STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING _____ B. WING _____	C 05/09/2024

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
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00432902, IN00433296, and IN00431331.

Complaint IN00432902 - Federal/State deficiencies related to the allegations are cited at F689.

Complaint IN00433296 - Federal/State deficiencies related to the allegations are cited at F689.

Complaint IN00431331- Federal/State deficiencies related to the allegations are cited at F689.

Survey dates: May 8 and 9, 2024

Facility number: 012448
Provider number: 155785
AIM number: 201039500

Census Bed Type:
SNF/NF: 22
SNF: 24
Residential: 51
Total: 97

Census Payor Type:
Medicare: 14
Medicaid: 19
Other: 13
Total: 46

This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed May 13, 2024.

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

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure effective supervision was provided to a cognitively impaired, dependent resident to prevent falls and failed to ensure the bed was in low position with a fall mat in accordance with the plan of care to prevent injury for 1 of 3 residents reviewed for falls. This deficient practice resulted in Resident B experiencing an unwitnessed fall from the bed, landing on the floor, and sustaining a left clavicle fracture. (Resident B) Finding includes: On 5/8/24 at 8:41 a.m., Resident B was observed sitting in a wheelchair in his room. On 5/8/24 at 9:39 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, fracture of unspecified part of left clavicle, subsequent encounter for fracture with routine healing, unspecified fall, subsequent encounter, dysphagia following cerebral infarction, contracture, left hip, contracture left knee, contracture right knee, vascular dementia.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

A Quarterly MDS (Minimum Data Set) assessment, dated 1/12/24, indicated Resident B's cognition was severely impaired, the resident required substantial assistance of staff to roll left and right for bed mobility and was dependent on staff for moving from lying to sitting on side of bed.

The Care Plans included, but were not limited to: Resident is at risk for falls related to a history of falls, CVA (cerebral vascular accident), weakness, unsteady, cognitive impairment, dementia. The interventions included, but were not limited to, low bed with fall mat next to bed, initiated 6/20/22.

A Fall Risk Review, dated 10/31/23, indicated a fall risk score of 20, indicating a high risk for falls.

A Progress Note, dated 2/8/24 at 3:29 p.m., indicated CNA called a nurse to resident's room. The resident was noted on the floor beside bed lying on his right side with a skin tear to left elbow. There were no signs or symptoms of pain noted. POA (Power of Attorney) was called and a message was left to the return call. Neurological checks initiated. Nursing Home Triage (NHT) notified.

A Progress Note, dated 2/9/24 at 1:30 p.m., indicated staff reported dark bruising on residents left shoulder area. Resident yelling out a lot during ADL's (Activities of Daily Living) this morning during care. NHT called to obtain order for left shoulder x-ray. Area has some swelling, pulses present, circulation normal, able to move hands.

A Progress Note, dated 2/9/24 at 5:24 p.m.,

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F 689	Continued From page 3	F 689		

indicated the nurse called POA to report the results of the x-ray. No answer, had to leave a message to return call to facility.

A Progress Note, dated 2/9/24 at 8:00 p.m., indicated NHT called with orders from Nurse Practitioner. Ok to order x-ray of shoulder and clavicle (collar bone) left arm. If family wants to can send to ED (Emergency Department) or be seen by orthopedic partners on Monday. Family calling other family at this time to discuss what they want to do.

A Progress Note, dated 2/9/24 at 8:13 a.m., indicated the family has decided to have resident go to the ED for assessment and treatment.

A Progress Note, dated 2/14/24 at 3:24 a.m., indicated the Interdisciplinary Team (IDT) note on 2/8/24 resident had a fall from bed. Root cause: Resident rolled out of bed and noted on floor. Intervention: Nurse to ensure residents placement in bed. On 2/9/24 resident was sent to ER per family request related to pain. Resident returned with new order for Lortab (pain medication).

On 5/8/24 at 12:36 p.m., a State Reportable incident was reviewed for Resident B. The report indicated Resident B had rolled out of bed and sustained a clavicle fracture.

During an interview, on 5/9/24 at 9:04 a.m., the DON (Director of Nursing) indicated she observed the resident's bed to not be in low position with a fall mat immediately after the fall. The DON indicated the post-fall investigation identified that CNA 1 exited the resident's room without ensuring the bed was in the low position

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F 689	Continued From page 4	F 689		

with a fall mat next to it and the resident experienced an unwitnessed fall.

On 5/9/24 at 9:20 a.m., the DON provided typed statement forms for CNA 1 and CNA 2. The statements included, but were not limited to:

Date of interview - 2/9/24 CNA 1
"I started working 100/300 hall mid shift. Around 3pm [sic] I went in and helped [CNA 2] do a check and change on [Resident B] due to him having BM [bowel movement]. We cleaned him up and got everything out of his room. When we left room, he was in the middle of the bed and his knees were facing the tv. [CNA 2] went over to Skilled Legacy. When we left the room bed was how I originally walked in, bed was in highest position and no mat was put down. It was about 20-30 min [minutes] later and I was walking back down the 300 hall, and I overheard [Resident B] yell "help". I went into the room and seen he was on the floor by the bed. I turned on the call light and got the nurse [DON]. The nurse came in and did an assessment."

Date of interview 2/13/24 CNA 2
"[CNA 2] states she went into [Resident B] room with [CNA 1] to check and change him. [Resident B] was in a wheelchair at the time, and we used the Hoyer lift. After checking and changing him I took out the trash. [CNA 1] was still in the room finishing up cleaning. Then I went to skilled legacy to finish out my shift. I thought [CNA 1] knew that his bed was to be in the lowest position and mat on floor."

On 5/8/24 at 11:18 a.m., CNA 3 indicated resident fall interventions are found on assignment sheets, if there was a change, the nurse lets them know.

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F 689	Continued From page 5 On 5/9/24 at 11:38 a.m., the Clinical Support Nurse provided the current policy for fall management program guidelines with a review date of 12/31/23. The policy included, but was not limited to, care plan interventions should be implemented that address the resident's risk factors. On 5/9/24 at 11:38 a.m., the Clinical Support Nurse provided the current policy for Comprehensive Care Plan Guideline with a revision date of 5/22/18. The policy included, but was not limited to, pertinent care plan approaches are communicated to the nursing staff per the 24-hour CRCA (CNA) assignment or the care tracker profile depending on campus preference. The deficient practice was corrected on 2/13/24 after the facility implemented a systemic plan that included the following actions: the facility inserviced the staff on ensuring fall interventions were implemented and ongoing monitoring of ensuring fall interventions were in place. This citation relates to Complaints IN00432902, IN00433296, IN00431331. 3.1-45(a)(1)	F 689		