STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Anderson	1821 Lindberg Rd Anderson, IN 46012

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours for a resident admitted with pressure injury for 1 of 2 residents reviewed for pressure injury. (Resident 56) Findings include:Resident 56's clinical record was reviewed on 4/9/26 at 11:24 a.m. The resident was admitted [DATE]. A 4/1/26 admission assessment indicated the resident had a wound on his coccyx (tailbone). A risk for impaired skin integrity baseline care plan outline prompt was included in the assessment. Intervention options included diet as ordered, observe skin with daily cares, and notify the nurse of any new or worsening areas, and treatments as ordered. A current resident care plan, initiated 4/2/26, indicated the following: At risk for impaired skin integrity related to impaired mobility, self-care deficit. Goal: Resident will have no further skin breakdown through next review. Interventions included encourage good nutrition and hydration, keep skin clean and dry. Use lotion on dry skin, observe skin with daily cares. Notify nurse of any new or worsening areas, and treatments as ordered. The record lacked a baseline care plan with individualized interventions for the coccyx wound present on admission. During an interview, on 4/10/26 at 10:49 a.m. RN 4 indicated, during the admission assessment, certain questions within the assessment caused a baseline care plan to trigger and the responses to those questions create the problem, goal, and interventions. After admission, the baseline care plan should have been found in either the care plan or assessments tab of the Electronic Health Record (EHR). The baseline care plan included anything staff would have needed to start caring for the resident. During an interview, on 4/10/26 at 11:49 a.m., the DON indicated questions answered in the admission assessment generated a baseline care plan for residents. When the resident was seen by the providers or other staff, changes were made to the care plan. A wound found during the admission assessment should have been included in the baseline care plan. A current facility policy, titled Care Plans, Comprehensive Person-Centered, and revised 8/2024, indicated the following: .3. The care plan interventions are derived from a thorough analysis of the information gathered Cross reference F686.410 IAC (Indiana Administrative Code) 16.2-3.1-30(a)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure treatment orders were in place and interventions developed and implemented to promote healing of a pressure injury for 1 of 2 residents reviewed for pressure injuries. (Resident 56)Findings include:Resident 56's clinical record was reviewed on 4/9/26 at 11:24 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included stage III chronic kidney disease, congestive heart failure, and atrial fibrillation (abnormal heart rhythm).A 4/1/26 Braden Scale assessment indicated the resident was at moderate risk for pressure injury formation. A 4/1/26 nursing admission evaluation indicated the resident presented to the facility with a stage 2 pressure ulcer to his coccyx (tailbone area). A 4/1/26 nurse's note indicated the resident arrived to the facility with a stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) on his coccyx. The area was cleansed with wound cleanser and a bordered gauze was applied. A 4/3/25 Nurse Practitioner's (NP) note indicated the resident's representative reported a wound to the resident's left heel and coccyx. The physical exam included a left heel Deep Tissue Injury (DTI) (intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue.), was present and a coccyx wound was reported prior to admission. The clinical record did not indicate implementation of a treatment plan. A 4/7/26 wound note indicated the resident admitted to the facility with a reported DTI to the left heel and a stage 2 pressure injury to the left buttock. Previous treatments for the wound included skin protectant, offloading heels with pressure-relieving boots and dry dressing to the left buttock. The wound assessment indicated a left medial foot DTI present on admission, measuring 0.5 centimeters (cm) length (L) by 0.5cm width (W) by no depth (pen cap tip - sized). Wound 2 was located on the left lateral foot, present on admission, and unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured), measuring 3cm L by 3.5cm W by no depth (half dollar sized). Wound 3 was a stage 2 pressure ulcer/injury, present on admission, measuring 1.1cm L by 1cm W by 0.1cm depth (dime sized).A 4/7/26, admission, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired. The resident was fully dependent on staff for toilet hygiene and rolling left to right. He was always incontinent of bowel and bladder. The resident had two unhealed pressure injuries noted during the assessment as follows: one stage 2 pressure injury and one unstageable pressure injury. Treatments for the pressure injuries during the assessment period included use of a pressure reducing device for his chair and bed. A current resident care plan, revised 4/7/26, indicated the following: Requires the use of enhanced barrier precautions related to presence of wound to reduce the risk of transmission of Multi Drug Resistant Organisms (MDROs) (initiated 4/2/26) and the resident has a pressure ulcer related to immobility: left medial foot- DTI left lateral foot-unstageable, and left buttock-stage 2, initiated 4/7/26. The clinical record lacked an individualized care plan with goals for healing and individualized interventions to promote healing and comfort. During a wound care observation, on 4/9/26 at 1:04 p.m., LPN 6 indicated no other wound treatment orders were in place other than applying skin protectant to the resident's heels. The resident's pressure relief boots were removed, and skin protectant was applied to both heels. A large, irregularly circular, dark area was present on the resident's right heel. LPN 6 indicated he was unsure how long the area had been present and no orders were in place to treat the area. During the observation, Resident 56 declined observation of his coccyx. Current physician's orders included the following: Braden assessment (assessment to for measuring risk of skin breakdown) once a week for three weeks (ordered 4/8/26), mechanical lift with assist of two staff (ordered 4/1/26), and skin protectant to bilateral heels for protection twice a day (ordered 4/1/26).The clinical record lacked orders for wound treatment to Resident 56's coccyx wound. During an interview, on 4/10/26 at 9:20 a.m., LPN 3 indicated when residents were admitted , a head-to-toe (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment was performed and documented under the assessments tab. If any abnormalities were found, she would notify the provider and wound nurse using a secure messaging system. Resident 56 had treatment orders for his wound placed last night (4/9/26). Previous treatment orders only included skin protectant to both heels. During an interview, on 4/10/26 at 10:49 a.m., RN 4 indicated when a resident was admitted , a head-to-toe assessment was completed, including a skin and wound assessment. The results were documented in a progress note and if any abnormal findings were found, a message was sent to the provider through a secure messaging system. If wounds were found on the admission assessment and no orders were in place, she would reach out to the provider for treatment orders until the resident was seen by the provider or wound team. During an interview, on 4/10/26 at 11/49 a.m., the DON indicated when a resident was admitted , a head-to-toe assessment was performed to check for any abnormalities including wounds. Findings were placed in the chart in an admission assessment and then communicated with the providers in a secure message. If the physician worked at the facility the resident came from, wound orders were put in place on admission. When wounds were found during an admission assessment, treatment and monitoring should start as soon as practicable. A current facility policy, titled, Pressure Injury and Skin Condition Assessment, and reviewed 6/2022, included the following: .Pressure and other ulcers (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by a licensed nurse and documented in the resident's clinical record.Procedures 1. A skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer assessment will be updated quarterly and as necessary. 2. Residents identified will have a weekly skin assessment by a licensed nurse. 3. A wound assessment will be initiated and documented in the resident chart when pressure and/or other ulcers are identified by a licensed nurse. 3. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.6. Care givers are responsible for promptly notifying the charge nurse of skin breakdown. 7. At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described in the nursing progress notes.10. Pressure injuries and other ulcers (arterial, diabetic, venous) will be measured at least weekly and record in centimeters in the resident's clinical record. 11. A wound assessment for each identified open area will be completed and will include: a. Site location b Size (length x width x depth) c. Stage of Pressure Ulcer d. Odor e. Drainage f. Description g. Date and initials of the individual performing the assessment.16. The licensed nurse is responsible for notifying the attending physician, Director of Nursing, and legal representative of any suspected wound infection. 17. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches, and goals for care. 19. A licensed nurse shall observe the condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, the physician and responsible party will be notified by the charge nurse. Notification will be documented in the resident's clinical record. 410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(7)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies related to implementing interventions to promote healing of pressure injuries.Findings include:Review of the Summary Statement of Deficiencies (2567), for the facility's last annual recertification and licensure survey, completed on July 25, 2025, indicated the facility had deficiencies related to failure to obtain wound assessments, monitoring, and treatments in a manner to promote the healing of a pressure injury.During an interview, on 4/10/26 at 12:02 p.m., the Administrator indicated the facility Quality Assessment and Assurance (QAA) committee met monthly and reviewed areas of concerns, areas showing trends, and/or areas with an increase in occurrence. Previous annual survey citations are reviewed through the time frame listed on the Plan of Correction (POC), usually for six months. If the audits and/or evaluations met the required threshold, those areas were considered corrected and removed from the QAA committee's review tasks. The facility did not have a current QAPI plan or action plan in place related to pressure injury.Repeat concerns regarding pressure injuries were cited during the April 10, 2026, survey as follows:Based on interview, observation, and record review, the facility failed to provide wound assessments/monitoring and wound treatments in a manner to promote healing of a pressure ulcer for 1 of 1 resident reviewed for pressure ulcers (injuries). A current facility policy, revised 8/24, titled, Quality Assurance and Performance Improvement (QAPI)-Governance and Leadership provided by the Administrator on 4/6/26 at 9:20 a.m., indicated the following: . 4. The responsibility of the QAPI committee are to: a. collect and analyze performance indicator data and other information; b. identify, evaluate, monitor, and improve facility systems and processes that support the delivery of care and services; c. identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process.e. help departments, consultants, and ancillary services implement systems to correct potential and actual issues in quality of care. Cross reference F686. 410 IAC (Indiana Administrative Code) 16.2-3.1-52(b)(2)

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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, record review, and interview, the facility failed to follow enhanced barrier precautions (EBP) during a wound dressing change observation for 1 of 2 residents reviewed for pressure injuries. (Resident 9)Findings include:Resident 9's clinical record was reviewed on 4/8/26 at 10:55 a.m. Diagnoses included peripheral vascular disease, unspecified bipolar disorder, and stage 4 (full-thickness wound, extending through deep tissue to expose muscle, tendon, ligament, or bone) pressure injury of the sacrum (tailbone area).Current orders indicated to cleanse the sacrum pressure injury with an external wound cleanser, apply calcium alginate (a wound dressing) to the wound bed. Apply zinc paste (a barrier cream) around the wound bed and cover with a bordered silicone dressing. Change once daily and as needed (3/17/26) and required the use of EBP related to the presence of a wound and to reduce the risk of transmission of multidrug-resistant organisms (MDROs) (10/23/25).A 10/17/25, pressure injury care plan indicated Resident 9 had a stage 4 pressure injury. Interventions included administer treatments as ordered and monitor for effectiveness (10/17/25), monitor dressing to ensure it is intact and adhering (10/17/25), and assess/record/monitor wound healing (10/17/25).A 10/24/25, EBP care plan indicated Resident 9 required the use of personal protective equipment (PPE) for a wound to prevent the spread of organisms. Interventions included following CDC guidelines for enhanced barrier precautions when performing the following high-contact resident care (10/25/25).A 1/23/26, quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and had one stage 4 pressure injury.A 4/7/26 wound progress note indicated a stage 4 pressure injury to the sacrum measuring 4.3 centimeters (cm) length (L) x 4.5 cm width (W) x 0.2 cm depth (D), (roughly the size of a large walnut). The wound was 100% granulized (bright red, moist connective tissue) tissue. Cleanse the sacrum wound with an external wound cleanser, apply calcium alginate (a wound dressing) to the wound bed. Apply zinc paste (a barrier cream) around the wound bed and cover with a bordered silicone dressing. Change once daily and as needed. The wound was improving.During a wound treatment observation, on 4/9/26 at 9:25 a.m., LPN 6 set up a clean area on the resident's bedside table and deposited his supplies. He completed hand washing and donned gloves. The resident was able to roll by himself onto his right side. The current bandage was dated 4/8/26. He removed the current dressing, placed it in the trash, and removed his gloves. He completed hand washing and donned new gloves. He opened a roll of gauze and moistened it with the external wound cleanser. He cleaned the wound bed. The wound bed was shallow, bright red, and oblong in shape, roughly the size of large walnut. The skin surrounding the wound appeared red and blotchy. LPN 6 applied the calcium alginate to the wound bed and skin protectant (a barrier wipe) to the area surrounding the wound. He covered the wound with a bordered silicone dressing. He removed his gloves and completed hand washing.During an interview, at the time of the observation, LPN 6 indicated Resident 9 required EBP to help prevent the spread of infection and that he (the nurse) had forgotten to wear the proper PPE for the wound treatment observation. He indicated he had gotten nervous and simply forgot to wear the gown during the process.During an interview, on 4/10/26 at 11:31 a.m., the DON indicated EBP was required for residents who had wounds, medical devices, and/or a history of MDRO's. This precaution required staff to wear specific PPE when providing direct care to residents. LPN 6 should have worn both a gown and gloves when changing the dressing and applying the new treatment to Resident 9's pressure ulcer.A current facility policy, dated 8/22, titled, Enhanced Barrier Precautions, provided by the Administrator on 4/10/26 at 9:54 a.m., indicated the following: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . h. wound care (any skin opening requiring a dressing) . 410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post current and accurate nursing staff information daily for residents and visitors. This deficiency had the potential to affect 53 of 53 residents in the facility.Findings include:The facility nurse staffing information, dated 4/2/26 and observed on 4/6/26 at 6:13 a.m., was posted on a small table, to the right of the entrance doors and indicated the following:The form lacked a census number.Number of Registered Nurses (RN): Day shift hours: 0.00, Evening shift hours: 4.00, and Night shift hours: 8.00.Number of Licensed Practical Nurses (LPN): Day shift hours: 16.00, Evening shift hours: 16.00, and Night shift hours: 8.00.Number of Qualified Medication Aides (QMA): Day shift hours: 16.00, Evening shift hours: 0.00, and Night shift hours: 8.00Number of Certified Nursing Assistant (CNA): Day shift hours: 32.00, Evening shift hours: 32.00, and Night shift hours: 16.00.During an observation, on 4/6/26 at 9:22 a.m., the 4/6/26 facility nurse staffing posting indicated the following:Census: 53Number of RN: Day shift hours: 0.00, Evening shift hours: 4.00, and Night shift hours: 8.00.Number of LPN: Day shift hours: 8.00, Evening shift hours: 8.00, and Night shift hours: 8.00.Number of QMA: Day shift hours: 16.00, Evening shift hours: 4.00, and Night shift hours: 0.00Number of CNA: Day shift hours: 32.00, Evening shift hours: 32.00, and Night shift hours: 24.00.During an observation, on 4/7/26 at 9:06 a.m., the 4/6/26 facility nurse staffing posting remained. During an observation, on 4/7/26 at 11:30 a.m., the facility nurse staffing, dated 4/7/26, indicated the following:Census 53Number of RN: Day shift hours: 8.00, Evening shift hours: 4.00, and Night shift hours: 8.00.Number of LPN: Day shift hours: 16.00, Evening shift hours: 12.00, and Night shift hours: 8.00.Number of QMA: Day shift hours: 8.00, Evening shift hours: 4.00, and Night shift hours: 0.00Number of CNA: Day shift hours: 32.00, Evening shift hours: 32.00, and Night shift hours: 24.00.During an observation, on 4/8/26 at 9:07 a.m., the facility nurse staffing, dated 4/7/26, remained.During an observation, on 4/8/26 at 10:07 a.m., the facility nurse staffing information, dated 4/8/26, indicated the following:Census 54Number of RN: Day shift hours: 8.00, Evening shift hours: 4.00, and Night shift hours: 0.00.Number of LPN: Day shift hours: 16.00, Evening shift hours: 12.00, and Night shift hours: 16.00.Number of QMA: Day shift hours: 16.00, Evening shift hours: 8.00, and Night shift hours: 0.00Number of CNA: Day shift hours: 24.00, Evening shift hours: 24.00, and Night shift hours: 24.00.During an interview, on 4/10/26 at 11:35 a.m., the facility Scheduler indicated she created this document utilizing a system to calculate the nursing hours needed for each shift. She used the schedule to break down how many RNs, LPNs, QMAs, and CNAs would be on each shift, and noted the census number. She completed the form the night before and placed it underneath the current one posted on the table to the side of the entrance door as she left the facility. The management team would remove the previous days posting when they arrived the following morning. There were times when she had needed to remove the previous days staff posting when she arrived, at the start of her shift, which was at 9:00 a.m. She completed the form in advance for the weekends. She had worked on the floor as a CNA for the previous weekend, on 4/3/26, 4/4/26, and 4/5/26, and forgot to update the form. The staff posting would not have been updated and/or current on 4/3/26, 4/4/26, 4/5/26, or on the morning of 4/6/26. A current facility policy, revised 8/24, titled, Posting Direct Care Daily Staffing Numbers, provided by the Administrator on 4/10/26 at 9:54 a.m., indicated the following: .Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.