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	01/07/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain an informed consent (a process in which patients are given important information, including possible risks and benefits, about a medical procedure or treatment) prior to the administration of medication and a lab test. The facility administered psychotropic medications without informed consent (Resident 21, Resident 3, Resident 5, and Resident 1) and completed a serum drug screen without informed consent (Resident 21 and Resident 3).Findings include: 1. During an interview on 1/4/26 at 2:03 P.M., Resident 21 indicated that the facility gave him a drug test without his consent. They told him the blood draw was to check on the status of his diabetes. On 1/5/26 at 2:42 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, acquired absence of left leg above knee, osteoarthritis, and polyneuropathy. The most current Annual Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated that Resident 21 had no cognitive impairment, was independent in all Activities of Daily Living (ADLs), and received an antipsychotic, antidepressant, and an antianxiety medication during the 7-day lookback period. A care plan conference was completed on 11/13/25 with Resident 21 in attendance. His care plan was reviewed. Care plans included, but were not limited to:Resident has a history of substance use such as diagnosis of cannabis use, stimulate abuse and nicotine dependence, initiated 11/4/25 I receive antipsychotic medication related to schizophrenia, dated 12/28/24 I receive antidepressant medication related to depression, dated 12/28/24 I receive antianxiety medication related to anxiety disorder, dated 12/28/24 Physician orders included, but were not limited to:buspirone (an antianxiety medication) 15 milligrams (mg) tablet - Give one tablet by mouth two times a day for anxiety, dated 12/27/24 duloxetine (an antidepressant) delayed released sprinkles 60 mg tablet - Give one capsule by mouth two times a day for major depressive disorder, dated 12/27/24 aripiprazole (an antipsychotic medication) 10 mg tablet - Give one tablet by mouth one time a day for schizophrenia, dated 12/28/24 mirtazapine (an antidepressant) 30 mg tablet - Give one tablet by mouth at bedtime for insomnia related to major depressive disorder, dated 8/12/25 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CBC (complete blood count) with differential, BMP (basic metabolic panel), serum drug screen to be drawn 12/17/25 one time only, dated 12/17/25 A nursing progress note, dated 12/17/25 at 10:30 A.M., indicated the Medical Director (MD) was in the facility for routine rounds. Resident 21 was assessed and medications were reviewed. New lab orders were obtained for CBC with differential, BMP, and serum drug screen. The note indicated all appropriate parties notified. The clinical record lacked documentation to indicate who the appropriate parties were. An MD encounter note, dated 12/17/25 and signed by the MD on 12/30/25 at 6:33 P.M., indicated that Resident 21 was seen for a regulatory visit at the facility. Today seen resting in bed. He will not wake up to speak with me. Per staff he leaves for hours at a time in the evening and sometimes out all night with concern for drug abuse . concern of drug abuse, obtain drug test . will obtain labwork and make adjustments as needed. Otherwise continue current management. The clinical record lacked documentation of informed consent prior to the administration of the buspirone 15 mg medication, duloxetine 60 mg medication, aripiprazole 10 mg medication, mirtazapine 30 mg medication, and initiation of the CBC, BMP, and serum drug screen lab work. During an interview on 1/6/26 at 11:15 A.M., the Director of Nursing (DON) indicated that Resident 21 did not have documented informed consent for the serum drug screen. 2. During an interview on 1/5/26 at 9:35 A.M., Resident 3 indicated that he was not sure if he had ever been drug tested at the facility. On 1/5/26 at 10:35 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome, acquired absence of right leg below knee, long term use of opiate analgesic, and opioid dependence. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25, indicated Resident 3 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and received an antidepressant medication during the 7-day lookback period. A care plan conference was completed on 10/9/25 with the resident in attendance. His care plans were reviewed. A current risk for complications related to substance abuse, dated 6/26/25, included, but was not limited to, the following intervention:Answer questions honestly and provide factual information. Keep your word when agreements are made. Physician orders included, but were not limited to:duloxetine (an antidepressant) delayed release particles 60 milligrams (mg) tablet - Give one capsule by mouth one time a day related to chronic pain syndrome, dated 12/18/25 duloxetine delayed release particles 30 mg tablet - Give two capsules by mouth two times a day for pain/depression related to chronic pain syndrome, dated 9/11/25 and discontinued on 12/16/25 CBC (complete blood count) with differential, BMP (basic metabolic panel), serum drug screen to be drawn 12/17/25 one time only, dated 12/17/25 (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note, dated 12/17/25 at 10:28 A.M., indicated the Medical Director (MD) was in the facility for routine rounds. Resident 3 was assessed and medications were reviewed. New lab orders were obtained for CBC with differential, BMP, and serum drug screen. The note indicated all appropriate parties notified. The clinical record lacked documentation to indicate who the appropriate parties were. An MD encounter note, dated 12/17/15 and signed by the MD on 12/30/25 at 6:29 P.M., indicated that Resident 3 was seen for a regulatory visit in the facility. Per staff patient leaves facility often at night for several hours and sometimes out all night with concerning behavior for drug use . concern for drug abuse, obtain drug test . will obtain labwork and make adjustments as needed. The clinical record lacked documentation of informed consent prior to the administration of the duloxetine 60 mg medication and the initiation of the CBC, BMP, and serum drug screen lab work. During an interview on 1/6/26 at 11:15 A.M., the Director of Nursing (DON) indicated that Resident 3 did not have documented informed consent for the serum drug screen. 3. On 1/5/26 at 9:30 A.M., Resident 5's clinical record was reviewed. Resident 5 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, major depressive disorder. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/15/25, indicated Resident 5 was moderately cognitively impaired, was dependent on staff (staff does all of the work) for toileting and bathing, and received antipsychotic, antianxiety, and antidepressant medication during the 7-day lookback period. Current physician orders included, but were not limited to: buspirone HCl (an antianxiety medication) oral tablet 15 milligrams (mg) - Give one tablet by mouth three times a day for anxiety take with 10 mg tab; Start date 3/8/25 desvenlafaxine succinate (an antidepressant medication) ER (extended release) oral tablet 24 Hour 25 mg - Give one tablet by mouth one time a day for depression; Start date 3/8/25 Zyprexa (an antipsychotic medication) oral tablet 15 mg (milligrams) - Give 15 mg by mouth at bedtime; Start date 3/15/25 Zyprexa oral tablet 10 mg - Give one tablet by mouth one time a day; Start date 4/2/25 clonazepam (an antianxiety medication) oral tablet 1 mg - Give one tablet by mouth three times a day; Start date 9/5/25 The current care plan included, but was not limited to:I receive antidepressant medication related to depression; Date initiated 3/10/25 I receive anti-anxiety medications related to anxiety disorder; Date Initiated 3/10/25 I receive antipsychotic medications related to delusional disorder, mental disorder, schizophrenia, revised on 4/21/25 The clinical record lacked documentation of informed consent obtained prior to the administration of (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychotropic medications. 4. On 1/5/26 at 8:58 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia, bipolar disorder, and cerebral infarction. The current admission Minimum Data Set (MDS) Assessment, dated 12/13/25, indicated Resident 1 was cognitively intact. Resident 1 was dependent on staff for hygiene, dressing, and transferring. During the 7-day lookback period Resident 1 received an antipsychotic medication. Current physician orders included, but were not limited to:iloperidone (an antipsychotic medication) oral tablet 1 milligram (mg) - Give one tablet by mouth two times a day, dated 12/6/25 clonazepam (an antianxiety medication) oral tablet 0.5 mg - Give one tablet by mouth one time a day, dated 12/6/25 The clinical record lacked an informed consent for the use of psychotic medications. During an interview on 1/7/26 at 10:53 A.M., the Director of Nursing (DON) indicated that she was unable to find an informed consent for psychotropic medications for Resident 21, Resident 3, Resident 5, and Resident 1. At that time, Clinical Regional Nurse 2 indicated that he forgot to follow up with the facility about informed consents when the regulation changed in July. On 1/7/26 at 12:15 P.M., the Administrator provided a current Health, Medical Conditions, and Medical Treatment Options, Informing Residents of policy, dated 8/2024. The policy indicated The resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the resident's:.type of care or treatment recommended (based on the assessment and care plan).risks and benefits of proposed care or treatment.right to discontinue or refuse care or treatment. 3.1-3(n)(2)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to treat residents with dignity, respect, and freedom from discrimination. (Resident 21 and Resident 3) The provider decreased pain medication dosages after Resident 21 and Resident 3 tested positive for marijuana.Findings include:1. During an interview on 1/4/26 at 2:03 P.M., Resident 21 indicated that the facility gave him a drug test without his consent. They told him the blood draw was to check on the status of his diabetes. He tested positive for marijuana and as a result the facility decreased his pain medication. He indicated he was not getting relief for his pain anymore. His pain was due to his leg amputation and hip pain from sitting in a wheelchair all the time. On 1/5/26 at 2:42 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, acquired absence of left leg above knee, osteoarthritis, and polyneuropathy. The most current Annual Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated that Resident 21 had no cognitive impairment, was independent in all Activities of Daily Living (ADLs), received an opioid medication during the 7-day lookback period, and received as needed (PRN) pain medication. A care plan conference was completed on 11/13/25 with Resident 21 in attendance. His care plan was reviewed.A current risk for acute/chronic pain care plan, dated 12/28/24, included, but was not limited to, the following interventions:Administer analgesia as per orders.Evaluate the effectiveness of pain interventions. Review for compliance, alleviation of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.Physician orders included, but were not limited to:hydrocodone-acetaminophen 7.5-325 milligrams (mg) tablet - Give one tablet by mouth three times a day for pain related to polyneuropathy and osteoarthritis, started 12/11/25 and discontinued on 1/1/26.hydrocodone-acetaminophen 5-325 mg tablet - Give one tablet orally three times a day until 1/7/26 for pain related to polyneuropathy and osteoarthritis, dated 1/1/26hydrocodone-acetaminophen 5-325 mg tablet - Give one tablet orally two times a day for pain related to polyneuropathy and osteoarthritis, dated 1/8/26CBC (complete blood count) with differential, BMP (basic metabolic panel), serum drug screen to be drawn 12/17/25 one time only, dated 12/17/25May sign out LOA (leave of absence) independently, dated 5/16/25A nursing progress note, dated 12/17/25 at 10:30 A.M., indicated the Medical Director (MD) was in the facility for routine rounds. Resident 21 was assessed and medications were reviewed. New lab orders were obtained for CBC with differential, BMP, and serum drug screen.An MD encounter note, dated 12/17/25 and signed by the MD on 12/30/25 at 6:33 P.M., indicated that Resident 21 was seen for a regulatory visit at the facility. Today seen resting in bed. He will not wake up to speak with me. Per staff he leaves for hours at a time in the evening and sometimes out all night with concern for drug abuse . concern of drug abuse, obtain drug test . will obtain labwork and make adjustments as needed. Otherwise continue current management.A laboratory report, dated 12/17/25, indicated that Resident 21 tested positive for 9-carboxy-tetrahydrocannabinol (THC) (a main secondary metabolite which is found in the body after consuming cannabis) and hydrocodone opiates.A nursing progress note, dated 1/1/26 at 1:35 A.M., indicated the Nurse Practitioner (NP) decreased Resident 21's hydrocodone-acetaminophen to 5-325 mg three times a day for one week and then to twice a day. The resident was made aware of the new order.The clinical record lacked documentation to indicate why Resident 21's hydrocodone-acetaminophen was being decreased from one 7.5-325 mg tablets three times a day to one 5-325 mg tablet twice daily.During an interview on 1/7/26 at 10:53 A.M., the Director of Nursing (DON) indicated that Resident 21's hydrocodone-acetaminophen was decreased because he tested positive for marijuana.2. During an interview on 1/5/26 at 9:35 A.M., Resident 3 indicated that the facility decreased his methadone two or three days ago. He indicated that it was messing him up and making him nauseous and decreasing his appetite. He smoked cigarettes and occasionally marijuana and needed to smoke more marijuana the past few days to help with the increased pain and nausea.On (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/5/26 at 10:35 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome, acquired absence of right leg below knee, long term use of opiate analgesic, and opioid dependence.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25, indicated Resident 3 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and received an opioid medication during the 7-day lookback period.A care plan conference was completed on 10/9/25 with the resident in attendance. His care plans were reviewed.A current acute/chronic pain care plan, dated 6/25/25, included, but were not limited to, the following intervention:Administer analgesics as per ordersPhysician orders included, but were not limited to:methadone 10 milligrams (mg) tablet - Give nine tablets by mouth one time a day for pain related to opioid dependence, dated 11/14/25 and discontinued on 12/31/25methadone 10 mg tablet - Give eight tablets by mouth one time a day for pain related to opioid dependence and chronic pain syndrome, dated 1/1/26CBC (complete blood count) with differential, BMP (basic metabolic panel), serum drug screen to be drawn 12/17/25 one time only, dated 12/17/25May go LOA (leave of absence) with responsible party PRN (as needed), 6/25/25A nursing progress note, dated 12/17/25 at 10:28 A.M., indicated the Medical Director (MD) was in the facility for routine rounds. Resident 3 was assessed and medications were reviewed. New lab orders were obtained for CBC with differential, BMP, and serum drug screen. An MD encounter note, dated 12/17/15 and signed by the MD on 12/30/25 at 6:29 P.M., indicated that Resident 3 was seen for a regulatory visit in the facility. Per staff patient leaves facility often at night for several hours and sometimes out all night with concerning behavior for drug use . concern for drug abuse, obtain drug test . see methadone clinic to increase / change methadone medication . will obtain labwork and make adjustments as needed.A laboratory report, dated 12/17/25, indicated Resident 3 tested positive for 9-carboxy-tetrahydrocannabinol (THC) (a main secondary metabolite which is found in the body after consuming cannabis) and methadone.A nursing progress note, dated 12/31/25 at 11:43 A.M., indicated that the MD and Nurse Practitioner (NP) were notified after a bag of marijuana was found in Resident 3's room. Orders were given by the MD to decrease the methadone to 80 mg to wean off due to illegal activities when outside facility. During an interview on 1/6/26 at 11:15 A.M., the Director of Nursing (DON) indicated that the MD ordered drug screens for certain residents when she rounded on 12/17/25 because it was a new thing she was doing in all her facilities. She was unsure why Resident 3's methadone was decreased but assumed it had something to do with his marijuana use.On 1/4/26 at 1:44 P.M., the Administrator provided a current admission Packet that included a copy of the Resident Rights. Resident Rights included, but was not limited to, You have a right .to be treated with respect and dignity .On 1/7/26 at 2:17 P.M., the Administrator provided a current Pain Assessment and Management policy, dated 8/2024, that indicated The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.3.1-3(a)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure grievances were documented and resolved for 1 of 2 residents reviewed for misappropriation of property. (Resident 8)Finding includes:On 1/4/26 at 11:04 A.M., Resident 8's family member indicated Resident 8's cell phone was missing. It was reported to the facility, it had not been found, and he had not had any follow up from the facility. On 1/5/26 at 2:25 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, encephalopathy. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/4/25, indicated Resident 8 had severe cognitive impairment and required setup assistance for eating and substantial to maximal assistance (staff does more than half the effort) for transferring. A care conference was completed on 10/23/25 with the resident's family in attendance. Care conferences notes indicated that the resident's phone with the pink case was missing and that the facility was looking for it. A Social Service note, dated 10/23/25 at 11:46 A.M., indicated that a care conference had been completed, and that the resident's family member voiced concern about the resident's missing phone. During an interview on 1/6/26 at 10:53 A.M., the Social Services Director indicated that the facility was still looking for the phone. She indicated that neither the initial grievance nor the ongoing investigation had been documented anywhere, and that there was no time frame for a resolution.On 1/7/26 at 2:03 P.M., the Administrator provided a Resident Concern / Grievance policy, dated 8/2/23, that indicated Employees should document concerns on the paper Resident Concern form and submit to their supervisor . Follow-up from the department leader will occur within 24-48 with resolution documented and submitted to the Executive Director . The department leader will investigate and discuss the concerns with the team and will implement or educate to prevent further concerns . The department leader will document the resolution on the concern form using an addendum when needed and will follow up with the person reporting the concern to explain the resolution .3.1-7(a)(2)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacist medication recommendations were reviewed and responded to in a timely manner for 2 of 5 residents reviewed for unnecessary medications. (Resident 5 and Resident 21)Findings include:1. On 1/5/26 at 9:30 A.M., Resident 5's clinical record was reviewed. Resident 5 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, major depressive disorder. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/15/25, indicated Resident 5 was moderately cognitively impaired, was dependent on staff (staff does all of the work) for toileting and bathing, and received antianxiety and antidepressant medication during the 7-day lookback period. Current physician orders included, but were not limited to: buspirone HCl (an antianxiety medication) oral tablet 15 mg (milligrams) - Give one tablet by mouth three times a day for anxiety take with 10 mg tab; Start date 3/8/25 desvenlafaxine succinate (an antidepressant medication) ER (extended release) oral tablet 24 Hour 25 mg - Give one tablet by mouth one time a day for depression; Start date 3/8/25 The current care plan included, but was not limited to: I receive antidepressant medication related to depression, initiated 3/10/25 I receive anti-anxiety medications related to anxiety disorder, initiated 3/10/25 A Psychotropic Medication Utilization Report, dated 12/10/25, indicated Gradual Dose Reductions (GDR) were suggested by the pharmacist on 9/10/25 for buspirone 25 mg, and on 11/9/25 for desvenlafaxine 25 mg. A Drug Regimen Review (DRR) report, dated 11/9/25, indicated that the order for desvenlafaxine succinate 25 mg one time a day was due for a review and gradual dose reduction attempt. The DRR report was not filled out or signed by the provider. 2. On 1/5/26 at 2:42 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder. The most current Annual Minimum Data Set (MDS) Assessment, dated 11/7/25, indicated that Resident 21 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and received an antidepressant medication during the 7-day lookback period. A care conference was completed on 11/13/25 with the resident in attendance. The care plan was reviewed. Current care plans included, but were not limited to:I receive antidepressant medication related to depression, initiated 12/28/24 Physician orders included, but were not limited to:duloxetine (an antidepressant) delayed release (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sprinkle 60 milligrams (mg) tablet - Give one capsule by mouth two times a day for major depressive disorder, dated 12/27/24 A Drug Regimen Review (DRR) report, dated 7/6/25, indicated that the order for duloxetine 60 mg two times daily for major depressive disorder was due for a review and dose reduction attempt. The recommendation was to decrease the duloxetine to 50 mg two times daily or for the provider to provide a detailed reason why a dose reduction was not indicated. The DRR report was not filled out or signed by the provider. The clinical record lacked documentation to indicate that the provider acted upon or provided a detailed reason that a dose reduction for the duloxetine was contraindicated. During an interview on 1/7/26 at 10:53 A.M., the Director of Nursing (DON) indicated she was unable to find DRRs that were signed by the physician for Resident 21 and Resident 5 or documentation to indicate why the medication did not have a dose reduction attempt. On 1/7/26 at 2:03 P.M., the Administrator provided a current Tapering Medication and Gradual Drug Dose policy, dated 8/2024, that indicated Residents who use psychotropic medications shall receive gradual dose reductions (GDR), unless clinically contraindicated, in an effo1t to discontinue the use of such drugs . Within the first year after a resident is admitted on a psychotropic medication or after the resident has been stated on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quai1ers (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a GDR at least annually, unless clinically contraindicated . For any individual who is receiving a psychotropic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder . 3.1-48(a)(2)3.1-48(b)(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of abuse and misappropriation of property were reported to the State Survey Agency or in accordance with State law for 1 of 1 residents reviewed for abuse and 1 of 1 residents reviewed for misappropriation of property. (Resident 33 and Resident 3)Findings include: 1. During an interview on 1/4/26 at 10:44 A.M., Resident 33 indicated staff were rough with her when incontinence care was provided, they were mumbling hateful words to her, and she had to request pain medication after she received care. On 1/4/26 at 2:38 P.M., Resident 33 indicated she considered the incident with staff to be rudeness, roughness, and abuse. Administration was immediately notified of alleged abuse. On 1/5/26 at 8:43 A.M., Resident 33's clinical record was reviewed. Resident 33 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, diabetes mellitus. The most recent admission Minimum Data Set (MDS) Assessment, dated 1/2/26, indicated Resident 33 was cognitively intact and was dependent on staff (staff does all of the work) for toileting and bathing. On 1/5/26 at 8:43 A.M., Resident 33's electronic medication administration record was reviewed for December 2025 and January 2026. The medication record lacked documentation that pain medication had been administered since admission. A nursing progress note, dated 1/5/26 at 9:08 A.M., indicated the Administrator spoke with Resident 33 and the resident indicated staff were grumbling with her while providing care and staff appeared bothered having to provide care to the resident. During an interview on 1/7/26 at 10:28 A.M., Resident 33 indicated that staff came to talk to her about the incident and she told them the same thing she reported during her interviews on 1/4/26. During an interview on 1/7/26 1:48 P.M., the Administrator indicated she did not report the abuse allegation to the State Survey Agency because the resident did not use the word abuse during her interview with the resident. 2. During an interview on 1/5/26 at 9:35 A.M., Resident 3 indicated that after Thanksgiving he had $480 stolen from him by a staff member. He reported the missing money to Registered Nurse (RN) 4 who reported it to the Administrator and Social Services Director. He knew that the Social Services Director had been taking statements from staff and residents, but he was unsure if there was a resolution. On 1/5/26 at 10:35 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25, indicated Resident 21 was cognitively intact, was independent for all Activities of Daily Living (ADLs), and had no behaviors. The clinical record lacked documentation about the resident's missing money or subsequent investigation. During an interview on 1/6/26 at 1:52 P.M., the Administrator indicated that she had done an investigation into Resident 3's missing money on 12/5/25 and that the issue had been resolved because the missing money could not be located and the resident's claim could not be substantiated. During an interview on 1/7/26 at 11:54 A.M., the Administrator indicated that she did not report the (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation of misappropriations of funds to the State Survey Agency because it could not be proven. On 1/7/26 at 2:03 P.M., the Administrator provided an Abuse, Neglect, Exploitation and Misappropriation, Reporting and Investigating policy, dated 8/2024, that indicated All reports of resident abuse, neglect, exploitation, or theft/misappropriation .are reported to local, state, and federal agencies, and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 3.1-28(c)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that sufficient supporting documentation to meet criteria was obtained prior to giving a diagnosis of schizophrenia for 1 of 1 residents reviewed for a new schizophrenia diagnosis. (Resident 5) Finding includes:On 1/5/26 at 9:30 A.M., Resident 5's clinical record was reviewed. Resident 5 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, paranoid schizophrenia, added on 4/18/25 when Resident 5 was [AGE] years old. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/15/25, indicated Resident 5 was moderately cognitively impaired, was dependent on staff (staff does all of the work) for toileting and bathing, and received an antipsychotic medication during the 7-day lookback period.Current physician orders included, but were not limited to: Zyprexa (an antipsychotic medication) oral tablet 15 mg (milligrams) Give 15 mg by mouth at bedtime related to mental disorder; Start date 3/15/25Zyprexa oral tablet 10 mg Give one tablet by mouth one time a day related to paranoid schizophrenia; Start date 4/2/25The current care plan included, but was not limited to: I receive antipsychotic medications related to delusional disorder, mental disorder, schizophrenia, revised on 4/21/25A document titled Medication Regimen Review, dated 4/14/25, was sent from pharmacy to the Medical Director, and indicated Resident 5 received an antipsychotic and the current diagnosis of mental disorder was not acceptable per CMS regulation, and stated the diagnosis associated with antipsychotic use must be an enduring condition. The Medical Director selected schizophrenia as a diagnosis and returned to pharmacy on 4/17/25.The clinical record lacked documentation supporting the schizophrenia diagnosis, why the diagnosis was given, or any assessment that led to the diagnosis.During an interview on 1/7/26 at 12:35 P.M., a request for documentation to support the schizophrenia diagnosis was given to the Director of Nursing. Documentation was not provided.On 1/7/25 at 2:13 P.M., the Administrator provided a policy titled Physician Services, dated 8/2024, that indicated Physician orders and progress notes are maintained in accordance with current OBRA regulations and facility policy. The medical director identifies attending physician qualifications and responsibilities, based on clinical and regulatory requirements and the recommendations of relevant professional associations.3.1-35(g)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents dependent on staff for assistance with daily living (ADL) tasks were provided showers or baths for 1 of 1 residents reviewed for bathing care. (Resident 33)Finding includes:During an interview on 1/4/25 at 10:44 A.M., Resident 33 indicated she had not received a shower since admission to the facility. Resident 33's hair was disheveled and had a strong pungent odor prevalent when opening the resident's room door. On 1/5/26 at 8:43 A.M., Resident 33's clinical record was reviewed. Resident 33 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, type two diabetes mellitus. The most recent admission Minimum Data Set (MDS) Assessment, dated 1/2/26, indicated Resident 33 was cognitively intact and was dependent on staff (staff does all of the work) for toileting and bathing. A Point Of Care (a Certified Nurse Aide charting system) task labeled ADL - Bathing indicated Resident 33's bathing schedule was Monday and Thursday night shift. The Point Of Care bathing task indicated Resident 33 had not received, or refused, a complete bed bath or shower from 12/26/25 to 1/5/26. During an interview on 1/6/25 at 2:45 P.M., the Director of Nursing (DON) indicated staff documented all baths and showers in the Point Of Care bathing task within the electronic medical record. On 1/7/25 at 2:45 P.M., the Administrator provided a policy titled Shower/Tub Bath, dated 8/2024, that indicated Notify the supervisor if the resident refuses . Report other information in accordance with facility policy and professional standards of practice. 3.1-38(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 of 1 residents reviewed for surgical wounds. The surgical wound was not thoroughly assessed, and a wound vac was not changed according to the physician's orders. (Resident 31) Finding includes:On 1/5/26 at 11:32 A.M., Resident 31's clinical record was reviewed. Resident 31 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, type 2 diabetes mellitus and osteomyelitis. The most recent admission Minimum Data Set (MDS) Assessment, dated 12/31/25, indicated Resident 31 was cognitively intact, was dependent on staff (staff does all of the work) for toileting and bathing, and had a foot infection and surgical wound.Physician orders included, but were not limited to:Cleanse area with wound cleanser and pat dry. Skin prep peri-wound and allow to dry. Cut and place drape around wound bed. Cut to fit foam and place directly in wound bed. Place [NAME]-pad and secure in place. Wound vac set to 150 mmHg (millimeters of mercury) continuous, instill 6mL (milliliters) for 10 minutes every two hours every day shift every Monday, Thursday for wound vac related to osteomyelitis; Start date 1/1/26 Check placement and function of wound vac to right foot every shift every shift; Start date 12/29/25 The current care plan included, but was not limited to: I require enhanced barrier precautions related to right IJ/PICC (internal jugular peripherally inserted central catheter), urinary catheter, and wound vac to right foot; Date initiated 12/29/25 I receive IV (intravenous) antibiotic therapy related to osteomyelitis, sepsis, strep B; Date initiated 12/29/25 During an observation on 1/6/26 at 9:35 A.M., Resident 31 indicated staff did not change the wound vac the previous day. The saline irrigation bag was empty. The wound was covered with foam and the foam was covered with a clear, undated, drape. During an observation on 1/7/26 10:25 A.M., Resident 31 indicated staff did not change the wound vac the previous day. The saline irrigation bag was undated and empty. The wound was covered with foam and the foam was covered with a clear, undated, drape. On 1/7/26 at 10:35 A.M., Resident 31's electronic treatment record was reviewed. Physician ordered wound vac was due to be changed on 1/5/26 and was not marked as completed. The clinical record lacked documentation that the wound vac had been changed from 12/24/25 to 12/31/25 or from 1/2/26 to 1/7/26, or assessment of the wound the days the wound vac was ordered to be changed. During an interview on 1/7/26 at 11:06 A.M., Licensed Practical Nurse (LPN) 21 indicated she was not comfortable changing Resident 31's wound vac and that the Director of Nursing (DON) handled wound vac changes. On 1/7/26 at 2:13 P.M., the Administrator provided a policy titled Negative Pressure Wound Therapy, dated 8/24, that indicated Verify that there is an order for this procedure. Assess the wound prior to selecting the type, size and thickness of dressing material. Change dressings per physician orders and manufacturer guidelines. Document the following in the resident's medical record: The wound status at time of application of negative pressure. The number of sponge pieces used in the wound dressing. The negative pressure and time settings on the pump. The resident's tolerance of the procedure. The date and time of the dressing application/change. The date and time negative pressure therapy was started and stopped. The name and initials of the person performing the procedure. Marked changes in the wound from baseline or previous dressing change. 3.1-37(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure proper tracheal suctioning and oxygen services were provided according to physician orders for 1 of 1 residents reviewed for respiratory care. (Resident 24)Finding includes:On 1/4/26 at 11:23 A.M., Licensed Practical Nurse (LPN) 15 was observed walking into Resident 24's room without donning Person Protective Equipment (PPE). Resident 24 was on Enhanced Barrier Precautions (EBP) because of a tracheostomy. Prior to preparing to suction the tracheostomy, the inner cannula was observed sitting on the resident's bedside table with the speaking valve present. LPN 15 donned clean gloves and proceeded to take the used (contaminated) suction catheter from an open package near the suction machine. LPN 15 then proceeded to use the catheter to suction the tracheostomy several times without the inner cannula present. LPN 15 replaced the used (contaminated) inner cannula with the speaking valve on.On 1/5/26 at 12:50 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Larynx, Tracheostomy, and Gastrostomy The most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/25/25, indicated Resident 24 was cognitively intact and was dependent on staff for eating, hygiene, dressing, and transferring. Resident 24 had a gastrostomy tube and tracheostomy tube.Current physician orders included, but were not limited to:Trach care Q (every) shift and PRN (as needed) every shift, dated 11/24/25.Change inner cannula daily (6 uncuffed Shiley XLT) every day shift, dated 11/25/25.A current tracheostomy care plan related to a laryngeal mass was dated 11/24/25. Interventions included, but were not limited to:Provide trach care as ordered by the provider, dated 11/24/25.Suction as ordered, dated 11/24/25.The Treatment Administration Record (TAR) for December and January 2026 indicated tracheostomy care and suctioning was conducted each shift for the resident [DATE] through [DATE]. The most recent time the inner cannula care for the tracheostomy was performed the Director of Nursing (DON) at 11:50 A.M., on 1/4/26.During an interview on 1/4/26 at 12:15 P.M., the Director of Nursing (DON) indicated Resident 24 should be suctioned once a shift and as needed.During an interview on 1/5/26 at 1:52 P.M., LPN 21 indicated the inner cannula for the trach was changed every 24 hours using sterile technique.On 1/4/26 at 12:15 P.M., the DON provided a current Suctioning the Tracheostomy Tube policy, dated 8/2024. The policy indicated .put on protective mask and eye ware .open suction catheter kit .apply sterile gloves (the dominant hand will remain sterile) .holding the suction catheter in the dominant hand and the suction tubing in the non-dominant hand connect the catheter to the tubing .insert the catheter into the tracheostomy tube without suction advance the catheter until resistance is met .disconnect catheter from suction. Wrap the catheter around the gloved hand. Pull the glove off over the catheter. Discard in designated receptacle .On 1/4/26 at 12:15 P.M., the DON provided a current Tracheostomy Care policy, dated 8/2024. The policy indicated .tracheostomy care should be provided .at least once daily .3.1-47(a)(4)3.1-47(a)(5)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly assess resident for pain, failed to follow the facility policy for pain management, and ensure attempts for pain management were made for residents who experienced pain for 1 of 1 residents reviewed for fall resulting in fracture. (Resident 7) A resident did not receive pain management after a fall that resulted in a fractured shoulder. Finding includes:On 1/5/26 at 2:37 P.M., Resident 7's clinical record was reviewed. Resident 7 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/25, indicated Resident 7 was cognitively intact, required substantial assistance (staff does most of the work) for toileting and transfers, and indicated the resident had a fall with major injury since the prior MDS assessment. The MDS Assessment indicated Resident 7 had frequently experienced pain in the last five days, the pain made it difficult to sleep or complete day-to-day activities, and the highest pain experienced in the last five days was a 10, on a scale of 1-10 (lowest to highest). The previous MDS Assessment, dated 8/20/25, indicated Resident 7 was cognitively intact, required substantial assistance for toileting, and required partial assistance for transfers. Resident 7 indicated they had not experienced any pain during the last five days. Current physician orders included, but were not limited to: acetaminophen tablet 325 mg (milligrams) - Give two tablets by mouth every four hours as needed for pain; Start date 11/9/25 morphine sulfate oral solution 20 mg/5mL (milligrams/milliliters) - Give 0.63 mL by mouth every six hours for basal cell carcinoma as needed; Start date 9/23/25 The clinical record lacked direction for staff to know which pain medication to attempt first when Resident 7 complained of pain. Current care plans included, but were not limited to: I am at risk for falls/injury due to impaired mobility, history of falls; Date initiated 7/9/25Interventions included, but were not limited to:Anticipate and meet the resident's needs; Date initiated 8/13/25 I am at risk for acute/chronic pain; Date initiated 7/9/25Interventions included, but were not limited to: Evaluate the effectiveness of pain interventions. Review for compliance, alleviating symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability, and impact on cognition; Date initiated 7/9/25 A Fall Risk Evaluation Note, dated 11/13/25 at 12:02 P.M., indicated that the resident had a fall, and the provider was notified. A nursing progress note, dated 11/13/25 at 8:16 P.M., indicated X-ray results were sent to the physician's answering service. The clinical record lacked documentation that a physician's order was given to obtain an X-ray or what X-ray views to order, and documentation of when the X-ray service was in the facility and obtained the X-rays on 11/13/25. An X-ray report, dated 11/13/25, indicated the X-ray views ordered were the right elbow and right forearm. The X-ray of the right elbow view indicated No acute fractures are noted in the right elbow. The X-ray report of the right forearm view indicated Subtle linear lucency (a possible fracture) involving the radial head; clinical and CT (computed tomography, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) correlation is recommended. An Interdisciplinary Team (IDT) note, dated 11/14/25 at 12:25 P.M., indicated that during the fall occurrence, a staff member was entering the resident's room and witnessed the resident attempting to self-ambulate from the chair in his room to the bed. The resident lost his balance and fell on his right side, hitting his elbow. When asked what happened, the resident stated that he was attempting to walk back to bed. The fall resulted in a skin tear to the right elbow (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with no other observed/identified injuries at the time of the fall. Post fall, the resident voiced complaints of pain in his right shoulder. An order was obtained to have a STAT (immediate) x-ray completed of the resident's right shoulder and elbow. The clinical record did not contain an X-ray obtained of Resident 7's right shoulder from 11/13/25 to 11/16/25. A nursing progress note, dated 11/14/25 at 3:21 P.M., indicated Resident 7 continued to complain of right arm pain. The clinical record lacked assessment of the right arm following the Resident 7's complaints of pain. On 11/14/25 at 4:18 P.M., Resident 7 received acetaminophen 650 mg, after the resident rated the pain a 3 on a pain scale of 1-10. On 11/14/25 at 7:29 P.M., Resident 7's pain medication was documented as effective. A nursing progress note, dated 11/14/25 at 8:02 P.M., indicated Resident 7 continued to complain of pain to the right elbow. The clinical record lacked documentation of additional pain relief methods, including non-pharmacological and pharmacological, following the resident's complaints of continuous pain on 11/14/25 at 8:02 P.M. A nursing progress note, dated 11/16/25 at 9:41 A.M., indicated Resident 7 continued to complain of pain in his right extremity. Resident 7's right shoulder was swollen and malformed, and received orders from the physician's answering service to obtain a right shoulder X-ray. The clinical record lacked documentation of additional pain relief methods, including non-pharmacological and pharmacological, following the resident's complaints of continuous pain from 11/16/25 at 9:41 A.M. to 11/16/25 at 7:40 P.M. A nursing progress note, dated 11/16/25 at 3:30 P.M., indicated the X-ray service obtained the right shoulder X-ray. The X-ray report, dated 11/16/25 at 4:56 P.M., right shoulder view indicated Fracture of the humeral neck, with moderate displacement of the distal segment. A nursing progress note, dated 11/16/25 at 7:38 P.M., indicated the resident's right shoulder two-view X-ray results had been faxed to the physician. A nursing progress note, dated 11/16/25 at 7:40 P.M., indicated Resident 7 continued to complain of discomfort to his right arm. Pain medication was offered but not administered. The clinical record lacked documentation that pain medication was administered to or refused by the resident on 11/16/25. The clinical record lacked documentation that non-pharmacological pain relief methods were offered to Resident 7 on 11/16/25. A nursing progress note, dated 11/16/25 at 9:34 P.M., indicated Resident 7 was transferred to the emergency room for treatment of a right shoulder fracture. During an interview on 1/7/26 at 10:51 A.M., the Director of Nursing (DON) indicated she was unaware of Resident 7 not being treated for pain following the fall on 11/13/25. On 1/7/26 at 2:17 P.M., the Administrator provided a current Pain Assessment and Management policy, dated 8/2024, that indicated The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain . Acute pain should be assessed every 30 to 60 minutes and reassessed as indicated until relief is obtained . Review the medication administration record to determine how often the individual requests and receives PRN pain medication, and to what extent the administered medications relieve the resident's pain . Non-pharmacological interventions may be appropriate alone or in conjunction with medications . If pain has not been adequately (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. 3.1-37(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 1 of 6 residents (Resident 24) observed during the medication pass. There were 31 opportunities observed with 6 errors, resulting in a 19.35 percent medication error rate. Finding includes: During an observation of medication administration on 1/6/26 at 7:50 A.M., Qualified Medication Aide (QMA) 7 prepared the following medications for Resident 24. The QMA did not check for residual or flush the PEG tube prior to administration of the medications. The following medications were all crushed together along with the liquid medications and given to the resident through the Percutaneous Endoscopic Gastrostomy (PEG) at one time:methadone 30 milligrams (mg) from 10 mg/mL (milliliters) liquidlorazepam 0.5 mg tabletNorvasc 5 mg tabletSenna 8.6 mg tabletLexapro 10 mg from 5mg/5mL liquidFerrous Sulfate 325 mg taabOn 1/5/26 at 12:50 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Larynx, Tracheostomy, and Gastrostomy.Current physician's orders included but were not limited to:Flush enteral tube with 30 ML H2O before and after medications every shift dated 11/24/25.Check for residual beforemeds/flushed/feedings ifgreater than 100 ml hold x 2hours, recheck if still greaterthan 100ml notify MDevery shift dated 11/24/25.The most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/25/25, indicated Resident 24 was cognitively intact and was dependent on staff for eating, hygiene, dressing, and transferring. Resident 24 had a gastrostomy tube and tracheostomy tube. Current physician orders included, but were not limited to:methadone (synthetic opioid) 30 mg oral solution10 mg/5mL - Give 15 mL via PEG-Tub, dated 11/25/25lorazepam 0.5 mg (an antianxiety medication - Give one tablet via PEG-Tube, dated 11/24/25Norvasc 5 mg (a medication used to treat blood pressure) - Give one tablet via PEG-Tube, dated 11/25/25Senna-Docusate Sodium (a laxative-stool softener) oral tablet 8.6-50 mg - Give one tablet via PEG-Tube, dated 11/24/25ferrous sulfate (iron supplement) oral tablet 325 mg - Give one tablet via PEG-Tube, dated 11/26/25Lexapro (an antidepressant) 10 mg from 5mg/5mL - Give 10 mL via PEG-Tube, dated 12/17/25During an interview on 1/6/26 at 10:30 A.M., Regional Clinical Nurse 9 indicated the facility followed the policy for Enteral Tube Medication Administration.On 1/6/26 at 10:30 A.M., the Director of Nursing (DON) provided a current undated Enteral Tube Medication Administration policy. The policy indicated .crushed medications are not mixed together .3.1-48(c)(1)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain radiology services, or transportation to receive radiology services in a timely manner, to meet the needs of a resident following a fall for 1 of 1 residents reviewed for fall with fracture. (Resident 7) Finding includes: On 1/5/26 at 2:37 P.M., Resident 7's clinical record was reviewed. Resident 7 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/25, indicated Resident 7 was cognitively intact, required substantial assistance (staff does most of the work) for toileting and transfers, and indicated the resident had a fall with major injury since the prior MDS assessment. The previous MDS Assessment, dated 8/20/25, indicated Resident 7 was cognitively intact, required substantial assistance for toileting, and required partial assistance for transfers. Current physician orders included, but were not limited to: acetaminophen tablet 325 mg (milligrams) - Give two tablets by mouth every four hours as needed for pain; Start date 11/9/25 morphine sulfate oral solution 20 mg/5mL (milligrams/milliliters) - Give 0.63 mL by mouth every six hours as needed; Start date 9/23/25 Current care plans included, but were not limited to: I am at risk for falls/injury due to impaired mobility, history of falls; Date initiated 7/9/25Interventions included, but were not limited to:Anticipate and meet the resident's needs; Date initiated 8/13/25 A Fall Risk Evaluation Note, dated 11/13/25 at 12:02 P.M., indicated that the resident had a fall, and the provider was notified. An X-ray report, dated 11/13/25 at 7:00 P.M., indicated the X-ray views ordered were right elbow and right forearm. The X-ray of the right elbow view indicated No acute fractures are noted in the right elbow. The X-ray report of the right forearm view indicated Subtle linear lucency (a possible fracture) involving the radial head; clinical and CT (computed tomography, a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) correlation is recommended. A nursing progress note, dated 11/13/25 at 8:16 P.M., indicated X-ray results were sent to the physician's answering service. The clinical record lacked documentation that a physician's order was given to obtain an X-ray or what X-ray views to order, and documentation when the X-ray service was in the facility and obtained the X-rays on 11/13/25. An Interdisciplinary Team (IDT) note, dated 11/14/25 at 12:25 P.M., indicated that during the fall occurrence, a staff member was entering the resident's room and witnessed the resident attempting to self-ambulate from the chair in his room to the bed. The resident lost his balance and fell on his right side hitting his elbow. When asked what happened, the resident stated that he was attempting to walk back to bed. The fall resulted in a skin tear to the right elbow with no other observed/identified injuries at time of the fall. Post fall, the resident voiced complaints of pain to his right shoulder. An order was obtained to have a STAT (immediate) x-ray completed of the resident's right shoulder and elbow. The clinical record lacked documentation that an order was given or obtained on 11/13/25 for a right shoulder X-ray. A nursing progress note, dated 11/14/25 at 3:21 P.M., indicated Resident 7 continued to complain of right arm pain and the resident was unable to use his arm to full extent. The physician was notified. A nursing progress note, dated 11/14/25 at 5:38 P.M., indicated a CT scan of the right elbow/forearm was ordered to be completed 11/14/25 or 11/15/25 at (Name of Diagnostic Center). A nursing progress note, dated 11/15/25 at 2:40 P.M., indicated the facility was unable to schedule transport to the CT scan. A nursing progress note, dated 11/16/25 at 9:41 A.M., indicated Resident 7's right shoulder was swollen and malformed. A nursing progress note, dated 11/16/25 at 7:38 P.M., indicated the resident's right shoulder two view X-ray results had been faxed to the physician. The clinical record lacked documentation when the X-ray service was in the facility and obtained the X-rays on 11/16/25. The X-ray report, dated 11/16/25 at 4:56 P.M., right shoulder view indicated Fracture of the humeral neck, with moderate displacement of the distal segment. A nursing progress (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note, dated 11/16/25 at 9:34 P.M., indicated Resident 7 was transferred to the emergency room for treatment of right shoulder fracture. During an interview on 1/7/26 at 10:51 A.M., the Director of Nursing (DON) indicated that transportation to the STAT CT was unavailable when ordered. She was unaware of Resident 7 not being appropriately treated for pain and was unsure why the correct X-ray view was not ordered on 11/13/25. During an interview on 1/7/26 10:53 at A.M., Regional Clinical Nurse 2 indicated that when the facility could not transfer Resident 7 to the physician ordered CT scan on 11/14/25 the facility should have sent the resident to the emergency room for evaluation.On 1/7/26 at 2:13 P.M., the Administrator provided a policy titled Charting and Documentation, dated 8/2024, indicated The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.3.1-49(g)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility Administrator failed to dispose of illegal substances, report illegal substances to law enforcement and the State Survey Agency (SSA), and follow the Controlled Medication Disposal policy. Confiscated marijuana was kept in an open container in an unlocked closet in the Administrator's office. (Administrator)Finding includes:During an interview on 1/5/26 at 9:35 A.M., Resident 3 indicated that a staff member had confiscated smoking paraphernalia out of his bedside table drawer. On 1/5/26 at 10:35 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25 indicated Resident 3 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and had no behaviors.A care plan conference was completed on 10/9/25 with the resident in attendance. His care plan was reviewed.Current care plans included, but were not limited to:I am at risk for complications related to substance abuse: alcohol abuse, opioid dependence, initiated 6/26/25I desire to use tobacco products: cigarettes, initiated 6/26/25A nursing progress note, written by Licensed Practical Nurse (LPN) 21 and dated 12/31/25 at 11:43 A.M., indicated that the Medical Director (MD) and Nurse Practitioner (NP) were notified after a bag of marijuana was found in Resident 3's room.The clinical record lacked documentation of follow up to the marijuana that was confiscated from Resident 3's room.During an interview on 1/6/26 at 1:52 P.M., the Administrator indicated that the facility was a non-smoking building and if a resident wanted to smoke, they would need to go off property to do so. Residents could store their smoking paraphernalia in their room. If they broke a smoking rule listed in the Smoking Policy, the paraphernalia was held up front for the resident. There were no current residents who had smoking paraphernalia that had been confiscated.During an interview on 1/6/26 at 3:00 P.M., the Director of Nursing (DON) indicated she had been out of town when staff found the marijuana in Resident 3's room and was unsure about the situation.During an interview on 1/6/26 at 3:24 P.M., LPN 21 indicated that she reported finding marijuana in Resident 3's room and the DON had it.During an interview on 1/6/26 at 3:26 P.M., the DON indicated that she was unsure where the marijuana was, and she thought that the Administrator had it.During an interview on 1/7/26 at 8:54 A.M., the Administrator indicated that the marijuana was in her office and she was unsure what to do with it. She indicated she didn't know if she should call the police to dispose of it and that she didn't want to get the resident in trouble. She wasn't sure what the facility's policy was when illegal substances were found in the building. She indicated that she did not report the occurrence to the State Survey Agency either, but she probably should have, as it was an unusual occurrence. At that time, a plastic bag with dry, shredded green and brown plant matter that smelled like skunk was observed in an open tin container in an unlocked closet in the Administrator's office.During a continuous observation from 1/7/26 at 8:58 A.M. to 9:24 A.M., the Administrator's office was observed unoccupied and unlocked with the door open and with the closet that contained the open tin container open and unlocked. On 1/7/26 at 9:44 A.M., the Administrator provided an undated copy of the Rights & Responsibilities Code of Conduct from the admission Packet and a Controlled Medication Disposal policy, dated 2020. The Code of Conduct indicated Do not use, sell or have any involvement with illegal substances. The Controlled Medication Disposal policy indicated Schedule II, III, IV and V medications .can also be returned to the Drug Enforcement Administration (DEA), or by retaining for destruction by an agent of the DEA, as directed by the state laws, regulations, and/or the DEA.The article, Drug Scheduling, undated, was retrieved on 1/7/26 from the DEA website at https://www.dea.gov/drug-information/drug-scheduling. The guidance included: Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are: . marijuana (cannabis).During an interview on 1/7/26 at 10:04 A.M., Clinical Regional Nurse 2 indicated that the Controlled Medication Disposal policy was to be used for all scheduled drugs, including marijuana which was a Schedule I (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drug. At that time, he indicated that the Administrator should have called law enforcement as soon as it was confiscated.On 1/7/26 at 2:52 P.M., the Administrator provided a current Unusual Occurrence Policy, dated 8/2024, that indicated Our facility will report the following events to appropriate agencies .Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.3.1-13(a)(1)3.1-13(q)3.1-13(r)(1)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interview and record review, the facility failed to obtain a written contract with an outside resource detailing the services provided and the timeliness of the services. A pain clinic was providing services to a resident without a contract or communication about those services to the facility. (Resident 3)Finding includes:On 1/5/26 at 10:35 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome and opioid dependence. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/27/25, indicated that Resident 3 was cognitively intact, was independent in all Activities of Daily Living (ADLs), and received an opioid medication during the 7-day lookback period. A care conference was completed on 10/9/25 with the resident in attendance. His care plan was reviewed. Current care plans included, but were not limited to:I am at risk for complications related to substance abuse: alcohol abuse, opioid dependence, initiated 6/26/25I have acute/chronic pain related to ulcerative colitis, sacral wound with osteomyelitis, chronic pain syndrome, PVD (Peripheral Vascular Disease), GERD (gastroesophageal reflux disease)/Peptic ulcer, opioid dependence, Right BKA (below the knee amputation), initiated 6/25/25Care plans lacked documentation related to Resident 3 seeing the Pain Clinic Doctor for management of opioid medication and/or pain.Physician orders included, but were not limited to:methadone (a synthetic opioid used medically to treat chronic pain and opioid use disorder) 10 milligrams (mg) tablet - Give eight tablets by mouth one time a day for pain related to opioid dependence and chronic pain syndrome, dated 1/1/26The clinical record lacked a physician order related to (Pain Clinic).A nursing progress note, dated 7/3/25 at 2:41 P.M., indicated that Resident 3 had an appointment with (Pain Clinic) on 7/7/25. The nurse attempted to call (Pain Clinic) to clarify who was managing Resident 3's methadone and why the resident was being seen by (Pain Clinic). The nurse left a message for (Pain Clinic) to return call. The clinical record lacked documentation to indicate (Pain Clinic) returned the call.A nursing progress note, dated 7/4/25 at 1:32 P.M., indicated that (Pain Clinic) was contacted to verify the dose of methadone Resident 3 was supposed to be on. The nurse told (Pain Clinic) to not administer methadone because it was being administered at the facility.A nursing progress note, dated 7/14/25 at 3:39 P.M., indicated that Resident 3 returned from (Pain Clinic) with a follow-up appointment scheduled for September. The clinical record lacked documentation to indicate if (Pain Clinic) or Resident 3 provided any other communication about that appointment.A nursing progress note, dated 9/8/25 at 3:58 P.M., indicated that Resident 3 had an appointment with (Pain Clinic).The clinical record lacked documentation to indicate if (Pain Clinic) or Resident 3 provided any other communication about that appointment.A nursing progress note, dated 11/6/25 at 3:37 P.M., indicated that Resident 3 had an appointment with (Pain Clinic). The clinical record lacked documentation to indicate if (Pain Clinic) or Resident 3 provided any other communication about that appointment.A nursing progress note, dated 12/31/25 at 11:43 A.M., indicated that the Medical Director (MD) and Nurse Practitioner (NP) were notified after a bag of marijuana was found in Resident 3's room. Orders were given by the MD to decrease the methadone to 80 mg to wean off due to illegal activities when outside facility. A message was left with (Pain Clinic) to return call so the facility could inform them of the change in dose before Resident 3's appointment at (Pain Clinic) on 1/2/26. The clinical record lacked documentation to indicate that (Pain Clinic) returned the facility's call.During an interview on 1/6/26 at 11:15 A.M., the Director of Nursing (DON) indicated that Resident 3 was seen by (Pain Clinic) for management of his methadone. (Pain Clinic) did not communicate well with the facility. If the facility called (Pain Clinic), Pain Clinic Doctor would call Resident 3 back instead of the facility and sometimes Resident 3 would not pass on the information to the facility.During an interview on 1/6/26 at 3:00 P.M., the DON indicated that the facility did not have a contract with (Pain Clinic). At that time, six months of progress notes from (Pain Clinic) was requested.During an interview on 1/7/26 at 8:39 A.M., the DON indicated that she (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unable to get progress notes from (Pain Clinic) because Resident 3 would need to sign a release.During an interview on 1/7/26 at 10:22 A.M., the Pain Clinic Secretary indicated that Resident 3 did not show up for his appointment on 1/2/26 and there weren't any more appointments scheduled. They attempted to contact Resident 3 via phone to reschedule but he did not answer and his voicemail was full. (Pain Clinic) did not call the facility to schedule appointments for Resident 3.During an interview on 1/7/26 at 1:50 P.M., Clinical Regional Nurse 2 indicated that the facility did not have a specific policy addressing outside services, but if there was any work done with an outside vendor, the facility needed a contract with that vendor.3.1-13(m)

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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 implement infection prevention measures for 2 of 2 random observations, Hand washing was not completed according to professional standards and Personal Protective Equipment (PPE) was not worn as ordered. (Resident 24 and Resident 33)Findings include: 1. On 1/4/26 at 11:23 A.M., Licensed Practical Nurse (LPN) 15 was observed walking into Resident 24's room without donning Person Protective Equipment (PPE). Resident 24 was on Enhanced Barrier Precautions (EBP) because of a tracheostomy. Prior to preparing to suction the tracheostomy, the inner cannula was observed sitting on the resident's bedside table with the speaking valve present. LPN 15 donned clean gloves and proceeded to take a contaminated suction catheter from an open package near the suction machine. LPN 15 then proceeded to use the catheter to suction the tracheostomy several times without the inner cannula present. LPN 15 later replaced the contaminated inner cannula with the speaking valve on. On 1/5/26 at 12:50 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Larynx, Tracheostomy, and Gastrostomy. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/25/25, indicated that Resident 24 was cognitively intact and was dependent on staff for eating, hygiene, dressing, and transferring. Resident 24 had a gastrostomy tube and tracheostomy tube. Current physician orders included, but were not limited to:Require enhanced barrier precautions related to the placement of port to right upper chest, Gastronomy tube, tracheostomy every shift, dated 11/24/25. A current care plan for the use of Enhanced Barrier Precautions related to port placement to right upper chest, PEG tube, tracheostomy to reduce the risk of transmission of Multi-Drug-Resistant Organisms (MDRO), dated 11/24/25, included, but were not limited to the following interventions: Follow enhanced barrier guidelines as ordered, dated 11/24/25. PPE use high contact resident care activities including dressing, eating, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting. Device care or use: port, wound care, and skin opening requiring a dressing, dated 11/24/25. During an interview on 1/4/26 at 12:15 P.M., the Director of Nursing (DON) indicated PPE should be worn while providing care to Resident 24. 2. During an observation of care on 1/5/26 at 10:43 A.M., Certified Nurses Aide (CNA) 12 entered Resident 33's room. CNA 12 washed her hands for eight seconds and put gloves on. CNA 12 used the bed remote to raise the bed and lay the bed flat. CNA 12 pulled the covers down, pulled Resident 33's gown up, and took the resident's brief off. CNA 12 wet a wash cloth and sprayed it with peri-wash spray, cleaned Resident 33 from front to back in a downward motion. Resident 33 rolled to her left side and CNA 12 used a wet wash cloth with peri-wash spray to clean Resident 33. CNA 12 removed her gloves and performed a nine second hand wash. During an interview on 1/5/26 at 10:55 A.M., CNA 12 indicated hand washing should occur for 40 seconds. On 1/7/26 at 2:03 P.M., the Administrator provided a current Enhanced Barrier Precautions policy, dated 8/2024. The policy indicated .EBPs employ targeted gown and glove use during high contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) . Face protection may be used if there is also a risk of splash or spray . On 1/7/26 at 2:13 P.M., the Administrator provided a policy titled Handwashing and Hand Hygiene, dated 8/2024, that indicated Washing hands: Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3.1-18(b)3.1-18(b)(1)3.1-18(l)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff members providing direct care, including contractual staff, were thoroughly trained for provision of tracheostomy care for 1 of 1 resident reviewed for tracheostomy care and care of a wound vac for 1 of 1 residents reviewed for surgical wounds. (Resident 24 and Resident 31)Findings include: On 1/4/26 at 11:23 A.M., Resident 24 was observed to receive tracheostomy care from a contractual staff member, Licensed Practical Nurse (LPN) 15. During the observation, LPN 15 failed to follow infection control techniques, including but not limited to the following:Did not don Preventive Protective Equipment (PPE) prior to providing care, Used clean gloves with a contaminated suction catheter to suction a tracheostomy, Did not use sterile gloves for a sterile procedure, andReplaced a contaminated inner cannula. On 1/5/26 at 12:50 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, Malignant Neoplasm of Larynx, Tracheostomy, and Gastrostomy. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/25/25, indicated Resident 24 was cognitively intact and was dependent on staff for eating, hygiene, dressing, and transferring. Resident 24 had a gastrostomy tube and tracheostomy tube. Current physician orders included, but were not limited to:Trach care Q (every) shift and PRN (as needed) dated 11/24/25Change inner cannula daily (6 uncuffed Shiley XLT) every day shift, dated 11/25/25 On 1/5/26 at 1:30 P.M., the facility policy Suctioning the Tracheostomy was reviewed. LPN 15 failed to follow the procedure as listed in the policy: put on mask and protective eyewear, remove gloves, open suction catheter kit, place sterile drape across the resident's chest, remove the sterile cup, fill with sterile saline, applying sterile gloves, the dominant hand will remain sterile, holding the suction catheter in dominant hand and the suction tubing in the non-dominant hand connect the catheter to the tubing, .remove oxygen device with non-dominant hand .discard PPE in designated receptacles. Perform hand hygiene . On 1/5/26 at 1:45 P.M., in-service education for LPN 15 was requested. The Director of Nursing (DON) indicated LPN 5 was a contractual staff member from a contractual staffing agency, and the facility did not have specific training for contractual staff members. On 1/5/26 at 2:30 P.M., the DON contacted the contractual staffing agency. The contractual staffing agency indicated that each staff member completed modules for the field of work they were assigned. The agency also indicated that the content of the modules was not recorded and could not support the specific training for tracheostomy care. The schedule as work was reviewed from 12/23/25- 1/4/26, and the following days and nights shifts were covered by the [Agency Name] staff: 12/23/25 day and night, 12/24/25 days and night, 12/25/25 night,12/26/25 night, 12/27/25 night, 12/28/25 night, 12/29/25 night, 12/30/25 night, 1/1/26 night, 1/2/26 night, 1/3/26 night, 1/4/26 day and night. (continued on next page)

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	01/07/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment Administration Record (TAR) was reviewed from 12/24/25-1/4/26. Qualified nursing staff signed the completion of Trach Care on the day shift noted on the following dates: 12/25/25, 12/26/25 ,12/27/25, 12/28/25,12/29/25, 12/3/250, 12/31, 1/1/26, 1/2/26, 1/3/26. During an interview on 1/7/26 at 9:30 A.M., Regional Clinical Nurse 2 indicated that Regional Clinical Nurse 9 came in on the weekend. Resident 24 was admitted and did bedside training of tracheostomy care with the DON. He indicated there was no documentation of the training. He indicated the Respiratory Vendor also came into the facility and trained the staff, but there was no documentation of the training. On 1/7/26 at 2:03 P.M., the Administrator provided a current In-Service Training All Staff policy, dated 8/2024. The policy indicated .completed training is documented by the staff development coordinator, or his or her designee, and includes: date and the time of training, topic of the training, the method used for training, a summary of the competency assessment, and the hours of training completed . 2. On 1/5/26 at 11:32 A.M., Resident 31's clinical record was reviewed. Resident 31 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, type 2 diabetes mellitus and osteomyelitis. The most recent admission Minimum Data Set (MDS) Assessment, dated 12/31/25, indicated Resident 31 was cognitively intact, was dependent on staff (staff does all of the work) for toileting and bathing, and had a foot infection and surgical wound. Physician orders included, but were not limited to:Cleanse the area with wound cleanser and pat dry. Skin prep peri-wound and allow to dry. Cut and place a drape around the wound bed. Cut to fit foam and place directly in the wound bed. Place the [NAME]-pad and secure it in place. Wound vac set to 150 mmHg (millimeters of mercury) continuous, instill 6mL (milliliters) for 10 minutes every two hours every day shift every Monday, Thursday for wound vac related to osteomyelitis; Start date 1/1/26 Check placement and function of wound vac to the right foot every shift; Start date 12/29/25 The current care plan included, but was not limited to: I require enhanced barrier precautions related to the right IJ/PICC (internal jugular peripherally inserted central catheter), urinary catheter, and wound vac to the right foot; Date initiated 12/29/25 I receive IV (intravenous) antibiotic therapy related to osteomyelitis, sepsis, strep B; Date initiated 12/29/25 During an observation on 1/6/26 at 9:35 A.M., Resident 31 indicated that staff did not change the wound vac the previous day. The saline irrigation bag was empty. During an observation on 1/7/26 10:25 A.M., Resident 31 indicated staff did not change the wound vac the previous day. The saline irrigation bag was undated and empty. On 1/7/26 at 10:35 A.M., Resident 31's electronic treatment record was reviewed. The physician ordered the wound vac to be changed on 1/5/26, and it was not marked as completed. The clinical record lacked documentation that the wound vac had been changed since 1/1/26. During an interview on 1/7/26 at 11:06 A.M., Licensed Practical Nurse (LPN) 21 indicated she was not comfortable changing Resident 31's wound vac and that the Director of Nursing (DON) handled wound vac changes. On 1/7/26 at 11:45 A.M., training related to wound vacs was requested. The facility was unable to provide documented attendance of training or skills check-off specific to wound vacs for any staff employed in the facility. On 1/7/26 at 2:13 P.M., the Administrator provided a policy titled Staffing, Sufficient and Competent Nursing, dated 8/2024, that indicated Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: programming for staff training results in nursing competency; gaps in education are identified and addressed; education topics and skills needed are determined based on the resident population; tracking or other mechanisms are in place to evaluate effectiveness of training; and training includes critical thinking skills and managing care in a complex environment with (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple interruptions. 3.1-14(p)(6)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post a current Nurse Staffing Information form for 4 of 4 days during the survey period.Finding includes:On 1/4/26 at 8:53 A.M., a Nurse Staffing Information form was observed on the main lobby desk. It was dated 1/2/26. On 1/5/26 at 9:24 A.M., a Nurse Staffing Information form was observed on the main lobby desk. It was dated 1/5/25. On 1/6/26 at 3:22 P.M., a Nurse Staffing Information form was observed on the main lobby desk. It was dated 1/5/25. On 1/7/26 at 8:23 A.M., a Nurse Staffing Information form was observed on the main lobby desk. It was dated 1/5/25. During an interview on 1/7/26 at 8:39 A.M., the Director of Nursing (DON) indicated she oversaw the Posted Nurse Staffing form. She completed the form every morning that she was there, and on weekends the weekend night nurse would complete it. On 1/7/26 at 2:03 P.M., the Administrator provided a current Posting Direct Care Daily Staffing Numbers policy, dated 8/2024, that indicated Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.