prior to storage and use. This monitoring will occur daily x 4 weeks, weekly x 2 months, and monthly x 3 months for a minimum of six months total. Should a concern be found, immediate corrective action will occur. Results of the monitoring and any corrective actions will be reviewed during the facility's QA meetings for a minimum of six months with the monitoring increasing and decreasing until substantial compliance is achieved.	

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	disinfected during the observation. The top of the medication cart was not cleaned/disinfected during the observation. The resident's over bed table was not cleaned prior to placing the glucometer on the table. LPN 1 removed the Resident L's glucometer from a plastic bag in the medication cart. The glucometer was placed directly on the medication cart while LPN 1 gathered supplies and medications. Upon entering the resident's room, LPN 1 placed the glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned to the medication cart and placed the glucometer directly on the cart. She then returned it to the plastic bag and secured it to the medication cart. The glucometer was not disinfected during the observation. The top of the medication cart was not cleaned/disinfected during the observation. The resident's over bed table was not cleaned prior to placing the glucometer on the table. During the medication administration observation, LPN 1 indicated each resident had their own glucometer. During an interview on 4/15/25 at 9:03 a.m., RN 2 indicated glucometers were to be cleaned and allowed to dry before placing them back into the plastic storage bag. During an interview on 4/16/25 at 1:27 p.m. , the DON indicated resident glucometers were to be cleaned/disinfected prior to returning them to the medication cart. Review of the manufacture's cleaning guidelines, provided by the Regional Nurse on 4/16/25 at 1:13 p.m., indicated the following: "...The disinfecting procedure is needed to prevent the transmission			

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	of bloodborne pathogens....." Review of a current policy, dated 8/2024 and titled "Obtaining a Fingerstick Glucose Level," was provided by the Administrator on 4/15/25 at 10:17 a.m. and indicated the following: " .... Steps in the Procedure ....18. Clean and disinfect reusable equipment between uses according to the manufacture's instructions and current infection control standards of practice. ...." This citation relates to Complaint IN00456768. 3.1-18(l)			