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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155520	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of River City	909 North First Ave Evansville, IN 47710

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to notify the physician and resident representative when residents left the facility independently for 2 of 3 residents reviewed for elopement. (Resident 22, Resident 75) Findings include: 1. On 10/9/24 at 2:12 P.M., Resident 22's guardian indicated staff should contact her every time the resident left the facility. On 10/4/24 she let the facility know that it was ok for the resident to leave on Mondays, Wednesdays, and Fridays and did not need to be contacted on those days. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. Resident 22 was admitted to the facility on [DATE]. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment and was independent in all Activities of Daily Living (ADLs). A Letters of Temporary Guardianship document, dated 8/29/24, indicated Resident 22 was assigned a court-appointed guardian. An Admission Elopement Risk Assessment, dated 9/13/24, indicated Resident 22 was at low risk for elopement. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included, but was not limited to, Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The emergency contact listed was the court-appointed guardian. A physician order, dated 10/1/24, indicated that the resident had a state guardian and was not permitted to go outside and smoke or leave the facility unless approved by the guardian. An Ineffective Coping care plan, dated 9/18/24, included an intervention to ensure the resident's safety. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked a care plan related to the court-appointed guardian or elopement risk. A Release Of Responsibility For Leave Of Absence (LOA) document indicated the resident signed herself out of the facility on the following dates: 9/18/24 at 11:33 A.M. 9/18/24 at (illegible time) 9/18/24 at 5:10 P.M. 9/18/24 at 7:00 P.M. 9/19/24 at 3:50 P.M. 9/19/24 at 6:10 P.M. 10/3/24 at 1:30 P.M. A Nursing Progress note, dated 10/7/24 at 6:26 P.M., indicated the resident left the facility independently and returned weak. The clinical record lacked documentation that the guardian or the physician was notified that Resident 22 signed herself out of the facility on 9/18/24, 9/19/24, 10/3/24, and 10/7/24. On 10/9/24 at 12:30 P.M., the Director of Nursing (DON) indicated that the former administrator had allowed staff to take the resident outside to smoke to appease her complaining. The facility was aware she had a guardian since she was admitted . The physician order was entered on 10/1/24 to make staff aware the resident was not to leave without guardian approval and to safeguard the resident from leaving at night on her own. It was changed to Mondays, Wednesdays, or Fridays, but the DON was not sure when that was changed. The Social Service Director (SSD) was supposed to document that information, but the DON was unable to find any documentation related to the change of LOA approval. On 10/9/24 at 2:50 P.M., SSD indicated that from 9/13/24 to 9/30/24, Resident 22 was not to leave the facility under any circumstances. Between 9/30/24 and 10/4/30, the guardian changed her mind many times about when the resident could leave the facility. On 10/4/24, the guardian agreed to let Resident 22 go out on independent LOA on Mondays, Wednesdays, and Fridays from 1:30 P.M. to 2:30 P.M. The resident was to check in with the SSD when she left and came back. She indicated the resident had been doing that, but the SSD was not documenting those occurrences. At that time, she indicated a social service progress note, detailing the conversations with the guardian from admission to current had been entered in the clinical record on 10/9/24 at 1:24 P.M. The SSD was unable to provide documentation from conversations with the guardian before 10/9/24. On 10/10/24 at 1:40 P.M., the DON indicated that the guardian and physician were not notified when the resident left the facility sheet. The former administrator approved the resident to sign out to smoke with staff without approval from guardian. All notifications to the guardian and physician should be documented in a progress note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46758 2. On 10/09/24 at 7:33 A.M., Resident 75's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness, need for assistance with personal care, and muscle wasting. The most current 5 Day Admission MDS (Minimum Data Set) Assessment, dated 10/6/24, indicated that the resident was cognitively intact and was dependent on staff for transfer, dressing, hygiene, and mobility. Physicians orders included, but were not limited to: May go on LOA (Leave of Absence) with responsible party PRN (as needed), dated 9/29/24. A Release Of Responsibility For Leave Of Absence document indicated the resident signed himself out of the facility on the following dates: 10/3/24 at 12:47 P.M. 10/8/24 at 1:00 P.M. The document contained five signatures that did not specify a date or time and were illegible. The clinical record lacked documentation that the physician was notified when the resident left independently and without a responsible party. Interview on 10/10/24 at 1:36 P.M., the DON (Director of Nursing) indicated the order needed to be modified to indicate the resident could go LOA on his own. On 10/9/24 at 11:55 A.M., the DON provided a current Guidelines for LOA policy, dated 6/2023, that indicated A sign-out log should be available for the resident or responsible party to sign out prior to leaving campus for a leave of absence. On 10/9/24 at 3:55 P.M., the DON provided a current Wandering and Elopement policy, dated 8/2022, that indicated A list of residents at risk for elopement is maintained in a binder with corresponding pictures . When the resident returns to the facility, the Director of Nursing Services or Charge Nurse will .contact the attending physician and report findings and conditions of the resident; notify the resident's legal representative . On 10/10/24 at 9:13 A.M., the DON provided a current Adult Guardianship in Indiana: The Basics policy, dated 8/23/2018, that indicated unless limited by the court, a guardian is responsible for providing or supervising the protected person's care . On 10/11/24 at 8:30 A.M., the Administrator provided a current Change in a Resident's Condition or Status policy, dated 8/2024, that indicated The nurse will notify the resident's physician or physician on call when there has been a .discharge without proper medical authority. 3.1-5(a)(3)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 Based on observation, interview, and record review, the facility failed to ensure a resident had orders upon admission for their PICC (peripherally inserted central catheter), wound care, management of their wound vac, and an order for enhanced barrier precautions for 1 of 1 resident reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., Registered Nurse (RN) 9 was observed preparing vancomycin 750 milligrams (mg) / 150 milliliters (mL) to administer to Resident 225. A sign on the door indicated the resident was on enhanced barrier precautions (EBP). RN 9 did not donn a gown prior to caring for the resident. RN 9 flushed the first lumen on Resident 225's PICC line with 10 mL of saline and then flushed the second lumen on the PICC line with 8 mL of saline. RN 9 hooked the vancomycin to the PICC line and set the medication to run at 150 drops per minute. At that time, a wound vac was observed on the resident's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical record was reviewed. Resident 225 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). Current physician orders included, but were not limited to: Vancomycin HCl intravenous solution (antibiotic), 750 mg intravenously two times a day for infectious wound related to osteomyelitis, dated 10/7/24. Vancomycin trough (lab work that is checked to monitor levels of Vancomycin in blood stream), CBC (complete blood count), CMP (comprehensive metabolic panel), one time only for IV (intravenous) antibiotics for 1 day, dated 10/8/24. Assess IV site every shift for signs and symptoms of infection or infiltration every shift, dated 10/6/24. The clinical record lacked orders for saline flushes through Resident's PICC line, order for PICC line, wound vac orders and wound care, and enhanced barrier precautions or transmission-based precautions related to Resident's wound and PICC line. Current care plans for Resident 225 included, but were not limited to: I have a venous access device specify: picc, midline, Peripheral IV related to antibiotics, date initiated 10/5/2024. If Resident has swelling or increased pain during infusion, stop IV and notify provider, date initiated 10/5/2024. IV assessment as indicated, date initiated 10/5/2024. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Labs as ordered, date Initiated 10/5/2024. Notify provider for signs and symptoms of infection, extravasation, infiltration, increased pain, date initiated 10/5/2024. Treatments as ordered, date initiated 10/5/2024. I am receiving IV (intravenous) medications for: osteomyelitis and cellulitis (skin infection), date initiated 10/5/2024. An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated orders for PICC, enhanced barrier precautions, and wound care should have been put in upon admission. She indicated a resident with a PICC line should have basic orders related to the PICC line including saline flushes, infection prevention caps covering the lumens of the PICC, and wounds should have treatment orders. A Physician Services policy, provided by Regional Support on 10/11/24 at 10:01 A.M., indicated once a resident is admitted , orders for the resident's immediate care and needs . provided by physician, physician assistant, nurse practitioner, or clinical nurse specialist. 3.1-30(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure accurate Minimum Data Set (MDS) assessments were completed for a resident with Post Traumatic Stress Disorder and intravenous access and residents with falls for 1 of 1 residents reviewed for antibiotic use and 2 of 2 residents reviewed for falls. (Resident 21, Resident 10, Resident 2) Findings include: 1. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on [DATE]. Diagnoses on admission included, but were not limited to, osteomyelitis, Post Traumatic Stress Disorder (PTSD), and borderline personality disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact, did not have PTSD, and did not have IV (intravenous) access. A current care plan, dated 9/19/24, indicated (Resident) received IV Medications related to osteomyelitis of right foot, Date Initiated: 9/19/24. During an interview on 10/10/24 at 12:41 P.M., the Director of Nursing (DON) indicated the MDS Assessment should have indicated Resident 21 did have a diagnosis of PTSD and did have IV access at the time of the MDS Assessment on 9/25/24. 2. On 10/9/24 at 9:37 A.M., Resident 10's clinical record was reviewed. Resident 10 was admitted on [DATE]. Diagnoses included, but were not limited to, generalized muscle weakness and abnormality of gait and mobility. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/27/24, indicated Resident 10 was cognitively intact. Resident 10 required substantial assistance (staff perform more than half of the work) for toileting, bathing, and transfers. The MDS Assessment indicated no falls since the prior MDS Assessment on 6/27/24. A transfer to hospital summary, dated 7/20/2024 at 10:03 A.M., indicated Resident 10 experienced an unwitnessed fall resulting in a large hematoma on the back of her head, and was transported to the hospital. During an interview on 10/10/24 at 12:41 P.M., the Director of Nursing (DON) indicated the MDS Assessment should have indicated Resident 10 experienced a fall between the previous and most recent MDS Assessment. 46758 3. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most current Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no falls since the prior assessment on 6/14/24. Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: encourage staff to assist with transfer and ADL (Activities of Daily Living), footwear to prevent slipping, and anticipate and meet the resident's needs. A nursing progress note, dated 7/19/24 at 1:24 P.M., indicated the resident had an unwitnessed fall without injury in her room. During an interview on 10/10/24 at 3:41 P.M., the DON (Director of Nursing) indicated the resident was not coded for falls on the Quarterly MDS assessment dated [DATE] and should have been. On 10/11/24 at 8:30 A.M., Regional Support provided a policy titled Resident Assessment, dated 8/24, that indicated Assessments are completed by the staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. Information in the MDS assessment will consistently reflect information in the progress notes, plan of care, and resident observations/interviews.

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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** 50827 Based on observation, interview, and record review, the facility failed to ensure a resident had a baseline care plan related to their wounds and wound management for 1 of 1 residents reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., a wound vac was observed on Resident 225's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical record was reviewed. Resident 225 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. The clinical record lacked baseline care plans for 4 of 4 of Resident 225's documented wounds, as well as management with a wound vac the resident had in place. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated care plans were updated immediately and as needed. On 10/11/24 at 8:30 A.M., the Administrator provided a Care Plane, Comprehensive Person-Centered policy, dated 8/2024, that indicated The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 3.1-30(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46758 Based on record review and interview, the facility failed to ensure care plans were revised for 2 of 3 residents reviewed for accidents. Care plans were not revised after falls, substance misuse, and determination of elopement risk. (Resident 2, Resident 22) Findings include: 1. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no fall since the prior assessment. Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: Anticipate and meet the resident's needs, initiated on 4/8/24 Set up craft station in room, initiated on 6/14/24. An incident note, dated 6/29/24 at 1:00 P.M., indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. A nursing note, dated 7/19/24 at 1:24 P.M., indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. A nursing note, dated 9/22/24 at 4:32 P.M., indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. During an interview on 10/10/24 at 2:25 P.M., the Director of Nursing (DON) indicated that the care plans needed to be updated after each fall. 48147 2. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment, had no behaviors, and was independent in all Activities of Daily Living (ALDs). A current history of substance abuse (methamphetamines) care plan, dated 9/14/24, included the following interventions: Encourage verbalization of feelings, fears, and anxiety. Labs as ordered. Medications as ordered. Review facility policy on substance abuse with resident/responsible party and ensure they understand consequences of not following facility policy. Therapy evaluation as needed. A Social Services progress note, dated 9/27/24 at 11:39 A.M., indicated a Certified Nursing Aide (CNA) notified the Social Service Director (SSD) and Director of Nursing (DON) that Resident 22 and another resident were seen crushing a white substance in a baggy. The white substance was found hidden in the resident's deodorant container. Law enforcement was called. An officer tested the substance upon arrival and it tested positive for methamphetamine. Resident 22 admitted to using the drug but would not say how long she had the drugs in her possession or where she got them. The care plan was not updated following the incident with methamphetamines or law enforcement on 9/27/24. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The clinical record lacked a care plan related to Resident 22's elopement risk. On 10/9/24 at 11:50 A.M., the Director of Nursing (DON) indicated that all residents in the elopement binder should also have a care plan. On 10/10/24 at 9:04 A.M., the DON indicated the care plan was not updated following the incident with the methamphetamine and law enforcement on 9/27/24. On 10/11/24 at 8:45 A.M., the Regional Support indicated there was no substance abuse policy. That policy was retired the first week of September and was not replaced. The care plan was not updated to reflect that change. On 10/9/24 at 3:55 P.M., the DON provided a current Wandering and Elopements policy, dated 8/2022, that indicated Care plans will be developed and individualized for residents who are at risk of elopement. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48147 Based on interview and record review, the facility failed to ensure insulin was given in accordance with professional standards for 5 of 5 residents reviewed for insulin. Residents were given insulin late and by unqualified staff. (Resident 18, Resident 1, Resident 17, Resident 11, Resident 8) Findings include: 1. On 10/9/24 at 10:06 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/22/24, indicated Resident 18 had no cognitive impairment and received insulin. Physician orders included, but were not limited to: Humalog (insulin lispro - a short-acting insulin) KwikPen Subcutaneous Solution Pen-injector 100 unit/mL (milliliters) - Inject as per sliding scale: if 0 - 140 = 0 units; 141 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units subcutaneously before meals and at bedtime for type 2 diabetes mellitus, dated 7/11/24 The September 2024 Medication Administration Record (MAR) indicated that Resident 18 received 8 units of insulin lispro on 9/23/24 at 7:30 A.M. by Qualified Medication Aide (QMA) 2. On 10/9/24 at 1:49 P.M., employee files were reviewed. QMA 2's license did not include insulin administration certification. On 10/10/24 at 12:52 P.M., the Director of Nursing (DON) indicated QMAs were not allowed to administer insulin. 2. On 10/10/24 3:23 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 8/13/24, indicated Resident 1 had severe cognitive impairment and received insulin. Physician orders included, but were not limited to: Lantus SoloStar (insulin glargine - a long-acting insulin) Subcutaneous Solution Pen-injector 100 unit/mL (milliliters) - Inject 17 units subcutaneously at 8:00 A.M. and 8:00 P.M. for type 2 diabetes mellitus, dated 7/16/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 1 the 8:00 A.M. dose of insulin glargine on 9/23/24. (continued on next page)

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of River City	909 North First Ave Evansville, IN 47710

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M.

3. On 10/10/24 at 3:27 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/23/24, indicated Resident 17 had no cognitive impairment and received insulin.

Physician orders included, but were not limited to:

Lantus (insulin glargine - a long-acting insulin) Subcutaneous Solution 100 unit/mL (milliliters) - Inject 20 units subcutaneously at 8:00 A.M. for type 2 diabetes mellitus, dated 7/11/24

The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 17 the 8:00 A.M. dose of insulin glargine on 9/23/24.

On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M.

4. On 10/10/24 at 3:29 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated Resident 11 had mild cognitive impairment and received insulin.

Physician orders included, but were not limited to:

Insulin Glargine (a long-acting insulin) Solution 100 unit/mL (milliliters) - Inject 16 units subcutaneously at 8:00 A.M. and 8:00 P.M. for diabetes for type 2 diabetes mellitus, dated 2/1/24

Admelog SoloStar (insulin lispro - a short-acting insulin) Subcutaneous Solution Pen-injector 100 unit/mL - Inject as per sliding scale: if 141 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; above 400 12 units subcutaneously with meals for type 2 diabetes mellitus, dated 9/13/24

The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 11 the 8:00 A.M. dose of insulin glargine and insulin lispro on 9/23/24.

On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M.

5. On 10/10/24 at 3:33 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

(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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most current Significant Change Minimum Data Set (MDS) Assessment, dated 9/3/24, indicated Resident 8 had no cognitive impairment and received insulin. Physician orders included, but were not limited to: Insulin Glargine (a long-acting insulin) Solution 100 unit/mL - Inject 15 units subcutaneously at 8:00 A.M. for type 2 diabetes mellitus, dated 7/19/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 8 the 8:00 A.M. dose of insulin glargine on 9/23/24. On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M. On 10/10/24 at 1:40 P.M., the Director of Nursing (DON) indicated she was at the facility on 9/23/24 a little before 6:00 A.M. but worked as a CNA (Certified Nurse Aide) that morning. She could not provide documentation that placed her in the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. She indicated that she could not remember if she gave insulin that morning, and the insulin was probably given to residents late after RN 21 arrived for her shift at 9:40 A.M. At that time, she indicated that QMA 2 did not give insulin and it was documented in error, but she was not sure who gave the insulin on 9/23/24 at 7:30 A.M. On 10/8/24 at 11:30 A.M., the Administrator provided a Medication Administration and General Guidelines policy, dated 2020, that indicated Medications are administered within one hour of the scheduled time . Before or after meal orders are administered precisely as ordered . The resident's MAR is initialed by the person administering a medication . On 10/10/24 at 4:06 A.M., the Regional Support provided a current Charting and Documentation policy, dated 8/2024, that indicated Documentation in the medical record will be .accurate. On 10/10/24 at 4:06 P.M., the Regional Support provided a current Staffing, Sufficient and Competent Nursing policy, dated 8/2024, that indicated Licensed nurses .are available 24 hours a day, seven (7) days a week to provide competent resident care services. On 10/10/24 at 4:06 P.M., the Regional Support provided a current undated Qualified Medication Aide Scope of Practice policy that indicated The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all . The following tasks shall not be included in the QMA scope of practice: Administer medication by the injection route, including the following . subcutaneous route. 3.1-35(g)(1)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48147 Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 3 of 4 days during the annual survey period. Finding includes: During an observation on 10/8/24 at 3:12 P.M., a posted nurse staffing data sheet, dated 10/8/24, was observed on the front desk inside the main entrance. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aide (CNA). The sheet indicated that staff worked day shift, evening shift, and night shift, but did not indicate the actual hours of those shifts. The sheet indicated 1 CNA worked 4 hours during the evening shift, but did not specify the actual hours that the staff worked. On 10/10/24 at 10:30 A.M., the Director of Nursing (DON) provided a copy of posted nurse staffing sheets for dates 10/8/24, 10/9/24, and 10/10/24. Each of these dates did not reflect actual hours worked. On 10/10/24 at 11:00 A.M., the Administrator indicated the facility did not have an evening shift and was unable to tell the actual hours staff worked by looking at the posted nurse staffing sheet. On 10/10/24 at 4:06 P.M., the Regional Support provided a current Posting Direct Care Daily Staffing Numbers policy, dated 8/2024, that indicated The information recorded on the form shall include .the actual time worked during that shift for each category and type of nursing staff.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure social services were provided to meet a resident's mental and psychosocial needs for 1 of 1 residents reviewed for mood disturbances. (Resident 21) Finding includes: During an interview on 10/8/24 at 11:38 A.M., Resident 21 appeared to be anxious and indicated he had a history of PTSD (Post Traumatic Stress Disorder) but had not met with mental health services since admission. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on [DATE]. Diagnoses on admission included, but were not limited to, Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact and was independent for eating, toileting, and transfers. A review of current orders indicated Resident 21 was not receiving medications related to mental health diagnoses. Current care plans included, but were not limited to: Risk for Ineffective Coping due to [AGE] years in maximum security prison, PTSD diagnosis and incidences witnessed while detained all those years, Date Initiated: 8/15/24 Collaborate care with medical providers and psych services, Date Initiated: 8/15/24 On 8/8/24 a Preadmission Screening and Resident Review (PASRR) screening was completed for Resident 21 prior to admission. The screening indicated no mental health diagnosis was known or suspected. On 8/9/24 Resident 21 completed a form that indicated he would like to receive mental health services while in the facility. On 8/15/24 a form titled PHQ-9 Questionnaire (an assessment that measures the severity of depression), containing answers given by Resident 21, was completed by the Social Service Director (SSD). The total score indicated Resident 21 experienced mild depression. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/9/24 at 10:20 A.M., the SSD indicated the hospital completed the PASRR screening incorrectly prior to admission to the facility but the assessment should have been reviewed and resubmitted correctly on admission by the facility. The SSD indicated when a resident answered questions on the PHQ-9 Questionnaire that indicated depression, mental health services were offered, and indicated Resident 21 should have received mental health services but the behavioral health company that was contracted through the facility could not bill Resident 21's insurance and the facility would have to pay for the services. No other providers were contacted. On 10/11/24 at 8:30 A.M., the Regional Support provided a document titled Position Description Social Services Director that indicated The Social Services Director provides medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential position functions: Assesses each resident's psychosocial needs and develops a plan for providing care. Collaborates with other departments, physicians, consultants, community agencies, and institutions to improve the quality of services and resolve identified problems. 3.1-34(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48147 Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's as needed antianxiety medication was ordered for greater than 14 days. (Resident 18) Finding includes: On 10/9/24 at 10:06 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, generalized anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/22/24, indicated Resident 18 had no cognitive impairment and received an antianxiety medication. Physician orders included, but were not limited to: diazepam (an antianxiety medication) 2 milligrams (mg) - Give 0.5 tablet by mouth every 8 hours as needed for anxiety, dated 8/28/24 with no end date. The Medication Administration Record (MAR) from 8/28/24 to 10/9/24 indicated Resident 18 received as needed (PRN) antianxiety medication on the following dates: 8/28/24 8/29/24 8/30/24 9/2/24 9/3/24 9/4/24 9/6/24 9/10/24 9/11/24 9/16/24 9/17/24 (continued on next page)

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	155520	A. Building B. Wing	10/11/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/18/24 9/23/24 9/24/24 9/25/24 9/26/24 10/1/24 10/2/24 10/7/24 10/9/24 On 10/10/24 at 10:20 A.M., the Director of Nursing (DON) indicated that PRN antianxiety medications should have a stop date of 14 days. The medication needed to be reviewed by the physician every 14 days to evaluate for continuance. On 10/11/24 at 8:30 A.M., the Administrator provided a current Psychotropic Medication Use policy, dated 8/2024, that indicated PRN orders for psychotropic medications are limited to 14 days. 3.1-48(a)(2)

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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. 50827 Based on observation, interview and record review, the facility failed to ensure medications were labeled, opened-multi-dose containers were dated, and medication carts were free of loose pills for 1 of 2 medication carts observed. (100 hall med cart) Finding includes: On 10/9/24 at 7:40 A.M., the following were observed in the 100 hall med cart: an oblong maroon colored pill a small round white pill two dropper bottles of medication with no patient label two open bottles of multi-dose medications with no date written on them to indicate when they had been opened On 10/10/24 at 1:50 P.M., the Director of Nursing (DON) indicated that multi-dose medications such as Miralax, did not need to have the date opened written on them. A Medication Labeling and Storage policy, provided by the Administrator on 10/11/24 at 8:30 A.M., indicated medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received . multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 3.1-25(j)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48057 Based on observation and record review, the facility failed to ensure food was correctly prepared for 2 of 2 residents who received puree altered diets. Finding includes: During an observation on 10/10/24 at 10:02 A.M., Dietary [NAME] 4 was preparing puree foods for resident's with altered dietary needs. The recipe #1028 titled Ham with Raisin Sauce Pureed Thick indicated the following measurements for 15 servings: Baked Ham with Raisin Sauce - 15 of three slices, 2 tablespoons sauce Apple Juice - 7.5 of four fluid ounces Food thickener - 3/4 cup 3 tablespoons Dietary [NAME] 4 gathered food and supplies for five (5) servings for each food. Dietary [NAME] 4 indicated she was unsure of the conversion from 15 servings to 5 servings. The Administrator wrote the conversions on the recipe and gave it to Dietary [NAME] 4. The handwritten conversions were written as follows: Five ham slices with raisin sauce 14 ounces of fluid for apple juice Thickener 1/4 cup and one tablespoon Dietary [NAME] 4 put the following food amounts in the puree machine: 15 slices of ham 1/2 cup (four fluid ounces) apple juice one tablespoon of food thickener Dietary [NAME] 4 emptied the contents of the puree food into a food canister, wrapped the top with plastic wrap, and transferred the canister to the temperature holding area. During an interview on 10/10/24 at 11:15 A.M., the Administrator indicated the puree conversions were incorrect. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/24 at 9:02 A.M., Regional Support provided a document titled Food Preparation and Service, revised 11/22, that indicated Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Food preparation means the series of operational processes involved in preparing foods for serving such as: pureeing. 3.1-21(a)(3)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for elopement and 1 of 2 residents reviewed for falls. Documentation required for a resident leave of absence (LOA) was not completed and neurological checks were not completed as ordered after a fall. (Resident 22, Resident 21, Resident 2) Findings include: 1. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. Resident 22 was admitted to the facility on [DATE]. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment and was independent in all Activities of Daily Living (ADLs). A Letters of Temporary Guardianship document, dated 8/29/24, indicated Resident 22 was assigned a court-appointed guardian. An Admission Elopement Risk Assessment, dated 9/13/24, indicated Resident 22 was at low risk for elopement. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included, but was not limited to, Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The emergency contact listed was the court-appointed guardian. A physician order, dated 10/1/24, indicated that the resident had a state guardian and was not permitted to go outside and smoke or leave the facility unless approved by the guardian. A Release Of Responsibility For Leave Of Absence (LOA) document indicated the resident signed herself out of the facility on the following dates: 9/17/24 at 12:20 P.M. 9/18/24 at 11:33 A.M. 9/18/24 at 1:45 P.M. 9/18/24 at (illegible time) 9/18/24 at 5:10 P.M. 9/18/24 at 7:00 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/19/24 at 3:50 P.M. 9/19/24 at 6:10 P.M. 9/22/24 at (illegible time) 10/3/24 at 1:30 P.M. A Nursing Progress note, dated 10/7/24 at 6:26 P.M., indicated the resident left the facility independently and returned weak. The clinical record lacked documentation indicating who the resident left with, expected time of return, instructions provided, and a list of medications sent. On 10/9/24 at 2:50 P.M., Social Services Director (SSD) indicated the resident was to check in with the SSD when she left and came back. She indicated the resident had been doing that, but the SSD was not documenting those occurrences. On 10/10/24 at 1:40 P.M., the Director of Nursing (DON) indicated that documentation regarding the times Resident 22 went LOA could not be found. 48057 2. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on [DATE]. Diagnoses on admission included, but were not limited to, osteomyelitis, Post Traumatic Stress Disorder (PTSD), and Borderline Personality Disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact and was independent for eating, toileting, and transfers. On 10/9/24 at 11:55 A.M., the Leave of Absence (LOA) binder was reviewed. Resident 21 signed himself out on the following days and times: 10/6 12:50 10/6 2:32 10/7 1:05 10/7 4:05 10/8 9:51 10/8 2:10 10/9 8:43 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The leave of absence form and clinical record, including progress notes and assessments, lacked documentation indicating if medications were sent with Resident 21 during each leave of absence, date and time the resident arrived back to the facility, and signature of facility representative for each leave of absence. On 10/9/24 at 3:55 P.M., the facility elopement binder was reviewed. Resident 21 was observed in the binder along with an identifying photo. The clinical record lacked an order related to approval of physician for independent leave of absence. 46758 3. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness The current Quarterly Minimum Data Set (MDS) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no falls since the prior assessment. Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: Encourage staff to assist with transfer and ADL (Activities of Daily Living) Footwear to prevent slipping Anticipate and meet the resident's needs. On 10/9/24 at 2:15 P.M., the Administrator provided copies of the neurological check list for Resident 2 as follows: Fall 1 On 9/23/24 at 10:00 A.M., the fourth 4-hour neuro check was partially completed. On 9/23/23 at 2:00 P.M., the fifth 4-hour neuro check was left blank. On 9/23/23 at 4:00 P.M., the sixth 4-hour neuro check was left blank. Fall 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Envive of River City		STREET ADDRESS, CITY, STATE, ZIP CODE 909 North First Ave Evansville, IN 47710	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/19/24 at 1:15 P.M., the second 15-minute check was left blank. On 7/19/24 at 1:30 P.M., the third 15-minute check was left blank. On 10/10/24 at 9:43 A.M., the Director of Nursing (DON) indicated that when there was an unwitnessed fall, neuro checks were completed and should be filled out completely. If there was some reason that the checks could not be done at the scheduled time, it should be completed late. On 10/9/24 at 11:55 A.M., the DON provided a current Guidelines for LOA policy, dated 6/2023, that indicated Nursing documentation should include: the date and time the resident left, who they left with, expected time of return, instructions provided, and medications sent (type and number of doses). On 10/10/24 at 4:06 P.M., the Regional Support provided a current Charting and Documentation policy, dated 8/2024, that indicated Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. On 10/10/24 at 4:06 P.M., the Administrator provided a current policy Neurological Assessment (Routine), revised on 8/2024, that indicated .the following information should be recorded in the resident's medical record .all assessment data obtained during the procedure . 3.1-50(a)(1) 3.1-50(a)(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. 50827 Based on observation, interview, and record review, the facility failed to ensure a resident with a PICC (peripheral injection central catheter) and multiple wounds was provided enhanced barrier precautions (EBP) for 1 of 1 resident reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., Registered Nurse (RN) 9 was observed preparing vancomycin 750 milligrams (mg) / 150 milliliters (mL) to administer to Resident 225. A sign on the door indicated the resident was on enhanced barrier precautions (EBP). RN 9 did not donn a gown prior to caring for the resident. RN 9 flushed the first lumen on Resident 225's PICC line with 10 mL of saline and then flushed the second lumen on the PICC line with 8 mL of saline. RN 9 hooked the vancomycin to the PICC line and set the medication to run at 150 drops per minute. At that time, a wound vac was observed on the resident's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical record was reviewed. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. The clinical record lacked orders for enhanced barrier precautions or transmission-based precautions related to Resident 225's wound and PICC line. Current care plans for Resident 225 included, but were not limited to: I have a venous access device specify: picc, midline, Peripheral IV related to antibiotics, date initiated 10/5/2024. If Resident has swelling or increased pain during infusion, stop IV and notify provider, date initiated 10/5/2024. IV assessment as indicated, date initiated 10/5/2024. Labs as ordered, date Initiated 10/5/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify provider for signs and symptoms of infection, extravasation, infiltration, increased pain, date initiated 10/5/2024. Treatments as ordered, date initiated 10/5/2024. I am receiving IV (intravenous) medications for: osteomyelitis and cellulitis (skin infection), date initiated 10/5/2024. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated staff should wear personal protective equipment when providing care to resident. An Enhanced Barrier Precautions policy, provided by Regional Support on 10/11/24 at 10:01 A.M., indicated enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi drug resistance organisms to residents. EBPs employ targeted gown and glove used during high contact resident care activities examples of high-contact resident care activities are device care or use (central line). 3.1-18(b)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46758 Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP did not currently dedicate at least part time to the role of IP for 1 of 1 staff members reviewed for IP. Findings include: On 10/8/24 at 12:10 P.M., the Director of Nursing (DON) indicated she was currently responsible for the infection prevention and control program in the facility. She indicated she worked full time as the DON, and was able to dedicate about 8 hours per week on the infection control program. On 10/9/24 at 1:49 P.M., the DON's employee file was reviewed. The DON had an IP certification dated 11/14/21. On 10/11/24 at 8:50 A.M. the Administrator provided a current undated Job Description: Infection Preventionist Nurse job description. The job description indicated . the IP provides assistance to the Director of Nursing when needed. On 10/9/24 at 11:30 A.M., the Administrator provided a current Infection Prevention and Control Program (IPCP), dated 8/2022, that indicated The community shall designate a member of the clinical team to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP.