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	03/20/2023

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 a Recertification and State Licensure Survey and Investigation of Complaint IN00403738. This visit included a State Residential Licensure Survey. Complaint IN00403738. No deficiencies related to the allegations were cited. Survey dates: March 13, 14, 15, 16, 17, 20, 2023. Facility number: 002280 Provider number: 155723 AIM number: 201068770 Census Bed Type: SNF/NF: 20 SNF: 40 Residential: 43 Total: 103 Census Payor Type: Medicare: 30 Medicaid: 11 Other: 19 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 27, 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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

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

Jordan Shots | Executive Director | 04/07/2023

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	that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 3 of 3 residents observed with medications in their rooms. (Resident 30, Resident 12, Resident 161) Findings include: 1. On 3/16/23 at 6:32 A.M., QMA (Qualified Medication Aide) 9 was observed to administer medications for Resident 30 in the 300 Hall by the nurses station. QMA 9 indicated Resident 30's eye drops could not be found in the medication cart. QMA 21 (who was present at that time) indicated the eye drops were probably in Resident 30's room in his hearing aid case, as that was where he kept them. QMA 21 went to Resident 30's room, came out with eye drops, and handed them to QMA 9 who then administered the eye drops to Resident 30. At that time, QMA 9 indicated although Resident 30 kept his eye drops in his room, he did not have an order to do so. On 3/16/23 at 11:32 A.M., Resident 30's clinical record was reviewed. Diagnosis included, but were not limited to, dry eyes. The most recent quarterly MDS (minimum data set) Assessment, dated 2/14/23, indicated Resident 30 was cognitively intact, vision impaired, and wore corrective lenses. Current physician orders included, but were not limited to: GenTeal Tears Moderate (artificial tear drops) 0.1-0.3-0.2 %; one drop each eye for dry eyes, once a day between 6:00 and 10:00 A.M., dated 1/13/23	F 0554	1. Resident #12 and #161 have been discharged from the facility with no adverse effects noted from the alleged deficient practice. Resident #30 was assessed and resident able to keep eye drops at bedside per resident preference, but facility staff will administer in accordance with the physician's order. Resident assessed and no adverse effects noted from the alleged deficient practice. 2. All residents have the potential to be affected from the alleged deficient practice. Residents requesting to self-administer medications have had self-administration assessments completed to validate competency. All identified residents were verified to have care plans in place for self-administration. Nursing staff have been provided education regarding medication administration, self-administration, assessments, and care planning. 3. As a measure of ongoing compliance, the DHS and/or designee will audit/observe adherence to medication administration policy for self-administration. Audit to consist of 5 resident 5x/week for 4 weeks, then 5 residents 3x/week for 4 weeks, then 5 residents weekly for 4 months. 4. As a quality measure, the	04/14/2023

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	The clinical record lacked an order for self administration of medications. The clinical record lacked a care plan related to self administration of medications. The clinical record lacked a self administration of medication assessment. During an interview on 3/17/23 at 10:37 A.M., Clinical Support 43 indicated Resident 30 did not have an assessment for self administration of medications, and was not supposed to have any medications in his room. 2. On 3/13/23 at 11:46 A.M., Resident 12 was observed sitting in his wheelchair eating breakfast at the table in his room. At that time, a box with a prescription label indicating "diclofenac sodium 1% topical gel" (gel prescribed to rub on joints to relieve pain from arthritis) was observed laying on his bedside table and the resident indicated that he used it and staff were aware he had it at bedside. On 3/16/23 at 8:53 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus type II, and cellulitis of left lower limb. The most current admission MDS Assessment, dated 2/27/23, indicated resident was cognitively intact and was an extensive assist of 1 (one) staff member for transferring. Resident 12's clinical record lacked physician's orders for diclofenac sodium 1% gel and self administering medications, a self administering medications care plan, and a self administering medication assessment.		DHS and/or designee will review any findings and corrective action at least quarterly and on an ongoing basis until campus achieves 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% compliance met.	

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	On 3/17/23 at 9:28 A.M., Resident 12 was observed in his room with the same box of diclofenac sodium 1% topical gel on his bedside table. The prescription label indicated fill date was 1/30/23. At that time, Resident 12 indicated that staff was aware that he used it when he needed it. During an interview on 3/17/23 at 10:35 A.M., RN (Registered Nurse) 23 indicated she was not aware of diclofenac gel at Resident 12's bedside. At that time, she indicated she didn't think he had an order for it, was not sure where he got it, and he was not able to self administer medications. On 3/20/23 at 9:55 A.M., RN 18 indicated she was not sure what Resident 12 used the diclofenac gel for but it was usually prescribed to use topically (on surface of body) for pain. She further indicated the staff found the box in his drawer after they were made aware he had it at bedside and it had been removed. 3. On 3/14/23 at 9:30 A.M., Resident 161 was observed sitting in her room with a medicine cup containing 6 (six) pills, a small cup of applesauce with a spoon, and a small cup of water on the bedside table. At that time, the resident indicated that the nurse brought this medication into the room and left it there for the resident to take on their own. On 3/14/23 at 10:15 A.M., Resident 161's clinical record was reviewed. The resident was admitted on 3/12/23. Diagnoses included, but were not limited to, anxiety disorder, low back pain, history of falling, and weakness. The current admission MDS was still in progress.			

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	Resident 161's clinical record lacked physician's orders for self administering medications, a self administering medications care plan, and a self administering medication assessment. On 3/14/23 at 9:45 A.M., all care plans and all physician's orders were requested, but the DON (Director of Nursing) indicated the staff was working to get physician's orders and care plans in place for the resident to self administer medications but they were not completed at this time. During an interview on 3/14/23 at 10:04 A.M., QMA (Qualified Medication Aide) 21 indicated Resident 161 came from assisted living and the nurse was able to leave medications at bedside for the resident to take on her own. During an interview on 3/14/23 10:10 A.M., LPN (Licensed Practical Nurse) 25 indicated Resident 161 could administer their medications because she came from assisted living and was only on skilled for rehab after her fall. During an interview on 3/17/23 at 10:35 A.M., RN 23 indicated before residents could self administer medications, the resident had to have a physician's order and a self administering of medication assessment completed. On 3/17/23 at 10:41 A.M., a current Guidelines for Self-Administration of Medications policy, reviewed 12/31/22, indicated "Residents requesting to self- medicate or has self-medication as a part of their plan of care shall be assessed using the observation [company name] Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for			

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	evaluation and an order for self-medication ... A Self-Medication plan of care will be initiated and updated as indicated" 3.1-11(a)			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 4 of 5 residents reviewed for activities of daily living. Call lights were observed out of reach for residents. (Resident 11, Resident 35, Resident 12, Resident 48) Findings include: 1. On 3/13/23 at 10:19 A.M., Resident 11 was observed laying in bed with the call light hanging to the floor on the left side of the bed not within reach of the resident. On 3/20/23 at 8:45 A.M., Resident 11 was observed sitting in their recliner eating breakfast and the call light was on the bed not within reach of the resident. On 3/20/23 at 9:50 A.M., Resident 11's clinical record was reviewed. Resident 11 was admitted on 1/4/23. Diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of	F 0558	1. Resident # 11, 35, 12, and 48 have been assessed and no adverse effects noted from the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Clinical staff educated on resident accommodation available in relation to ensuring call light within reach. 3. As a measure of ongoing compliance, the DHS and/or designee will complete random audits of resident rooms to ensure call lights are within reach. Audit to consist of 5 resident 5x/week for 4 weeks, then 5 residents 3x/week for 4 weeks, then 5 residents weekly for 4 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at a minimum of quarterly and ongoing until campus achieves 100%	04/14/2023

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	consciousness of unspecified duration, unspecified dementia without behaviors, dysphagia, and anxiety disorder. The most recent admission MDS (Minimum Data Set) Assessment, dated 1/10/23, indicated Resident 11 was cognitively intact, an extensive assist of 1 (one) staff for bed mobility and toileting, and limited assist of 1 (one) staff for transfers. A current risk for falls care plan, dated 1/17/23, included, but was not limited to, the following intervention: Keep call light within reach, initiated 1/17/23 2. On 3/13/23 at 11:14 P.M., Resident 12 was observed sitting in their wheelchair eating breakfast at the table and the call light was on the bed not within reach of the resident. On 3/20/23 at 8:53 A.M., Resident 12 was observed sitting up in a chair eating breakfast. The call light was not within reach of the resident. On 3/16/23 at 8:53 A.M., Resident 12's clinical record was reviewed. Resident 12 was admitted on 2/22/23. Diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus type II, and cellulitis of left lower limb. The most current admission MDS Assessment, dated 2/27/23, indicated resident was cognitively intact and was an extensive assist of 1 (one) staff member for transferring. A current risk for falls care plan, dated 3/15/23, included, but was not limited to, the following intervention: Keep call light in reach, initiated 3/15/23		compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated based on findings. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	3. On 3/13/23 at 10:00 A.M., Resident 35 was observed sitting in their wheelchair on the left side of the bed. The call light was on the right side of the bed not within reach of the resident. On 3/20/23 at 8:40 A.M., Resident 35 was observed sitting in the recliner waiting for breakfast and the call light was not within reach of the resident. On 3/20/23 at 9:22 A.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on 2/13/23. Diagnoses included, but were not limited to, pneumonia, dementia without behaviors, and history of falling. The most recent admission MDS Assessment, dated 2/15/23, indicated Resident 35 was moderately cognitively impaired and an extensive assist of 2 (two) staff for bed mobility, transfers, and toileting. A current risk for falls care plan, dated 3/20/23, included but was not limited to, the following intervention: Keep call light within reach, initiated 3/20/23 During an interview on 3/20/23 at 8:40 A.M., Resident 35 and family representative both said Resident 35 used the call light. During an interview on 3/20/23 at 8:50 A.M., CNA 14 indicated Resident 11, Resident 12, and Resident 35 would use the call light. At that time, they also indicated that before they leave the resident's room, they would make sure the call light, bedside table, and water were within reach of the resident. 4. On 3/14/23 at 9:57 A.M. Resident 48 was			

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	observed in her wheelchair, sitting about 4 feet away from the recliner in her room. The call device was observed in the crack between the seat and the arm of the recliner. During an interview with the resident at this time, she said she did not know where her call device was and she said she could not see it. During an interview on 3/20/23 at 9:00 A.M., LPN 16 indicated that resident uses her call light. On 3/17/23 at 1:54 P.M. Resident 48's records were reviewed. Diagnoses included, but were not limited to, COVID on 12/11/23, Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of falling, cognitive communication deficit. The most recent quarterly MDS assessment dated 2/7/23 indicated resident has severe cognitive impairment, has adequate vision, and requires extensive assistance of two personnel for bed mobility, limited assistance of one personnel for transfers, supervision and assistance of one personnel for eating, and limited assistance of two personnel for toileting. Current physician orders lacked an order to keep call light within reach of resident. The care plan lacked intervention for keeping call light within reach of resident. A current Call Light policy, dated 5/11/16, was provided by Clinical Support 29 on 3/20/23 at 11:00 A.M., and indicated " ... 2. Ensure the call light is plugged in securely to the outlet and in			

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	reach of the resident ... 13. If nothing else is needed, return the call light to within reach of the resident" 3.1-3(v)(1)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of			

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	the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure resident privacy was maintained for 2 of 4 residents observed for medication administration, and 2 random observations. A resident's shirt was raised in the hall to apply a pain patch, the privacy curtain and door were not shut during care, and a computer screen was left up with resident information visible. (Resident 30, Resident 52) Findings include: 1. On 3/16/23 at 6:32 A.M., QMA (Qualified Medication Aide) 9 was observed to administer medications for Resident 30 in the hall by the nurses station. QMA 9 obtained a pain patch from the medication cart, raised Resident 30's shirt, and applied the patch to his back. At that time, another resident was observed within view of Resident 30, sitting in a wheelchair. On 3/16/23 at 11:45 A.M., Resident 30 was observed in his room with his shirt off while Hospice staff 22 was massaging his back. The privacy curtain and door were open, leaving Resident 30 visible from the hallway. 2. On 3/17/23 at 10:50 A.M., a computer screen with resident information visible from the hall was observed unattended on the 600 Hall. Resident 52's information, including, but not limited to, age, date of birth, admission date, room number, address, phone number, picture, continuity of care document, and emergency contact information, were visible on the computer screen. The computer screen was continuously observed until	F 0583	1. Resident #30 was assessed with no adverse effects from the alleged deficient practice noted. All residents, including resident #52, had no adverse effects from the alleged deficient practice. 2. All residents have the potential to be affected from the alleged deficient practice. Facility staff have been provided re-education regarding resident rights pertaining to privacy and confidentiality of resident records. 3. As a measure of ongoing compliance, the ED and/or designee will complete random audits to ensure privacy during resident care is provided. Audit to consist of 5 residents 5x/week for 4 weeks, then 5 residents 3x/week for 4 weeks, then 5 residents weekly for 4 months. DHS and/or designee will complete random audits of electronic devices to ensure confidentiality of records is maintained. Audit will consist of random rounds of units 5x/week for 4 weeks, then 3x/week for 4 weeks, and then weekly for 4 months. 4. As a quality measure, the DHS and/or designee will review any findings and corrective action at least quarterly and ongoing	04/14/2023

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	10:58 A.M., when RN (Registered Nurse) 5 entered the area and locked it. During that time, therapy staff, maintenance, and a housekeeper walked by the computer screen. During an interview on 3/17/23 at 1:04 P.M., LPN (Licensed Practical Nurse) 25 indicated when applying a pain patch to a resident, staff should do so in the resident's room to maintain privacy. LPN 25 further indicated when walking away from a computer, staff should put a lock on the screen to hide the resident information. During an interview on 3/17/23 at 1:08 P.M., CNA (Certified Nurse Aide) 27 indicated resident privacy curtains and doors should be closed when providing any type of care to provide privacy for that resident. On 3/17/23 at 2:05 P.M., a current Preparation and General Guidelines policy, revised 11/18, was provided and indicated "[during administration of medications] privacy is maintained at all times for all resident information (e.g., MAR (medication administration record]) when not in use" On 3/17/23 at 2:05 P.M., a current Resident Rights policy, dated 11/28/16, was provided and indicated "The resident has a right to personal privacy and confidentiality of his or her personal and medical records ... Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups" 3.1-3(o) 3.1-3(p)(2)		basis until the campus achieves 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% compliance met.	
F 0656 SS=D	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan			

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Bldg. 00	§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive			

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	care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical and nursing needs that were identified in the comprehensive assessment for 1 of 3 residents reviewed for respiratory care and 2 of 3 residents reviewed for antibiotic use. Resident's clinical record lacked a care plan and interventions for infection, IV (intravenous) site care, and antibiotic use. The resident's interventions on care plans were not being followed. (Resident 12, Resident 22, Resident 38) Findings include: 1. On 3/13/23 at 11:46 A.M., Resident 12 was observed sitting in their wheelchair eating breakfast at the table in their room. At that time, an IV line with a dressing dated 3/9/23 was observed in his right arm. The resident stated that they had an infection of the right ankle, were getting antibiotics by IV, and was using a wound VAC (therapeutic technique used to help heal wounds). On 3/16/23 at 8:53 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus type II, and cellulitis of left lower limb. The most current admission MDS (Minimum Data	F 0656	1. Resident #12 and #22 have been discharged from the facility with no adverse effects noted from the alleged deficient practice. Resident #38 was assessed for adverse effects from the alleged deficient practice with no findings. 2. All residents have the potential to be affected by the alleged deficient practice. All residents with respiratory care needs were identified and reviewed to ensure appropriate care plans were in place. All resident with IV access/IV antibiotic usage were also identified and reviewed to ensure appropriate care plans were in place. MDSC re-education was completed regarding Comprehensive Care Planning as specified by the RAI manual. Facility nurses were also provided re-education regarding care planning and implementation of interventions as indicated within each residents individualized plan of care. 3. As a measure of ongoing compliance, the DHS and/or designee will audit resident records to ensure care plan interventions are implemented in	04/14/2023

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	Set) Assessment, dated 2/27/23, indicated resident was cognitively intact and was an extensive assist of 1 (one) staff member for transferring. Current physician's orders included, but were not limited to the following: cefazolin (antibiotic) 2 (two) g (grams)/10 mL (milliliters) NaCl (sodium chloride) 0.9% IV push every 8 hours for cellulitis of left lower limb, started 2/22/23 Monitor IV site for signs and symptoms of infiltration twice a day, start date 2/23/23 Negative pressure dressing to left foot intact twice a day, start date 2/22/23 125 mmHG (millimeters of mercury) continuous therapy to left lower extremity wound twice a day, start date 2/26/23 Negative pressure dressing (wound vac) place today and begin changes three times weekly per podiatry on Mondays, Wednesdays, and Fridays, start date 3/13/23 The clinical record lacked a current care plan with interventions given to care for the resident's wound. 2. On 3/13/23 at 10:11 A.M., Resident 38 was observed sitting in his wheelchair with an IV dressing dated 3/12/23 in his left arm that he indicated was used to get antibiotics for the infection he had in his right knee. On 3/16/23 at 1:00 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, infection and inflammatory reaction due to internal right knee prosthesis,		accordance with each resident's individualized plan of care. Audits will consist of 5 residents 5x/week for 4 weeks, then 5 residents 3x/week for 4 weeks, then 5 residents weekly for 4 months. 4. As a quality measure, the DHS and/or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 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% compliance met.	

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	sepsis, and diabetes mellitus type II. The most recent admission MDS Assessment, dated 2/6/23, indicated that the resident was cognitively intact and an extensive assist of 2 (two) staff for bed mobility, transfers, and toileting. Current physician's orders included, but were not limited to, the following: Monitor IV site for signs and symptoms of infiltration every shift, start date 2/3/23 Vancomycin (antibiotic) 1.5 g in 500 mL of Na Cl 0.9% IV every 12 hours, start date 3/13/23 Aztreonam (antibiotic) 2 g injection three times a day, started 3/14/23 The clinical record lacked a care plan with interventions given to care for the resident's infection. During an interview on 3/17/23 at 10:51 A.M., the MDS coordinator indicated she would expect a care plan and interventions to be developed for residents related to IV, antibiotics, and infections. During an interview on 3/20/23 at 11:20 A.M., Clinical Support 50 indicated that nursing staff should open an infection event that will stay open until chronic and this is used as the care plan. During an interview on 3/20/23 at 11:25 A.M. QMA (Qualified Medication Aide) 14 indicated if the resident has a care plan, it should be located under care plans in (computer program) or staff can refer to physician's orders for interventions. During an interview on 3/20/23 at 11:30 A.M., RN			

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	(Registered Nurse) 18 indicated nursing staff should open an event for infections when the problem arises. At that time, they indicated the event is not updated but staff go over it in the morning meeting and if the MDS Coordinator thinks there should be a care plan, they will put one in the clinical record under care plans and list the interventions there. 3. On 3/14/23 at 8:15 A.M., Resident 22 was observed laying in bed with their nasal cannula shifted to the right and not left in left nostril. The flow rate on the oxygen concentrator was set at 4 LPM (liters per minute)and at that time, the resident indicated she does not adjust the setting. On 3/14/23 at 8:36 A.M., staff took ice water in to Resident 22 but did not adjust nasal cannula tubing. On 3/16/23 at 8:30 A.M., Resident 22 was observed laying awake in bed with the nasal cannula tubing wrapped around her body. The flow rate on the oxygen concentrator was set at 3 LPM. On 3/15/23 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), dementia, and anxiety. The most recent admission MDS Assessment, dated 1/30/23, indicated the resident was moderately cognitively intact and a limited assist of 1 (one) staff for bed mobility, transfers, and toileting. Current physician's orders included, but were not limited to the following: Oxygen at 2 LPM per nasal cannula continuous,			

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	start date 2/7/23 A current anxiety care plan, dated 1/30/23 included, but was not limited to, the following intervention: Oxygen per orders, initiated 1/30/23 During an interview on 3/17/23 at 10:35 A.M., RN 23 indicated that the resident's oxygen flow rate was set incorrectly to almost 3 LPM so she adjusted rate back to 2 LPM earlier that morning. During an interview on 3/20/23 at 11:15 A.M., Clinical Support 29 indicated there was not a policy for following the plan of care for residents, but each residents care plan should have "follow the plan of care" at the end of the interventions and they would expect staff to do so. A current Comprehensive Care Plan policy, dated 5/22/2018, was provided by Clinical Support 29 on 3/20/23 at 11:00 A.M., and indicated " ... b. care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident ... c. should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan ... 6. Comprehensive care plans need to remain accurate and current. a. New interventions will be added and updated during or directly following CCM (morning staff meeting) b. Newly recognized problems will have a care plan developed and added after CCM meeting. 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(1)			
F 0921 SS=D	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, and comfortable environment for 3 of 16 resident rooms observed for water temperatures. Water temperatures were above 120 degrees Fahrenheit. (Room 306, 308, 314) Findings include: On 3/13/23 at 11:40 A.M., hot water was observed in the following rooms on the 300 Hall: Room 306: water temperature in the bathroom sink was 122.3 degrees Fahrenheit. At that time, the only resident in room 306 indicated he got up on his own and used the bathroom. Room 308: water temperature in the bathroom sink was 123.1 degrees Fahrenheit. Room 314: water temperature in the bathroom sink was 123.2 degrees Fahrenheit. On 3/14/23 at 10:40 A.M., the rooms that had temperatures higher than 120 degrees Fahrenheit were observed with the Maintenance Supervisor with the following temperatures: Room 306: 119.4 degrees Fahrenheit. Room 308: 118.5 degrees Fahrenheit. Room 314: 122.5 degrees Fahrenheit. At that time, the Maintenance Supervisor indicated the automatic water heater had been set to 150 degrees Fahrenheit, and 2 (two) days prior had been lowered to 140 degrees Fahrenheit. He indicated he had noticed the water temperatures getting high, and had contacted the water heater company for assistance lowering the temperatures. He further indicated the tank holding the water was still hot, and would notice a	F 0921	1. Room 306, 308, 314 have been reviewed and water temperature within range. No residents noted to have adverse effects noted from the alleged deficient practice. 2. All residents have the potential to be affected from the alleged deficient practice. The facility replaced the Navien system water heaters and water temperatures were tested and found to be within acceptable range. The DPO and/or designee was provided re-education regarding acceptable parameters regarding water temperatures. 3. As a measure of ongoing compliance, the DPO and/or designee will audit water temperatures daily, Monday through Friday, in accordance with the regulation in order to maintain compliance. 4. As a quality measure, the ED and/or designee will review findings and corrective actions quarterly, and on an ongoing basis until campus achieves 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% compliance met.	04/14/2023

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	decrease in water temperatures once that water was gone out of the tank. On 3/14/23 at 12:45 P.M., water temperature logs were provided from 1/2023 through 3/2023. The following days were recorded higher than 120 degrees Fahrenheit: 2/8/23: 123 (400 Hall), 122 (600 Hall) 2/9/23: 121 (300 Hall), 122 (400 Hall), 122 (600 Hall) 2/10/23: 123 (400 Hall), 123 (600 Hall) The logs lacked a temperature reading for 2/11/23 and 2/12/23 2/13/23: 122 (400 Hall), 123 (600 Hall) 2/14/23: 121 (300 Hall), 122 (400 Hall), 122 (600 Hall) 2/15/23: 121 (300 Hall), 122 (400 Hall), 122 (600 Hall) 2/16/23: 121 (300 Hall), 122 (400 Hall), 123 (600 Hall) 2/17/23: 121 (400 Hall), 121 (600 Hall) The logs lacked a temperature reading for 2/18/23 and 2/19/23 2/20/23: 121 (300 Hall), 121 (400 Hall), 121 (600 Hall) 2/21/23: 121 (300 Hall), 122 (600 Hall) 2/22/23: 121 (300 Hall), 121 (400 Hall), 122 (600 Hall) 2/23/23: 122 (600 Hall) 2/24/23: 121 (400 Hall) The logs lacked a temperature reading for 2/25/23 and 2/26/23 2/28/23: 121 (600 Hall) 3/2/23: 121 (600 Hall) 3/3/23: 121 (600 Hall) On 3/17/23 at 1:00 P.M., a communication document was provided from the water heater company. The document listed services they had provided for the facility since 1/2023. The services included:			

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	2/27/23: 2 (two) tankless water heaters were installed in the kitchen 1/9/23 and 1/30/23: Serviced leaking tankless water heater and replaced valve in wing 400 3/9/23: Installed new circulating pump in kitchen Nothing was provided regarding the 300 hall. On 3/15/23 at 10:27 A.M., a current Water Temperature Testing policy, revised 8/20/18, indicated "[when recording water temperatures] Note any discrepancies ... Adjust water heater settings as required ... Patient room temperatures are specified by state requirements ... Indiana 100 [degrees] - 120 [degrees]" 3.1-19(h)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00403738. Complaint IN00403738 - No deficiencies related to the complaint were cited. Survey dates: March 13, 14, 15, 16, 17, 20, 2023. Facility number: 002280 Residential Census: 43 River Pointe Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	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 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	

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			statute only. The facility respectfully requests from the department a desk review for substantial compliance.	