STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing and Rehabilitation	3400 Stocker Dr Evansville, IN 47720

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were properly dated and labeled, failed to keep medications refrigerated until opening, and failed to destroy expired medications for 4 of 4 medication carts observed. (North Hall Medication Cart, South Hall Medication Cart, Stocker 1 Medication Cart, Insulin Administration Cart, Resident W, Resident 13, Resident M) Findings include: Findings include:1.On 1/22/26 at 8:59 A.M., during a random observation of the North Hall Medication the following was observed:1/2 small round white pill2 medium round white pills1/2 large round white pill1 white capsule with the numbers (#) A-4691 large size stretch band2. On 1/22/2026 at 9:10 A.M., during a random observation of the South Hall Medication Cart the following was observed:1 container of pudding with a dated of 1/19/261 small round white pill with the # 051 large round white pill with the # 40971 large round white pill the # 66-4221 blue/light blue capsule with the # 6 and 20 Milligrams(mg)1 small round white pill with the # U-51 large round pill with the # DH-0201 large oval white pill with the #U-113. On 1/22/2026 at 9:20 A.M., during a random observation of the Stocker 1 Medication Cart the following was observed:1 bottle of Magnesium with no name1 bottle of Vitamin C 250 Mg with no name1 bottle of Lutein 20 with no name4. On 1/22/26 at 9:30 A.M., during a random observation of the Insulin Cart was observed:1 Lantus pen for Resident 13 with open date of 12/19/25 with no expiration date1 Lantus pen for Resident W with no open date or expiration date2 Lispro pens for Resident W with no open date or expiration date1 Lispro pen for Resident W with no open date1 unopened Lantus for Resident 451 [Product Name} glucometer for Resident name 45 noted to have 2 spots of blood on machineDuring an interview on 1/22/2026 at 9:05 A.M., Qualified Medicine Aide (QMA) 6 indicated there should be no pills in the medicine carts. She indicated the pills are placed in a drug buster solution and is reported to the Director of Nursing (DON).During an interview on 1/22/2026 at 9:30 A.M., Registered Nurse 8 (RN) indicated that insulin pen should have an open and expiration date. New insulin pens if not open should be refrigerated until needed. During an interview on 1/29/2026 10:27 A.M., the Infection Preventionist indicated ach resident has their own glucometer that should be cleaned in between use.On 1/29/26 at 1:29 P.M., the Administrator provided a current policy Storage of Medications and Biologicals dated 5/20/20. The current policy indicated .medication(s) labeled for individual residents are stored separately than floor stock.disposal of medication(s) should be completed for medication(s) without secure closure, outdated, contaminated or deteriorated.3.1-25(k)3.1-25(l)3.1-25(o)

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 3 of 5 residents reviewed for hospitalizations, 1 of 1 residents reviewed for tube feeding, and 1 of 1 residents reviewed for urinary catheter. (Resident D, Resident C, Resident Y, Resident M, and Resident R)Findings include: 1. On 1/23/26 at 2:46 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis and quadriplegia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/20/25, indicated that Resident C was cognitively intact and was dependent on staff (staff does all the work) for all Activities of Daily Living (ADLs). The clinical record indicated the most recent care conference was completed on 11/21/24 at 2:55 P.M. A care conference note, dated 4/15/25, was in progress but had not been completed. On 1/29/26 at 10:12 A.M., the Social Services Director (SSD) provided care conference notes for Resident C dated 4/15/25, 7/8/25, and 9/30/25. All three notes were created in the electronic health record (EHR) and signed on 1/29/26. During an interview on 1/29/26 at 11:55 A.M., the SSD indicated that care conferences were completed every three months. She took notes about the care conference in a notebook and then entered it into the resident's EHR whenever she had the chance. She indicated that she had gotten behind on documentation. 2. On 1/23/26 at 2:30 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, chronic kidney disease and diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/19/25, indicated Resident D was cognitively intact, was dependent on staff (staff does all the work) for toileting, weighed 184 pounds (lbs), and had no weight loss. A care conference was completed on 11/11/25 at 1:00 P.M. with the resident in attendance. Notes indicated to continue with the current plan of care. A current risk for weight changes care plan, initiated 8/2/21, included, but was not limited to, the following intervention:Monitor weight and intake. A current noncompliance care plan, initiated 2/20/23, included, but was not limited to, the following intervention:Educate on the possible consequences of refusing care, treatments, medications, etc. and document. Physician orders included, but were not limited to:Weigh patient monthly every one month starting on the first for health monitoring, dated 10/1/25 and discontinued on 1/13/26Monitor weight weekly every Wednesday for health monitoring, 1/14/2026 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A weight summary indicated the following weights had been obtained since 10/1/25:10/1/25 – 184.2 lbs1/1/26 – 166.4 lbs 1/2/26 166.4 lbs1/8/26 – 163.3 lbs The clinical record lacked documented weight refusals. An Interdisciplinary Team (IDT) note, dated 1/7/26 at 1:54 P.M., indicated that the resident had a three percent decrease in weight but no weight was recorded from October to January. The resident needed to be reweighed and an order to obtain weekly weights was given. Resident D's Treatment Administration Record (TAR) for November and December 2025 was reviewed. The monthly weights for November and December were blank and not signed by a staff member. During an interview on 1/29/26 at 1:21 P.M., the Director of Nursing (DON) indicated that Resident D was noncompliant with care, refused to be weighed in November and December, and staff did not document the weight refusals. 3. On 1/28/26 at 11:57 A.M., Resident R's clinical record was reviewed. Resident R was admitted on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/17/25, indicated Resident R was cognitively intact, was dependent on staff (staff do all of the work) for toileting, bathing, and transfers, used oxygen therapy, and had an indwelling catheter. The following physician orders on the electronic medication and treatment administrations (eMAR/eTAR) indicated the following days Resident R's medications or treatments were not administered to the resident or refused by the resident: Lyrica Oral Capsule 100 MG (a pain relief medication) Give one capsule by mouth three times a day for Neuropathy Start Date 7/30/25 10/17/25 9 P.M. 10/22/25 6 A.M. 11/10/25 6 A.M. 12/13/25 6 A.M. 12/13/25 2 P.M. Check blood sugar before meals and at bedtime before meals and at bedtime for monitoring Start Date 7/27/25 10/30/25 9 P.M. 11/6/25 9 P.M. BIPAP Check water level and fill if needed with distilled water every evening shift Start Date 7/22/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/17/25 evening 11/7/25 evening 11/24/25 evening 12/12/25 evening 12/28/25 evening 1/2/26 evening BIPAP clean mask every day shift Start Date 7/23/25 11/24/25 day 12/17/25 day Offer small more frequent meals every shift for gastroparesis Start Date 10/17/25 10/19/25 night 10/21/25 night 11/28/25 night During an interview on 1/30/26 at 9:12 A.M., The Director of Nursing indicated staff who were working during missing eMAR/eTAR administrations stated they provided the medications/treatments, documentation was just missed at the time. 4. On 1/27/26 at 10:21 A.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/25/25, indicated Resident M was mildly cognitively impaired and was dependent on staff (staff do all of the work) for toileting, bathing, and transfers. Physician orders included, but were not limited to: Insulin Lispro Subcutaneous Solution Pen injector 100 UNIT/ML (milliliters) Inject as per sliding scale: if 0 - 149 = 0; 150 - 179 = 1; 180 - 209 = 2; 210 - 239 = 3; 240 - 269 = 4; 270 - 299 = 5;300 - 999 = 6 and call MD, subcutaneously before meals Start date 7/16/25 The electronic medication administration record (eMAR) indicated the following days insulin lispro was not administered: 1/2/26 6 A.M. 1/6/26 6 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/8/26 6 A.M. 1/10/26 6 A.M. 1/12/26 6 A.M. 1/13/26 6 A.M. 1/14/26 6 A.M. 1/15/26 6 A.M. 1/17/26 6 A.M. 1/20/26 6 A.M. 1/21/26 6 A.M. 1/22/26 6 A.M. 1/24/26 6 A.M. 1/25/26 6 A.M. During an interview on 1/29/26 at 11:46 A.M., The Director of Nursing indicated the night shift nurse obtained A.M. blood sugars for residents, gave blood sugar results to day shift nurse, and day shift nurse gave insulin at breakfast, sometimes it gets missed in documentation. 5. During an interview on 1/23/26 at 8:27 A.M., Resident Y's responsible party indicated the facility had not invited them to a care conference in the last six to eight months. On 1/23/26 at 2:23 P.M., Resident Y's clinical record was reviewed. Resident Y was admitted on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/5/25, indicated Resident Y was severely cognitively impaired and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. Resident Y's clinical record lacked quarterly care plan conferences since admission. Care plan conferences were requested on 1/29/26 at 8:51 A.M. On 1/29/26 at 10:18 A.M., the social services director provided quarterly care plan conferences on dated 10/28/25 (created on 1/29/26), 6/26/25 (created on 1/29/26), and 5/13/25 (created on 1/29/26). 3.1-50(a)(1) 3.1-50(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment during four random observations. Odors were present in the facility. (Main lobby, Stocker Unit 1, Stocker Unit 2, Conference Room) Findings include: 1. On 1/22/26 at 9:40 A.M., The hallways on Stocker Unit 1 and Stocker Unit 2 had a strong smell of urine. 2. On 1/23/26 at 8:56 A.M., the main lobby, Stocker Unit 1, and Stocker Unit 2 had a strong, pungent smell consistent with sewer gas. 3. On 1/28/26 at 9:05 A.M., the hallway outside of the conference room had a smell consistent with bowel movement. During an interview on 1/29/26 at 11:20 A.M., the Administrator indicated odors in the facility should be controlled by general routine cleaning and staff should increase cleaning in areas that are prone to odors. On 1/29/26 at 1:16 P.M., the Administrator provided a policy titled Environmental, dated 5/17, that indicated The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: pleasant, neutral scents; The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include: institutional odors This citation relates to intake 2707708. 3.1-19(f)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interview, the facility failed to ensure staff completed training related to dementia management for 4 of 5 staff, employed longer than one year, reviewed. (QMA 6, RN 14, CNA 15, and LPN 16) Finding includes: On 1/28/26 at 8:53 A.M., employee files were reviewed. QMA 6 started employment on 9/6/24. QMA 6 was missing two of three hours of dementia management related in-services required since 2024. RN 14 started employment on 11/3/24. RN 14 was missing two of three hours of dementia management related in-services required since 2024. CNA 15 started employment on 8/3/23. CNA 15 was missing three of three hours of dementia management related in-services required since 2024. LPN 16 started employment on 8/26/24. LPN 16 was missing one of three hours of dementia management related in-services required since 2024. Additional in-service trainings were requested and were not provided. During an interview on 1/29/26 at 1:32 P.M., the regional clinical support nurse indicated staff should have six hours first year and three hours annually of dementia related in-services. On 1/29/26 at 2:24 P.M., the Administrator provided a policy titled Staffing, Sufficient and Competent Nursing, dated 4/25, that indicated Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure 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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that care conferences were conducted every 3 months in 3 of 18 residents reviewed for care conferences. (Resident 26, Resident N, Resident 7) Findings include:1. On 1/23/26 at 1:36 P.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, undifferentiated schizophrenia and generalized anxiety disorder. The current Annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident L was mildly cognitively intact. Resident 26 needed set up help to eat, for transfer and hygiene partial to moderate assistance, and substantial to maximum assistance for dressing and toileting. A Social Service note dated 4/29/2025 at 12:01 P.M., indicated the social worker had reached out to the resident's guardian to schedule a care conference and a message was left. The clinical record lacked any further documentation of care conferenced. During an interview on 1/27/26 at 8:35 A.M., the current Social Services Director indicated the previous social services director was behind with the conferences and that they were still trying to catch up with the conferences and this resident was one of them. 2. On 1/23/26 at 11:30 A.M., Resident N's clinical record was reviewed. Resident N was admitted on [DATE]. Diagnoses included, but were not limited to, chronic respiratory failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/19/25, indicated the resident was rarely or never understood and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. The clinical record lacked quarterly care plan conferences held since 6/26/25. 3. On 1/23/26 at 11:16 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/29/25, indicated Resident 7 was unable to be assessed for cognitive impairment because she was unable to complete the interview. Resident 7 was dependent on staff for all Activities of Daily Living (ADLs). A care conference was completed on 6/24/25 at 11:00 A.M. with the resident's family member attending by phone. The clinical record lacked documentation to indicate a care conference had been completed since 6/24/25.During an interview on 1/29/26 at 10:12 A.M., the Social Services Director (SSD) indicated that the last care conference completed for Resident 7 was on 6/24/25.During an interview on 1/29/26 at 11:55 A.M., the SSD indicated that care conferences were to be completed every three months.On 1/29/26 at 1:23 P.M., the Administrator provided a current Care Planning – Interdisciplinary Team policy, revised March 2022, that indicated Resident care plans are developed according to the timeframes and criteria established by 483.21 . The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.3.1-3(n)(3)3.1-35(d)(2)(B)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that a resident who had medication at bedside had a physician order for the medication to be kept at bedside and self-administer, a completed assessment to self-administer, and a care plan based on 2 of 3 residents reviewed for self-administration of medications. (Resident W and Resident 62) Findings include:1. On 1/23/2026 at 1:30 P.M., during a random observation, Resident 62 was observed lying in bed with a medication cup of unlabeled pills sitting on the over bedside table. There were a total of at 8 pills observed.The resident indicated the pills were A.M. medicines and did not know how long the pills had been there. On 1/23/2026 at 1:49 P.M., Resident 62's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes type 2, dialysis, and cerebral infarction. The Current Discharge with Return Anticipated Minimum Data Set (MDS) assessment dated [DATE], indicated Resident was cognitively intact and required dialysis. Resident 62 required set up for eating and hygiene, needed substantial help for dressing, and partial to moderate assistance for transferring. The current physician orders lacked an order for self-administration of medication. The current medical record lacked a self-administration assessment. The record lacked a care plan for self-administration of medications. During an interview on 1/23/2026 at 1:40 P.M., Qualified Medicine Aide (QMA) 7 indicated she did not know where the medications came from and were probably left from night shift. 2. On 1/27/26 at 9:30 A, M., during a random observation, Resident W was observed lying in bed with a medication cup containing 1 large white pill observed lying on the over bedside table. On 1/23/26 at 1:38 P.M., Resident W's clinical record was reviewed. Resident W's diagnoses included, but were not limited to, acute pulmonary edema and dysphagia, oropharyngeal phase.The Current Significant Change MDS assessment dated [DATE] indicated Resident W was cognitively intact. Resident W needed set help with eating, dressing, hygiene, and transferring.The clinical record lacked an order for self-administration of medications.The clinical record lacked a care plan for self-administration of medications.The clinical record lacked an assessment for self-administration of medication.During an interview on 1/27/26 at 9:10 A.M., with Housekeeper Aide 10 she indicated that she finds medications at the bedside several times, especially in the 400 hall. She indicated that she immediately would tell the nurse about the medications.During an interview on 1/27/26 at 10:22 A.M., QMA 6 indicated that no medication should be left at bedside. If medications are found, they should be destroyed and she will notify nurse.On 1/29/26 at 1:37 P.M., the Administrator provided a current policy Self-Administration of Medications reviewed 5/20/20. The policy indicated .the interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis .deferred this right to the facility. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process .all nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party . 3.1-11

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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** Based on observation, interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 5 resident reviewed for unnecessary medications. (Resident 6)Finding includes:On 1/23/26 at 1:46 P.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on [DATE]. Diagnoses included, but were not limited to, end stage renal disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/29/25, indicated Resident 6 was cognitively intact, was dependent on staff (staff do all of the work) for toileting, bathing, and transfers, and received antianxiety medication during the seven day lookback period. Physician orders included, but were not limited to: hydroxyzine HCl Oral Tablet 25 MG (milligrams) Give one tablet by mouth every eight hours as needed for itching, Start Date 12/23/25.The electronic medication administration record (eMAR) indicated Resident 9 was given zero doses of hydroxyzine during December 2025.During an interview on 1/28/26 at 10:19 A.M., the Regional Clinical Support Nurse indicated Resident 9 did not receive an antianxiety medication during seven day lookback and was marked in error on the MDS assessment. On 1/29/26 at 2:24 P.M., the Administrator provided a policy titled Certifying Accuracy of the Resident Assessment, dated 11/19, that indicated Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plan interventions were implemented for 1 of 2 residents reviewed for falls and 1 of 1 residents reviewed for pressure ulcers. Fall interventions were observed out of place and wound treatment was not completed according to physician orders. (Resident S and Resident N)Findings include: 1. On 1/22/26 at 11:06 A.M., Resident S was observed sitting in her wheelchair in the small tv room next to the nurse's station wearing white socks. The socks did not have nonskid tread on the bottoms.On 1/23/26 at 2:20 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, senile degeneration of the brain and muscle weakness. Resident S's most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident S was not assessed for cognitive impairment because she was rarely or never understood, was independent in eating, and had no falls since the prior assessment on 12/18/25. Resident S refused to complete other Activities of Daily Living (ADLs) during the assessment period.The most current fall risk assessment, dated 12/11/25, indicated that Resident S was at a high risk for falls.A care conference was completed on 11/25/25 at 11:30 A.M. with the resident's family member in attendance. Notes indicated to continue with the current plan of care.A current high-risk for falls care plan, initiated 7/27/16, included, but were not limited to the following interventions:The resident needs a safe environment with: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Slide rails as ordered; and personal items within reach. This was initiated 7/27/15 and revised on 9/19/25Be sure the resident's call light is within reach and encourage use of it for assistance as needed, initiated 7/27/16 and revised on 9/19/25 Resident to wear nonskid socks at all times as patient allows, dated 8/30/25Resident's A.D. (assistive device) and w/c (wheelchair) to be stored in a safe location to be used with staff assist in order to assist the resident with mobility due to the resident's impaired cognition and decreased ability to sequence mobility safely, initiated 11/24/25The clinical record indicated Resident S sustained falls on the following dates since 1/1/25:3/17/25 at 8:29 A.M. - unwitnessed fall while attempting to self-transfer. The Scoop mattress was added to the plan of care.6/10/25 at 4:30 P.M. - witnessed fall while attempting to self-transfer. A floor pressure alarm was added to the plan of care.8/30/25 at 4:01 P.M. - unwitnessed fall while attempting to self-transfer. Nonskid socks at all times as the patient allows, was added to the plan of care.9/1/25 at 6:45 P.M. - unwitnessed fall while attempting to self-transfer. Hospice to install missing fall interventions was added to the plan of care.10/13/25 at 3:35 A.M. - unwitnessed fall while attempting to self-transfer. Dycem under the fall mat was added to the plan of care.11/24/25 at 5:10 P.M. - unwitnessed fall while attempting to self-transfer. Resident's A.D. and w/c to be stored in safe location to be used with staff assist in order to assist the resident with mobility due to the resident's impaired cognition and decreased ability to sequence mobility safely was added to the plan of care.12/8/25 at 8:25 A.M. - witnessed a fall while ambulating unassisted. A bed alarm and high floor mat was added to the plan of care. On 1/29/26 at 8:34 A.M., Resident S was observed lying in bed. The bed was positioned in the back on the right side of the room with the resident's feet pointing towards the door. The call light was observed under her bed. Her wheelchair was across from her bed next to a small half dresser in the middle of the left side of the room in the resident's line of sight.During an interview on 1/29/26 at 8:36 A.M., Licensed Practical Nurse (LPN) 16 indicated that Resident S's wheelchair was stored between her recliner, which was positioned at the foot of the bed, and the door because if it was in her line of sight she would try to self-transfer into it. At that time, she indicated that Resident S was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	capable of using her call light but usually yelled out when she needed help. 2. During an observation on 1/28/26 at 1:41 P.M., RN 8 performed hand hygiene, put a gown and gloves on, and entered Resident N's room. RN 8 pulled the curtain closed, turned Resident N to their left side, used the bed remote to lay the bed down, pulled the bed covers down, and used the pad under Resident N to wipe the paste off of Resident N's coccyx area. RN 8 changed gloves and used a cotton swab to mix collagen and triad (a zinc oxide paste) to Resident N's coccyx area. RN 8 did not cleanse the area before applying the paste. RN 8 did not pause Resident N's continuous tube feeding machine before laying the resident down. On 1/23/26 at 11:30 A.M., Resident N's clinical record was reviewed. Resident N was admitted on [DATE]. Diagnoses included, but were not limited to, chronic respiratory failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/19/25, indicated the resident was rarely or never understood and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. Physician orders included, but were not limited to: Coccyx: cleanse with wound cleanser, pat dry, mix triad and collagen particle together, apply the mixture to the wound bed and leave open to air every day shift for wound Start Date 12/25/25 Diabetisource AC Oral Liquid (Nutritional Supplement) Give 55 ml/hr (milliliters/hour) via PEG (percutaneous endoscopic gastrostomy) Tube (a feeding tube into the stomach) every shift for peg tube continuous feeding Start Date 10/17/25 The current care plan included, but was not limited to: The resident has pressure ulcer or potential for pressure ulcer development related to vegetative state, no mobility, quadriplegia; Administer treatments as ordered and observe for effectiveness Date Initiated: 4/1/25 The resident requires tube feeding related to vegetative state with tracheostomy; Aspiration precautions: Keep head of bed elevated 45 degrees during tube feeding and for one hour after completion of tube feeding. Date Initiated: 4/1/25 During an interview on 1/29/26 at 10:27 A.M., the Infection Prevention Nurse indicated a resident who received continuous tube feeding should not be laid flat and staff should follow treatment orders as ordered by the physician. On 1/29/26 at 2:24 P.M., the Administrator provided a policy titled Enteral Nutrition, dated 11/18, that indicated Risk of aspiration is assessed by the nurse and provider and addressed in the individual care plan. Risk of aspiration may be affected by improper positioning of the resident during feeding. This citation relates to Intake 2707708. 3.1-35(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. Based on observation, interview, and record review, the facility failed to revise residents' care plans to reflect changes in condition for 1 of 2 residents reviewed for advanced directives and 1 of 2 residents reviewed for falls. An advanced directive care plan was not revised to reflect a full code status, and a fall intervention was not revised following a change of equipment. (Resident 18 and Resident 29)Finding includes:1. On 1/23/26 at 2:07 P.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome and peripheral vascular disease.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/1/25, indicated Resident 18 was cognitively intact and was independent in all Activities of Daily Living (ADLs).A care conference was completed on 12/23/25 at 5:02 P.M. with the resident in attendance. Notes indicated to continue with the current plan of care. Notes also indicated that the resident was a full code and wished to remain that way.Current care plans included, but were not limited to:Resident 18 has an advanced directive of DNR (do not resuscitate), dated 9/2/22 and last revised on 7/25/24Current physician orders included, but were not limited to:Full Code, dated 6/19/25An Indiana Physician Orders for Scope of Treatment (POST) Form, dated 8/1/25, indicated that Resident 18 wished to be full code.During an interview on 1/29/26 at 8:36 A.M., Licensed Practical Nurse (LPN) 16 indicated that Resident 18 was a full code.During an interview on 1/29/26 at 11:55 A.M., the Social Services Director (SSD) indicated that the MDS Coordinator revised the care plans as needed. Resident 18's advanced directives care plan needed to be changed to reflect his full code status.2. On 1/23/26 at 2:36 P.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of lower end of right tibia, osteoarthritis, and muscle wasting and atrophy.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/18/25, indicated that Resident 29 had severe cognitive impairment, was dependent on staff (staff does all the work) for eating, toileting, and bathing, and had no falls since the prior assessment.A current fall risk assessment, dated 11/14/25, indicated that Resident 29 was at a high risk for falls.A care conference was completed on 12/30/25 at 11:15 A.M. with the resident in attendance. The care plan was reviewed.A current high risk for falls care plan, initiated 11/14/25, included, but were not limited to, the following interventions:Bright colored tape to call light, initiated 12/22/24 and revised on 1/31/25Sensor call light due to decreased ability to utilize standard call light, initiated on 1/27/25On 1/29/26 at 8:28 A.M., a pressure-sensitive pad call light was observed lying on Resident 29's bed. There was no bright tape on the call light.During an interview on 1/29/26 at 1:21 P.M., the Director of Nursing (DON) indicated that the intervention for the bright tape was for the old standard call light, and that intervention should have been removed from the plan of care when the call light was changed to the pressure-sensitive pad.On 1/29/26 at 1:23 P.M., the Administrator provided a current Comprehensive Person-Centered Care Plans policy, revised March 2022, that indicated Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.3.1-35(b)(1)

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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. Based on observation record review, and interview, the facility failed to ensure there was an order and care plan for oxygen, tubing was properly dated, and there was an administration posted on door for 1 of 2 residents reviewed for oxygen administration.(Resident W) Finding includes:During a random observation on 1/22/26 at 10:27 A.M., Resident W was observed lying in bed with Oxygen (O2) tubing connected to concentrator with no date on the tubing or water bottle along with the nebulizer, and there was no oxygen administration sign on the door. During a random observation on 1/27/26 at 9:05 A.M., Resident W was observed lying in bed without oxygen on. The nebulizer face mask was observed on the floor and lacked a date on the tubing. Current physician orders lacked documentation of an oxygen order The current clinical record lack documentation of a care plan for oxygen.During an interview on 1/27/26 at 9:30 A.M., Hospice Provider 2 indicated residents on oxygen will have an order for the resident with them but should also have an order with the facility for O2.During an interview on 1/27/26 at 10:30 A.M., Registered Nurse (RN) 4 indicated there should be an order for oxygen for anyone utilizing it.On 1/29/26 at 1:42 P.M., the Administrator provided a current policy Oxygen Administration revised October 2010. The policy indicated .Verify that there is a physician's order.review the resident's care plan to assess for any special needs of the resident. Place an Oxygen in Use sign on the outside of the room entrance door. This citation relates to Intake 2707708. 3.1-47(a)(6)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently provide coordination between facility staff and hospice staff to meet residents' nursing needs for 1 of 1 residents reviewed for falls. Fall interventions were not installed on a resident's wheelchair which resulted in a fall with injury. (Resident S)Finding includes:During a confidential interview on 1/22/26 at 2:08 P.M., it was indicated that Resident S used to receive hospice services but did not receive hospice services any longer. The resident utilized Hospice Provider 1 for a while and then switched to Hospice Provider 2 due to communication issues. The resident discontinued hospice services altogether after Resident S fell in December and broke her hip.On 1/23/26 at 2:20 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, senile degeneration of the brain and muscle weakness. Resident S was admitted to the facility on [DATE].Resident S's most current Significant Change Minimum Data Set (MDS) Assessment, dated 12/15/25, indicated Resident S was not assessed for cognitive impairment because she was rarely or never understood, was independent in eating, and had no falls since the prior assessment on 12/18/25. Resident S refused to complete other Activities of Daily Living (ADLs) during the assessment period.Physician orders included, but were not limited to:Resident admitted on [DATE] to Hospice Provider 1 with diagnosis of senile dementia of the brain, all concerns/changes need to go through Hospice Provider 1, dated 7/17/24 with an end date of 12/11/25The clinical record lacked a physician order indicating that Resident S changed hospice providers.The most current fall risk assessment, dated 12/11/25, indicated Resident S was at a high risk for falls.A care conference was completed on 11/25/25 with Resident S's family member in attendance. Notes indicated to continue with the current plan of care.A resolved hospice care plan, initiated on 7/17/24 and resolved on 1/20/26, indicated that Resident S was admitted on [DATE] to Hospice Provider 1 and all concerns and changes needed to go through the hospice provider.The clinical record lacked care plans indicating that Resident S changed hospice providers.A current risk for falls care plan, initiated 7/27/16, included, but were not limited to, the following interventions:Anti rollbacks, initiated 4/25/24 and revised on 7/30/24Anti-tippers on wheelchair, initiated 5/8/24Hospice to install missing safety interventions to resident's wheelchair that they delivered, initiated 9/1/25A Long Term Care Status Form, dated 7/17/24 and signed by Hospice Provider 1, indicated that Resident S was admitted to hospice services on 7/17/24 and that Durable Medical Equipment (DME) would be provided by Hospice Provider 1. A health status progress note, dated 3/17/25 at 8:29 A.M., indicated Resident S had an unwitnessed fall while attempting to self-transfer. The following injuries were noted: hematoma measuring 2.5 centimeters (cm) by 2 cm by 1.5 cm to right hair line; abrasion measuring 0.5 cm by 0.3 cm by 0.1 cm to side of forehead; abrasion measuring 0.4 cm by 0.3 cm by 0.1 cm to temple; and abrasion measuring 0.5 cm by 0.3 cm by 0.1 cm to cheek.An Interdisciplinary (IDT) note, dated 3/17/25 at 9:16 A.M., indicated the root cause of the fall was unassisted transfer and weakness, and scoop mattress to be issued by hospice provider was added to the care plan.An incident note, dated 6/10/25 at 4:30 P.M., indicated Resident S had a witnessed fall while attempting to put a brief on her walker. No injuries were noted.An IDT note, dated 6/11/25 at 10:12 A.M., indicated the root cause of the fall was unassisted transfer and weakness, and resident to be issued floor pressure alarm was added to the care plan.A health status note, dated 8/30/25 at 4:01 P.M., indicated Resident S had an unwitnessed fall in her room. Resident S was noted to be on her floor mat without socks or a brief on.A risk management report, dated 9/1/25 at 6:45 P.M., indicated that Resident S had an unwitnessed fall in the common room. The resident's wheelchair was found beside her. It was noted that the region to the upper portion of the skull was bleeding and had swelling consistent with the size of a medium goose-egg. Her scalp was noted to have a small 2 cm skin tear. The resident was sent to the emergency room (ER) for evaluation and treatment. A (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health status note, dated 9/1/25 at 10:15 P.M., indicated Resident S returned from the emergency room (ER) with new orders to apply triple antibiotic ointment/bacitracin to scalp wound twice a day for ten days. ER staff indicated that the CT (computed tomography) scan of the resident's head and spine were negative as well as the x-ray of the pelvis. Resident S complained of her head hurting and as needed (PRN) morphine was administered.An IDT note, dated 9/1/25 at 11:13 P.M., indicated IDT met to review Resident S's fall on 8/30/25. The root cause of the fall was determined to be unassisted transfer and weakness. Resident to wear nonskid socks at all times as patient allows was added to the care plan.An IDT note, dated 9/1/25 at 11:17 P.M., indicated IDT met to review Resident S's fall on 9/1/25. The IDT review determined that the hospice-issued wheelchair did not contain the individualized fall interventions previously in place on facility-issued equipment. The Social Services Director (SSD) contacted Hospice Provider 1 to inform them of the concern regarding the appropriateness of the wheelchair. Hospice staff acknowledged the report and indicated they would address the issue and ensure correct fall interventions were installed onto the wheelchair. At that time, the facility provided appropriate seating equipment with all safety features in place and discussed with facility staff the importance of monitoring residents' equipment and to follow-up with hospice as needed. Hospice to install missing safety interventions to resident's wheelchair that they delivered was added to the care plan.A health status note, dated 10/13/25 at 3:35 A.M., indicated Resident S had an unwitnessed fall while attempting to self-transfer. No injuries were noted. The fall mat was observed to have slid away from the side of the bed.An IDT note, dated 10/14/25 at 1:10 P.M., indicated the root cause of the fall was unassisted transfer and weakness, and Dycem to be issued and placed under fall mat to decrease risk of mat shifting out of place was added to the care plan.A social services note, dated 11/17/25 at 9:56 A.M., indicated the SSD spoke with a nurse from Hospice Provider 1 regarding the ongoing concerns of the hospice company not providing equipment necessary for appropriate fall interventions for Resident S. The hospice nurse informed her that the anti-tippers and standard wheelchair were present, but not the anti-rollbacks. The hospice nurse questioned why the anti-rollbacks were necessary and indicated that it would take special approval for Hospice Provider 1 to order them. The SSD and Director of Rehab (DOR) explained the necessity for the anti-rollbacks as an intervention. Discussions with Hospice Provider 1 had occurred over the last three months in an attempt to resolve concerns with services provided. The note indicated DME is not being delivered appropriately, installed appropriately or labeled appropriately. Their company has ordered DME multiple times and state it's been delivered but the DME company is not installing the equipment and therefore is not being found in the facility. It is the responsibility of the DME company delivering the equipment, to install the equipment. The hospice company providing the DME need to label their equipment as well and not facility staff. This SSD called to discuss concerns with the resident's family as concerns have not improved. The family informed me they never chose (Hospice Provider 1) to begin with and were comfortable with switching hospice providers. This SSD informed (Hospice Provider 1) to perform a transfer, and referral has been sent to (Hospice Provider 2) as the family did not have any preference for hospice provider to continue with.A Transfer Statement, dated 11/17/25, indicated Resident S was transferring care from Hospice Provider 1 to Hospice Provider 2. The resident was discharged from Hospice Provider 1 on 11/17/25 and admitted to Hospice Provider 2 on 11/18/25.During an interview on 1/29/26 at 8:55 A.M., the DOR indicated that hospice providers were responsible for implementing all fall interventions of their clients. The facility had difficulty with one hospice provider who was ordering parts and having them delivered to the facility but not communicating with the facility that the parts were on the way or who the parts were for. That hospice provider was no longer welcome in the building.During a confidential interview on 1/29/26 at 11:04 A.M., it was indicated that the anti-rollbacks were not on the wheelchair when Resident S changed hospice companies. They were unsure when the anti-rollbacks were installed.During an interview on 1/29/26 at 12:25 P.M., the DOR indicated that when the facility discovered Hospice Provider 1 had not added the anti-rollbacks to Resident S's wheelchair, the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility moved Resident S into a facility wheelchair with anti-rollbacks and anti-tippers. There was a large period of time between when the anti-rollbacks were added to Resident S's care plan and when they were installed and she was unsure how long the resident went with the anti-rollbacks. She indicated that should not have happened.On 1/29/26 at 1:21 P.M., the Director of Nursing (DON) provided a hospice binder for Resident S from Hospice Provider 1. Hospice notes dated 6/26/25 and 7/23/25 were in the binder. At that time, scanned in hospice notes were reviewed. Hospice notes were dated 7/26/24, 9/4/24, 10/16/24, 11/18/24, 11/20/24, 11/25/24, 12/5/24, 12/26/24, 1/8/25, 1/15/25, 1/22/25, 2/5/25, 3/21/25, and 4/16/25. A hospice recertification plan of care update note, dated 1/8/25, indicated Add DME Wheelchair, Add DME Wheelchair Cushion, Add DME Wheelchair Footrest. The clinical record lacked documentation to indicate Hospice Provider 1 provided any other information about Resident S's care, including, but not limited to, care plan updates, medication changes, physician notes, care provided, fall interventions put in place, DME ordered and installed, and change of condition.During an interview on 1/29/26 at 2:36 P.M., the DOR indicated Hospice Provider 1 did not communicate with the facility and would just change things, including fall interventions, without telling the facility.During an interview on 1/29/26 at 3:17 P.M., the Social Services Director (SSD) indicated she was in charge of coordinating care between residents and hospice providers. The SSD started employment with the facility on 2/10/25 and Resident S was admitted to Hospice Provider 1 before she started employment. Part of the referral process to a hospice provider was to send the resident's plan of care, orders, post form, and anything else necessary to ensure the hospice provider was aware of what services the resident received to ensure continuity of care. The resident's wheelchair was switched to a hospice provided chair as soon as the hospice provider was able. She indicated that she was unable to provide any documentation of when Resident S was switched from a facility chair to the hospice chair and if the anti-rollbacks were attached when she was switched. She indicated that all communication and care plans were supposed to be placed in the hospice binder following the visit. Hospice Provider 1's nurse case manager was in the building two to three times a week to see the two residents that were receiving their services. Communication with Hospice Provider 1 was poor and communications were not always placed in the binder. She was unsure how long Resident S went without the anti-rollbacks attached to her wheelchair. At that time, the DOR indicated that she did not lay eyes on residents who did not receive therapy services regularly to monitor their equipment.On 1/23/26 at 10:10 A.M., the Administrator provided a hospice contract for Hospice Provider 1, dated 9/22/22, that indicated 'Hospice Services means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: . (vii) medical supplies . In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care . Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. At, a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility: The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility . Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection.On 1/29/26 at 1:20 P.M., the Administrator provided a Hospice Program policy, revised July 2017, that indicated In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following: . Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms.On 1/29/26 at 1:20 P.M., the (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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator provided an undated Hospice Service Agreement document that indicated Hospice is responsible for providing all Hospice services including.Provision, in a timely manner, of all supplies, medications and medical equipment needed for the palliation and management of the terminal illness and related conditions . Nursing Facility Responsibilities.Furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before Hospice care was elected . Communication with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care will include the following: Development of each provider's portion of the plan of care to assure that the plans are complimentary and reflect common goals and the resident/patient's expressed desire for hospice care. Documentation in all providers' clinical records, or other means to ensure continuity of communication and easy access to ongoing information. Role of hospice in delivering supplies or medications. Ordering, renewal, delivery and administration of medications. Role of the attending physician, and process for obtaining and implementing physician orders.On 1/29/26 at 1:20 P.M., the Administrator provided a Falls - Clinical Protocol, revised March 2018, that indicated If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Nursing and Rehabilitation	3400 Stocker Dr Evansville, IN 47720

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 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, record review, and interview, the facility failed to ensure infection control practices and standards were performed on 2 of 2 random observations. Staff observed not utilizing the proper use of PPE of donning and doffing a gown when entering and exiting a room on Enhanced Barrier Protocol (EBP), did not utilize proper hand hygiene and changing gloves when performing tracheostomy suctioning, and locating a glucometer that was not cleaned after use. (Resident N, glucometer) Findings include:Findings include:1. On 1/22/26 at 9:30 A.M., during a random observation of the Insulin Cart, was observed to have a glucometer noted to have 2 spots of blood on the machine.2. On 1/23/2026 at 8:25 A.M., during a random observation of tracheal suction of Resident N, the following was observed:Resident N was noted to be on Enhanced Barrier Protocol due to a tracheostomy.Registered Nurse (RN)11 did not wash hands prior to donning gloves and did not place a gown of Personal Protective Equipment.2 Certified Nurses Assistants (CNA) 12 and 13 entered the room to help pull the resident up and neither donned gowns on for EBP, but they did have gloves. RN 11 paused tube feeding and obtained a tracheostomy care kit.Opened the kit with the same gloves, and also open sterile water container.Removed gloves, washed hands for 60 seconds with soap and water.Placed a sterile glove on the right hand.Touched the trach collar with a sterile gloved hand. Did not remove the glove or wash hands.Touched the suction catheter with a dirty gloved hand. Did not remove the dirty/soiled glove and change to a sterile one and wash hands.Passed a suction catheter into the tracheostomy with the suction on.Cleared the suction catheter with sterile water and proceeded to do 2 more passes with the suction catheter.Put the suction catheter into the container uncurled.Reattached trach collar.Removed gloves and then threw away the contaminated suction catheter. During an interview on 1/22/2036 at 9:30 A.M., Registered Nurse 8 (RN) indicated there should be no blood on glucometers, and the machines are cleaned in between each use.During an interview on 1/23/26 at 9:50 A.M., RN 11 indicated that she should have worn a gown.During an interview on 1/23/26 at 9:55 A.M., CNA 13 and CNA 12 should have worn gowns also.During an interview on 1/29/26 at 10:27 A.M., with the Infection Preventionist, she indicated if residents are in high contact circumstances, such as tracheostomy, there should be a sign for EBP sign on the door and wear proper PPE. She also indicated that if gloves were worn, the gloves should be changed when going from dirty to clean. When asked about cleaning glucometers, she indicated that glucometer should be cleaned after each use.On 1/29/26 at 1:23 P.M., the Administrator provided a policy Handwashing/Hand Hygiene dated October/ 2023. The policy indicated .hand hygiene is indicated with the following: performing an aseptic task.g. immediately after glove removal.Applying and removing gloves should be performed.Perform hand hygiene before applying non-sterile gloves.On 1/29/26 at 2:04 P.M., the Administrator provided a policy Personal Protective Equipment dated October/2018. The policy indicated .The type of PPE required for a task is based on. the type of transmission-based precaution.Personal protective equipment provided to our personnel includes but is not necessarily limited to a. gowns. (disposable, cloth, and/or plastic)); gloves (sterile, non-sterile) .On 1/29/26 at 2:44 P.M., the Administrator provided a current, non-dated policy, Assure Glucometer Platinum Policy. The policy indicated .The meter should be cleaned and disinfected after use on each patient. This citation relates to Intake 2707708. 3.1-18(b)3.1-18(l)