

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00176061.</p> <p>Complaint IN00176061 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 10, 11, 12, 13, 17, 18, 2015</p> <p>Facility number: 004130 Provider number: 155732 AIM number: 200491050</p> <p>Census bed type: SNF: 26 SNF/NF: 36 Residential: 33 Total: 95</p> <p>Census payor type: Medicare: 16 Medicaid: 27 Other: 19 Total: 62</p> <p>These deficiencies reflect state findings</p>	F 0000	This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0280 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review the facility failed to revise the comprehensive care plan for 1 of 24 residents reviewed during Stage 2. (Resident #6)</p> <p>Findings include:  On 8/11/15 at 3:35 p.m., Resident #6's clinical record was reviewed.</p>	F 0280	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Res #6 careplans have been reviewed/updated to reflect current continence status.</p> <p><b>Completion Date 9-17-15</b></p>	09/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The care plans included, but were not limited to:</p> <p>I am occasionally incontinent of bladder, dated 5/29/15, with a review date of 8/29/15. The interventions included, but were not limited to, check me for incontinence every two hours and as needed.</p> <p>The Assessment Review and Considerations tool, dated 5/28/15, indicated Resident #6 had immobility which could contribute to incontinence but was continent at that time.</p> <p>The Monthly Nursing Assessment, dated 6/29/15, 7/10/15, and 8/6/15, indicated Resident #6 was always continent.</p> <p>On 8/12/15 at 9:41 a.m., CNA #3 indicated Resident #6 was always continent.</p> <p>On 8/12/15 at 1:57 p.m., the MDS (Minimum Data Set Assessment) Coordinator was interviewed. The MDS Coordinator indicated the resident was no longer incontinent and the care plan should have been updated since staff was no longer checking the resident for incontinence every two hours.</p> <p>On 8/12/15 at 9:14 a.m., Resident #6 was observed. Resident #6 had no overt signs</p>		<p>No other residents were affected by the deficient practice and through corrective action will ensure that continence status is updated on the careplan timely when there is a change.</p> <p><b>Completion Date 9-17-15</b></p> <p>Systemic change is that the unit manager will audit/review monthly summaries before filing them in the record and continence status will be checked and compared to careplan for any discrepancies/updates.</p> <p><b>Completion Date 9-17-15</b></p> <p><b>Audits will be forwarded to QA committee monthly x3 and then quarterly.</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0282 SS=D Bldg. 00	<p>of incontinence.</p> <p>On 8/13/15 at 3:24 p.m., the Administrator provided the Guidelines for Care Plan Development policy, dated June 2013, and indicated the policy was the one currently being used by the facility. The policy indicated its purpose was to ensure care plans were developed to communicate resident preferences and care needs.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the care plan was followed for 1 of 16 residents reviewed for care plans. (Resident #42)</p> <p>Findings include:</p> <p>During an observation on 8/10/15 at 2:45 p.m., Resident #42 was observed to be in his room sitting in a recliner.</p>	F 0282	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Res #42 had psychological consult completed per plan of care.</p> <p><b>Completion Date 9-17-15</b></p> <p>No other residents were affected by</p>	09/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The clinical record for Resident #42 was reviewed on 8/12/15 at 9:42 a.m. Resident #42 had clinical diagnoses including, but not limited to, mild dementia, anxiety, and depressive disorder. A quarterly MDS (Minimum Data Set) assessment, dated 7/20/15, indicated Resident #42 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated no cognitive impairment.</p> <p>A care plan, dated 8/6/15, for a diagnosis of major depression indicated a psychological consult should be obtained.</p> <p>Resident #42 had a physician's order which indicated 3/1/12 (start date), Citalopram (an antidepressant) 20 mg (milligram) 1 (one) tablet orally daily for depression. Resident #42 had a physician's order on 11/14/14, to reduce the Citalopram 10 mg 1 tablet orally daily for depression.</p> <p>Resident #42 had a physician's order which indicated 3/1/12 (start date), for Seroquel (an antipsychotic) 25 mg 1 tablet orally daily for depression and anxiety; and a physician's order, dated 3/20/15 (start date), for Seroquel 12.5 mg orally at bedtime for major depressive disorder.</p>		<p>the deficient practice and through corrective action will ensure that careplans are followed.</p> <p><b>Completion Date 9-17-15</b></p> <p>Inservice of SS Director and assistant regarding careplans and psychological counseling protocols.</p> <p><b>Completion Date 9-17-15</b></p> <p>SS will keep a log of ordered psychological consult orders and track to ensure they get completed.</p> <p><b>Completion Date 9-17-15</b></p> <p><b>Audits will be forwarded to QA committee monthly x3 and then quarterly.</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0325 SS=D Bldg. 00	<p>During an interview with the SS Director (Social Services Director) on 8/13/15 at 9:10 a.m., the SS Director indicated Resident #42 had not had a psychological evaluation. The SS Director indicated the resident had not had any behaviors.</p> <p>During an interview on 8/13/15 at 10:33 a.m., the Medical Records Director indicated Resident #42 had not had any behaviors and had not had a psychological evaluation.</p> <p>On 8/13/15 at 3:24 p.m., the Administrator provided the Guidelines for Care Plan Development, dated June 2013, and indicated the policy was the one currently being used by the facility. The policy indicated the care plans are developed to communicate resident care needs.</p> <p>3.1-35(g)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015	
NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to monitor a resident for significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident #56)</p> <p>Findings include:</p> <p>On 8/11/15 at 3:33 p.m., Resident #56's clinical record was reviewed. Resident #56 was admitted on 5/16/15.</p> <p>The Nutrition Assessment and Data Collection tool, dated 5/16/15, indicated Resident #56 weighed 153 pounds on admission. The tool further indicated the dietician would follow up as needed.</p> <p>The Vital Signs and Weight Record tool, indicated on 6/9/15, Resident #56 weighed 145 pounds. This was a 5.2 percent weight loss in 24 days.</p> <p>The care plans dated 5/26/15 through 8/27/15, indicated please review my overall weight trends at least monthly and make any necessary recommendations to my physician for approval should I experience any undesired weight change. The care plan also included, my weight should remain at a healthy range for me</p>	F 0325	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Resident #56 has been reviewed by RD with current weight and careplan of interventions to address weight loss with documented MD and family notification.</p> <p><b>Completion Date 9-17-15</b></p> <p>There were no other residents affected by the alleged deficient practice and through corrective actions will ensure that all residents weights and variances are monitored.</p> <p><b>Completion Date 9-17-15</b></p> <p>Nursing staff inserviced on documentation of weights when obtained and policy regarding significant weight variances.</p> <p><b>Completion Date 9-17-15</b></p> <p>DHS/Designee will calculate and monitor weights monthly to ensure</p>	09/17/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015	
NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 0329 SS=D Bldg. 00	<p>and be without any unwarranted significant weight change.</p> <p>The clinical record lacked documentation regarding the significant weight loss.</p> <p>On 8/12/15 at 1:47 p.m., the DON indicated the facility would monitor residents who had significant weight loss. The DON was unable locate any additional weight monitoring for Resident #56.</p> <p>On 8/13/15 at 3:24 p.m., the Administrator provided the "Guidelines for Weight Tracking" policy, dated June 2012, and indicated the policy was currently used by the facility. The policy included, but was not limited to, the physician, responsible party, and dietician shall be notified of a weight variance of greater than 5 percent.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate</p>				<p>that significant changes are followed up on.</p> <p><b>QA committee will review all residents with significant weight changes monthly x6 mos and quarterly thereafter.</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview the facility failed to ensure 3 of 5 residents reviewed, for unnecessary medications, were free of unnecessary medication, as an antipsychotic medication was administered without a medical indication. (Resident #1, #23, #42)</p> <p>Findings include:</p> <p>1. On 8/11/15 at 4:03 p.m. the resident record review for Resident #1 indicated diagnoses included, but not limited to, Alzheimer's, anxiety disorder, diabetes, hypertension, dementia, stenosis of lumbar. The resident was placed on Hospice on 10/23/14.</p>	F 0329	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Res #1 has had antipsychotic reduced for trial. <b>Completion Date 9-17-15</b> Res #42 has had antipsychotic reduced for trial. <b>Completion Date 9-17-15</b> Res #23 has had antipsychotic reduced for trial. <b>Completion Date 9-17-15</b> All residents receiving antipsychotic medications have the potential to be affected by the alleged deficient practice therefore DHS/designee have reviewed their medications and evaluation of necessity with physician for continued use. <b>Completion Date</b></p>	09/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015
NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The 7/27/15, monthly Nursing Assessment Record the resident was totally dependent on staff for grooming, eating, toileting, and up in gerichair. Resident #1 hardly ever spoke, but smiles at staff. Her mood and behavior indicated: fidgety/restless, poor appetite, trouble falling asleep, get anxious and yells out, responds to name.</p> <p>The August 2015, doctor's orders for medications indicated: On 10/13/13 (start date), an order for Risperdal (an antipsychotic) 0.5 mg (milligrams)1 tablet by mouth every evening for dementing illness with associated behavioral symptoms. On 5/6/11 (start date), an order for Gabapentin (a mood stabilizer and neuropathy medication)100 mg 1 capsule orally twice daily for diabetic neuropathy. On 6/22/15 (start date), an order for Lorazepam (anti-anxiety) 1 tablet twice daily for anxiety.</p> <p>On 10/2/14, a note was made from psychological services that indicated the resident had been placed on hospice services. Services with me are now closed.</p> <p>GDR (Gradual Dose Reduction) per pharmacy indicated:</p>		<p><b>9-17-15</b> Licensed nursing personnel and Social Service Director inserviced on indications for use of antipsychotic medication and lowest therapeutic dose as well as requirement for dosage reductions per OBRA guidelines. <b>Completion Date 9-17-15</b> SSD/Designee will monitor Diagnoses that support use of antipsychotic medication as well as active behaviors daily and when reduction of med is reasonable based on those behaviors to request from physician. <b>Completion Date 9-17-15</b> <b>Results of audits and complete list of those residents receiving antipsychotic medications will be forwarded to QA committee</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>11/14/13 no change - hallucinations</p> <p>4/17/14 no changes in Risperdal</p> <p>5/18/14 no changes to Risperdal</p> <p>10/9/14 no changes to Risperdal</p> <p>4/19/15 no changes to Risperdal</p> <p>On 10/14/14, the doctor's GDR reply indicated to continue current Risperdal order- benefits outweigh risk.</p> <p>On 08/12/2015 at 10:37 a.m., on 4/18/14 the pharmacy recommended a decrease of Risperdal, but the physician disagreed and wanted to continue with 0.5 mg dosage.</p> <p>On 8/12/15 at 1:00 p.m., an antipsychotic dose evaluation was faxed from Pharmacy to the doctors office was requested to consider reducing the dose of Risperdal 0.5 mg every evening. This dose had been in place since 10/10/13. Please consider decreasing the dosage to 0.25 mg, a fax was received from the doctors office, the same day which indicated, no change for dosage of Risperdal.</p> <p>The nursing assessment for May of 2015 and June of 2015, indicated no behaviors.</p> <p>On 8/12/15 at 9:18 a.m. during dressing change and peri- care the resident did not exhibit any behaviors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 8/10/15 at 2:00 p.m., an observation and attempted conversation with Resident #1 revealed the resident was pleasant and trying to communicate, but could not.</p> <p>On 08/11/2015 4:16 p.m., an observation of Resident #1 was sleeping.</p> <p>On 8/12/2015 9:28 a.m., an observation of care was observed for Resident #1. The resident was pleasant, but appeared in pain when being turned and positioned. The resident had severe contractures of legs unable to straighten.</p> <p>On 7/8/15, Resident First Conference Note mood behavior indicated no specific behaviors noted. Resident #1 was on Risperdal and Ativan (lorazepam).</p> <p>The MDS (Minimum Data Set) assessment for behaviors dated 3/30/15 through 6/28/15, indicated no behaviors.</p> <p>Review of nurses notes dated 6/28/14, indicated the nurses notes for Resident #1 exhibited increased anxiety yesterday, stating repeatedly, "Oh dear", attempts were unsuccessful to calm resident.</p> <p>A Behavior Tracking sheet for August 2015, completed by CNA's was received</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>on 8/12/15 at 1:00 p.m., from RN #1, which indicated no behaviors.</p> <p>An Initial Psychosocial Assessment on 9/23/14, indicated Resident #1 had dementia with behaviors, repeating "oh boy."</p> <p>On 3/26/15, the nurses notes indicated some tearfulness.</p> <p>On 08/12/2015 11:16 a.m., RN #1 indicated the medication was used for crying, which Resident #1 doesn't do anymore. She could not remember if they had ever tried to reduce the dose and had to restart or not.</p> <p>On 08/12/2015 2:56 p.m., interview with Director of Nursing indicated they had been trying to get the doses reduced but have not been able to. She also indicated she recognized that benefit versus risk was not an adequate reason for no dose reduction.</p> <p>On 9/13/14, SS notes indicated resident repeats "Oh boy, Oh boy" when upset.</p> <p>3/30/15, Social Service (SS) notes indicated resident cried out.</p> <p>A 4/29/15, SS progress note indicated resident was at nursing station, alert,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>making repetitive noise and stationary. Resident was smiling at worker, 1:1 given, reassured resident and held her hand. Resident responded by smiling.</p> <p>On 08/12/2015 1:40 p.m., interview with Social Services indicated the doctor declined recommendations, because Resident #1 repeats "oh dear" and had anxiousness and the Risperdal had alleviated that behavior. SS thought they had tried to reduce medication dosage and also reiterated Resident #1 became frightful, anxious, saying "oh dear" and they don't want her in that state. The Pharmacist was being contacted to see if any dose reductions had been tried in the past. Received from Social Services notes on documentation of behaviors, which indicated no behaviors.</p> <p>2. During an observation on 8/10/15 at 2:45 p.m., Resident #42 was observed to be in his room sitting in a recliner. Resident #42 indicated he attended activities and led the morning exercise class daily and also lead the rosary group every Friday for the residents. The only difficulty he had was with insomnia.</p> <p>The clinical record for Resident #42 was reviewed on 8/12/15 at 9:42 a.m. Resident #42 had clinical diagnoses including, but not limited to, mild dementia, anxiety, and depressive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>disorder. A quarterly MDS (Minimum Data Set) assessment, dated 7/20/15, indicated Resident #42 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated no cognitive impairment. The MDS further indicated the resident had not had any behaviors.</p> <p>Resident #42 had a physician's order which indicated 3/1/12 (start date), for Citalopram (an antidepressant) 20 mg (milligram) 1 (one) tablet orally daily for depression. Resident #42 had a physician's order, dated 11/14/14, to reduce the Citalopram 10 mg 1 (one) tablet orally daily for depression.</p> <p>Resident #42 had a physician's order which indicated 3/1/12 (start date), for Seroquel (an antipsychotic) 25 mg 1 tablet orally daily for depression and anxiety. Resident #42 had a physician's order, dated 3/20/15, for Seroquel 12.5 mg orally at bedtime for major depressive disorder.</p> <p>The "Medication Regimen Review" indicated a gradual doses reduction had been requested in 9/11/14, for the Seroquel. The review indicated there was no change per the physician for the medication.</p> <p>The "Initial Psychosocial</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Assessment/MDS Supportive Documentation Tool &amp; Progress Note", dated 8/3/15, 7/20/15, 4/21/15, 3/16/15, 12/16/14, 9/30/14, and 9/17/14, indicated Resident #42 had no psychotic behaviors.</p> <p>During an interview on 8/12/15 at 2:40 p.m., the Director of Social Services indicated she thought a Gradual Dose Reduction (GDR) for the Seroquel had been attempted in the past and the resident became, "fidgety." The Director of Social Services indicated she would need to locate the GDR attempt.</p> <p>During an interview on 8/13/15 at 9:10 a.m., the Director of Social Services indicated Resident #42 had not had any behaviors for a long time and had not had any behavior tracking. The physician had indicated Resident #42 had been diagnosed with a "major depressive disorder" when the GDR for the Seroquel was done on 3/20/15. The resident had never had a psychiatric evaluation completed. The facility had been trying to educate the facility physicians recently regarding GDR and psychotropic medications.</p> <p>3. Resident #23 was observed on 8/12/15 at 1:35 p.m., resting quietly in bed with her eyes closed.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The clinical record of Resident #23 was reviewed on 8/12/15 1:36 p.m. The record indicated the diagnoses of Resident #23 included, but were not limited to, dementia, hypertension, glaucoma, osteoporosis, low blood sugar, breast cancer, basal cell carcinoma, depression, chronic sinusitis, esophageal stricture, mild gastritis, osteoarthritis, recurring bronchitis, chronic allergies, peripheral vascular disease, syncopal episode, bradycardia, dehydration, delusions, and anxiety.</p> <p>A physician's order dated 4/7/14 (start date), indicated an order for Risperdal (antipsychotic medication) 0.25 mg (milligrams) 1 tablet orally at bedtime.</p> <p>No behaviors were documented in the nurses notes between the dates of 4/24/15 through 8/1/15.</p> <p>Monthly nursing assessments for May and June of 2015, for behavior risk indicated no plan of care was required at this time and continue to assess/observe.</p> <p>The last psychosocial assessment/MDS (Minimum Data Set) supportive documentation tool and progress note dated 5/30/15, 3/1/15, 12/22/14, and 9/23/15, indicated the resident had no episodes of psychosis in the past 7 days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The quarterly review MDS assessment dated 5/30/15, indicated Resident #23 had severe cognitive impairment.</p> <p>An interview with RN #2 on 8/12/15 at 3:07 p.m., indicated that she had not known the resident to have had any behaviors for a long time.</p> <p>On 8/13/15 at 11:13 a.m., the Administrator provided a policy on psychoactive medications and indicated it was the current facility policy. The policy indicated:</p> <ol style="list-style-type: none"> <li>1. The resident shall receive psychotropic medications only if designated medically necessary by the prescribe, with appropriate diagnosis or documentation to support its usage.</li> <li>2. Regular review for continued need,</li> <li>3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing.</li> <li>4. A GDR will be attempted for two separate quarters, gradual dose reduction must be attempted annually thereafter.</li> </ol> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015	
NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 0371 SS=F Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure the kitchen and kitchen equipment were clean, that food was prepared and served under sanitary conditions, that food was stored properly in the walk in freezer, and that hand washing was performed by the kitchen staff as indicated by facility policy. This had the potential to affect 62 of 62 residents who resided in the building.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 8/10/15 at 9:35 a.m., the following were observed:</p> <ol style="list-style-type: none"> <li>1. A bag of mashed potato bites were opened and undated.</li> <li>2. A bag of "Wing Dings" in the freezer was opened and undated.</li> <li>3. A box of chicken thighs were open to air in the freezer.</li> <li>4. A box of chicken wings were open to air in the freezer.</li> </ol>	F 0371	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. The residents suffered no ill effects from the alleged deficiencies. Dietary staff was in-serviced on hand washing, proper equipment cleaning, proper sequence of serving meals/trays and labeling and storage of food in the walk-in freezer. Completion Date: 9-17-2015 All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing, will ensure the campus procures food from sources approved or considered satisfactory by Federal, State and local authorities and stores, prepares, distributes and serves food under sanitary conditions. Completion Date: 9-17-2015 All dietary employees have been in-serviced on labeling and storing food, guidelines for hand washing and proper equipment</p>	09/17/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>5. A box of biscuits were open to air in the freezer.</p> <p>6. A box of catfish fillets were open to air in the freezer.</p> <p>7. A box of breaded cod was open to air in the freezer.</p> <p>8. A bag of french fries was opened and undated.</p> <p>9. Grease and food build up were observed on the grill.</p> <p>10. Hand washing was performed by the staff less than 20 seconds.</p> <p>11. On 8/13/15 at 11:15 a.m., during a food preparation observation, Cook #1 was observed to wash her hands for 10 seconds . She was observed to do the same at 11:27 a.m., for 7 seconds. Cook # 2 was observed to wash her hands for 1 second at 11:17 a.m., she was observed to do the same at 11:29 a.m. for 5 seconds, and 12:10 p.m. for 6 seconds.</p> <p>During an interview on 8/13/15 at 9:36 a.m., the Director of Food Services indicated foods that have been opened should be dated and resealed. The kitchen had a cleaning schedule that is to be followed.</p> <p>During an interview on 8/18/15 at 9:35 a.m., the Assistant Director of Nursing indicated the Director of Food Services does inservices on hand washing for the</p>		<p>cleaning procedures. Systemic changes are: All employees will complete a competency check off for hand washing, labeling and storage of food. Staff has been in-serviced on proper sequence of meal/tray service and in-serviced on Daily/Weekly/Monthly cleaning lists. Completion Date: 9-17-2015 ED/designee will complete unannounced audit of kitchen for proper labeling and storing of food, hand washing, equipment cleaning checklist and proper sequencing of serving meals/trays 5x a week for a month, then 3x a week for a month, then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>kitchen staff. She also indicated hand washing is part of the onboarding that employees do.</p> <p>On 8/13/15 at 10:40 a.m., the Director of Food Services provided policies on storage procedures, kitchen cleaning procedures, and hand washing and indicated the policies were currently being used by the facility. The storage procedure indicated that all foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn, items are labeled and dated. The hand washing procedure indicated to rub hands together vigorously to work up lather for a minimum of 20 seconds. Wash hands , forearms and pay special attention to fingernails. The a.m. weekly cleaning list indicated to clean stove every Wednesday, for night shift to clean the grill.</p> <p>11. During an observation on 8/10/15 at 12:10 p.m., the Community Service Representative (Comm. Ser. Rep.) was observed to be serving food in the main dining room. The Community Service Representative was observed to obtained a plate of food and carry it to a table by the rims of the plate. The Community Service Rep was also observed to handle glasses by the rims. During the meal</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>service the Community Service Rep was observed to open and close his jacket and hold his hands below his waist in front of his pants. No hand hygiene was performed.</p> <p>12. During an observation in the Restorative dining room on 8/10/15 at 12:05 p.m., CNA #1 was observed to serve food to Resident #58 at a table close to the hall door( first served). CNA #1 served food to Resident #1, Resident #59, and Resident #15 at the table next to the window. CNA #1 was observed to then serve Resident #29 at the table which CNA #1 had served first. A plate of uneaten food was observed to be sitting on the first served table. CNA #1 indicated the food was for Resident #13 who had not arrived in the restorative dining room. CNA #1 was observed to request a co-worker to obtain Resident #13.</p> <p>During an interview with the DON (Director of Nursing) on 8/13/15 at 11:25 a.m., the DON indicated the residents should be served at the same table before serving residents at another table.</p> <p>On 8/13/15 at 3:24 p.m., the Administrator provided the Sequence of Meals/Trays and Tray Cards policy, dated 2009, and indicated the policy was the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0465 SS=E Bldg. 00	<p>one currently being used by the facility. The policy indicated meals and trays should be delivered to the same location or table at the same time.</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 8 of 35 rooms observed in stage 1 sample. ( Room 107,111, 206, 305 ,304, 306, 310, 312 ).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation on 8/10/15 at 11:22 a.m., urine odor was observed in room 111 in the living area and the bathroom. The same was observed on 8/12/15 at 8:57 a.m.</li> <li>2. During an observation on 8/10/15 at 11:32 a.m., Room 107 had a strong urine odor. The same odor remained on 8/12/15 at 1:43 p.m.</li> </ol>	F 0465	<p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Rooms 107, 111, 206, 304, 305, 312, 306 and 310 including their bathrooms were cleaned, had the caulking redone and walls repaired as well as resident care items properly stored and labeled.</p> <p><b>Completion Date 9-17-15</b></p>	09/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Room 206 was observed on 8/11/15 at 10:21 a.m. The wall over the bathroom sink was in the process of being repaired. On 8/13/15 at 10:30 a.m. the room was unchanged.</p> <p>4. Room 304 was observed on 8/11/15 at 9:17 a.m. Commode screws were uncovered. On 8/13/14 at 10:35 a.m. the room was unchanged.</p> <p>5. On 8/10/15 at 11:19 a.m., Room 305 was observed. The caulking around the bathroom sink was observed to be cracked. On 8/12/15 at 1:37 p.m., the same was observed.</p> <p>6. On 8/10/15 at 3:09 p.m., Room 312 was observed. The bathroom sink was observed to be cracked. On 8/13/15 at 10:28 a.m., the same was observed.</p> <p>7. On 8/11/15 at 9:07 a.m., Room 306 was observed. The paint behind the resident's recliner was observed to be chipped and peeling. On 8/12/15 at 1:37 p.m., the same was observed.</p> <p>8. On 8/11/15 at 11:17 a.m., Room 310 was observed. In the bathroom, two unlabeled denture cups were observed. On 8/12/15 at 1:37 p.m., the same was observed.</p>		<p>Environmental Services Director will have directed inservice on work order system that includes filling them out upon completion of room inspection when routine room cleaning is finished.</p> <p><b>Completion Date 9-17-15</b></p> <p>Systemic change is that housekeeping will add maintenance issues found to deep clean checklist.</p> <p><b>Completion Date 9-17-15</b></p> <p>Housekeeping and Maintenance staff inserviced on this process and maintenance supervisor will check work orders daily for schedule of completion.</p> <p><b>Completion Date 9-17-15</b></p> <p>Executive Director will randomly inspect 3 rooms per week for environmental issues and compliance with process.</p> <p><b>Environmental audits will be forwarded to QA committee monthly for review.</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000  Bldg. 00	<p>On 8/13/15 at 10:28 a.m., CNA #2 indicated if resident equipment was in disrepair, the nurse was notified and a work order was submitted.</p> <p>On 8/17/15 at 11:10 a.m., the Administrator provided an Environmental Policy and Procedures for Room Cleaning and indicated it was the current policy being used by the facility. The policy indicated the room cleanliness was the top priority of the ES department, and daily cleaning in the rooms and restrooms. The procedure indicated each bathroom was to be cleaned and disinfected. The disinfecting of the bathrooms was to be the first task when the resident's room was entered. Each room was to be checked daily by ES team or Aids.</p> <p>3.1-19(f)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 33 Sample: 7</p>	R 0000	This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2015
NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
R 0349  Bldg. 00	<p>This State finding is cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were signed for 1 of 7 residents reviewed. (Resident #7)</p> <p>Findings include:</p> <p>On 8/17/15 at 1:45 p.m., Resident #7's clinical record was reviewed. Resident #7 was discharged on 4/11/15.</p> <p>Resident #7's physician recapitulation orders had not been signed since 7/9/14.</p> <p>On 8/17/15 at 2:50 p.m., the Medical Records Coordinator (MRC) was interviewed. The MRC indicated the</p>	R 0349	<p>credible allegation of compliance.</p> <p>This Plan of Correction for Survey Event ID4E5S11 is submitted under Federal and State regulations and statutes applicable to long term care providers. We request this 2567 Plan of Correction serve as our credible allegation of compliance. Resident #7 has had orders signed.</p> <p><b>Completion Date 9-17-15</b></p> <p>There were no other residents affected by the noncompliance and through electronic update will ensure that all recap orders are signed timely for this physician.</p> <p><b>Completion Date 9-17-15</b></p>	09/17/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVER OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>physician's recapitulation orders should have been signed again in February of 2015.</p> <p>On 8/17/15 at 3:40 p.m., the MCR provided the History and Physical dated 4/1/15. The MCR was unable to provide signed physician recapitulation orders since 7/9/14.</p>		<p>Assisted Living Manager will be in serviced on requirements of signing physician orders.</p> <p><b>Completion Date 9-17-15</b></p> <p>Medical Records/designee will perform audits of physician orders monthly for 6 months and then quarterly.</p> <p><b>Results of audits will be forwarded to QA committee monthly x6 months and then quarterly for review and further suggestion.</b></p>	