STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

(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
F000000	This visit was for the Investigation of Complaint IN00147386. Complaint IN00147386 - Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225, and F226. Survey dates: April 16 and 17, 2014 Facility number: 012448 Provider number: 155785 AIM number: 201039500 Survey team: Anne Marie Crays RN Census bed type: SNF: 46 SNF/NF: 14 Residential: 69 Total: 129 Census payor type: Medicare: 17 Medicaid: 9 Other: 103 Total: 129 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on April 21, 2014 by Jodi Meyer, RN	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies.This plan of correction is prepared and executed solely because it is required by Federal and state law.This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a complaint survey review concluding on April 17, 2014.Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before May 9, 2014.We respectfully request a desk review for compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712	

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F000223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from physical abuse, in that a nurse was witnessed slapping at a resident, for 1 of 6 residents reviewed for abuse, in a sample of 7. Resident B Findings include: 1. On 4/16/14 at 10:10 A.M., the Executive Director (ED) provided Indiana State Department of Health Incident Report Forms. An "Initial report" included: "Incident Date: March 16, 2014, Incident Time: no exact time, Resident Name: [Resident B]...Diagnosis: Dementia with Behavior Disturbances, Bipolar with Psychotic Features...Staff Name: [LPN # 1], Brief Description of Incident: Family member of another resident located on [name of unit] reported to a charge nurse on this date (March 27, 2014) and the charge nurse reported to the Executive Director. This reporter phoned family member which stated, 'Sunday before last she heard a loud commotion and went to investigate. The family member witnessed charge nurse [LPN # 1] pushing and hitting at [Resident B]. She	F000223	Resident B no longer resides at the campus. LPN #1 was suspended immediately following the reported allegation to the ED on March 26, 2014 and terminated from the campus following the investigation. All residents have the potential to be affected by the alleged deficient practice therefore through systematic changes stated below the campus will ensure residents have the right to be free from verbal, secual, physical and mental abuse, corporal punishment and involuntary seclusion. ADDENDUM: All alert and oriented residents have been interviewed to determine if abuse issues have occured or if they have witnessed abuse involving another resident. All campus staff have been in-serviced regarding the definition of abuse and requirements of reporting all allegations of abuse and neglect immediately to the Executive Director. Systemic change is Campus to complete a quarterly in-service concerning abuse and neglect procedural guidelines.	05/09/2014

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WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

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	stated [Resident B] was hitting at nurse and nurse was hitting back at resident around resident's shoulder, hands and upper body. There was one other resident present, however she has a dementia diagnosis and does not recall incident. The location of this incident was in the living room area located directly in front of the nurses station. [LPN # 1] proceeded to administer medication to [Resident B] which resident immediately spit back at her. Nurse returned back to nurses station and sat down...Immediate Action Taken: [LPN # 1] was suspended from all duties on this date...." An ISDH "Follow-up Report" included: "[LPN # 1's] employment has been terminated...." On 4/16/14 at 1:00 P.M., RN # 1 was interviewed. RN # 1 indicated the daughter of Resident G approached her and was discussing Resident G. She indicated during their conversation, the daughter told her approximately 1 week prior, Resident B was hitting at LPN # 1 and "[LPN # 1] was hitting him back." RN # 1 indicated she informed the family member that she would have to tell her ED, which she did immediately. RN # 1 indicated Resident G had since passed away. On 4/16/14 at 4:00 P.M., during interview with the ED, she indicated as soon as she heard the abuse allegation, she began her investigation and suspended LPN # 1. She indicated LPN # 1 was then terminated. 2. On 4/16/14 at 9:35 A.M., the Executive Director provided the current facility policy on "Abuse and Neglect Procedural Guidelines," revised 9/16/11. The policy included: "[Name of corporation] has developed and implemented processes, which strive to		ED or her designee will administer a post test to two (2) random campus staff to verify understanding of abuse prevention procedure 5x a week for one month, 3x per week for one month and then one time weekly thereafter with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for review and further suggestions or comments.	

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	ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions: Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish...Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc....." This Federal tag relates to Complaint IN00147386. 3.1-27(a)(1)			
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).			

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	The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a staff member who received an allegation of physical abuse by a nurse towards a resident immediately reported the allegation to the Executive Director, for 1 of 6 residents reviewed for abuse, in a sample of 7. Resident B Findings include: 1. On 4/16/14 at 10:10 A.M., the Executive Director (ED) provided Indiana State Department of Health Incident Report Forms. An "Initial report" included: "Incident Date: March 16, 2014, Incident Time: no exact time, Resident Name: [Resident B]...Diagnosis: Dementia with Behavior Disturbances, Bipolar with Psychotic Features...Staff Name: [LPN # 1], Brief Description of Incident: Family member of another resident located on [name of unit] reported to a charge nurse on this date (March 27, 2014) and the charge nurse reported to the Executive Director. This	F000225	Resident B no longer resides at the campus. LPN #1 was suspended immediately following the reported allegation to the ED on March 26, 2014 and terminated from the campus following the investigation. All residents have the potential to be affected by the alleged deficient practice therefore through systematic changes stated below the campus will ensure all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). ADDENDUM: Alert and oriented residents on Health Center were interviewed regarding issues of	05/09/2014

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	reporter phoned family member which stated, 'Sunday before last she heard a loud commotion and went to investigate. The family member witnessed charge nurse [LPN # 1] pushing and hitting at [Resident B]. She stated [Resident B] was hitting at nurse and nurse was hitting back at resident around resident's shoulder, hands and upper body. There was one other resident present, however she has a dementia diagnosis and does not recall incident. The location of this incident was in the living room area located directly in front of the nurses station. [LPN # 1] proceeded to administer medication to [Resident B] which resident immediately spit back at her. Nurse returned back to nurses station and sat down...Immediate Action Taken: [LPN # 1] was suspended from all duties on this date...." On 4/16/14 at 1:00 P.M., RN # 1 was interviewed. RN # 1 indicated the daughter of Resident G approached her and was discussing Resident G. She indicated during their conversation, the daughter told her approximately 1 week prior, Resident B was hitting at LPN # 1 and "[LPN # 1] was hitting him back." RN # 1 indicated she informed the family member that she would have to tell her ED, which she did immediately. RN # 1 indicated Resident G had since passed away. On 4/16/14 at 1:20 P.M., CNA # 1 was interviewed. CNA # 1 indicated she worked week-ends with LPN # 1. CNA # 1 indicated she was not working on March 15 or 16, 2014, but that "[Resident G's] daughter told me about it." CNA # 1 indicated on approximately March 22 or March 23, Resident G's daughter informed her that "it had been a bad weekend. [Resident B] swatted at [LPN # 1] and [LPN # 1] swatted		abuse or witnessed abuse. Incident reports were reviewed for the prior two months with particular focus on bruising and injuries of unknown origin. All campus staff have been in-serviced regarding the definition of abuse and requirements of reporting all allegations of abuse and neglect immediately to the Executive Director. Systemic change is Campus to complete a quarterly in-service concerning abuse and neglect procedural guidelines. ED or her designee will administer a post test to two (2) random campus staff to verify understanding of abuse prevention procedure 5x a week for one month, 3x per week for one month and then one time weekly thereafter with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for review and further suggestions or comments.	

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	back at him. He spit his meds out, and she went back to the nurses station and played games on her phone." CNA # 1 indicated, "I know I should have told [the Director of Nursing, or DON], but I told the daughter she should report that to the DON." On 4/16/14 at 4:00 P.M., during interview with the ED, she indicated as soon as she heard the abuse allegation, she began her investigation and suspended LPN # 1. She indicated LPN # 1 was then terminated. The ED indicated she counseled CNA # 1 regarding the immediate reporting of an abuse allegation. 2. On 4/16/14 at 9:35 A.M., the Executive Director provided the current facility policy on "Abuse and Neglect Procedural Guidelines," revised 9/16/11. The policy included: "[Name of corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions: Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish...Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc...Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...IMMEDIATELY notify the Executive Director...." This Federal tag relates to Complaint IN00147386.			

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F000226 SS=D	3.1-28(c) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a staff member who received an allegation of physical abuse by a nurse towards a resident, followed the policy by immediately reporting the allegation to the Executive Director, for 1 of 6 residents reviewed for abuse, in a sample of 7. Resident B Findings include: 1. On 4/16/14 at 10:10 A.M., the Executive Director (ED) provided Indiana State Department of Health Incident Report Forms. An "Initial report" included: "Incident Date: March 16, 2014, Incident Time: no exact time, Resident Name: [Resident B]...Diagnosis: Dementia with Behavior Disturbances, Bipolar with Psychotic Features...Staff Name: [LPN # 1], Brief Description of Incident: Family member of another resident located on [name of unit] reported to a charge nurse on this date (March 27, 2014) and the charge nurse reported to the Executive Director. This reporter phoned family member which stated, 'Sunday before last she heard a loud commotion and went to investigate. The family member witnessed charge nurse [LPN # 1] pushing and hitting at [Resident B]. She stated [Resident B] was hitting at nurse and	F000226	Resident B no longer resides at the campus. LPN #1 was suspended immediately following the reported allegation to the ED on March 26, 2014 and terminated from the campus following the investigation. All residents have the potential to be affected by the alleged deficient practice therefore through systematic changes stated below the campus has develooped and implemented written policies and procedures that prohibit mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. All campus staff have been in-serviced regarding the definition of abuse and requirements of reporting all allegations of abuse and neglect immediately to the Executive Director.Systemic change is Campus to complete a quarterly in-service concerning abuse and neglect procedural guidelines.ED or her designee will administer a post test to two (2) random campus staff to verify understanding of abuse prevention procedure 5x a week for one month, 3x per week for	05/09/2014

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	nurse was hitting back at resident around resident's shoulder, hands and upper body. There was one other resident present, however she has a dementia diagnosis and does not recall incident. The location of this incident was in the living room area located directly in front of the nurses station. [LPN # 1] proceeded to administer medication to [Resident B] which resident immediately spit back at her. Nurse returned back to nurses station and sat down...Immediate Action Taken: [LPN # 1] was suspended from all duties on this date...." On 4/16/14 at 1:00 P.M., RN # 1 was interviewed. RN # 1 indicated the daughter of Resident G approached her and was discussing Resident G. She indicated during their conversation, the daughter told her approximately 1 week prior, Resident B was hitting at LPN # 1 and "[LPN # 1] was hitting him back." RN # 1 indicated she informed the family member that she would have to tell her ED, which she did immediately. RN # 1 indicated Resident G had since passed away. On 4/16/14 at 1:20 P.M., CNA # 1 was interviewed. CNA # 1 indicated she worked week-ends with LPN # 1. CNA # 1 indicated she was not working on March 15 or 16, 2014, but that "[Resident G's] daughter told me about it." CNA # 1 indicated on approximately March 22 or March 23, Resident G's daughter informed her that "it had been a bad weekend. [Resident B] swatted at [LPN # 1] and [LPN # 1] swatted back at him. He spit his meds out, and she went back to the nurses station and played games on her phone." CNA # 1 indicated, "I know I should have told [the Director of Nursing, or DON], but I told the daughter she should report that to the DON."		one month and then one time weekly thereafter with results forwarded to the QA committee monthly times 6 months and quarterly thereafter for review and further suggestions or comments.	

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	On 4/16/14 at 4:00 P.M., during interview with the ED, she indicated as soon as she heard the abuse allegation, she began her investigation and suspended LPN # 1. She indicated LPN # 1 was then terminated. The ED indicated she counseled CNA # 1 regarding the immediate reporting of an abuse allegation. 2. On 4/16/14 at 9:35 A.M., the Executive Director provided the current facility policy on "Abuse and Neglect Procedural Guidelines," revised 9/16/11. The policy included: "[Name of corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...Definitions: Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged)...This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish...Physical abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc...Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...IMMEDIATELY notify the Executive Director...." This Federal tag relates to Complaint IN00147386. 3.1-28(a)			