STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE :	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155785	B. WI	B. WING		05/15/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				EICKHOFF RD		
WEST RI	VER HEALTH CAM	1PUS			VILLE, IN 47712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
5	This visit was for a	Recertification and State	F 00	000	The submission of this plan of		
	Licensure Survey. This visit included a State			.00	correction does not indicate an		
	Residential Licensu				admission by West River Heal	th	
		-			Campus that the findings and		
	Survey dates: May 9	9, 10, 11, 12, 15, 2023			allegations contained herein a	re	
					accurate, true representation of		
	Facility number: 01	2448			the quality of care provided, ar		
	Provider number: 1:	55785			the living environment provide	d to	
	AIM number: 2010	39500			the residents of West River He	alth	
					Campus. The facility recogniz	es	
	Census Bed Type:				its obligation to provide legally	and	
	SNF/NF: 19				medically necessary care and		
	SNF: 14				services to its residents in an		
	Residential: 52				economic and efficient manner.		
	Total: 85				The facility hereby maintains it is		
					in substantial compliance with		
	Census Payor Type:				state and federal requirements		
	Medicare: 8				governing the management of		
	Medicaid: 19				facility. It is thus submitted as		
	Other: 6				matter of statute only. The fac	sility	
	Total: 33				respectfully requests from the		
	These deficiencies	reflect State Findings cited in			department a desk review for		
	accordance with 410	-			substantial compliance. Corrections to be completed b	.,	
	accordance with 410	0 1110 10.2-3.1.			6/9/23.	у	
	Quality review com	pleted on May 24, 2023.			0/9/23.		
F 0582	483.10(g)(17)(18)	(i)-(v)					l l
SS=A		e Coverage/Liability Notice					
Bldg. 00	§483.10(g)(17) Th						
2.59.00		edicaid-eligible resident, in					
	• •	of admission to the					
	•	d when the resident					
	becomes eligible f						
	•	services that are included					
	` '	services under the State					
		the resident may not be					
	•						

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

(X6) DATE

TITLE

Lisa Stallman, RN-BC Clinical Support 06/08/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155785	B. W	ING		05/15	/2023
NAME OF	DD OT ALL DE LA CALLED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	ζ.			EICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
	charged;	ama and conjugathat the					
	1 ' '	ems and services that the					
		for which the resident may					
	be charged, and the amount of charges for those services; and						
		(ii) Inform each Medicaid-eligible resident					
	1 ' '	e made to the items and					
	services specified in §483.10(g)(17)(i)(A) and (B) of this section.						
	(3) 3. 4.10 3334011	•					
	§483.10(g)(18) The facility must inform each resident before, or at the time of admission,						
	and periodically during the resident's stay, of						
	services available in the facility and of						
	charges for those	services, including any					
	charges for service	es not covered under					
	Medicare/ Medica	id or by the facility's per					
	diem rate.						
	(i) Where change	s in coverage are made to					
	items and service	s covered by Medicare					
	1	dicaid State plan, the facility					
	1	ce to residents of the					
		is is reasonably possible.					
	1 \ /	es are made to charges for					
		ervices that the facility					
	1	must inform the resident in					
	writing at least 60						
	implementation of	_					
	1 ' '	ies or is hospitalized or is					
		oes not return to the facility,					
		efund to the resident,					
	1	tative, or estate, as eposit or charges already					
	1	lity's per diem rate, for the					
	1 -						
	days the resident actually resided or reserved						
	or retained a bed in the facility, regardless of any minimum stay or discharge notice						
	requirements.	, c. dicondigo nonce					
		ust refund to the resident or					
	1 ' '	tative any and all refunds					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155785	A. BU B. WI	ILDING NG	00	COMPLETED 05/15/2023	
		100/00	B. WI			00/10/2023	
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
WEST R	IVER HEALTH CAN	MPUS			EICKHOFF RD VILLE, IN 47712		
	Г				, ··· · ·	(VE)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	J
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	'
		vithin 30 days from the					
	resident's date of	discharge from the facility.					
		n admission contract by or					
	on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide necessary documentation to ensure a resident or responsible party was issued						
			F 05	382	No plan of correction needed	06/09/2023	3
			1 0.	04	140 plan of confedition needed	00/03/202.	ر
		acility Advanced Beneficiary					
	· · · · · · · · · · · · · · · · · · ·	before the proposed end of					
	services for 2 of 3 beneficiary notices reviewed. (Resident 7, Resident 13)						
	Findings include:						
	On 5/12/23 at 9:18	A.M., during review of three					
		esident Medicare Part A					
		Resident 7 and Resident 13's					
	notice stated, "The	facility/provider initiated the					
	_	dicare Part A services when					
	· ·	ot exhausted," and a SNF					
		orm was not provided, and a					
		ovided from the facility that rvices under MCD [sic]."					
	stated Red [Ste] Se	TVICES UNION IVICED [SIC].					
	On 5/12/23 9:29 A.	M., the social services director					
		7 and Resident 13 were					
		edicaid to Medicare due to					
	_	9. The residents were					
		Medicaid after the Covid 19					
	coverage ended.						
	On 5/15/23 8:58 A.	M., a policy was requested. At					
	that time, the Regional Consultant indicated they do not have a policy, and that the facility honors CMS (Centers for Medicare and Medicaid						
	Services) guidelines	s for completing ABN's.					
	3.1-4(i)						
	i 3.1-4(1)		1		Ī.	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING O D. NING		(X3) DATE SURVEY COMPLETED	
		155785	B. WII	NG		05/15/	/2023
	PROVIDER OR SUPPLIER			714 S E	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1) Free from Unnec Use §483.45(e) Psych §483.45(c)(3) A particle for the system of t	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any orain activities associated sses and behavior. These are not limited to, drugs in gories: Int; Ind rehensive assessment of a ty must ensure that sidents who have not used as are not given these drugs ation is necessary to treat a as diagnosed and a clinical record; sidents who use as receive gradual dose achavioral interventions, ontraindicated, in an effort		TAG			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155785	B. W	ING _		05/15	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			EICKHOFF RD		
WEST R	IVER HEALTH CAN	//PUS			VILLE, IN 47712		
	Т		-				Г
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
		14 days, he or she should					
	document their rationale in the resident's medical record and indicate the duration for						
	the PRN order.						
	8/83 /5/a)/5) DD	N orders for anti-psychotic					
	- ' ' ' '	to 14 days and cannot be					
	_	ne attending physician or					
		ioner evaluates the resident					
		eness of that medication.					
	Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's as needed anti-anxiety medication		F 0'	758	1. Resident #10 was		06/09/2023
				. •	assessed, no adverse effects		
					noted from psychotropic		
					medication use. Resident is or	า	
					hospice services and orders		
	was ordered for gre	ater than 14 days (Resident			updated to reflect hospice end	of	
	10).				life care.		
					All like residents have the	ne	
	Finding includes:				potential to be affected by the		
					alleged deficiency. Resident #		
		3 A.M., Resident 10 was			medications updated to reflect		
		in reclining wheelchair, legs			hospice end of life care. Educa		
		n reach, eyes closed, snoring,			completed with licensed nursing	•	
	bedside table next t	o resident.			staff on Psychotropic Medicati	on	
	On 5/11/22 of 10:06	5 A.M., Resident 10 was			Usage and Gradual Dose	ro	
		reclining wheelchair, eyes			Reduction policy and procedul 3. DHS/designee will audit		
	_	r her legs with call light in			psychotropic medications to	•	
	reach.	iner 1050 with can fight in			ensure documentation presen	t for	
					risk vs benefits, orders design		
	On 5/12/23 at 10:36	6 A.M., Resident 10 was			being used for hospice end of		
		reclining wheelchair, call light			care. Audits will consist of like		
	_	le table next to resident.			resident's random audit of 3		
					residents orders weekly x 4		
	On 5/15/23 at 10:48	3 A.M., Resident 10 was			weeks, every other week x 4		
	observed sitting in reclining wheelchair, call light				weeks, and monthly x 4 month	ıs.	
	in reach, bedside table next to resident. Resident 10 was yelling out "Hey."				4. As a quality measure, th	ne	
					DHS or designee will review a	ny	
					findings and corrective action	at	
	On 5/11/23 at 10:07	7 A.M., Resident 10's clinical			least quarterly and ongoing ur	ıtil	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/15/2023	
	PROVIDER OR SUPPLIER		714 S E	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD SVILLE, IN 47712	
	SUMMARY: (EACH DEFICIEN REGULATORY OR record was reviewe not limited to, demed disturbance, anxiety The current quarter assessment, dated 2 was moderately imp hospice, and receive of 7 days of the asse Current physician's limited to, "lorazepa [milligram]; amt: 0. dx [diagnosis]: Anx sublingual, crush ar [water] Every 30 M dated 9/30/22. Ther medication ordered	APUS STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION d. Diagnosis included, but was entia, with other behavioral of disorder, and depression. y MDS (Minimum Data Set) /3/23, indicated Resident 10 entired, was currently on entired an anti-anxiety medication 7 essment look back period. orders included, but were not entire included. To give in mix with 0.5 ml [milliliter] h20 inutes - PRN [as needed]" e was no extension of the by the physician.			plan as g will
	record) indicated Re 0.5 mg prn on the for 10/2/22 8:14 A.M. 10/4/22 8:33 P.M. 10/8/22 9:43 A.M. 10/16/22 8:11 A.M. 10/18/22 8:20 A.M.	behavior yelling out yelling out yelling into hallway behavior . very anxious and crying behavior issues behavior issues behavior issues f. anxiety anxiety nxious anxiety restlessness pain nxiety behavior issues			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155785	(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE COMPI 05/15	LETED
	PROVIDER OR SUPPLIER		714 S	FADDRESS, CITY, STATE, ZIP COD EICKHOFF RD ISVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
TAG	3/1/23 8:07 P.M. ar 3/26/23 6:38 P.M. bunconditionally 4/25/23 3:24 P.M. p 5/9/23 2:34 P.M. p 5/9/23 2:34 P.M. p 5/11/23 8:54 P.M. r Review of the nurse following: 11/14/2022 11:03 A Hospice) nurse (Na resident increase in also that resident is nursing staff come climb out of bed. O 0.5 mg TID [three tresident behaviors. am, will monitor reother side effects." During an interview Regional Consultant physician had not d days since the loraz 9/30/22. On 5/15/23 at 11:52 Medication Usage a policy, dated 10/9/1 "PRN order for psy 14 days. Except as physician or prescriappropriate for the beyond 14 days, he	oxious sehavior issues, crying sain sair	TAG	DEFICIENCY)	MATE.	DATE
	indicate the duration orders for anti-psyc days and cannot be	n for the PRN order. PRN hotic drugs are limited to 14 renewed unless the attending bing practitioner evaluated the				

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i f		ľ í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLI	
		155785	B. W.	ING		05/15/2	2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 714 S EICKHOFF RD EVANSVILLE, IN 47712			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\E	DATE
	medication".						
F 0759	3.1-48(a)(6) 483.45(f)(1)						
SS=D	` , ` ,	n Error Rts 5 Prcnt or More					
Bldg. 00	§483.45(f) Medica						
Blug. 00	The facility must e						
	§483.45(f)(1) Med percent or greater	ication error rates are not 5					
		on, interview, and record	F 0'	759	1. Resident #14 was		06/09/2023
	_	failed to ensure it was free of a			assessed, no adverse effects		
	medication error rate of greater than 5 percent (%) for 2 of 6 residents (Resident 14, Resident				noted from alleged deficient		
	238) observed during medication pass. 2				practice. Resident #238 was		
	238) observed during medication pass. 2 medication errors were observed during 25				assessed and no adverse effe	ected	
		_			noted from alleged deficient		
	opportunities for err	ror in medication s resulted in a medication error			practice.		
		ent choked and was unable to			2. All residents have the		
		on of unidentified partially			potential to be affected by the		
		and the incorrect dose of an			alleged deficiency. Nursing sta	all	
		was given to a resident.			educated on medication	10 on	
		was given to a resident.			administration policy with focu medication refusals and crush		
	Findings include:				medications. 3. DHS or designee will		
		8 A.M., LPN (Licensed			conduct random audits of		
	· ·	vas observed to crush and			medication administration		
	administer the follo	wing 10 medications to			observations during medicatio	n	
	Resident 14:				pass. Audit will be at random a	and	
		nilligram) (for blood pressure)			will be on random hallways an	nd	
	Buspar 7.5 mg (for				times, will be completed 3 time	es a	
	calcium 600 mg (for	- '			week x 4 weeks, weekly x 4		
		oa 25/100 mg (for Parkinson's			weeks, every other week x 4		
	disease)				weeks, and then monthly x 3		
		J (international unit) (vitamin to			months.		
	help with calcium a				4. As a quality measure, the		
		0 mg (stool softener)			DHS or designee will review a	,	
	lisinopril 5 mg (for				findings and corrective action	at	
	omeprazole 20 mg ((for stomach)			least quarterly and ongoing ur	ntil	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155785	B. W	NG		05/15/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2			EICKHOFF RD		
WEST RI	IVER HEALTH CAN	ADI IS			VILLE, IN 47712		
WESTIN	IVERTILALITI CAN	WI 00		LVANO	VILLE, IN 477 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	UTI stat liquid 30 n	nL (milliliter) in a cup (UTI			campus achieves 100%		
	prevention)				compliance in the campus Quality		
	venlafaxine 37.5 mg	g (for mood)			Assurance Performance		
					Improvement meetings. The p		
		was drinking a liquid after the			will be reviewed and updated a		
	_	I medications mixed with		warranted. Ongoing monitor	-		
	* *	nt 14 started coughing.			continue past 6 months, if nee	ded,	
	· ·	piece of a white pill the size of			until 100% compliance met.		
		her mouth and put it in a					
		PN 3. LPN 3 disposed of the pill.					
	At that time, LPN 3 indicated he did not know						
	what pill it was.						
	5/15/22 - 11 00 1 15						
	_	v on 5/15/23 at 11:00 A.M., the					
	_	at indicated a medication spit as treated as a refusal and staff					
	•	ented in the EHR the					
		why the resident refused it.					
	circumstances as to	why the resident refused it.					
	2 On 5/10/23 at 8·/	14 A.M., LPN 3 was observed to					
		Senexon-S 8.6-50mg for					
	constipation to Resi	_					
	constipation to Resi	ident 256.					
	The current physici	an's orders included, but were					
		following medication:					
		ides-docusate sodium) tablet;					
	· ·	by mouth twice a day					
	0.0 0 0 18 = 1						
	During an interview	v on 5/15/23 at 11:50 A.M., the					
	_	at indicated physician's orders					
	•	when administering					
	medications.	S					
	A current Medication	on Administration policy,					
	revised 11/2018, wa	as provided by the Regional					
		cated " Medications are					
	administered in acc	ordance with written orders of					
	the prescriber If a	a dose of regularly scheduled					
	-	ield, refused it is documented					
		on administration record) or in					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2023	
	PROVIDER OR SUPPLIER		714 S I	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the EHR. An explar 3.1-48(c)(1)	natory note is also entered ".			
F 0761 SS=E Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper tempermit only author access to the keys §483.45(h)(2) The separately locked, compartments for listed in Schedule Drug Abuse Preved 1976 and other drexcept when the fapackage drug dist the quantity stored dose can be readilistication.	and Biologicals ang of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary and expiration date when The expiration date when The of Drugs and Biologicals accordance with State and accility must store all drugs allocked compartments accerdance controls, and aized personnel to have accepted and accepted			
	review, the facility of medications for 2 medication storag were observed in the temperature logs were	on, interview, and record failed to ensure proper storage 2 of 2 medication carts and 2 of e rooms observed. Loose pills e medication cart drawers, and ere not completely filled out for the medication rooms (200 Hall,	F 0761	1. No residents noted to hany adverse effects from alleg deficiency of loose pills noted medication carts, loose pill no in medication room, refrigerat temperature logs not filled out completely. Audit completed of	ged in ted or

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155785	B. W	ING _		05/15/2	2023
			1	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			EICKHOFF RD		
WEST R	IVER HEALTH CAN	/IPUS			SVILLE, IN 47712		
	1		1		T	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		+	DATE
	300 Hall).				medication carts, medication		
	Eindines in dede				rooms, and medication		
	Findings include:				refrigerators to ensure all	.h.	
	1 On 5/12/23 at 0:42 A M, the 200 Hall medication				medication stored appropriate	iy.	
	1. On 5/12/23 at 9:42 A.M., the 200 Hall medication cart was reviewed. The following loose pills were				2. All residents have the		
	observed in the bott				potential to be affected by the		
		vith marking "894/5"			alleged deficiency. Nursing sta		
		vith marking "894/3" with marking "B"			educated on medication stora	-	
		ls with marking "80/A"			and refrigerator temperature le	ugs	
	1 pink circle pill wi	_			being filled out completely. 3. DHS or designee will		
		with marking "AN/44"			conduct random audits of		
	_	l with marking "A/18"			medication carts to ensure no		
		l with marking "421/U"			loose pills noted. Audit will be		
	1 blue circle pill wi				random and will be on random		
	_	ill with marking "B15"			hallways and times, will be	'	
	1 pink oval pill with	_			completed 3 times a week x 4		
		with marking "318/93"			weeks, weekly x 4 weeks, eve		
	1 white circle pill w	_			other week x 4 weeks, and the	-	
	1 yellow oval pill w	_			monthly x 3 months.		
		ith no marking visible			DHS or designee will conduct		
	_	pills with no marking visible			random audits of medication		
		ll with no marking visible			rooms ensure no loose pills no	oted.	
	1 white capsule wit				medication stored according to		
	_	indicated when staff observed			policy. Audit will be at random		
		edication carts, they should			will be on random hallways ar		
	_	PN 3 indicated he was unsure			times, will be completed 3 times		
	_	e for cleaning the medication			week x 4 weeks, weekly x 4		
	carts.	-			weeks, every other week x 4		
					weeks, and then monthly x 3		
	On 5/12/23 at 9:55	A.M., the 300 Hall medication			months.		
	cart was observed.	The following loose pills were			DHS or designee will conduct		
	observed in the bott				random audits of temperature	logs	
	1 white circle pill with marking "HP/24"				to ensure logs are filled out		
	1 yellow oval pill with marking "152"				completely. Audit will be at		
	_	ll with no marking visible			random and will be on random	n	
	_	th marking "APO/A10"			hallways and times, will be		
		indicated night shift was			completed 3 times a week x 4		
	responsible for clea	ning out the medication carts.			weeks, weekly x 4 weeks, eve	ery	
					other week x 4 weeks, and the	en	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/15/2023		
	PROVIDER OR SUPPLIEF			714 S E	NDDRESS, CITY, STATE, ZIP COD CICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
1/40	2. On 5/12/23 at 9:2 storage room was of temperature log post temperatures for the 5/1/23 5/2/23 5/5/23 5/6/23 5/7/23 5/8/23 5/10/23 5/11/23 At that time, LPN 3 responsible for filling temperature logs in 3. On 5/12/23 at 9:3 storage room was of temperature log was filled in. The May 2 the refrigerator lack following days: 5/3/23 5/10/23 In the 300 Hall meeting for filling out the refrigerator lack following days: 5/3/23 5/10/23 In the 300 Hall meeting for filling out the refrigerator lack for filling out the refrigerator lack for filling out the responsible for filling filling filling for filling	42 A.M., the 200 Hall medication bserved. The May 2023 sted on the refrigerator lacked		IAU	monthly x 3 months. 1. As a quality measure, the DHS or designee will review at findings and corrective action aleast quarterly and ongoing uncampus achieves 100% compliance in the campus Quarkssurance Performance Improvement meetings. The piwill be reviewed and updated a warranted. Ongoing monitoring continue past 6 months, if nee until 100% compliance met.	ny at til ality an as g will	DATE

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785 A. BUILDING 00 B. WING			COMPLETED 05/15/2023		
	ROVIDER OR SUPPLIER		714 S E	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD VILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION wo times a day, per CDC	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Guidelines". 3.1-25(m)	vo times a day, per CDC			
F 0812 SS=E Bldg. 00	§483.60(i) Food sa The facility must - §483.60(i)(1) - Pro approved or consi- federal, state or lo (i) This may includ directly from local applicable State an regulations. (ii) This provision of facilities from using gardens, subject to applicable safe gro practices. (iii) This provision from consuming for facility. §483.60(i)(2) - Sto	e food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility			
	failed to ensure food dishwasher tempera completed for 1 of 1 was not labeled corn expired food was no refrigerator and the	In and interview, the facility It was stored appropriately and tures were within range and kitchen observations. Food sectly, left open to air, and of disposed of from the freezer. Dishwasher final wash mented in logs were not at an	F 0812	Failure to have properly labeling, dating, and cleaning of foods and beverages in the kitchen and pantry areas. All foods and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have be cleaned. Temperature log for the dishwashing machine wa	e e en

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155785	B. W	ING		05/15/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	8			EICKHOFF RD	
WEST R	IVER HEALTH CAN	MPUS			SVILLE, IN 47712	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE
	Findings include:				not filled out completely. The	
	On 5/0/22 at 9.40 A	M the fellowing was			were no residents affected b	
On 5/9/23 at 8:49 A.M., the following was observed in the kitchen:				the alleged deficient practice		
	observed in the kitchen.				and through corrective actio	
	Der storage				will prevent further recurren	
	Dry storage:	acto without a label and anon			of monitoring of dishwasher	
	to air	asta without a label and open			temperatures.	tial
		ood on the floor			All residents have the potent	• • • • • • • • • • • • • • • • • • •
	Boxes containing food on the floor				to be affected by this. All foc and beverages have been	ous
	Freezer:				discarded that were not	
An opened bag of peas with a prep					properly labeled or dated. The	,
	(preparation/open) date of 4/11/23 and open to air				kitchen and pantries have be	
		proceedi with handwritten date			cleaned. Culinary staff will b	
	of 5/4 (no year)	roccon with handwritten date			in educated on the procedur	
		nilla ice cream on a tray			and expectations regarding	
	without a label	inna ice cream on a tray			dishwasher temperatures an	
		on rings without a label and			logging of temperatures,	
	open to air	on imgo wiaiout a lacer and			logging food temperatures,	
	^	n in brown bag without label			and policy and procedure	
	and open to air	in ore an eag winter meet			related to food storage.	
	_	ood items on the floor				
					The Director of Food Servic	es
	Refrigerator:				or designee will conduct	
	Poppy seed dressing	g out of original container			random audits of food storage	ge
	with a use by date of	of 5/8/23			to ensure that food is stored	
	White dressing out	of original container without a			and labeled in a safe and	
	label				sanitary manner. Audits will	be
	Honey mustard dres	ssing out of original container			completed 5 times a week x	
	with a use by date of				weeks, weekly x 4 weeks,	
		with manufacturer's use by			every other week x 4 weeks,	
	date of 5/7/23				and then monthly for 3	
	Diced potatoes in a				months. Director of Food	
	^	in a bag labeled "pot 5/8/23"			Service/designee will monito	or
	and open to air				and/or verify dishwasher wa	sh
		ut a label and open to air			temps reach 150 degrees an	d
		ontainer with fuzzy white			rinse cycle reaches 180	
	substance covering				degrees; as well as monitori	ng
	An opened bag of S	Swiss cheese slices with a use			of dishwasher temperature le	og
by date of 5/7 (no year indicated)				to ensure it is filled out. Aud	ite	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	- 1	JILDING	00	COMPI	
		155785	B. W	ING	_	05/15	12023
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
WEST R	IVER HEALTH CAN	MPLIS	714 S EICKHOFF RD EVANSVILLE, IN 47712				
	1				I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION DATE
IAG	 	American cheese slices with	+	IAG	will be completed 5 times a		DATE
	received date of 5/1				week x 4 weeks, weekly x 4		
					weeks, every other week x 4	4	
	Walk in refrigerator	r (HCR3):			weeks, and then monthly fo		
	A drink pitcher con	taining brown liquid without a			months.		
	label						
		nberry juice with a use by date			As a quality measure, the D		
	of 5/5/23 and manu 3/29/23	facturer's expiration date of			or designee will review any		
		nberry juice with a use by date			findings and corrective acti at least quarterly and ongoi		
	of 5/9/23 and manufacturer's expiration date of 5/4/23 A drink pitcher of sweet tea with use by date of 5/7/23				until campus achieves 100%	-	
					compliance in the campus	•	
					Quality Assurance Performa	ance	
					Improvement meetings. The	•	
	-	taining clear liquid without a			plan will be reviewed and		
	label	- 4 h 4h			updated as warranted.		
	5/8/23	oot beer with a use by date of			Ongoing monitoring will continue past 6 months, if		
	3/0/23				needed, until 100% complia	nce	
	During an interview	on 5/9/23 at 9:34 A.M.,			met.		
	Kitchen Staff 2 ind	cated they did the dishes that					
	-	time indicated they were not					
		es drawn on the gauges were					
	reach for the rinse a	nperature the dishwasher must					
	Todon for the thise a	ma mai wasii.					
	On 5/9/23 at 9:35 A	.M., the dishwasher					
	temperature gauges	were observed to be at a high					
		water splotches which made					
		read. At that time, the Kitchen					
	-	the wash temperature should ees Fahrenheit and the final					
		east 180 degrees Fahrenheit,					
		ed to read, they did not have					
		check the temperatures, and					
		all [company name] that does					
		machine to have them come					
	look at it.						
	I		1		l		1

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On 5/9/23 at 10:05 A.M., the log book with

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2023	
	PROVIDER OR SUPPLIER		714 S E	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	dishwasher tempera Kitchen Manager an should be documen	tures was provided by the nd they indicated kitchen staff			
	The dishwasher terr from 4/5/23 to 5/9/2 4/5/23 breakfast fin 4/5/23 noon meal fi 4/5/23 evening mea 175 4/6/23 breakfast fin 4/6/23 noon meal fi The wash and final filled in for the ever 4/7/23 breakfast fin 4/7/23 noon meal fi The wash and final filled in for the ever 4/8/23 breakfast fin 4/8/23 oon meal fi 4/8/23 evening mea 172 4/9/23 breakfast fin 4/9/23 noon meal fi The wash and final filled in for the ever 4/10/23 breakfast fin 4/9/23 noon meal filled in for the ever 4/10/23 breakfast fin 4/10/23 noon meal filled in for the ever 4/10/23 breakfast filled in	apperature log was reviewed 23 and indicated the following: all rinse temperature was 170 nall rinse temperature was 175 l final rinse temperature was 170 nall rinse temperature was 171 rinse temperature was 171 rinse temperatures were not ning meal on 4/6/23. all rinse temperature was 175 rinse temperatures were not ning meal on 4/7/23. all rinse temperature was 175 rinse temperature was 170 nall rinse temperature was 175 l final rinse temperature was 175 l final rinse temperature was 170 nall rinse temperature was 170 nall rinse temperature was 170 final rinse temperature was 170 final rinse temperature was 175 rinse temperature was 175 rinse temperatures were not ning meal on 4/10/23.			
	4/11/23 breakfast fi 4/11/23 noon meal: 4/11/23 evening me 170 4/12/23 breakfast fi 4/12/23 noon meal: The wash and final	nal rinse temperature was 170 final rinse temperature was 175 al final rinse temperature was nal rinse temperature was 170 final rinse temperature was 170 final rinse temperature was 175 rinse temperatures were not ning meal on 4/12/23.			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155785		JILDING	onstruction 00	(X3) DATE COMPL 05/15/	ETED
	ROVIDER OR SUPPLIER		<u> </u>	714 S E	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
7 7	(EACH DEFICIENT REGULATORY OR There was not a log 4/13/23 4/14/23 breakfast fit 4/14/23 noon meal if the wash and final filled in for the even 4/15/23 breakfast fit 4/15/23 evening meal if the wash and final filled in for breakfast 4/16/23 evening meal if the wash and final filled in for breakfast 4/16/23 evening meal if the wash and final filled in for breakfast fit 4/17/23 noon meal if the wash and final filled in for breakfast fit 4/18/23 evening meal if the wash and final filled in for breakfast fit 4/19/23 breakfast fit 4/19/23 noon meal if the wash and final legible for the evening mean final legible for the evenin				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	
	180 4/23/23 breakfast fi	nal rinse temperature was 170 final rinse temperature was 173					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING O B. WING		00	COMPL 05/15/	ETED			
	PROVIDER OR SUPPLIER			714 S E	DDRESS, CITY, STATE, ZIP COD		
WESIK	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		rinse temperatures were not					
		ing meal on 4/23/23. rinse temperatures were not					
		st, noon meal, or evening meal					
	on 4/24/23.	st, noon meal, or evening meal					
		nal rinse temperature was 170					
		final rinse temperature was 175					
		eal final rinse temperature was					
	170						
		nal rinse temperature was 170					
		final rinse temperature was 175					
	The wash and final rinse temperatures were not						
	legible for the evening meal on 4/26/23.						
	4/27/23 breakfast final rinse temperature was 170						
	4/27/23 noon meal :	final rinse temperature was 172					
	The wash and final	rinse temperatures were not					
	legible for the even	ing meal on 4/27/23.					
		nal rinse temperature was 170					
		final rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 4/28/23.					
		nal rinse temperature was 170					
		final rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 4/29/23.					
	1 here was not a log 4/30/23	included for the date of					
		al rinse temperature was 170					
		nal rinse temperature was 175					
		rinse temperatures were not					
	legible for the even						
		al rinse temperature was 170					
		nal rinse temperature was 175					
		rinse temperatures were not					
	legible for the even						
		al rinse temperature was 170					
		nal rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 5/3/23.					
	3/4/23 breakfast fin	al rinse temperature was 175					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 05/15/2023			
	PROVIDER OR SUPPLIER		714 S	T ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD ISVILLE, IN 47712	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E NATE	(X5) COMPLETION DATE
140	5/4/23 noon meal fi 5/4/23 evening mea 180 5/5/23 breakfast fin 5/5/23 noon meal fi 5/5/23 evening mea 180 There was not a log 5/7/23 breakfast fin 5/7/23 noon meal fi 5/7/23 evening mea 180 5/8/23 breakfast fin The wash and final filled in for the noo 5/9/23 breakfast fin During an interview Regional Consultan residents in the faci diseases or gastroin On 5/12/23 at 11:15 observed in the kite Freezer: An opened bag of p (preparation/open) of Refrigerator: Strawberries in a co substance covering During an interview Kitchen Manager ir received label place received. Once the a label placed on it description, date op "the labels are confi	al rinse temperature was 175 Il final rinse temperature was 172 nal rinse temperature was 175 Il final rinse temperature was 175 Il final rinse temperature was 175 Il final rinse temperature was 171 nal rinse temperature was 170 Il final rinse temperature was 170 Il final rinse temperature was 170 rinse temperature was 170 rinse temperatures were not n and evening meals on 5/8/23. al rinse temperature was 172 If on 5/9/23 at 10:14 A.M., the not indicated there were not any lity with communicable testinal upset. S.A.M., the following was hen: Deas with a prep date of 4/11/23 and open to air container with fuzzy white	IAU			DATE

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155785	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMP! 05/15	
	PROVIDER OR SUPPLIEF		714 S E	ADDRESS, CITY, STATE, ZIP CO EICKHOFF RD VILLE, IN 47712))D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	they should check thave fallen off and should be discarded regards to the dishw do not feel like they form indicates becathey should be mon make sure they are dishwasher is going investigation into the temperatures. The grade been changed by [content of the facility of the facility, the item received on label by production need BC use by date. Foods a production when the original container A mandwritten label date and time the facilities of staff men properly covered (no being labeled and do the facility of the facility	real lower recorded rauges on the machine have company name] because they read. reling policy, revised 4/26/22, gional Consultant on 5/15/23 at red " When a food item enters in needs to be labeled with a refore it is put away Foods in DTH a production date AND a reconsidered to be in rey have been taken out of the LND the seal has been broken as must include: item name, and was labeled, use by date, aber all food items must be of exposed to air) prior to read ". rasher] manual, Rev 2.01A, was read " After the machine has to ten minutes (5 - 10 min.), and rinse temperatures. The rust be 155 degrees F rum. The rinse temperature must				

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	OF CORRECTION	IDENTIFICATION NUMBER 155785	A. BUILI B. WING	DING	00	COMPL 05/15/	ETED
	PROVIDER OR SUPPLIER		7	'14 S E	DDRESS, CITY, STATE, ZIP COD ICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION A.M., indicated "	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	recommended guide final rinse 180 degre On 5/15/23 at 10:41 Temperature Log po Regional Consultan	Dishwasher (heat sanitization) eline: wash 150-165 degrees F, ees F ". A.M., a current Dishwasher elicy was asked for from the t; however, they indicated there was one and one was not					
R 0000	3.1-21(i)(2) 3.1-21(i)(3)						
Bldg. 00	Survey. This visit in State Licensure Sur Survey dates: May 9 Facility number: 01 Residential Census:	2, 10, 11, 12, 15, 2023 2448 52 Itial Findings are cited in	R 0000		The submission of this plan of correction does not indicate at admission by West River Heal Campus that the findings and allegations contained herein a accurate, true representation of the quality of care provided, at the living environment provided the residents of West River Heal Campus. The facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. The facility requests from the department a desk review for substantial compliance.	n tth re of nd d to ealth res r and r. t is all s	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155785 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2023	
	PROVIDER OR SUPPLIER		714 8	T ADDRESS, CITY, STATE, ZIP COD S EICKHOFF RD NSVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Corrections to be completed be 6/9/23.	ру
R 0092	410 IAC 16.2-5-1. Administration and				'
Bldg. 00	Noncompliance (i) The facility must disaster prepared continuity of care emergency as follows: (1) Fire exit drills in transmission of a simulation of emergency that the more except that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At least held every year. We between 9 p.m. ar announcement manualible alarms. (2) At least every shall attempt to he in conjunction with A record of all train	at maintain a written fire and mess plan to assure of residents in cases of ows: In facilities shall include the fire alarm signal and regency fire conditions, overment of nonambulatory areas or to the exterior of required. Drills shall be ally on each shift to the personnel with signals of twelve (12) drills shall be all the drills are conducted and 6 a.m., a coded as be used instead of six (6) months, a facility of the local fire department. The local fire department in and drills shall be the names and signatures			
	Based on interview failed to ensure the	and record review, the facility fire department was invited to east every 6 months.	R 0092	1. No residents were affect by the alleged deficient praction. The Director of Plant Operation and the Executive Director immediately educated on inviting the fire department to a fire director.	ce. ons ting
	provided for 2022 a lacked documentation	P.M., fire drill reports were nd 2023. The drill reports on of the fire department being the fire drills. At that time, the		every 6 months. The fire department has been invited the attend the next fire drill. 2. All residents have the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155785	B. WI	NG		05/15/	2023
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				EICKHOFF RD		
WEST RI	VER HEALTH CAM	IDLIS			VILLE, IN 47712		
WESTIN	VERTILALITI CAIV			LVANO	VILLE, III 477 12		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	visor indicated he was aware			potential to be affected. The l		
	•	should be invited to attend fire			(interdisciplinary team) educat		
	-	as but was unaware of			on the regulation of inviting the		
	_	invitations being extended and was unable to			department to a fire drill every	6	
		produce documentation showing the fire			months.		
	department had been invited to attend.				3. As measure of ongoing		
	0 5/15/22 + 1 27/1	D.M. E. D.II D.I.			compliance, the Executive		
	On 5/15/23 at 1:27 P.M., a Fire Drills Policy was provided, dated 9/13/18. It lacked requirements on				Director or designee will monit		
	-	tation or participation in			the fire department attendance	aı	
	facility fire drills.	tation of participation in			the facility's fire drill weekly x4 weeks, then every other week	vΩ	
	facility fire driffs.				months, then monthly x3 mont		
					4. As a quality measure, th		
					DHS or designee will review a		
					findings and corrective action	-	
					least quarterly and ongoing un		
					campus achieves 100%		
					compliance in the campus Qua	ality	
					Assurance Performance	,	
					Improvement meetings. The p	lan	
					will be reviewed and updated	as	
					warranted. Ongoing monitoring	g will	
					continue past 6 months, if nee	ded,	
					until 100% compliance met.		
R 0214	410 IAC 16.2-5-2(•					
	Evaluation - Defici	•					
Bldg. 00		of the individual needs of					
		ll be initiated prior to					
		all be updated at least					
	-	upon a known substantial					
	-	dent's condition, or more					
		nt ' s or facility ' s request. shall evaluate the nursing					
	needs of the resid	9					
		iew and interview, the facility	R 02	214	Resident #3 was assess	.ed	06/09/2023
		i-annual evaluations were	K U2	۷1 4	and no adverse effects noted t		00/03/2023
	completed or signed				alleged deficiency. Service pla		
		r 2 of 5 residents reviewed			completed for Resident #3.		
	(Resident 3, Residen				2. All residents have the		
		*	1				

State Form Event ID: 3HOO11 Facility ID: 012448 If continuation sheet Page 23 of 35

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155785		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 05/15	LETED	
	PROVIDER OR SUPPLIEF		714 S	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	Findings include: 1. On 5/12/23 at 12 record was reviewe evaluation was date 2. On 5/12/23 at 12 record was reviewe semi-annual evalua During an interviewe Regional Consultar evaluations should On 5/15/23 at 9:55 evaluation and serviewe dated 12/11/2017, wUpon admission significant change if the licensed nurses	:35 P.M., Resident 3's clinical d. The most recent semi-annual d 12/8/21. :30 P.M., Resident 4's clinical		potential to be affected by the alleged deficiency. DHS/de will audit to establish a base all service plans that are dupast due. DHS/designee to schedule service plans to be completed for those resider are due or past due. Clinical educated on Evaluation and Service Plan Guidelines por procedure. 3. As a measure of ong compliance, the DHS or dewill audit Service Plans to estimely completion. Audit to consist of 5 random resider weekly x4 weeks, then 5 raresidents every other week months, then 5 random resmonthly for 3 months. 4. As a quality measure DHS or designee will review findings and corrective active least quarterly and ongoing campus achieves 100% compliance in the campus Assurance Performance Improvement meetings. The will be reviewed and update	signee eline of eline or e hts that al staff d licy and oing signee ensure hts ndom for 2 idents v any on at until Quality e plan	
				warranted. Ongoing monito continue past 6 months, if r until 100% compliance met	ring will needed,	
R 0216	410 IAC 16.2-5-2(Evaluation - Nonc					
Bldg. 00	(c) The scope and shall be delineate manual, but at a n	I content of the evaluation d in the facility policy ninimum the needs include an evaluation of the				

State Form Event ID: 3HOO11 Facility ID: 012448 If continuation sheet Page 24 of 35

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETE	ED
		155785	B. W	ING		05/15/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 714 S EICKHOFF RD EVANSVILLE, IN 47712				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.112	DATE
	(1) The resident 'mental status. (2) The resident 'activities of daily li (3) The resident 'admission and set (4) If applicable, the self-administer met (d) The evaluation writing and kept in Based on observation review, the facility were self administe assessed for capabilismedications for 1 of accidents (Resident Finding includes: During an observation and the counter. During an observation in he Resident 4's medication in he Resident 4's room at the counter. During an observation and the resident 's paper cup with 3 pin seat of the resident's room table eating. A medication cup was on 5/15/23 at 12:20	s physical, cognitive, and s independence in the living. s weight taken on miannually thereafter. The resident 's ability to edications. In shall be documented in a the facility. Son, interview, and record failed to ensure residents that tring medications were lity to self administer of 3 residents observed for 14. Sion on 5/15/23 at 11:38 A.M., Nurse (LPN) 9 dispensed attion. At that time, Resident 4 and requested that LPN 9 leave er room. LPN 9 entered and placed the medications on sion on 5/15/23 at 11:47 A.M., king in the hallway and the lls was observed sitting on the swalker. Sion on 5/15/23 at 12:11 P.M., erved sitting at the dining At that time, the paper is empty. D. P.M., Resident 4's clinical d. The record lacked a self-	R 0		1. Resident #4 was assess and resident able to self-administration medication but facility staff will administer Resident assessed and no aff noted from the alleged deficie practice. 2. All residents have the potential to be affected from the alleged deficient practice. All residents requesting to self-administer medications has completed self-administration assessments to validate competency. All identified residents were verified to have care plans in place for self-administration. Nursing sthave been provided education regarding medication administration, self-administration assessments, and care planni 3. As a measure of ongoin compliance, the DHS or design will audit/observe adherence the medication administration. Audit to consist of 5 residents weekly a weeks, then 5 residents every other week for 2 months, then	s,	6/09/2023

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155785		ľ í	UILDING	nstruction 00	(X3) DATE COMPL 05/15 /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 714 S EICKHOFF RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
	Regional Consultan should be present w medication. On 5/15/23 at 1:27 light Self Administration 5/22/2018, was prover equesting to self-m as a part of their plausing the observation Administration of Melectronic health recassessment will be passessment will be passessment.	on 5/15/23 at 1:50 P.M., the tindicated that nursing staff then Resident 4 receives P.M., a current guidelines for of Medications policy, dated rided and indicated "Residents edicate or has self-medication in of care shall be assessed in [name of corporation] Self fedication within the tord. Results of the presented to the physician for order for self-medication"			residents monthly for 3 months 4. As a quality measure, th DHS or designee will review a findings and corrective action a least quarterly and ongoing un campus achieves 100% compliance in the campus Qua Assurance Performance Improvement meetings. The p will be reviewed and updated a warranted. Ongoing monitoring continue past 6 months, if nee until 100% compliance met.	ne ny at atitil ality lan as g will		
R 0217	410 IAC 16.2-5-2(e)(1-5)						
Bldg. 00	facility, using appromembers, shall ideservices to be profollows: (1) The services or resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services or revised as appropresident and facility change. Either the request a service; (3) The agreed up signed and dated	obletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as ffered to the individual ppropriate to the: ffered shall be reviewed and riate and discussed by the y as needs or desires facility or the resident may blan review. on service plan shall be by the resident, and a copy shall be given to the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/15/2023		
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 714 S EICKHOFF RD EVANSVILLE, IN 47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	services provided subsequent to the no need for a cha (5) If administratic provision of reside both, is needed, a involved in identif the services to be Based on record refailed to ensure ser signed by the reside of 5 residents review as dated 12/8/21. 2. On 5/12/23 at 12 record was reviewed was dated 12/8/21. 2. On 5/12/23 at 12 record was reviewed plan was dated 3/7/20 During an interviewed Regional Consultar should be completed on 5/15/23 at 9:55 evaluation and service dated 12/11/2017, 10 "A service plan simplemented in residence of the subsequence	on of medications or the ential nursing services, or a licensed nurse shall be ideation and documentation of a provided. view and interview, the facility vice plans were completed or ent or responsible party for 2 wed (Resident 3, Resident 4). 35 P.M., Resident 3's clinical ed. The most recent service plan 30 P.M., Resident 4's clinical ed. The most recent service 22. v on 5/15/23 at 9:51 A.M., the at indicated service plans ed every 6 months. A.M., a current assisted living rice plan guidelines policy, was provided and indicated hall be identified and ponse to the resident's ollaboration with the resident	R 0	217	1. Resident #3 was assess and no adverse effects noted alleged deficiency. Service placompleted for Resident #3. 2. All residents have the potential to be affected by the alleged deficiency. DHS/desig will audit to establish a baselir all service plans that are due of past due. DHS/designee to schedule service plans to be completed for those residents are due or past due. Clinical seducated on Evaluation and Service Plan Guidelines. 3. As a measure of ongoin compliance, the DHS or desig will audit Service Plans to ensitimely completion. Audit to consist of 5 random residents weekly x4 weeks, then 5 random residents every other week for months, then 5 random reside monthly for 3 months. 4. As a quality measure, the DHS or designee will review a findings and corrective action least quarterly and ongoing uncampus achieves 100% compliance in the campus Qui Assurance Performance	from an nee ne of or that taff ag nee ure om r 2 ints ne ny at ntil	06/09/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/15/2023		
WEST R	PROVIDER OR SUPPLIER	1PUS	714 S I EVANS	ADDRESS, CITY, STATE, ZIP COD EICKHOFF RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX FACE OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
				Improvement meetings. The partial will be reviewed and updated warranted. Ongoing monitoring continue past 6 months, if need until 100% compliance met.	as g will	
R 0273	410 IAC 16.2-5-5.	, ,				
Bldg. 00	(f) All food prepara (excluding areas in maintained in acco local sanitation an standards, includin Based on observation	on and interview, the facility	R 0273	="" a=""> Failure to have	06/09/2023	
	failed to ensure food was stored appropriately and dishwasher temperatures were within range and completed for 1 of 1 kitchen observations. Food was not labeled correctly, left open to air, and expired food was not disposed of from the refrigerator and the freezer. Dishwasher final wash temperatures documented in logs were not at an appropriate level. (Kitchen) Findings include: On 5/9/23 at 8:49 A.M., the following was observed in the kitchen:			properly labeling, dating, an cleaning of foods and beverages in the kitchen and pantry areas. All foods and beverages have been discarded that were not properly labeled or dated. Ti kitchen and pantries have be cleaned. Temperature log fo	d ne een	
				the dishwashing machine want filled out completely. The were no residents affected by the alleged deficient practice.	as ere by e	
	Dry storage: An opened bag of p to air Boxes containing fo	asta without a label and open		and through corrective action will prevent further recurrent of monitoring of dishwasher temperatures. All residents have the potent to be affected by this. All foo	ce · tial	
	An opened bag of b of 5/4 (no year)	eas with a prep date of 4/11/23 and open to air roccoli with handwritten date nilla ice cream on a tray		and beverages have been discarded that were not properly labeled or dated. The kitchen and pantries have be cleaned. Culinary staff will be in educated on the procedurand expectations regarding	ne een ee	

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155785	B. W	ING		05/15/2	2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			EICKHOFF RD		
WEST R	IVER HEALTH CAN	APLIS			VILLE, IN 47712		
WEGIN				LV/IIVO	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	, ,	on rings without a label and			dishwasher temperatures an	d	
	open to air				logging of temperatures,		
		n in brown bag without label			logging food temperatures,		
	and open to air	1.			and policy and procedure		
	Boxes containing to	ood items on the floor			related to food storage.		
	Refrigerator:				The Director of Food Samilar	_	
	_	g out of original container			The Director of Food Service	50	
	Poppy seed dressing out of original container with a use by date of 5/8/23				or designee will conduct random audits of food storage	,	
	White dressing out of original container without a				to ensure that food is stored		
	label				and labeled in a safe and		
	Honey mustard dressing out of original container				sanitary manner. Audits will	be	
	with a use by date of $5/7/23$				completed 5 times a week x		
	Tub of sour cream with manufacturer's use by				weeks, weekly x 4 weeks,		
	date of 5/7/23				every other week x 4 weeks,		
	Diced potatoes in a	bag open to air			and then monthly for 3		
	Shredded potatoes	in a bag labeled "pot 5/8/23"			months. Director of Food		
	and open to air				Service/designee will monito	r	
		ut a label and open to air			and/or verify dishwasher was		
		ontainer with fuzzy white			temps reach 150 degrees and	d	
	substance covering				rinse cycle reaches 180		
		Swiss cheese slices with a use			degrees; as well as monitori	-	
	by date of 5/7 (no y				of dishwasher temperature lo	_	
	received date of 5/1	American cheese slices with			to ensure it is filled out. Aud	its	
	received date of 3/1	.1 43			will be completed 5 times a week x 4 weeks, weekly x 4		
	Walk in refrigerator	r (HCR3)·			weeks, every other week x 4		
	_	taining brown liquid without a			weeks, and then monthly for	3	
	label	6 ·· q u ··· ···· ··· u			months.	-	
		nberry juice with a use by date					
		facturer's expiration date of			As a quality measure, the DI	FS	
	3/29/23	-			or designee will review any		
	A box of nectar cra	nberry juice with a use by date			findings and corrective actio	n	
	of 5/9/23 and manu	facturer's expiration date of			at least quarterly and ongoin		
	5/4/23				until campus achieves 100%		
	_	sweet tea with use by date of			compliance in the campus		
	5/7/23				Quality Assurance Performa	nce	
	-	taining clear liquid without a			Improvement meetings. The		
	label				plan will be reviewed and		
	A drink pitcher of r	oot beer with a use by date of			updated as warranted.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155785		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 05/15	LETED	
	PROVIDER OR SUPPLIEI		714 S	ADDRESS, CITY, STATE, ZIP EICKHOFF RD SVILLE, IN 47712	COD	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	Juice machine in di Thick, sticky, brow juice spout came of On 5/9/23 at 9:34. A they did the dishes indicated they were drawn on the gauge temperature the dis rinse and final wash. On 5/9/23 at 9:35. A temperature gauges level and filled with the gauges hard to Manager indicated be at least 160 degrinse should be at let the gauges were ha another method to they may need to camaintenance on the look at it. On 5/9/23 at 10:05 dishwasher temperatures for the times every day. The dishwasher tem from 4/5/23 to 5/9/4/5/23 breakfast find 4/5/23 evening mean 175	ning room: In substance where orange at of machine A.M., Kitchen Staff 2 indicated that morning and at that time anot sure if the black lines as were to indicate what hwasher must reach for the hand. A.M., the dishwasher are were observed to be at a high hand water splotches which made read. At that time, the Kitchen the wash temperature should rees Fahrenheit and the final reast 180 degrees Fahrenheit, and to read, they did not have check the temperatures, and all [company name] that does are machine to have them come A.M., the log book with attures was provided by the not they indicated kitchen staff thing the dishwasher are rinse and final wash three A.M., the log was reviewed 23 and indicated the following: the rinse temperature was 170 inal rinse temperature was 175 all final rinse temperature was 175 all final rinse temperature was	TAG	Ongoing monitoring continue past 6 mon needed, until 100% comet.	will ths, if	DATE
	1/0/25 of cakrast III	al rinse temperature was 170	1	1		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155785		A. BUILDING 00 COMPLETED B. WING 05/15/202			ETED		
NAME OF I	PROVIDER OR SUPPLIER	- L			ADDRESS, CITY, STATE, ZIP COD		
WEST R	IVER HEALTH CAN	MPUS			ICKHOFF RD VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nal rinse temperature was 171					
		rinse temperatures were not ning meal on 4/6/23.					
		al rinse temperature was 170					
		nal rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 4/7/23.					
		al rinse temperature was 170					
		nal rinse temperature was 175					
		l final rinse temperature was					
	172						
	4/9/23 breakfast final rinse temperature was 170						
	4/9/23 noon meal final rinse temperature was 170						
	The wash and final rinse temperatures were not						
		ning meal on 4/9/23.					
		nal rinse temperature was 170					
		final rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 4/10/23.					
		nal rinse temperature was 170					
		final rinse temperature was 175					
	170	al final rinse temperature was					
		nal rinse temperature was 170					
		final rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 4/12/23.					
		included for the date of					
	4/13/23.						
	4/14/23 breakfast fi	nal rinse temperature was 170					
	4/14/23 noon meal:	final rinse temperature was 175					
	The wash and final	rinse temperatures were not					
		ning meal on 4/14/23.					
		nal rinse temperature was 170					
		final rinse temperature was 172					
	4/15/23 evening me 180	al final rinse temperature was					
		rinse temperatures were not					
		st or noon meals on 4/16/23.					
	4/16/23 evening me	eal final rinse temperature was					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
		155785	B. WI	NG		05/15	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	ROVIDER OR SUPPLIER	8			EICKHOFF RD			
WEST R	VER HEALTH CAN	MPUS			VILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	190							
		nal rinse temperature was 175						
		final rinse temperature was 175						
	4/1 //23 evening me 175	eal final rinse temperature was						
	The wash and final rinse temperatures were not							
		st or noon meals on 4/18/23.						
	4/18/23 evening meal final rinse temperature was 170							
	4/19/23 breakfast final rinse temperature was 170							
	4/19/23 noon meal final rinse temperature was 171							
	The wash and final rinse temperatures were not							
	legible for the evening meal on 4/19/23.							
	4/20/23 breakfast final rinse temperature was 170							
	4/20/23 noon meal	final rinse temperature was 175						
	4/20/23 evening me 175	eal final rinse temperature was						
	4/21/23 breakfast fi	nal rinse temperature was 175						
		final rinse temperature was 175						
		eal final rinse temperature was						
		nal rinse temperature was 175						
		final rinse temperature was 175						
		eal final rinse temperature was						
	180	•						
	4/23/23 breakfast fi	nal rinse temperature was 170						
		final rinse temperature was 173						
	The wash and final	rinse temperatures were not						
		ing meal on 4/23/23.						
	The wash and final	rinse temperatures were not						
	filled in for breakfa	st, noon meal, or evening meal						
	on 4/24/23.							
		nal rinse temperature was 170						
		final rinse temperature was 175						
	4/25/23 evening me 170	eal final rinse temperature was						
	4/26/23 breakfast fi	nal rinse temperature was 170						
		final rinse temperature was 175						
		rinse temperatures were not						
		ing meal on 4/26/23.						
	1		1				I	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155785	B. W	NG		05/15/	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			EICKHOFF RD		
WFST RI	VER HEALTH CAN	MPUS			VILLE, IN 47712		
							ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCI		DATE
		inal rinse temperature was 170					
		final rinse temperature was 172 rinse temperatures were not					
		ing meal on 4/27/23.					
	_	nal rinse temperature was 170					
		final rinse temperature was 175					
		rinse temperatures were not					
		-					
	filled in for the evening meal on 4/28/23. 4/29/23 breakfast final rinse temperature was 170						
		final rinse temperature was 175					
	The wash and final rinse temperatures were not						
	filled in for the evening meal on 4/29/23.						
	There was not a log included for the date of						
	4/30/23.						
	5/1/23 breakfast fin	al rinse temperature was 170					
		inal rinse temperature was 175					
	The wash and final	rinse temperatures were not					
	legible for the even	ing meal on 5/1/23.					
	5/2/23 breakfast fin	al rinse temperature was 170					
	5/2/23 noon meal fi	inal rinse temperature was 175					
	The wash and final	rinse temperatures were not					
	legible for the even						
		al rinse temperature was 170					
		inal rinse temperature was 175					
		rinse temperatures were not					
		ning meal on 5/3/23.					
		al rinse temperature was 175					
		inal rinse temperature was 175					
	5/4/23 evening mea 180	al final rinse temperature was					
	5/5/23 breakfast fin	al rinse temperature was 172					
		inal rinse temperature was 175					
		al final rinse temperature was					
	180						
	There was not a log	included for the date of					
	5/6/23.						
	5/7/23 breakfast fin	al rinse temperature was 171					
	5/7/23 noon meal fi	inal rinse temperature was 170					
	5/7/23 evening mea	l final rinse temperature was					
	180						
			1				1

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155785	(X2) MUL A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE : COMPL 05/15/	ETED
	ROVIDER OR SUPPLIER			714 S E	DDRESS, CITY, STATE, ZIP COD ICKHOFF RD /ILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Strawberries in a cosubstance covering On 5/15/23 at 8:37 indicated there should have it such a waste of indicated that staffs their shift for sealed twice daily for label expired products. Miscarded. The kitch juice machine nozzi dump out the drip to are done doing dish regards to the dishwado not feel like they	al rinse temperature was 170 rinse temperatures were not n and evening meals on 5/8/23. al rinse temperature was 172 A.M., the Regional Consultant e no residents in the facility diseases or gastrointestinal 5 A.M., the following was hen: eas with a prep date of 4/11/23 and open to air ontainer with fuzzy white them A.M., the Kitchen Manager ald be a received label placed are received. Once the item is ave a label placed on it that escription, date opened, and "the labels are confusing and product". They further should check at the end of I bags and they should check les that may have fallen off and foldy foods should be nen staff should wipe off the les and juice boxes inside and rays after each meal when they es. They further indicated in vasher temperature logs, they of need to be filled out as the		I	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
	they should be mon	use while staff is doing dishes, itoring the temperatures to high enough while the the There was not an					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155785	lì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/15/	ETED
	PROVIDER OR SUPPLIER			714 S E	DDRESS, CITY, STATE, ZIP COD ICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	investigation into the temperatures. The grade been changed by [content of the were so difficult to the facility of the facility, the item received-on label by production need Bouse by date. Foods production when the original container of the facility of	ne lower recorded gauges on the machine have ompany name] because they read. peling policy, revised 4/26/22, gional Consultant on 5/15/23 at ted " When a food item enters in needs to be labeled with a efore it is put away Foods in DTH a production date AND a are considered to be in ey have been taken out of the AND the seal has been broken lis must include: item name, bod was labeled, use by date, inberall food items must be not exposed to air) prior to lated". I washer] manual, Rev 2.01A, was lated " After the machine has to ten minutes (5 - 10 min.), and rinse temperatures. The must be 155 degrees F lum. The rinse temperature must minimum". Pethine policy, revised ed by the Regional Consultant of A.M., indicated " Dishwasher (heat sanitization) eline: wash 150-165 degrees F,		TAG	DEFICIENCY)		DATE
	there was one and o	one was not provided.					

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