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	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Anderson	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. A. Based on record review and interview, the facility failed to provide bed hold policy and transfer/discharge notifications to the resident/representative for 2 of 5 residents reviewed for hospitalizations. (Resident 36 and 61)B. Based on record review and interview, the facility failed to provide notification of hospitalization to the Long-Term Care Ombudsman for 2 of 5 residents reviewed of hospitalization. (Residents 20 and 61) Findings include:A1. Resident 61's clinical record was reviewed on 7/22/25 at 2:36 p.m. Diagnoses included acute and chronic respiratory failure with hypoxia and malignant neoplasm of the right breast. A 6/23/25 progress note indicated the resident was non-responsive and transported to the local hospital. A 6/24/25 progress note indicated the resident was hospitalized for a change in level of consciousness. A 7/14/25 progress note indicated the resident remained hospitalized . The clinical record lacked information indicating the resident or the representative received a copy of the transfer/discharge form or the bed hold policy. During an interview on 7/25/25 at 11:14 a.m., LPN 7 indicated when a resident required a transfer/discharge to a hospital, she was required to get a provider's order, notify the DON, notify the family, and call report to the receiving facility. The face sheet, code status, medications list, and the last time the resident took their medications paperwork was provided to the paramedics or the family if they transported the resident to the hospital. Staff were required to document all the information in the resident's clinical record. During an interview on 7/25/25 at 11:25 a.m. the DON indicated she did not have further information to provide that indicated who may have received copies of the transfer/discharge form or the bed hold policy. She indicated Resident 61's paperwork was sent with the emergency transportation staff because the resident was unresponsive. When the information was not in the resident's clinical record, the facility did not have a way to ensure copies were provided to the resident or the resident representative. A2. Resident 36's clinical record was reviewed on 7/23/25 at 9:10 a.m. Diagnoses included metabolic encephalopathy, unspecified severe protein-calorie malnutrition, and atherosclerotic heart disease of the coronary artery. (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

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 07/25/2025
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/19/25 nurse's note indicated the resident was transferred to the emergency room for an evaluation and treatment. The physician, Director of Nursing, and resident representative were notified. A 5/19/25 Change of Condition Evaluation form indicated the resident was sent to the emergency room for evaluation and treatment. The resident's representative was notified. A 5/19/25 discharge MDS assessment indicated the resident discharged with a return anticipated. The clinical record lacked information indicating the resident or the representative received a written copy of the transfer/discharge form or the bed hold policy. During an interview, on 7/25/25 at 11:18 a.m., LPN 4 indicated when a resident was sent out to the emergency room she would print out the following documents: the resident's transfer/discharge page which had diagnoses, contact information, and code status, a bed hold policy, and any current orders. She printed out two copies and provided one copy to the emergency medical technicians (EMTs) and the hospital got the other copy. A current facility policy, revised 8/24 and titled, Bed Holds and Returns, provided by the Corporate Nurse Consultant on 7/25/24 at 10:04 a.m., indicated the following: . 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about the policies at least twice: .b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) .3. Multiple attempts to provide the resident representative with the notice 2 should be documented in cases where staff were unable to reach and notify the representative timely. A current facility policy, revised 8/24 and titled, Transfer or Discharge, Facility-Initiated, provided by the Corporate Nurse Consultant on 7/25/25 at 10:04 a.m., indicated the following: . 17. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility.18. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge. 19. Notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable. B1. Resident 20's clinical record was reviewed on 7/22/25 at 2:11 PM. Diagnoses included vascular dementia, schizoaffective disorder, and chronic obstructive pulmonary disease (COPD). A progress note dated 6/29/25 at 11:24 a.m. indicated the resident was vomiting a foul-smelling black liquid and was unable to express himself. The nurse practitioner (NP) and DON were notified, and the resident was sent to the emergency room (ER). A progress note dated 7/1/25 at 5:40 p.m. indicated the resident returned to the facility on 7/1/25 at 5:40 p.m. The record lacked documentation of ombudsman notification. A review of the facility's June 2025 Discharge and Transfer Form Ombudsman Fax Log, provided by Corporate Nurse Consultant on 7/23/25 at 1:00 p.m., lacked notification of Resident 20's transfer. (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B2. Resident 61's clinical record was reviewed on 7/22/25 at 2:36 p.m. Diagnoses included acute and chronic respiratory failure with hypoxia and malignant neoplasm of the right breast. A 6/23/25, progress note indicated the resident was non-responsive and transported to the local hospital. A 6/24/25, progress note indicated the resident was hospitalized for a change in level of consciousness. A 7/14/25, progress note indicated the resident remained hospitalized . The clinical record lacked documentation of Ombudsman notification. A review of the facility's June 2025 Discharge and Transfer Form Ombudsman Fax Log, provided by Corporate Nurse Consultant on 7/23/25 at 1:00 p.m., lacked notification of Resident 61's transfer. During an interview with the Corporate Nurse Consultant on 7/23/25 at 1:32 p.m., he indicated Resident 20 was not on the ombudsman notification list for 6/2025. The ombudsman should have been notified of the transfer. During an interview on 7/25/25 at 10:58 a.m., the Social Service Director (SSD) indicated she typically submitted the notification of transfers and discharges to the State Ombudsman. The log for June 2025 included all of the residents' names of the transfer/discharge notifications submitted to the Ombudsman for June 2025. She was not at the facility to submit the June transfer and discharges. In her absence, the Corporate [NAME] President of Life Enrichment submitted the State Ombudsman Notifications for June 2025. During an interview on 7/25/25 at 11:00 a.m., the Corporate [NAME] President of Life Enrichment indicated the June 2025 transfer/discharge notifications sent to the State Ombudsman did not include all residents who were transferred or discharged in the month of June 2025. The report ran in the health record had been filtered incorrectly, resulting in missed transfers and discharges, including Resident 20. A facility policy, revised 8/24, titled, Transfer or Discharge, Facility-Initiated, provided by the Corporate Nurse Consultant on 7/25/25 at 10:04 a.m., indicated the following: . 20. Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer.25. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 26. Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative. 3.1-12(a)(6)(A) 3.1-12(a)(6)(A)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to follow physician's orders regarding placement of heel boots for a resident with current skin conditions for 1 of 2 residents reviewed for skin conditions. (Resident 36) Finding includes: During an observation, on 7/21/25 at 1:10 p.m., Resident 36 was lying in bed with bare feet. Resident 36 indicated she had a wound on her right ankle and foot. A dressing was noted to her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.On 7/22/25 at 10:10 a.m. , Resident 36 was lying in bed with bare feet. A dressing was noted to her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.Resident 36's clinical record was reviewed on 7/23/25 at 9:10 a.m. Diagnoses included metabolic encephalopathy, unspecified severe protein-calorie malnutrition, and atherosclerotic heart disease of the coronary artery.Current orders included cleanse area to right lateral ankle with normal saline, pat dry, apply medical grade honey and cover with bordered foam every day for skin care and as needed. Apply padded boots (7/20/25). Cleanse area to right lateral foot with normal saline, pat dry, and apply medical grade honey and cover with bordered foam every day for skin care and as needed. (7/20/25)A current skin integrity care plan, dated 9/5/24, indicated the resident was at risk for altered skin integrity related to impaired mobility and dementia. Interventions included keep skin clean and dry (9/5/24), observe skin with daily care and notify nurse of any changes (9/5/24), and treatments as ordered (9/5/24).A 6/17/25 quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired and at risk for pressure ulcers. A 7/17/25 Wound Document indicated Resident 36 had a new open area to the right lateral foot with an undetermined cause and to apply medical grade honey, foam, and apply boots.A 7/18/25 wound infection/cellulitis care plan indicated Resident 36 had a wound infection or cellulitis to the right lateral ankle. Interventions included medications as ordered (7/18/25), monitor/document and report to doctor the following symptoms of cellulitis: red, swollen, tender skin, reddened area begins to spread, small red dots appear on the reddened skin, small blisters (7/18/25), and treatments as ordered (7/18/25).A 7/20/25 progress note indicated a new order was provided by the wound nurse practitioner for the right lateral ankle. Cleanse area with wound cleanser to normal saline. Apply medical grade honey and cover with bordered foam. Apply padded boots every day/shift for skin care and as needed.On 7/23/25 at 9:20 a.m. Resident 36 was seated upright in bed with bare feet. A dressing was on her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.On 7/23/25 at 12:45 p.m., Resident 36 was lying in bed with bare feet. A dressing was noted to her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.On 7/24/25 at 10:12 a.m., Resident 36 was sleeping in bed with bare feet. A dressing was noted to her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.During a wound observation, on 7/24/25 at 1:30 p.m. , with the ADON and LPN 4, the resident was lying in bed with bare feet. A dressing was noted to her right lateral ankle and foot. The resident's right ankle and foot was positioned with the dressing side facing down, flat on the bed. The resident was not wearing heel boots.During an interview, on 7/24/25 at 2:00 p.m., the ADON indicated Resident 36 was not wearing heel boots as ordered. The purpose of the heel boots was to assist with wound healing, resident comfort, and to prevent further wound development.During an interview, on 7/25/25 at 10:05 a.m., the Corporate Nurse Consultant indicated the facility did not have a policy for following physician's orders. The staff followed the acceptable standards for care and followed all physicians' orders.

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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. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. (Resident 1)Finding includes: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. (Resident 1)Finding includes:During an interview on 7/21/25 at 10:15 a.m., Resident 1 was in her bed on a low air loss mattress and turned slightly to her right side. She indicated she had a wound on her buttock that was present on admission. She did not feel well and was uncertain why. The resident was dependent on staff for repositioning. Resident 1's clinical record was reviewed on 7/22/225 at 3:41 p.m. Diagnoses included multiple sclerosis, weakness, and pressure ulcer of the sacral region, stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). Current orders included cleanse area to the coccyx with Dakins External Solution (wound treatment) 0.25%, pack area with light Dakins fluffed gauze, cover with superabsorbent pad, and secure with a silicone bordered superabsorbent dressing daily and as needed. (7/23/25) Weekly skin assessments on day shift every Saturday. (2/11/25) Ensure a pressure reducing mattress to the bed every shift. (2/11/25)A 7/8/25, quarterly, Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact. The resident required maximum assistance from staff for upper body dressing, bathing, and personal hygiene. She was dependent on staff assistance for lower body dressing, toileting hygiene, transfers, and repositioning. The resident was at risk for pressure ulcers and had a stage IV pressure ulcer, present on admission. Skin interventions included pressure ulcer treatments/care, a pressure reducing device for the bed, and nutrition or hydration. A current care plan, dated 2/19/25, indicated the resident had a stage IV pressure injury to the coccyx. Interventions included the following: Administer treatments as ordered and monitor for effectiveness. (2/19/25) Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. (2/19/25) Report improvements and declines to the MD. (2/19/25) Encourage and assist the resident to change position frequently. (2/19/25) Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate. (2/19/25) A progress note, dated 2/10/25 at 6:06 p.m., indicated the resident admitted to the facility on [DATE]. A skin assessment was completed with a coccyx wound that measured 14 centimeters (cm) length by 14 cm width (size of a drink coaster) by 1.5 cm depth. Wound center notes included the following:On 5/27/25, the stage IV sacrum pressure injury measured 10 cm length by 10 cm width by 3 cm depth. Bone was exposed with moderate drainage. The resident's next wound center appointment was 6/24/25. The resident's most recent wound center progress note, dated 7/8/25, indicated the resident's stage IV sacrum pressure injury measured 9.5 cm length by 10.5 cm width by 3.3 cm depth, with 3.8 cm undermining present from 1:00 o'clock to 5 o'clock. Bone was exposed with moderate serosanguineous drainage. The plan included no brief use. The resident's next appointment was scheduled for 7/29/25. A progress note, dated 7/17/25 at 7:19 p.m., indicated the resident's wound was not assessed by the wound team due to a wound center appointment. The clinical record indicated Resident 1 was not seen by the wound center on this date.Review of the clinical record lacked weekly wound assessments of the sacrum pressure injury, including a description of the wound with measurements, from the resident's last wound clinic appointment on 7/8/25 through 7/25/25. A progress note, dated 7/23/25 at 3:38 p.m., indicated the wound to the coccyx area was noted to have purulent drainage with foul odor. The provider was notified. During a wound treatment observation on 7/23/25 at 2:25 p.m., Resident 1 was turned to her left side upon entrance to the room. Both LPN 7 and CNA 9 performed hand hygiene and donned a gown, gloves, mask, and face shield prior to entering the room. With gloved hands, LPN 7 picked up a bottle of Dakins Solutions, a stack of individually packaged 4x4 gauze, and a large super absorbent foam dressing that were directly against the top of the medication cart and carried them into the resident's room. Without a barrier, LPN 7 placed the wound care supplies on top of personal items on the resident's nightstand, beside the bed. CNA 9 and LPN 7 repositioned the resident onto her right side for wound care with their gloved hands. The resident's brief was removed by LPN 7. LPN 7 then removed the old foam bordered dressing and gauze packing in the wound bed from the resident's sacrum/coccyx. The foam dressing, dated 7/22/24, was

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review the facility failed to ensure dietary employees where competent in dishwasher sanitation testing. This deficient practice had the potential to impact 57 of 57 residents who consumed meals prepared in the facility kitchen. Findings include:During an observation of dishwasher operations in the facility kitchen on 7/24/25 at 8:48 a.m. the following was observed:The Dietary Manager indicated the dishwasher was a low temp machine, which used sanitizer in its final rinse. The sanitizer was a chlorine-based sanitizer. The dish machine that was in operation washing the breakfast dishes, plates, bowls, cups, glasses etc. The Dietary Manager placed a test strip inside the dish machine for testing. He indicated the test strip could be used to test the sanitizer level both internally and externally in the water well located on the outside of the dishwasher. The test strips used had red writing and a red band across the edges. They were not the traditional all white dip stick style. The Dietary Manager indicated, using the test strips with the red writing, he did not know how many parts per million of sanitizing agent needed to be reached to equal proper sanitation. He then displayed the test strip. The test strip indicated Temp-Dishwasher Temperature test strip. The test strip did not indicate it tested for chlorine content. The Dietary Manager indicated he was unable to find chlorine test strips and he would look for said product. During an interview on 7/24/25 at 9:35 a.m., the Dietary Manager indicated he had last seen the chlorine test strips on 7/21/25. He believed the test strips had gotten wet and were thrown away. He had not been told by staff when the test strips were thrown away. He could not find any other chlorine test strips. He had used the temperature test strips as a backup without knowledge of how they worked.During an interview with the DON on 7/25/2025 at 10:04 a.m., she indicated 57 of the facility's 58 residents consumed food orally and therefore ate meal prepared in the facility kitchen. A current, undated, facility policy titled Sanitization, provided by DON on 7/24/25 at 10:02 a.m. indicated: 3. All equipment, food, contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.5. Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: .b. Low-Temperature Dishwashers (Chemical Sanitization):(1) Wash temperature (120 [degrees sign] F);(2) Final rinse 50 parts per million (ppm) hypochlorite (chlorine) on dish surface in finale rinse;and(3) The chemical solution is maintained at the correct concentration. based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines Low-temperature dishwashers and chemical sanitization:The dishwashers rely on chemical sanitizers (like chlorine or quaternary ammonium) to disinfect dishes, rather than high heat 1.3-20(h)