STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Lawrenceburg	403 Bielby Rd Lawrenceburg, IN 47025

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to follow the physicians' orders related to hold parameters for cardiac medications for 2 of 16 residents reviewed for quality of care. (Residents 37 and 63)Findings include:1. Resident 37's clinical record was reviewed on 02/18/2026 at 2:24 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/26/2025, indicated the resident's diagnoses included, but were not limited to, Cancer and Adverse Effects of Antineoplastic (agents, drugs, or therapies that inhibit or prevent the development maturation, or spread of caner/tumor cells) and Immunosuppressive Drugs. The resident's current physician's orders included an open-ended order, with a start date of 12/02/2025, for midodrine (a medication used to treat low blood pressure) 5 mg (milligrams) with meals for hypotension. The medication was to be held if the resident's Systolic Blood Pressure (SBP; the top number) was greater than 120. The December 2025, January 2026, and February 2026 Electronic Medication Administration Records (EMAR) indicated the medication was administered when the resident's SBP was over 120 on the following dates and times: - On 12/04/2025 at 12:00 P.M., the resident's blood pressure was 126/74,- On 12/06/2025 at 12:00 P.M., the resident's blood pressure was 124/78 and at 5:00 P.M., the resident's blood pressure was 126/52,- On 12/07/2025 at 12:00 P.M., the resident's blood pressure was 134/86,- On 12/13/2025 at 12:00 P.M., the resident's blood pressure was 122/86 and at 5:00 P.M., the blood pressure was 128/82,- On 12/14/2025 at 12:00 P.M., the resident's blood pressure was 126/84,- On 12/15/2025 at 5:00 P.M., the resident's blood pressure was 121/82,- On 12/20/2025 at 12:00 P.M., the resident's blood pressure was 121/70,- On 12/21/2025 at 7:00 A.M., the resident's blood pressure was 126/72 and at 12:00 P.M., the resident's blood pressure was 134/74,- On 12/26/2025 at 5:00 P.M., the resident's blood pressure was 125/76,- On 12/27/2025 at 12:00 P.M., the resident's blood pressure was 128/80 and at 5:00 P.M., the resident's blood pressure was 122/72,- On 12/28/2025 at 7:00 A.M., the resident's blood pressure was 129/80,- On 12/31/2025 at 7:00 A.M., the resident's blood pressure was 126/78 and at 12:00 P.M., the blood pressure was 122/78,- On 01/03/2026 at 5:00 P.M., the resident's blood pressure was 128/82,- On 01/04/2026 at 12:00 P.M., the resident's blood pressure was 122/80,- On 01/08/2026 at 7:00 A.M., the resident's blood pressure was 141/79,- On 01/11/2026 at 7:00 A.M., the resident's blood pressure was 126/78,- On 01/16/2026 at 5:00 P.M., the resident's blood pressure was 129/62,- On 01/17/2026 at 12:00 P.M., the resident's blood pressure was 132/81,- On 01/30/2026 at 7:00 A.M., the resident's blood pressure was 131/72,- On 02/03/2026 at 5:00 P.M., the resident's blood pressure was 121/78,- On 02/19/2026 at 7:00 A.M., the resident's blood pressure was 131/79, and - On 02/20/2026 at 7:00 A.M, the resident's blood pressure was 135/71 and at 12:00 P.M., the resident's blood pressure was 138/75. During an interview, on 02/20/2026 at 3:07 P.M., Licensed Practical Nurse (LPN) 6 indicated some (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents had hold parameters for their cardiac medications. She would assess the resident's blood pressure before administering the medication. If the resident's blood pressure was too high or too low (based on how the physician wrote the order), she would not administer the medication and she would make a note that indicated why the medication was held in the EMAR. 2. The clinical record for Resident 63 was reviewed on 02/19/2026 at 11:49 A.M. A Quarterly MDS assessment, dated 01/19/2026, indicated the resident was cognitively intact. The resident's diagnosis included but was not limited to, hypertension (high blood pressure). An open-ended physician's order, with a start date of 03/14/2025, indicated the resident was to be given Carvedilol (a hypertensive medication) 12.5 mg, twice a day. The staff were to hold the medication if the resident's heart rate was less than 60. The December 2025, January and February 2026 EMAR indicated the resident had received the medication when their heart rate was less than 60 on the following dates and times: -On 12/10/2025 at 8:00 P.M., when the resident's heart rate was 51,-On 12/11/2025 at 9:00 A.M., when the resident's heart rate was 58, -On 12/17/2025 at 9:00 A.M., there was no heart rate documented for the resident, -On 12/19/2025 at 8:00 P.M., when the resident's heart rate was 59, -On 12/20/2025 at 8:00 P.M., when the resident's heart rate was 59, -On 12/25/2025 at 9:00 A.M., when the resident's heart rate was 58, -On 12/26/2025 at 9:00 A.M., when the resident's heart rate was 58, -On 12/27/2025 at 9:00 A.M., when the resident's heart rate was 58,-On 01/01/2026 at 9:00 A.M., when the resident's heart rate was 45, -On 01/04/2026 at 9:00 A.M., when the resident's heart rate was 51, -On 01/09/2026 at 8:00 P.M., when the resident's heart rate was 59,-On 01/10/2026 at 9:00 A.M., when the resident's heart rate was 51, -On 01/11/2026 at 9:00 A.M., when the resident's heart rate was 51, -On 01/16/2026 at 8:00 P.M., when the resident's heart rate was 51, -On 01/18/2026 at 9:00 A.M., when the resident's heart rate was 52, -On 01/23/2026 at 8:00 P.M., when the resident's heart rate was 51, -On 01/27/2026 at 9:00 A.M., when the resident's heart rate was 59, -On 01/29/2026 at 8:00 P.M., when the resident's heart rate was 55, -On 02/04/2026 at 9:00 A.M., when the resident's heart rate was 58, and -On 02/13/2026 at 9:00 A.M., when the resident's heart rate was 55. During an interview, on 02/20/2026 at 10:13 A.M., Qualified Medication Aide 2 indicated if a resident had hold parameters, she would obtain the resident's vitals prior to administering the medication and if the vitals were outside the parameters the physician ordered then she would not administer the medication. The current facility policy titled, Medication and Treatment Orders, with a revised date of 08/2024, was provided by the Corporate Support Staff (CSS) 5 on 02/20/2026 at 2:32 P.M. The policy indicated, .Orders for medications and treatments will be consistent with principles of safe and effective order writing.Medications shall be administered only upon the written order. 3.1-37(a)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review and interview, the facility failed to ensure appropriate transfer or discharge documentation was provided for 2 of 3 residents reviewed for transfer or discharge. (Residents 66 and 68)Findings include: 1. The clinical record for Resident 68 was reviewed on 02/19/2026 at 11:00 A.M. A Comprehensive Minimum Data Set (MDS) assessment, accepted on 11/17/2025, indicated the resident admitted to the facility from a short-term hospital stay on 11/03/2025 for care after experiencing a stroke. A Social Services Note, dated 11/21/2025 at 3:49 P.M., indicated the resident was accepted at a different long term care facility. The receiving facility would pick her up on 11/24/2025. The resident's census page in her Electronic Health Record (EHR) indicated she was discharged from the facility on 11/24/2025. During an interview, on 02/20/2026 at 1:34 P.M., Licensed Practical Nurse (LPN) 4 indicated when a resident was discharged from the facility, staff were to complete a discharge summary in the computer that recapped the resident's stay and provided information about the resident's care needs. They would make sure to included information about upcoming appointments and prescriptions they might need. The nurse would call report to the receiving facility and send the discharge summary, a face sheet, medication list, nursing notes, and any other discharge documentation required with the resident to the new facility. During an interview, on 02/20/2026 at 2:46 P.M., the Direct of of Nursing (DON) indicated nursing staff had a bad habit of not making copies of transfer/discharge paperwork when they sent someone out of the facility. The facility could not provide the transfer/discharge paperwork that should have been sent with the resident. 2. The clinical record for Resident 66 was reviewed on 02/19/2026 at 10:42 A.M. A Quarterly MDS assessment, dated 11/13/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, cancer and heart failure. A Progress Note, dated 11/14/2025 at 7:00 P.M., indicated the resident's family member had requested the resident be sent to the emergency room. The resident was sent to the local hospital per the request. A Progress Note, dated 11/14/2025 at 10:00 P.M., indicated the resident was admitted to the hospital. The clinical record lacked documentation the resident was provide a transfer/discharge form. The current facility policy, titled Transfer or Discharge, Facility-initiated, dated 08/2024, was provided by Corporate Support Staff (CSS) 5 on 02/20/2026 at 3:19 P.M. The policy indicated, .When a resident is transferred or discharged from the facility, the following information is documented in the medical record.That an appropriate notice was provided to the resident and/or legal representative. 3.1-12(a)(6)(A)

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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. Based on record review and interview, the facility failed to provide a bed hold for a resident sent to the hospital for 1 of 3 residents reviewed for discharge. (Resident 66)Findings include:The clinical record for Resident 66 was reviewed on 02/19/2026 at 10:42 A.M. A Quarterly MDS assessment, dated 11/13/2025, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, heart failure (a chronic progressive condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen and nutrients). A Progress Note, dated 11/14/2025 at 7:00 P.M., indicated the resident's family member had requested the resident be sent to the emergency room. The resident was sent to the local hospital per the request. A Progress Note, dated 11/14/2025 at 10:00 P.M., indicated the resident was admitted to the hospital for heart failure.The clinical record lacked the resident receiving a bed hold policy with the discharged . During an interview, on 02/20/2026 1:39 P.M., the Director of Nursing (DON) indicated when a resident went to the hospital they should have been given a bed hold policy. During an interview, on 02/20/2026 at 2:03 P.M., Corporate Support Staff (CSS) 5 indicated the resident's bed hold could not be found and the resident should have had one when they discharged in November in their clinical record. The current facility policy titled, Bed Holds and Returns, with a revision date of 08/2024, was provided by CSS 5 on 02/20/2025 at 2:04 P.M. The policy indicated, .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 payor source, are proved written notice about these policies at least twice:.notice 2: at time of transfer (or, if the transfer was an emergency, within 24 hours).Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff were unable to reach and notify the representative timely.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to follow the physicians' orders related to daily weights for 1 of 1 residents reviewed for Hydration Status. (Resident 52)Finding included:The clinical record for Resident 52 was reviewed on 02/19/2026 at 11:21 A.M. An admission MDS assessment, dated 01/12/2026, indicated the resident was cognitively intact. The resident's diagnosis included but was not limited to, metabolic encephalopathy (brain dysfunction caused by chemical imbalances, systemic illness, or organ failure).A physician's order, dated 01/31/2026 through 02/11/2026, indicated the resident was to be weighed daily in the morning for fluid retention. An open-ended physician's order, with a start date of 02/12/2026, indicated the resident was to be weighed daily for fluid retention. The Vitals Record and February 2026 EMAR lacked documented weights for the resident for the following dates: 02/02/2026 through 02/09/2026; 02/08/2026, 02/12/2026, 02/13/2026, 02/15/2026, 02/16/2026, 02/18/2026, and 02/19/2026. During an interview, on 02/20/2026 at 10:11 A.M., QMA 2 indicated if a resident had an order for a daily weight, then the Certified Nurse Aides would usually get the weight and report to her or the nurse. The weight would then be transcribed in the resident's EMAR. If the resident refused the weight, then it would also be documented in the EMAR. During an interview, on 02/20/2026 at 2:58 P.M., CSS 5 indicated daily weights should be documented in the resident's clinical record. The facility did not have a policy related to daily weights. 3.1-46(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store medications appropriately for 1 of 4 medication carts reviewed and 1 of 3 medication rooms reviewed. (South Medication Cart on the third floor and third floor Medication Room) Findings include: 1. On 02/20/2026 at 9:39 A.M., the South Medication Cart on the third floor was observed with Qualified Medication Aide (QMA) 2 and contained the following: - A small round white pill was lying loose in the bottom of the second drawer along with dust and paper debris,- A small round white pill was lying loose in the bottom of the third drawer along with dust and several pieces of paper debris. During an interview at the time of the observation, QMA 2 indicated she was unaware of what the pills were or who they belonged to. There shouldn't be any loose pills in the medication cart. The current Medication Labeling and Storage policy, dated 8/2024, was provided by Corporate Support Staff (CSS) 5 on 02/20/2026 at 2:04 P.M. The policy indicated, .Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they arrived .2. The third-floor medication room was observed, on 02/20/2026 at 1:21 P.M., with Licensed Practical Nurse (LPN) 4. The medication refrigerator contained an opened vial of Tuberculin (TB) serum, with no date that indicated when it was opened. The vial was half full. LPN 3 indicated the TB serum should be dated when opened and should be discarded after 30 days. There was no delivery date on the serum bottle. She was unsure when it was last used. The TB serum package insert was provided by the CSS 5 on 02/20/2026 at 2:17 P.M. The manufacturer's insert indicated, .vials in use more than 30 days should be discarded .3.1-25(o)

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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, interview, and record review, the facility failed to follow infection control guidelines related to Enhanced Barrier Precautions (EBP) for 1 of 16 residents reviewed for infection control. (Resident 63)Findings include:During an observation, on 02/19/2026 at 10:58 A.M., Licensed Practical Nurse 3 gathered supplies from a treatment cart and entered Resident 63's room. She sanitized her hands and donned gloves. She then provided wound treatment care to the resident. There was no gown donned prior to or during the wound treatment. There was no indication outside or inside the resident room that they were on EBP. The clinical record for Resident 63 was reviewed on 02/19/2026 at 11:49 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/19/2026, indicated the resident was cognitively intact. The resident's diagnoses included but were not limited to, anemia, hypertension, renal insufficiency, diabetes, anxiety, depression, cirrhosis of liver, and liver transplant status. A Wound Nurse Practitioner Report, dated 02/03/2026, indicated the resident had dermatosis to the right buttock buttocks. The wound measured 7 centimeters (cm) X (by) 3.8 cm X 0.3 cm. The wound had a moderate amount of serosanguineous (pale red to pink, thin and watery) drainage. The impairment started on 10/28/2025. A Wound Culture Report, dated 02/05/2026, indicated there was a culture from the resident's right buttocks. The wound had the following bacteria:-Sparse growth of Proteus mirabilis,-Very sparse growth of Enterococcus faecalis, and -Sparse growth of Methicillin Resistant Staphylococcus aureus.A physician's order, dated 02/09/2026 through 02/16/2026, indicated the resident was to take Amoxicillin (an antibiotic) 500-125 milligrams for 7 days for a wound infection. The resident's physician's orders lacked and order for EBP. During an interview, on 02/20/2026 at 10:19 A.M., the Director of Nursing (DON) indicated residents were placed on EBP if they had any drains, catheters, colostomy bags, any non-natural device, and chronic wounds. If resident were in EBP then staff should wear a gown, gloves, and face mask. Resident 63 was not on EBP because the wound was clean and not draining. The resident did have a wound infection recently. The resident had the wound since 10/28/2025.The current facility policy titled, Enhanced Barrier Precautions, dated August 2022, was provided by Corporate Support Staff 5 on 02/20/2026 at 2:04 P.M. The policy indicated, .Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.EBPs employ targeted gown and glove use during high contact resident care activities.Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:.wound care (any skin opening requiring a dressing).3.1-18(b)