PRINTED: 05/07/2025
FORM APPROVED

	R MEDICARE & MEDIC	Ť	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO		(X3) DATE SURVEY				
					COMPLETED			
155549			B. WING		04/16/2025			
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD				
				JACKSON STREET				
ENVIVE	OF MUNCIE		MUNC	IE, IN 47302				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
F 0000								
Bldg. 00								
Diag. 00	This visit was for t	he Investigation of Complaints	F 0000	Preparation and/or execution	of			
	IN00457515, IN00456613, IN00456677, IN00456768,		1 0000	this plan of correctio in genera				
	IN00457079.	7130013, 11100130077, 11100130700,		this corrective action does no				
	11100137075.			constitute an admission of				
	Complaint IN0045	7515 - No deficiencies related to		agreement by this facility of th	10			
	the allegations are			facts alleged or conclusions s				
	the diregutions are	oned.		forth in this statement of				
	Complaint IN0045	6613 - No deficiencies related to		deficiencies. The plan of				
	the allegations are			correction and specific corrective				
	the diregutions are	oned.		actions are prepared and/or	uvc			
	Complaint IN0045	6677 - No deficiencies related to		executed in compliance with	State			
	the allegations are			and Federal Laws. Facility's				
	the diregutions are	oned.		of alleged compliance is	date			
	Complaint IN0045	6768 - Federal/state deficiencies		04/29/2025. The facility is				
	_	ations are cited at F880.		respectfully requesting paper				
	Tenated to the unego	ations are creat at 1 000.		compliance for all deficiencies				
	Complaint IN0045	7079 - No deficiencies related to						
	the allegations are							
	Survey dates: Apri	1 15 and 16, 2025						
	Facility number: 0							
	Provider number:	155549						
	AIM number: 100	286100						
	Census Bed Type:							
	SNF/NF: 36							
	Total: 36							
	10tal. 50							
	Census Payor Type	e:						
	Medicare: 3							
	Medicaid: 30							
	Other: 3							
	Total: 36							
	This deficiency ref	lects State Findings cited in						
	accordance with 41	10 IAC 16 2-3 1						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Roberta A Shull Executive Director 04/29/2025

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
155549		B. WING 04/16/			/2025		
NAME OF PROVIDER OR SUPPLIER ENVIVE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP COD 7524 E JACKSON STREET MUNCIE, IN 47302				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0880 SS=E	Quality review com 483.80(a)(1)(2)(4) Infection Prevention						
Bldg. 00							
		on, interview, and record	F 08	380	F880		04/29/2025
	review, the facility	failed to ensure staff (LPN 1)			1. Residents B, H, J, K, and L		
	followed the facility	cleaning protocol for resident			were not negatively affected b	ut all	
	glucometers to redu	ce the risk of contamination			residents have the potential to	be	
	-	ion for 5 of 5 residents			affected by this alleged deficie	ent	
	reviewed for infecti	on control during medication			practice. RN's, LPNs, and QM	A's,	
	administration. (Res	sident B, H, J, K, and L)			including LPN 1, have been		
	Findings include:				educated on completing equipment and surface disinfe with appropriate disinfectants	prior	
	-	n administration observation			to storing and use of equipme	nt.	
		.m., the following infection			2. All residents who need		
	control concerns we	ere observed:			glucometer checks have the potential to be affected by this		
	LPN 1 removed the	Resident B's glucometer from a			alleged deficient practice. RN'		
		edication cart. The glucometer			LPNs, and QMA's, have been		
	was placed directly	on the medication cart while			educated on completing		
	LPN 1 gathered sup	plies and medications. Upon			equipment and surface disinfe	cting	
	entering the residen	t's room, LPN 1 placed the			with appropriate disinfectants	-	
	glucometer on the o	ver the bed table. After			to storing and use of equipme	nt.	
	performing the bloo	d sugar check, LPN 1 returned			3. Education has been provide		
	to the medication ca	art and placed the glucometer			all RN's, LPNs, and QMA's, a	nd	
	directly on the cart.	She then returned it to the			the return demonstration was		
	plastic bag and secu	red it to the medication cart.			completed. All RN's, LPNs, ar	ıd	
	The glucometer was	s not disinfected during the			QMA's, have been educated of	n	
	observation. The top	of the medication cart was			equipment and surface disinfe	cting	
	not cleaned/disinfec	eted during the observation.			with appropriate disinfectants		
	The resident's over	bed table was not cleaned			before storing and using		
	prior to placing the	glucometer on the table.			equipment. Staff have comple	ted a	
					return demonstration of surfac	e	
	LPN 1 removed the	Resident H's glucometer from			and equipment sanitation. A		
	a plastic bag in the	medication cart. The			monitoring form has been		
	glucometer was place	ced directly on the medication			implemented.		
cart while LPN 1 gathered supplies and				4. The Director of Nursing and	lor		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155549		A. BUILDING B. WING	WING 04/16/						
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD					
ENVIVE OF MUNCIE				7524 E JACKSON STREET MUNCIE, IN 47302					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	medications. Upon of LPN 1 placed the glucometer directore returned it to the plasmedication cart. The disinfected during the medication cart was during the observation table was not cleaned glucometer on the table was not cleaned glucometer on the table was placed directly LPN 1 gathered supentering the resident glucometer on the operforming the bloot to the medication can directly on the cart. plastic bag and secun The glucometer was observation. The top not cleaned/disinfectore prior to placing the glucometer was placed the glucometer directore turned to the glucometer directore turned to the placed the glucometer directored it to the placed to the glucometer directored it to the placed the glucometer directored the glucometer directored the glucometer directored the glucometer directored the	entering the resident's room, ucometer on the over the bed ing the blood sugar check, he medication cart and placed etly on the cart. She then astic bag and secured it to the endication. The top of the not cleaned/disinfected on. The resident's over bed ed prior to placing the able.  Resident J's glucometer from a edication cart. The glucometer on the medication cart while plies and medications. Upon t's room, LPN 1 placed the ever the bed table. After disugar check, LPN 1 returned ent and placed the glucometer. She then returned it to the red it to the medication cart was ted during the object of the medication cart was ted during the observation.  Resident K's glucometer from medication cart. The check directly on the medication cart. The check directly on the medication cart. The check directly on the medication		designee will be responsible for monitoring staff to ensure appropriate surface and equip disinfection is completed prior storage and use. This monitor will occur daily x 4 weeks, were x 2 months, and monthly x 3 months for a minimum of six months total. Should a concert found, immediate corrective a will occur. Results of the monitoring and any corrective actions will be reviewed during facility's QA meetings for a minimum of six months with the monitoring increasing and decreasing until substantial compliance is achieved.	oment to ring ekly rn be ction				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE		LETED			
		155549	B. WING 04/16/2		/2025			
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER								
ENVIVE OF MUNCIE				7524 E JACKSON STREET MUNCIE, IN 47302				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	the observation. The top of the						
		s not cleaned/disinfected						
	_	ion. The resident's over bed						
		ed prior to placing the						
	glucometer on the t	able.						
	I DNI 1	D 11 (II 1 ) (C						
		Resident L's glucometer from a						
		nedication cart. The glucometer						
		on the medication cart while						
		oplies and medications. Upon						
	_	nt's room, LPN 1 placed the						
	glucometer on the over the bed table. After performing the blood sugar check, LPN 1 returned							
		art 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,							
	_	ch resident had their own						
	glucometer.	on resident had then own						
	<i>G</i>							
	During an interview on 4/15/25 at 9:03 a.m., RN 2 indicated glucometers were to be cleaned and							
		ore placing them back into the						
	plastic storage bag.							
	During an interview on 4/16/25 at 1:27 p.m., the							
		dent glucometers were to be						
	cleaned/disinfected	prior to returning them to the						
	medication cart.							
	Review of the manu	ufacture's cleaning guidelines,						
	provided by the Re	gional 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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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 04/16/2025				
NAME OF PROVIDER OR SUPPLIER ENVIVE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP COD 7524 E JACKSON STREET MUNCIE, IN 47302					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPLE		(X5)		
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG				COMPLETION DATE		
	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 Procedure18. 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.								

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