STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. Building B. Wing	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Indianapolis	45 Beachway Dr Indianapolis, IN 46224

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38768 Based on observation, interview, and record review, the facility failed to monitor for new or worsening wounds which resulted in actual harm when a change of condition in his skin integrity led to his hospitalization and a diagnosis of a necrotic decubitus ulcer and coccygeal osteomyelitis; and the facility failed to ensure interventions to prevent the wound from worsening were in place per his plan of care and infection control techniques were taken during wound treatments for 1 of 1 resident reviewed for wounds (Resident B). Findings include: On 9/12/22 at 11:36 a.m., Resident B was observed. He was lying in bed, flat on his back. Although his eyes were open, he did not respond appropriately to questions and closed his eyes and appeared to sleep. His bed was a low air loss mattress bed and was observed to be operating at the appropriate setting. On 9/13/22 at 10:56 a.m., Resident B was observed. He was lying flat on his back. On 9/13/22 at 11:33 a.m., Resident B remained on his back. On 9/13/22 at 11:51 a.m., Resident B was observed and remained lying flat on his back. On 9/14/22 at 9:57 a.m., Resident B was observed. He was lying in bed flat on his back. On 9/14/22 at 2:10 p.m., Resident B remained flat on his back. On 9/15/22 at 10:00 a.m., Resident B was observed. He was lying flat on his back. On 9/15/22 from 11:45 a.m., Resident B was observed. He was lying flat on his back. On 9/15/22 from 1:05 p.m., until 2:35 p.m., a continuous observation was conducted for Resident B. Although he had been assisted to try and eat lunch, Resident B was never turned or repositioned to offload the pressure from his bottom. On 9/16/22 at 12:13 a.m., Resident B was observed. He remained in bed, flat on his back. (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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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/16/22 at 12:33 a.m., LPN 23 indicated Resident B should be turned or repositioned to offload the sore on him bottom at least every two hours. On 9/19/22 at 3:05 p.m., Resident B's medical record was reviewed. His record indicated he had been a long-term care resident for many years, and previously resided on the Behavioral Health Unit. He had chronic disease diagnoses which included, but were not limited to schizoaffective disorder, type II diabetes, and chronic obstructive pulmonary disease (COPD). He had an active order for weekly skin assessments to be completed every Wednesday on day shift. On 9/16/22 at 10:28 a.m., the Director of Nursing (DON) provided copies of Resident B's weekly skin assessments and were reviewed at this time. On 3/30/22, no skin alterations were noted on the weekly skin check log. However, a Nurse Practitioner (NP) progress note, dated 3/31/22 at 10:33 a.m., indicated Resident B was being seen per nursing request for rash on buttocks. Nursing was unclear of onset of rash, and Resident B reported tenderness, local pain and itching, down there. The NP diagnosed Resident B with genital herpes and prescribed Acyclovire (an oral antiviral medication). The skin assessment logs indicated from 3/16/22 to 4/20/22 indicated LPN 23 had conducted the assessments and no new alterations in his skin integrity were noted. The record lacked documentation of a change in condition related to the development of a new wound/skin area. The record lacked documentation of continued monitoring of the outbreak area. The record lacked documentation that the diagnosis was added to his comprehensive plan of care. On 9/19/22 at 9:30 a.m., the DON provided copies of Resident B's March and April Certified Nursing Assistant (CNA) Point of Care (POC) documentation for March indicated: Resident B was at risk for behaviors and monitored each shift with no refusal of care noted. Resident B was at risk for alterations in skin integrity but only monitored as needed. March 1st-24th were all blank, NA (not applicable), or 5 (none observed). March 25, 26 and 27th were left blank. On March 30th, a new area of discoloration was noted but also coded no, it was not a new area. March 31st, was coded NA (not applicable). It appeared no bed baths or showers had been provided as each observation was blank or coded NA. Shower sheets were requested for March but were not able to be provided by survey exit. Point of care Documentation for the month of April indicated: Resident B was at risk for behaviors and monitored each shift with no refusal of care noted. Resident B was at risk for alterations in skin integrity but still only monitored as needed. On April 24th, 25th and 26th, no new areas were noted. On the 27th an open area was noted but not coded a new. A nursing progress note, dated 4/24/22 at 5:52 a.m., indicated Resident B had an open wound on his coccyx. The nurse assessed the area and applied a dressing. The Resident was repositioned on his left side and the nurse educated the resident about the importance of being turned every two hours. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An NP progress note, dated 4/25/22 at 1:46 p.m., indicated Resident B was being seen for a new open area on his intergluteal cleft. Alleyn ([ALLEVYN]] is a range of moist wound environment dressings designed specifically for the management of chronic and exuding fluid from the wounds) currently covering open area. A small amount of serosanguinous dressing was noted on the dressing. No slough was noted within wound. An order was given for silver alginate and to cover with Alleyn. The NP note did not include measurements. A Pressure Ulcer Skin Log, dated 4/27/22, indicated Resident B had three areas that were acquired on 4/24/22. Wound 1: Stage III (full thickness skin loss where fat is visible) pressure ulcer to the coccyx with moderate serosanguinous drainage that measured 3 cm (centimeters) long by 3 cm side and 0.5 cm deep. Wound 2: Unstageable (full thickness skin loss where the wound bed is not visible due to slough or eschar) to the left buttock, purple in color which measured 11 cm long by 6.8 cm wide. Wound 3: Unstageable to the left glute, red/purple in color which measured 8 cm long by 6 cm wide. A nursing progress note, dated 5/1/22 at 6:15 a.m., indicated Resident B was noted to have difficulty swallowing pills and was shaking uncontrollably with signs/symptoms of shortness of breath. The On-Call doctor was notified and gave no new orders, just continue to monitor. His O2 (oxygen) was not in place and his 02 saturation (sats) was 87%. When his 02 was placed his sats increased to 94%. A Pressure Ulcer Skin Log, dated 5/4/22, indicated Resident B's areas were improved. Wound 1: Unstageable to the left glute, purple/red in color and measured 7.5 cm long by 5.5 cm wide, being treated with skin prep. Wound 2: Unstageable to the sacrum, red in color with slough and serosanguineous drainage that now measured 13 cm long by 9 cm wide. A NP progress note, dated 5/4/22 at 2:28 a.m., indicated Resident B was being seen after nursing staff reported he had a decreased level of orientation for the last day, and she ordered labs for a CBC (complete blood count) and Urinalysis. A nursing progress note, dated 5/6/22 at 11:11 a.m., indicated Resident B was sent to the ER (emergency room) for further evaluation due to continued decreased levels of conscious. On 5/16/22 Resident B remained at the hospital and required a surgical debridement of the wound and a bone biopsy was conducted which revealed necrosis of the bone. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A hospital Discharge Summary dated 6/1/22 indicated, .Collateral was obtained via his nurse at his ECF [extended care facility]. His nurse stated that normally patient is AAx4 [alert and oriented to person, time, place and situation] at baseline but this morning he woke up and remained somnolent and would not open his eyes or swallow his medicines. He stated that he was overall sluggish and had to manually remove the medication from his mouth after he administered them. When asking patient regarding his symptoms he did endorse feeling confused The primary diagnosis was a necrotic decubitus ulcer and coccygeal osteomyelitis (infection of the bone). An MRI completed on 5/8/22 revealed findings consistent with osteomyelitis of coccygeal segments with subjacent cellulitis. Resident B's current CNA assignment sheet was reviewed and indicated, up for all meals, however throughout the surveyor timeframe, Resident B was never observed out of bed. The record lacked documentation of Resident B's refusals to get out of bed. The pressure ulcer wound treatments were observed twice. 1. A wound treatment observation occurred on 9/14/22 from 3:15 p.m., until 4:00 p.m. The following was observed: Licensed Practical Nurse (LPN 23) indicated she would be changing the wound vacuum (vac) dressing to Resident B's coccyx wound. Certified Nursing Assistant (CNA) 23, CNA 51, and CNA 22 were present for the treatment of wounds. CNAs 23 and CNA 51 entered room after using hand sanitizer in the hall and applied a clean pair of gloves. CNA 23 indicated it usually took two people to hold and position the resident during the treatment. The CNAs stood on the right side of the resident and held him over to his left side. LPN 23 put on a clean pair of gloves at the door, then opened sani-wipes and wiped off the overbed table surface, placed a plastic barrier on the table and set up station with supplies to provide wound care. LPN 23 removed the old dressing dated with yesterday's date from the resident's ischium. There was a minimal amount of yellow fluid on the old dressing. LPN 23 did not have the ordered dressing present to apply to the wound. LPN 23 received the xeroform dressing and applied it to the wound to the intact skin around the peri-wound. She applied a dressing over the xeroform and secured the dressing with a white adhesive tape over the xeroform. CNA 23 was waving away gnats during the treatment. LPN 23 indicated that resident had a wound on his sacrum and was going to change the wound vac dressing. LPN 23 exited the room and came back into the room with linens. She placed a new pair of gloves on and did not perform hand hygiene prior to putting on gloves. LPN 23 cleaned a pair of scissors with a disinfectant. LPN 23 called Resident B by name, adjusted his nasal cannula tubing and lowered the head of his bed. LPN 23 measured from the peri-wound to the opposite peri-wound instead of the wound edges. LPN 23 removed the wound vac dressing. She measured the wound that was a stage 4 pressure ulcer (full thickness skin and tissue loss with muscle, bone, and/or tendon visible). She used a saline syringe and pushed saline into the wound on his sacrum to clean the wound. LPN 23 adjusted the resident's indwelling catheter. She used hand sanitizer and then applied a new pair of gloves. She used a saline syringe and pushed the saline into the wound on his sacrum. She opened the wound vac dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	LPN 23 indicated that the depth of the sacral wound was 2.2 centimeters and used a cotton tipped applicator to obtain the depth. There was undermining around the entire the wound. The VP of clinical operations came into the room to assist LPN 23. LPN 23 was cutting a clear adhesive dressing to the peri-wound after applying skin prep to the peri-wound. LPN 23 was using the clear adhesive dressing and placing on the dressing to border of the wound (windowpane) instead of using the clear dressing sheet and covering the entire wound. LPN 23 cut the foam dressing and placed the foam dressing against her uniform. On 9/14/22 at 3:56 p.m., the [NAME] President (VP) of Clinical Operations was summoned to the room. She attempted to identify tunneling of the wound with a tongue depressor. The VP of Clinical Operations placed gloved fingers into the wound. She cut the foam dressing with scissors that were laying on the bed on and placed the foam dressing into the wound. The VP of Clinical Operations stayed with LPN 23 and finished the dressing change. As Resident B was lying on his side, there were abnormal areas observed on the back of his left calf. LPN 23 indicated that the areas were bruising and shearing. One area was open and had a black edge at the top of the wound. These areas were identified as deep tissue injuries by the VP of Clinical Operations. When asked when the last time Resident B had been turned or repositioned, CNA 51 started to give an answer, but was interrupted by the LPN 23 who indicated, it's 4:00 p.m. now, so he would have been turned at 2:00 p.m. 37981 2. A second wound treatment observation occurred on 9/16/22. The following was observed: At 1:18 p.m., Resident B's active sacral pressure ulcer change order was reviewed. It indicated to cleanse with normal saline (NS) and apply the wound vac on every dayshift on Mondays, Wednesdays, and Fridays for wound care related to a stage 4 sacral pressure ulcer. At 1:38 p.m., Certified Nursing Assistant (CNA) 22 entered Resident B's room to assist the Director of Nursing (DON) with positioning the resident during the sacral wound dressing change. She did not wash her hands before putting on disposable gloves that she had in her pocket. At 1:38 p.m., the DON did not wash her hands before she put on gloves. She used a Super Sani cloth to wipe the resident's over-the-bed table and laid a white trash bag on it. The DON's table set up included wound vac supplies, hand sanitizer, an Optifoam gentle dressing, and a pink bin of dressing supplies. The DON removed her gloves and did not wash her hands but used hand sanitizer gel on her hands. The resident's door was left wide open and the resident's privacy curtain was left partially open. When CNA 22 removed Resident B's hip pillow, the resident's body did not shift to center. The DON and CNA 22 moved the resident onto his left side. Bodily fluids were observed on the resident's calf pillow that was used to relieve pressure on his heels. A weeping wound was observed on his left posterior-lateral calf. The bodily fluids were a tannish color, some fluids were dried on the pillowcase in several places, some were still wet. The wound was not dressed, and it was slightly larger than the size of a quarter. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 1:43 p.m., LPN 23 did not knock and wait for permission to enter the resident's room, she just called out knock knock. She requested to assist with holding the resident in position for the sacral dressing change. She did not wash her hands or use hand sanitizer gel. She put on gloves and held the resident's legs. The DON removed the outer portion of the previous sacral dressing and indicated it did not have the date, time, or initials for the staff person who placed it. It should have been labeled correctly. She removed her gloves, sanitized her hands, and put on new gloves. She laid a white towel on the resident's bed as a clean area. She removed the soiled black sponge from the resident's deep wound. She removed her gloves, sanitized her hands, and put on new gloves. The DON indicated she would clean the resident's wound with normal saline (NS). She was observed digging in the pink bin of dressing supplies with her gloved hands. She retrieved a 10 mL syringe of NS and opened it. Without changing gloves, she squirted the NS into the surface of the center of the wound. She indicated there was undermining of the wound from 3:00 to 6:00. She did not clean the undermined areas. With the same soiled gloves, she put a gauze square over the end of her index finger and wiped the center of the resident's wound, she did not wipe the undermined area. She the indicated the wound measured 3 cm (centimeter) x 6 cm and she would measure the depth of wound after she changed her contaminated gloves. She removed the gloves and sanitized her hands. After putting on new gloves she opened the sterile packaging for the wound vac dressing and suction system. She reached back into the bin of dressing supplies and pulled out a pair of scissors. She did not clean them before cutting the plastic adhesive part of the wound vac system into strips. Then, she cut the black sponge into 2 round circles and a long black strip. She placed the cut wound supplies inside the sterile packaging to keep them clean. The DON indicated the resident's wound was 70% granulation tissues and 30% slough. She indicated she forgot to measure the depth. At 1:53 p.m., the DON began placing adhesive plastic strips on the resident skin around the sacral wound. The first strip was from 9:00 to 12:00, the second strip, slightly over the wound was from 12:00 to 6:00 o'clock position. She placed the round black sponge in the wound. She placed another long plastic strip and adhesive plastic from the top of the wound to the left lateral hip. Then placed the long black sponge over it. She began placing cut adhesive plastic strips over the black sponges but was not able to make a seal. LPN 23 lifted her hand off of the resident's unwashed legs and pressed her unwashed gloved hand on the long plastic covered sponge before it was sealed. She pressed down with her hand trying to affect a seal. The DON was cutting more adhesive plastic strips with the unwashed scissors and continued to place them, trying the get a seal on the wound vac. The DON placed a suction device with tubing attached to it at the end of the long plastic covered black sponge. She attached additional tubing and then attached it to the wound vac machine. She checked the wound vac machine again. She placed an additional plastic adhesive strip over the wound. She pressed down on the plastic covered sponges many times trying to create a seal. She continued to push on the wound and the long plastic covered foam strip in several places for 3 minutes, from 2:05 to 2:08 p.m. She was unable to create a seal and was out of the plastic strips. At 2:09 p.m., LPN 23 opened the resident's curtain, removed her gloves, washed her hands, and left to get more adhesive plastic for the wound. She did not close the door when she left. The Nurse Practitioner (NP) did not knock and entered the room, she was in a position to see the resident exposed in his bed. She wanted the keys to the QMA's cart. As soon as the NP left, an x-ray technician did not knock and came into the room, she was in a position to see the resident exposed in his bed. She wanted to know if we were almost finished with him. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 2:12 p.m., the DON indicated the wound on Resident B's left lower leg area was open with a stage 3 pressure wound. This open area was not over a bony prominence. The three raised, irregular, deep purple areas around the wound, she indicated were pressure ulcers at stage 2. These areas were not over a bony prominence. CNA 22, with her unwashed gloves hands that had been holding the resident on his side, pressed on the purple areas to see if they wound blanch. They did not. CNA 22 removed her gloves, sanitized her hands, and put on new gloves. At 2:15 p.m., the [NAME] President of Clinical Services (VPCS) came in the room to see if the staff needed assistance, she was in a position to see the resident exposed in his bed. At 2:17 p.m., the DON indicated there was an issue with privacy during Resident B's dressing change. The door and privacy curtains should have remained closed. At 2:18 p.m., after asking about hand washing during dressing changes, the DON left to wash her hands. She was observed to wash her hands correctly, but she rubbed the paper towels on water running from her hands to her elbows, then finished drying her hands with contaminated paper towels. At 2:21 p.m., LPN 23 provided another packaged wound vac system. The DON opened it, cut more adhesive plastic strips with the contaminated scissors, and used them on the resident's new wound vac dressing to complete the seal. During an interview on 9/16/22 at 9:20 a.m., the Former DON (who was DON at the time Resident B developed the wound) indicated at the time of the development of the wound, weekly skin assessments were being conducted by the nurse on the floor and documented on paper. During an interview on 9/16/22 at 10:30 a.m., with the DON and Administrator present, the DON indicated weekly skin assessments should have been conducted by the floor nurse on duty. Any new break in skin integrity were reported to the DON for follow up. A turning and repositioning program was standard practice. In the weeks leading up to the development of the area he was wanting to stay in bed more, and he did refuse a lot of care. Care plans were put into place for continuity of care so that all the nursing staff could have a complete picture of the resident and their specific needs. During an interview on 9/16/22 at 10:36 a.m., with the Administrator present, LPN 23 indicated she typically did not work on the floor. Every now and then she would be called to help the nurse on the floor with insulin if needed or would be pulled to the floor for call-ins. It was the floor nurses' responsibility to complete the weekly skin assessments. She had not assessed Resident B on a weekly basis, and only saw the area on his bottom after it had opened up, and at that time there was a dressing in place. So, she never visualized the wound until the resident returned from the hospital During an interview on 9/16/22 at 11:07 a.m., the DON indicated it was the nurse on duty's responsibility to conduct the weekly skin assessments and it was important for the direct care nurse to complete skin checks to maintain continuity of care. During a follow up interview on 9/16/22 at 11:22 a.m., LPN 23 indicated she had reviewed the weekly skin check log with her signature and indicated, oh, well if I signed it I did it. LPN 23 indicated if she was called down for a skin assessment, it was usually just a quick look over as the CNA would have been cleaning him up. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/19/22 at 8:40 a.m., the Former DON indicated, after a discussion with the current DON, Administrator, and VPCO, it was assumed that Resident B's osteomyelitis infection must have come from the genital herpes outbreak. Unfortunately, it looked like the new diagnosis had not been added to his medical record which meant it was missed for care planning. A current policy, titled, Handwashing/Hand Hygiene, dated 9/2022, was provided by the VPCS, on 9/19/22 at 10:53 a.m. A review of the policy indicated, .Handwashing is the single most important factor in preventing transmission of infections .All healthcare workers shall utilize hand hygiene frequently and appropriately A current policy, titled, Dressing Change, dated 9/2022, was provided by the VPCS, on 9/19/22 at 3:45 p.m. A review of the policy indicated, .to ensure measure that will promote and maintain good skin integrity while maintaining standard measures that will minimize/control contamination . create a clean field .Wash hands with soap and water. Open dressing pack. Put on first pair of disposable gloves. Remove soiled dressing and discard in plastic bag or trash can. Dispose of gloves in plastic bag or trash can. Wash hands with soap and water. Put on second pair of disposable gloves. Follow doctor's recommendations for treatment. Apply dressing and secure with tape when done with treatment if necessary. If using scissors make sure, it is clean with antiseptic .Removes gloves and discard. Wash hands with soap and water On 9/12/22, the Admissions Agreement was provided by the facility. A document titled, Federal Resident Rights and Facility Responsibilities, was reviewed. It indicated, .The resident has a right to personal privacy . includes accommodations, medical treatment This Federal tag related to Complaint IN00389598. 3.1-37