STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155723	A. BUILDING 00 B. WING	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER POINTE HEALTH CAMPUS	3001 GALAXY DR EVANSVILLE, IN 47715

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the Investigation of Nursing Home Complaint IN00408526. This visit included the Investigation of Residential Complaint IN00408532. Complaint IN00408526 - No deficiencies related to the allegations are cited. Complaint IN00408532 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: May 17, 18, 2023 Facility number: 002280 Provider number: 155723 AIM number: 201068770 Census Bed Type: SNF/NF: 50 Residential: 42 Total: 92 Census Payor Type: Medicare: 15 Medicaid: 13 Other: 22 Total: 50 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 23, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of River Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0602 SS=D	483.12 Free from Misappropriation/Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan Shots	Executive Director	06/02/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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Bldg. 00	§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of their property for 1 of 4 residents reviewed for misappropriation. Narcotics were unaccounted for. (Resident B) Finding includes: On 5/17/23 at 10:00 A.M., facility reported incident reports were reviewed. An incident report dated 5/4/23 indicated "Facility unable to locate Norco 7.5/325 mg [milligram] [a narcotic pain medication] belonging to resident [resident name]. Facility immediately initiated investigation. Resident [resident name] had no adverse affects noted due to having current supply of pain medication ..." On 5/18/23 at 7:30 A.M., Resident B's clinical record was reviewed. Resident B was admitted 4/14/23. Diagnosis included, but were not limited to, multiple rib fractures. The most recent admission MDS (minimum data set) Assessment, dated 4/20/23, indicated Resident B was cognitively intact, and received scheduled and PRN (as needed) pain medication. Physician orders included, but were not limited to: hydrocodone-acetaminophen (Norco, a narcotic pain medication) 7.5-325 mg 1 tablet every 4 hours PRN, dated 4/14/23.	F 0602	1.Resident B was assessed and noted to have no adverse effects from alleged deficiency. 2.All residents have the potential to be affected by alleged deficient practice. Nurses and QMAs educated on facility narcotic policy and procedure and the signing in of narcotics upon delivery. Staff educated on abuse and neglect including misappropriation. 3.As a measure of ongoing compliance, the DHS or designee will reconcile pharmacy delivery of narcotics to ensure medications are accounted for and located in the narcotic boxes 5x week x 30 days, then 2x week x 30 days, then monthly x 4 months. 4.As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus acheives 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% complaince is met.	06/02/2023

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	Lidocaine adhesive patch (pain patch) 4%, 1 patch to right ribs once a day, dated 4/24/23 Resident B's electronic MAR (medication administration record) from 4/14/23 (admission date) through 5/18/23 indicated the following dates Norco was administered: 4/15/23 (1 dose) 4/16/23 (1 dose) 4/17/23 (1 dose) 4/22/23 (1 dose) 4/23/23 (1 dose) 4/27/23 (1 dose) 4/28/23 (1 dose) 4/29/23 (1 dose) 5/5/23 (1 dose) 5/8/23 (1 dose) On 5/18/23 at 8:04 A.M., the narcotic binder on the 600 Hall (Resident B's hall) was reviewed from April and May 2023. The binder indicated one empty medication card was removed from the medication card for Resident B on 5/9/23 that had contained Norco 7.5 mg. The card tracking sheet lacked information that any narcotic had been added to the medication cart at any time during Resident B's residency at the facility. The narcotic count sheets were reviewed from 4/29/23 through 5/18/23 and indicated the following dates and times a narcotic count was not completed by staff at change of shift: 4/29/23 at 2:00 P.M. 4/30/23 at 2:00 P.M. and lacked other documentation until 6:00 A.M. the following morning 5/1/23 unreadable after 6:00 P.M. 5/2/23 at 10:00 P.M. 5/3/23 at 10:00 P.M. 5/4/23 at 6:00 P.M. with no signature from incoming nurse at 6:00 A.M.			

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	5/10/23 at 10:00 P.M. 5/11/23 at 10:00 P.M. 5/12/23 at 6:00 P.M. 5/15/23 at 6:00 A.M. 5/16/23 at 10:00 A.M. 5/17/23 at 6:00 P.M. At that time, QMA (Qualified Medication Aide) 5 indicated those were all of the sign-in sheets for staff from April and May 2023. The Controlled Drug Use Record indicated Resident B received Norco on the following dates: 4/20/23 (1 dose) - not indicated on resident's MAR 4/21/23 (1 dose) - not indicated on resident's MAR 4/22/23 (1 dose) 4/23/23 (2 doses) 4/24/23 (2 doses) - not indicated on resident's MAR 4/25/23 (2 doses) - not indicated on resident's MAR 4/26/23 (2 doses) - not indicated on resident's MAR 4/27/23 (1 dose) 4/28/23 (3 doses) 4/29/23 (1 dose) 4/30/23 (1 dose) - not indicated on resident's MAR 5/1/23 (3 doses) - not indicated on resident's MAR 5/2/23 (2 doses) - not indicated on resident's MAR 5/3/23 (2 doses) - not indicated on resident's MAR 5/5/23 (1 dose) 5/6/23 (1 dose) - not indicated on resident's MAR 5/8/23 (2 doses) 5/9/23 (3 doses) - not indicated on resident's MAR 5/10/23 (3 doses) - not indicated on resident's MAR 5/11/23 (2 doses) - not indicated on resident's MAR 5/13/23 (1 dose) - not indicated on resident's MAR 5/14/23 (2 doses) - not indicated on resident's MAR 5/16/23 (2 doses) - not indicated on resident's			

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	MAR 5/17/23 (3 doses) - not indicated on resident's MAR On 5/18/23 at 9:37 A.M., a police report, dated 5/5/23, was reviewed and indicated on 5/4/23 a medication (hydrocodone 7.5-325 mg) quantity 30 was lost from the facility belonging to Resident B. During an interview on 5/18/23 at 7:54 A.M., Resident B indicated was in the facility due to broken ribs and pain. Resident B indicated while in the facility, had received pain pills and a pain patch. Resident B indicated did not ask for pain pills every day due to having a pain patch that took care of most of the pain. During an interview on 5/18/23 at 7:59 A.M., QMA 5 indicated a count of all narcotic medications should be completed by staff at every shift change, and should be signed off by the off-going staff as well as the on-coming staff in the narcotic medication binder located on the medication cart. QMA 5 indicated any time a resident was given a narcotic pain medication, the staff administering the medication should be signing off on the narcotic binder as well as the resident's electronic MAR that it was given. QMA 5 indicated when a new narcotic medication was received or when a medication was finished, staff should write it on the back of the sign sheet in the narcotic binder. During an interview on 5/18/23 at 8:22 A.M., the Director of Nursing (DON) indicated while making rounds on 5/5/23, the QMA on the 600 Hall requested assistance with medications. While the QMA was going through the narcotic binder, a folded paper came out of it. Upon review, the folded paper was a narcotic count sheet for Norco belonging to Resident B. At that time, the DON			

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	began a search for the medication card that would have come with the narcotic count sheet, but it could not be located. The DON indicated all other medication carts and medication storage rooms were searched, then the Administrator was notified when the medications could not be located. The DON indicated there was documentation that the medication was delivered from the pharmacy on 4/23/23, and all staff that had the medication cart keys were interviewed but no one recalled the medications being in the building that day. The DON indicated drug testing was completed for all staff that had access to the medication cart keys with all negative results and a police report was initiated. The DON indicated she thought a staff member might have dropped the missing medication card into the medsafe (a locked medication container) but had no way of looking inside to be sure. During an interview on 5/18/23 at 9:10 A.M., the DON indicated prior to 4/20/23, Resident B's medications came from the "med bank" because the pharmacy had not sent her medications cards yet, and all medications that were given could be viewed on the med bank documentation. At that time, the DON indicated staff was supposed to sign off on narcotic medications given in the resident's electronic MAR as well as in the binder, but sometimes the nurses were not very good at signing off for medications given in the resident's MAR. The med bank documentation for Resident B indicated Norco was administered once on 4/14/23 and once on 4/15/23. During an interview on 5/18/23 at 9:52 A.M., the Lead Pharmacist indicated when delivering narcotic pain medications, the receiving staff at the facility would sign off that they were received and keep a copy, as well as the delivery driver.			

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	The delivery driver would also sign in their own electronic system that it was delivered. At that time, she indicated RN (Registered Nurse) 7 was the staff member that signed off on receiving the medication for Resident B on 4/23/23. During an interview on 5/18/23 at 12:30 P.M., the DON indicated RN 7 was on the 600 Hall (Resident B's hall) at the time Resident B's medication went missing, and signed for the medication the day it was delivered early that morning. She indicated she had spoken with RN 7 about the medication missing, and RN 7 did not recall what had been done with the medication. On 5/18/23 at 9:37 A.M., a current abuse, neglect, and exploitation policy, reviewed 12/31/22, indicated "[Company name] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect ... [company name] as implemented processes in an effort to provide a comfortable and safe environment ..." and to be free from abuse, neglect, exploitation, and misappropriation of property. 3.1-28(a)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00408532. This visit included the investigation of Nursing Home Complaint IN00408526. Complaint IN00408532 - No deficiencies related to allegations were cited. Complaint IN00408526 - No deficiencies related to	R 0000	The submission of this plan of correction does not indicate an admission by River Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of River Pointe	

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	allegations were cited. Survey date: May 17, 18, 2023 Facility number: 002280 Residential Census: 42 River Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00408532.		Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	