

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Envive of Anderson		STREET ADDRESS, CITY, STATE, ZIP CODE 1821 Lindberg Rd Anderson, IN 46012	
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to provide assessment and treatment of chronic wounds for 1 of 3 residents reviewed for wounds. (Resident B) This deficient practice resulted in the resident being hospitalized for the evaluation and treatment of infected lower extremity leg wounds with maggot infestation. The deficient practice was corrected on 7/6/26, prior to the start of the survey, and was therefore Past Noncompliance. Findings include: Review of an anonymous intake received by the Indiana Department of Health indicated Resident B had been found to have chronic cellulitis (inflammation and infection of the skin) to both legs with maggot activity noted in her wounds. The complainant indicated the resident had required hospitalization for treatment of her leg wounds. Resident B's clinical record was reviewed on 7/8/26 at 9:12 a.m. Diagnoses included gout, type 2 diabetes, peripheral vascular disease, stage 3 chronic kidney disease, and Parkinson's disease. The clinical record lacked orders for wound care. Review of the weekly skin assessment from 4/28/26 through 6/23/26 indicated the resident displayed no skin impairments or discoloration. The clinical record lacked a weekly skin assessment for the week of 7/20/26. Review of Resident B's facility shower sheets for the past 30 days indicated the following: On 6/3/26 and 6/10/26 the resident refused bathing. On 6/6/26, 6/7/26, 6/13/26, 6/24/26, and 6/27/26 no skin concerns were observed. On 7/1/26, the resident allowed staff to wash the back of her knees and no areas were identified. Review of a late entry progress note, dated 7/1/26 at 1:26 p.m., indicated LPN 1 documented resident education related to keeping legs elevated due to increased swelling. Review of a progress note, authored by LPN 6 and dated 7/4/26 at 2:36 a.m., indicated Resident B complained of bleeding, itching, and burning in the lower extremities. The resident had a gauze wrap to both extremities. When the bandage was removed, a seeping area infested with maggots was observed. The resident was transported to the hospital for further evaluation. No documentation for physician notification was noted. LPN 6 was unavailable for interview during the survey dates. Review of emergency department documentation, dated 7/4/26, indicated the resident arrived for evaluation of leg wounds. The resident reported her legs had been giving her trouble for approximately a month. The wounds worsened that night, and she reported to the nurse they were burning. The facility called an ambulance and transported the resident to the hospital. Emergency Medical Services noted maggots in the resident's leg wounds. The resident was positive for swelling in both legs and wounds were present. The resident had extensive chronic changes to both lower extremities with chronic thickening of the skin. There were maggots present in the wounds to both legs. The resident would require hospitalization for further evaluation and medical management. The resident reported pain at a 10 out of 10 on the pain scale. Review of a hospital wound care note, dated 7/6/27 at 1:36 p.m., indicated the wound to the right lower leg, measured 2 centimeters (cm) length x 2 cm width with approximately 100% red non-granulated (non-healing) tissue, scant serosanguinous (normal pale pink) drainage noted on the old dressing. The left lower leg wound measured 7 cm length x 5 cm width with (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
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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 0684 Level of Harm - Actual harm Residents Affected - Few	approximately 50% red non-granulated tissue and 50% macerated (soggy) epidermis (top layer of skin) and small amount of serosanguinous drainage on the old dressing. During an interview, on 7/9/26 at 12:38 p.m., CNA 3 indicated she provided care to Resident B on 7/2/26. She had applied lotion to the resident's legs but was only able to see the front of her legs. During an interview, on 7/10/26 at 10:46 a.m., QMA 8 indicated she had seen the resident's legs wrapped in gauze. During an interview, on 7/10/26 at 10:59 a.m., CNA 9 indicated the resident would ask to have her legs wrapped because she thought they were bleeding. During an interview on 7/10/26 at 11:05 a.m., the facility Wound Nurse indicated she had been working at the facility since March 2026. She never received notification of or a request for consultation for Resident B. During an interview on 7/10/26 at 11:43 a.m., LPN 1 indicated, on 7/1/26, Resident B asked to have her legs wrapped. LPN 1 informed the resident she did not have an order to wrap her legs. LPN 1 removed the resident's socks, and they were literally stuck to her legs. LPN 1 indicated there was no drainage and the resident's skin was crusty. The resident had an order for hydrocortisone cream. The resident allowed LPN 1 to apply the cream if she wrapped her legs. LPN 1 applied the cream and loosely wrapped the resident's legs in gauze wrap. LPN 1 indicated she had never wrapped the resident's legs before, but knew other nurses had been wrapping them in the past because she had removed the dressings in the past. LPN 1 indicated she should have notified the physician or nurse practitioner (NP) to get an order for treatment. During an interview, on 7/10/26 at 1:30 p.m., the NP indicated she never received any notification from the facility with concerns related to Resident B's legs. A current facility policy dated 8/2024 and titled Acute Condition Changes-Clinical Protocol, provided by the Administrator on 7/9/26 at 4:32 p.m. indicated the following: Assessment and Recognition .3. Direct care staff, including nursing assistance will be trained in recognizing subtle but significant changes in the resident (. changes in skin color or condition) and how to communicate these changes to the Nurse. A current facility policy dated 8/2024 and titled Dressings-Sterile, provided by the Administrator on 7/9/26 at 4:32 p.m. indicated the following: Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Preparation: Verify that there is a physician's order for this procedure. Review the resident's care plan, current orders, and diagnoses to determine if there are special resident needs. Check the treatment record. The deficient practice was corrected by 7/6/26 after the facility implemented a systemic plan that included the following actions: All residents have had a full head to toe skin assessment on 7/6/2026 by the DON and Wound Care nurse, newly identified areas skin impairment were assessed and documented, physicians and responsible parties were notified of newly identified skin impairments, appropriate treatments/orders were obtained from physician and implemented, care plans developed and reviewed/revised, licensed nurses re-educated by DON related to completing skin assessments, documentation of wound assessment, notification and treatment orders, and documentation of resident care refusals. This citation relates to Intake 3070979.410 Indiana Administrative Code 16.2-3.1-37(a)		