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	06/13/2024

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. This visit included a State Residential Licensure Survey. Survey dates: June 7, 10, 11, 12, & 13, 2024 Facility number: 002280 Provider number: 155723 AIM number: 201068770 Census Bed Type: SNF/NF: 19 SNF: 22 Residential: 37 Total: 78 Census Payor Type: Medicare: 11 Medicaid: 19 Other: 11 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 24, 2024.	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 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. Corrections to be completed by 7/10/24.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Stallman, RN-BC	Clinical Support	07/05/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure dignity was respected for 2 of 2 random observations. (Resident 24, Resident 31) Findings include:	F 0550	1.p paraid="26298436" paraeid="{2a2408c1-9a2b-44aa-af90-395a819bd391}{42}" >1. Resident 24 and Resident 31 were not affected by the alleged deficient practice. No adverse	07/10/2024

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	1. On 6/7/24 at 12:08 P.M., RN (Registered Nurse) 21 was observed in the dining room assisting Resident 24 to eat lunch. RN 21 was standing. On 6/11/24 at 10:42 A.M., Resident 24's clinical record was reviewed. Diagnoses included, but was not limited to, Parkinson's disease. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 5/29/24, indicated Resident 24 was rarely or never understood and dependent on staff to eat. On 6/12/24 at 9:27 A.M., the DON (Director of Nursing) indicated that staff should sit to assist residents to eat if they required constant assistance. 2. On 6/11/24 at 11:24 A.M., Resident 31 was observed sitting on the toilet with his pants around his ankles. The doors to the bathroom and the hallway were open. Two CNAs (Certified Nurse Aide) were assisting Resident 31 to use the toilet. On 6/12/24 at 8:17 A.M., Resident 31's clinical record was reviewed. Diagnosis included, but was not limited to, Parkinson's disease. The most current Quarterly MDS Assessment, dated 5/4/24, indicated Resident 31 was rarely or never understood and required substantial to maximal assistance of staff (staff does more than half) for toileting On 6/12/24 at 9:27 A.M., the DON indicated staff should provide privacy while assisting a resident to use the toilet. Staff should close one or both doors.		effects noted. ·2. All residents have the potential to be affected. Education provided to nursing personnel on resident rights and dignity when providing care to residents. ·3. As a measure of ongoing compliance, the DHS or will complete random audits of personal care provided to residents. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. ·4. As a quality measure, the DHS 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	

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	On 6/13/24 at 10:34 A.M., the Regional Support Nurse provided a current Resident Rights Guidelines policy, revised on 5/11/17, that indicated "Our residents have a right to...privacy...be treated fairly, courteously and with respect by all staff". 3.1-3(a)		past 6 months, if needed, until 100% 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 that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident that required assistance with transferring and moving had an order, evaluation, and care plan for the self administration of medication based on 1 of 1 residents reviewed for self-administration of medications. Finding includes: On 6/10/24 at 11:30 A.M., a bottle of Refresh brand eye drops and a bottle of Orajel oral pain analgesic were observed on the bedside tray of Resident 15. On 6/10/24 at 2:24 P.M., a bottle of Refresh brand eye drops were observed on the bedside tray of Resident 15. On 6/11/24 at 2:00 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, emphysema unspecified, and acute and chronic respiratory	F 0554	1.p paraid="500384088" paraeid="{2a2408c1-9a2b-44aa-af90-395a819bd391}{152}" >1. Resident 15 was not affected by the alleged deficient practice. Resident 15 was assessed, and no adverse effects noted. ·2. Residents with medications at bedside have been assessed for ability to self-administer medications following the self-administration policy. Education provided to nursing personnel on self-administration policy. Education provided to family members regarding bringing over the counter medications into facility.	07/10/2024

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	failure. The current Admission MDS (Minimum Data Set) Assessment, dated 5/16/24, indicated Resident 15 was cognitively intact and needed supervision for transferring and moving. Current physician orders lacked an order for eye drops, oral analgesic, and self-administration of medication. On 6/13/24 at 8:50, the Regional Support Nurse provided a copy of Resident 15's "Self-Administration of Medication" Assessment completed on 6/7/24. The assessment indicated the resident could self-medicate nebulizer treatments, pills after nurse set up, inhaler, and (medication) antacid after nurse set up. The inhaler could be kept at bedside and all others were to be kept at the nurse's station until set up. During an interview on 6/13/24 at 10:07 A.M., the DON (Director of Nursing) indicated a resident was expected to have a care plan and an order if the resident self-medicated. During an interview on 6/13/24 at 10:25 A.M., the DON indicated there was no care plan for self-administration of medication for Resident 15. On 6/13/24 at 10:20 A.M., the DON provided a current "Guidelines for the Self-Administration of Medications" policy, dated 12/31/23. The policy indicated "... the results of the assessment will be presented to the physician for evaluation and an order for self-medication. The order should include the type of medications the resident is able to self-medicate...". 3.1-11(a)		·3. As a measure of ongoing compliance, the DHS or will complete random audits of resident rooms for any medications at bedside. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. ·4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to notify the attending physician for 1 of 1 residents reviewed for skin conditions. The physician was not notified of new skin tears and orders for wound care were not obtained. (Resident 31) Finding includes: On 6/7/24 9:54 A.M., Resident 31 was observed to have two dressings on his left arm. On 6/10/24 at 12:54 P.M., a family member indicated Resident 31 had skin tears on his left arm due to shearing from the wheelchair. On 6/12/24 at 8:17 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and Alzheimer's disease. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 5/4/24, indicated Resident 31 was rarely or never understood, required substantial to maximal assistance (staff does more than half) for transfers, and did not have any skin conditions or issues.	F 0580	p="" paraid="1701666506" paraeid="{2a2408c1-9a2b-44aa-af90-395a819bd391}{200}">1. Resident 31 was not affected by the alleged deficient practice. No adverse effects noted. 2. Nursing personnel on skin impairment policy and procedure, including when to open appropriate and when notifications should be made. 3. As a measure of ongoing compliance, the DHS or will complete random audits of resident records regarding skin impairments to ensure appropriate and timely notification along with appropriate and orders when indicated are completed. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100%	07/10/2024

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	The clinical record lacked physician orders, care plans, assessments, and an Event form related to the two wounds on Resident 31's left arm. On 6/12/24 at 8:59 A.M., the Wound Nurse indicated Resident 31 had two skin tears on his left arm that she found during a skin assessment on 6/3/24. When she found them, they had steri-strips on them and she changed the dressing at that time to a foam border. She was unsure how he got the skin tears and who applied the steri-strips. She monitored the skin tears and changed the dressings every 5 days. At that time, she was unable to find orders related to the skin tears on the resident's left arm. She indicated she must have forgotten to put an event into the chart and had been monitoring the skin tears on her own. On 6/13/24 at 8:50 A.M., the Regional Support Nurse provided a current Comprehensive Care Plan Guideline policy, dated 5/22/18, that indicated "Acute problems that arise with the resident and are expected to be resolved within a short time frame will be addressed on the Event form specific for that problem". On 6/13/24 at 9:20 A.M., the Regional Support Nurse provided a current Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines policy, dated 5/10/16, that indicated "Complete one event for each Skin Tear/Laceration". On 6/13/24 at 10:34 A.M., the Regional Support Nurse provided a Notification of Change in Condition policy, dated 5/10/16, that indicated "The resident's representative/provider should be notified of change in condition or diagnostic testing results in a timely manner ... Documentation of notification or notification		compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will past 6 months, if needed, until 100% compliance .	

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	attempts should be recorded in the resident's electronic health record". On 6/13/24 at 10:38 A.M., the Regional Support Nurse indicated "a timely manner" would be within the shift. 3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §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.			

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	(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 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 care plans for 1 of 2 residents reviewed for ADLs (Activities of Daily Living) and 1 random observation. (Resident 31, Resident 15) Findings include: 1. On 6/10/24 at 12:54 P.M., a family member indicated staff transferred Resident 31 by grasping on to his shoulders which caused the resident pain. A gait belt was used while the resident was at home, but staff do not use the gait belt at the facility. On 6/11/24 at 11:24 A.M., Resident 31 was observed sitting on the toilet with CNA (Certified Nurse Aide) 3 and CNA 5 assisting him. The resident did not have a gait belt around his torso. At that time, the CNAs could not locate the gait belt and asked, "where's the gait belt". The CNAs	F 0656	1.p paraid="300438307" paraeid="{3218fe51-8008-443d-b20b-531518260d4e}{5}" >1. Resident 31 and Resident 15 were not affected by the alleged deficient practice. No adverse effects noted. ·2. All residents have the potential to be affected. Nursing personnel on following residents plan of care regarding gait belt usage and on self-administration policy. MDSC educated on ensuring plan of care implemented for residents assessed and able to self-administer medications.	07/10/2024

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	located a gait belt and transferred the resident from the toilet to his wheelchair. At that time, a family member indicated "Oh. They are using the gait belt this time." On 6/12/24 at 8:17 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and Alzheimer's disease. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 5/4/24, indicated Resident 31 was rarely or never understood and required substantial to maximal assistance (staff does more than half) with toilet transfers. A decline in functional status care plan, dated 10/17/23, indicated Resident 31 required assistance of 2 for transfers. Current physician's orders included, but were not limited to, the following: Activity: Assist x 2 for transfers, dated 10/17/23 A nursing progress note, dated 5/21/24 at 12:19 P.M., indicated that family noted bruising on the resident's bilateral upper arms that were reddish purple in color which might have happened during 2 person transfers. Hospice was made aware of the bruising and staff were encouraged to use a gait belt with transfers. On 6/12/24 at 9:27 A.M., the DON (Director of Nursing) indicated if a resident required assistance of 2 staff for transfers, a gait belt should be used. 2. On 6/10/24 at 11:30 A.M., a bottle of (Name of medication) eye drops and a bottle of (Name of medication) oral analgesic was observed on the bedside tray of Resident 15.		Residents with medications at bedside have been assessed for ability to self-administer medications following the self-administration policy. ·3. As a measure of ongoing compliance, the DHS or will complete random audits to ensure transfer order and care plan is followed correctly. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. ·MDSC or designee will audit random of care for residents to ensure self-administration and/or gait belt usage if applicable is in place. Audit will consist of 5 residents plan of care weekly for 1 month, then 5 residents plan of care every other week for 2 months, then 5 residents plan of care monthly for 3 months. ·4. As a quality measure, the DHS/MDSC or will review any findings and corrective action at least quarterly and ongoing until	

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	On 6/10/24 at 2:24 P.M., a bottle of (Name of medication) eye drops was observed on the bedside tray of Resident 15. On 6/11/24 at 2:00 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, emphysema unspecified, and acute and chronic respiratory failure. The current Admission MDS (Minimum Data Set) Assessment, dated 5/16/24, indicated Resident 15 was cognitively intact and needed supervision for transferring and moving. The clinical record lacked orders and a care plan for self-administration of medication. On 6/13/24 at 8:50, the Regional Support Nurse provided a copy of Resident 15's "Self-Administration of Medication" Assessment completed on 6/7/24. During an interview on 6/13/24 at 10:07 A.M., the DON (Director of Nursing) indicated a resident was expected to have a care plan and an order if resident self-medicated. During an interview on 6/13/24 at 10:25 A.M., the DON indicated there was no care plan for self-administration of medication for Resident 15. On 6/12/24 at 9:52 A.M., the DON provided a Caregiver New Hire Checklist, dated 3/22/23, that indicated all CNAs were trained on the use of gait belts upon hire to the facility. On 6/12/24 at 9:52 A.M., the DON provided a		campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will past 6 months, if needed, until 100% compliance .	

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	current Guidelines for Gait Belt Use policy, dated 5/10/17, that indicated "If a resident requires more than limited assists and does not require a lift, a gait belt may be used with transfers". On 6/13/24 at 8:50 A.M., the Regional Support Nurse provided a current Comprehensive Care Plan Guideline policy, dated 5/22/18, that indicated "Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident ... Comprehensive care plans need to remain accurate and current". On 6/13/24 at 10:20 A.M., the DON provided a current policy "Guidelines for the Self-Administration of Medications" dated 12/31/23. The policy indicated there should be a "...Self- Medication plan of care initiated and updated as indicated...". 3.1-35(a) 3.1-35(b)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have			

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	access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 1 of 2 medication carts observed and 2 of 2 medication storage rooms observed. Loose pills were observed in a medication cart, a medication refrigerator was observed propped open with a temperature out of range, and medication refrigerator temperature logs were not filled out completely. (300 Hall Medication Cart, 300 Hall Medication Storage Room, 400 Hall Medication Storage Room) Findings include: 1. On 6/7/24 at 9:38 A.M., the 300 Medication Cart was observed with the following loose pills: 1 oblong yellow pill with marking "151" 1 white round pill with marking "D5" 1 clear gel capsule with no markings 1 round yellow pill with marking "RP101" 3 round yellow pills with marking "G127" 1 round white pill with marking "GC422" 4 round brown pills with marking "08075" 1 round pink pill with marking "RP101" 2 round white pills with no marking 1 oblong cream pill with marking "J75" 1 oblong white pill with marking "KCM20" 1 oblong lavender pill with no marking	F 0761	p="" paraid="37949767" paraeid="{3218fe51-8008-443d-b20b-531518260d4e}{83}">1. No residents noted to have any adverse effects from alleged deficiency of loose pills noted in medication carts and refrigerator temperature logs not filled out completely. 2. Audit completed on medication carts, medication rooms, and medication refrigerators to ensure all medication stored appropriately. Nursing staff educated on medication storage and refrigerator temperature logs being filled out completely. Medication refrigerator on 400 replaced. 3. DHS or designee will conduct random audits of medication carts to ensure no loose pills . Audit will be at random and will be on random hallways and times, and will be completed weekly for 1 month, then every other week for 2	07/10/2024

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	1 round white pill with marking "502" 1 round pink pill with marking "20" on one side and "CUP/N" on the other side 1 round peach pill with marking "1717" 1 round red pill with no marking 2 blue half pills with no marking 1 round white pill with marking "RX52B" 1 round pink pill with marking "L26" 1 off-white capsule with no marking 1 white capsule with marking "216" 1 oblong white pill with marking "VF" on one side and "41" on the other side 1 round white pill with marking "500" At that time, Registered Nurse (RN) 21 indicated nursing staff was responsible for cleaning the medication carts. 2. On 6/7/24 at 9:52 A.M., the 400 Hall Medication Storage Room was observed. The medication refrigerator was observed cracked open and the temperature reading on the inside of the refrigerator was 54 degrees Fahrenheit. At that time, a sign was observed posted on the outside of the refrigerator that indicated temperatures should be kept between 36 and 46 degrees Fahrenheit. The temperature log at that time was observed to be not filled out from June 1st through the 4th. On 6/7/24 at 2:00 P.M., the 400 Hall Medication Storage Room was observed with the medication refrigerator reading 34 degrees Fahrenheit. RN 9 indicated the temperature was too low and adjusted it. 3. On 6/7/24 at 10:02 A.M., the 300 Hall Medication Storage Room was observed. The most recent temperature log that was posted was dated May 2024 and lacked temperatures on 5/28/24, 5/29/24, and 5/30/24. A current month		months, then monthly for 3 months. DHS or designee will conduct random audits of temperature logs to ensure logs are filled out completely. Audit will be at random and will be on random hallways and times, and will be completed weekly for 1 month, then every other week for 2 months, then monthly for 3 months. 4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	

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	temperature log was not posted. At that time, the Unit Manager indicated there should have been a temperature log for June posted and would look for it and provide it. The June temperature log was not provided. The following medications were observed sitting on a shelf in the 300 Hall Medication Storage Room cabinet: 1 bottle of bisacodyl 5mg with no label and expiration date of 5/23 1 bottle of glucose tabs with no date or label 1 bottle of escitalopram 5mg, belonging to Resident 10 1 bottle of amlodipine 10mg, belonging to Resident 10 4 bottles of glimepiride 4mg, belonging to Resident 10 2 bottles of PreserVision AREDS with no label At that time, the Unit Manager indicated Resident 10 had come to that unit from the Assisted Living side of the facility and had probably brought those medications with her. She indicated the medications should have been disposed of, and any nurse that observed them in the medication storage room could have done it. On 6/10/24 at 11:21 A.M., the Administrator provided a current Medication Storage in the Facility policy, dated 11/18, that indicated "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier ... Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopeia guidelines for temperature ranges ... Medications requiring refrigeration are kept in a refrigerator at temperatures between 2°C (36°F) and 8°C (46°F) ... The Facility should maintain a temperature log			

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	in the storage area to record temperature at least once a day". On 6/11/24 at 1:17 P.M., the Director of Nursing (DON) provided a current Disposal of Medications and Medication-Related Supplies policy, dated 11/18, that indicated "Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, should be destroyed, given to the appropriate family member/responsible party, or returned to the pharmacy for destruction where permitted by regulations". 3.1-25(m) 3.1-25(o)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure staff were following proper infection control protocols during 3 of 3 random observations. Staff were not changing gloves after performing care and were entering and exiting Enhanced Barrier Protection (EBP) rooms without donning and doffing Proper Protective Equipment (PPE). (Resident room 400-unit, Resident 31, Resident 19) Findings include: 1. On 6/12/24 at 8:50 A.M., during a random observation of toileting, CNA (Certified Nurse's Aide) 25 was observed touching a resident's clothes without changing gloves after performing care. 2. On 6/11/24 at 11:24 A.M., CNA (Certified Nurse Aide) 3 and CNA 5 were observed assisting Resident 31 to use the toilet. CNA 3 and CNA 5 had on gloves. The resident was assisted to stand. CNA 3 wiped the resident's buttocks with toilet paper and pulled up his pants. At that time, CNA 3 did not change her gloves. CNA 3 retrieved the resident's wheelchair from outside the bathroom. CNA 3 and CNA 5 transferred the resident to his wheelchair. CNA 3 cleaned up the bathroom and emptied the trash and then removed her gloves.	F 0880	1.p paraid="1477262083" paraeid="{3218fe51-8008-443d-b20b-531518260d4e}{148}" >1. Resident 31 and Resident 19 were not affected by the alleged deficient practice. No adverse effects noted to Resident 31 and Resident 19. ·2. All residents have the potential to be affected. Education provided to facility staff on Enhanced Barrier Precautions and glove usage/hand hygiene during toileting/incontinence care. ·3. As a measure of ongoing compliance, the DHS or will complete random audits of care being given to residents that are currently on Enhanced Barrier Precautions to ensure appropriate	07/10/2024

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	On 6/12/24 at 11:37 A.M., the DON (Director of Nursing) indicated staff should change their gloves after cleaning a resident and between dirty and clean tasks. 3. On 6/14/24 at 9:30 A.M., Certified Nurse Aide (CNA) 3 and CNA 5 were observed to enter Resident 19's room. At that time, a sign on the outside of the door indicated the resident was on enhanced barrier precautions (EBP) and required staff to put on a gown and gloves when providing care and making direct contact with the resident. Resident 19 indicated to both CNAs that he wanted to be adjusted in the bed. CNA 3 and CNA 5 were observed from the hall to assist the resident to adjust in the bed without putting on gloves or a gown. After the aides left the room, Resident 19 indicated the aides did not put on a gown or gloves when providing care for him. On 6/10/24 at 1:57 P.M., Resident 19's clinical record was reviewed. Diagnosis included, but was not limited to, obstructive uropathy and renal insufficiency. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/29/24, indicated a mild cognitive impairment, substantial to maximal assistance with bed mobility, and no behaviors or rejection of care. Current physician orders included, but were not limited to: Staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities (related to urinary catheter), dated 4/3/24. A current enhanced barrier precautions care plan, dated 4/1/24, indicated EBP was required during high-contact care related to presence of an indwelling catheter.		PPE being utilized. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. ·DHS or designee will complete random audits of care being given to residents to ensure proper glove/hand hygiene completed when providing toileting/incontinence care. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. ·4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	

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	On 6/11/24 at 1:06 P.M., the Director of Nursing (DON) provided a current EBP policy, dated 4/1/24, that indicated "Personal Protective Equipment (PPE) should be used even if blood and body fluid exposure is not anticipated ... At minimum, staff shall wear gloves and gowns during high-contact care activities". On 6/13/24 at 10:20 A.M., the DON (Director of Nursing) provided a current "Standard Precautions Guidelines" policy revised on 12/31/23. The policy indicated "...Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered...standard precaution include but are not limited to hand hygiene,...the proper use of PPE (example gloves, gown,)...in addition to proper hand hygiene, it is important for staff to use appropriate protective equipment as a barrier to exposure to any body fluids (whether known to be infected or not)...". 3.1-18(b) 3.1-18(j) 3.1-18(l)			
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza			

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	immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education			

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	regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure education was provided prior to administering flu vaccines for 5 of 5 residents reviewed for vaccines. (Resident 27, Resident 12, Resident 12, Resident 29, Resident 30) Findings include: On 6/10/24 at 8:41 A.M., resident vaccine information was reviewed for the following residents: 1. Resident 27 received a flu vaccine on 10/4/23. The clinical record lacked information about education provided to the resident and/or resident representative prior to administering the vaccine. 2. Resident 13 received a flu vaccine on 10/4/23. The clinical record lacked information about education provided to the resident and/or resident representative prior to administering the vaccine. 3. Resident 12 received a flu vaccine on 10/4/23. The clinical record lacked information about education provided to the resident and/or resident representative prior to administering the vaccine. 4. Resident 29 received a flu vaccine on 10/4/23. The clinical record lacked information about education provided to the resident and/or resident representative prior to administering the vaccine. 5. Resident 30 received a flu vaccine on 10/4/23. The clinical record lacked information about	F 0883	ol="" role="list" start="1" 1. Residents 27, 12, 29, and 30 were not affected by the alleged deficient practice. Residents 27, 12, 29, and 30 assessed and no adverse effects noted. 2. All residents have the potential to be affected. Nursing personnel educated on ensuring education provided to resident's responsible party/self and documented when offering and/or providing vaccinations to residents. ol="" role="list" start="3" 3. As a measure of ongoing compliance, the DHS or designee will complete random audits of vaccinations to ensure appropriate education was provided and documented. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 4. As a quality measure, the DHS 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	07/10/2024

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	education provided to the resident and/or resident representative prior to administering the vaccine. On 6/12/24 at 10:37 A.M., the Director of Nursing (DON) indicated she had administered the flu vaccines this season and was unaware that education for the flu vaccine was needed annually prior to administration. On 6/7/24 at 2:00 P.M., the Administrator provided a current Influenza Immunization policy, dated 4/12/17, that indicated "Each resident/responsible party will be provided annually with information regarding the risk and benefits of influenza vaccine and receive the immunization per their request, unless medically contraindicated". 3.1-13(a)		warranted. Ongoing monitoring will past 6 months, if needed, until 100% compliance .	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: June 7, 10, 11, 12, & 13, 2024 Facility number: 002280 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	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 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	

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

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			for substantial compliance. Corrections to be completed by 7/10/24.	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on interview, record review, and observation, the facility failed to ensure the oxygen equipment was maintained in a safe and operational condition to meet the needs of the resident for 1 of 1 residents reviewed for oxygen administration. (Resident 152) Finding includes: On 6/10/24 at 2:42 P.M., Resident 152's clinical record was reviewed. Resident 152 was admitted on 8/10/23. Diagnoses included, but were not limited to, diabetes mellitus and COPD (chronic obstructive pulmonary disease). Current physician orders included, but were not limited to: Clean external concentrator filter every two weeks, start date 12/31/23. During an observation on 6/11/24 at 9:18 A.M., Resident 152 was receiving oxygen via nasal cannula attached to an oxygen concentrator located behind the recliner Resident 152 was sitting in. Thick dust covering air intake was observed on the concentrator and the humidification bottle and oxygen tubing lacked dates. At 9:29 A.M., the maintenance employee opened the filter door, removed the soiled filter, and indicated filters are changed and cleaned by	R 0145	1.p paraid="26298436" paraeid="{2e539fab-ec9d-44dc-9c99-deaab04cc7dc}{11}" >1. Resident 152 was not affected by the alleged deficient practice. No adverse effects noted. ·2. All residents have the potential to be affected. Resident 152's oxygen concentrator has been cleaned and tubing was replaced and dated appropriately. residents' respiratory equipment has been inspected and cleaned as needed, tubing has been checked to ensure dated appropriately. Education provided to nursing personnel on respiratory equipment policy and procedures. ·3. As a measure of ongoing	07/10/2024

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	(oxygen company) when the company took the concentrators back from the facility. During an interview on 6/11/24 at 11:36 A.M., the Director of Nursing indicated (oxygen company) came weekly to check all concentrator filters, refill oxygen tanks, and remove oxygen concentrators no longer in use from the building. On 6/11/24 at 4:43 P.M., the Director of Nursing provided a policy titled Respiratory Equipment, dated 12/31/23, that indicated "To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to residents and staff ... Wash filters from oxygen concentrators every month and PRN (as needed) in soapy water. Rinse and squeeze dry".		compliance, the DHS or will complete random audits of respiratory equipment to ensure equipment is free from dust and tubing is dated appropriately. Audit will consist of 3 residents weekly for 1 month, then 3 residents every other week for 2 months, then 3 residents monthly for 3 months. ·4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the			

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	activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a resident, evaluated as unable to self administer medications, was free of accessible medications in their room during 1 of 1 random observations. (Resident 153) Finding includes: During an observation on 6/10/24 at 1:36 P.M., Resident 153 had a bottle of Tylenol extra strength, Deep Sea nasal spray, and Vicks vapor rub on his bedside table. On 6/10/24 at 2:15 P.M., Resident 153's clinical record was reviewed. Resident 153 was admitted on 3/11/22. Diagnoses included, but were not limited to, asthma and neuromuscular dysfunction of the bladder. The most recent service plan, dated 2/19/24, indicated the following: Resident has no pain- does not require any form of pain intervention routine or PRN (as needed) and complains of no pain. Resident is moderately cognitively impaired. Resident requires assist to administer, organize or store medications- staff provide any medication to resident. Current physician orders included, but were not limited to: Vicks vapor rub 4.8-1.2-2.6%: 1 application:	R 0216	1.p paraid="1660711106" paraeid="{2e539fab-ec9d-44dc-9c99-deaab04cc7dc}{123}" >1. Resident 153 was not affected by the alleged deficient practice. Resident 153 was assessed, and no adverse effects noted. ·2. All residents with medications at bedside have been assessed for ability to self-administer medications following the self-administration policy. Education provided to nursing personnel on self-administration policy. Education provided to family members regarding bringing over the counter medications into facility. ·3. As a measure of ongoing compliance, the DHS or will complete random audits of resident rooms for any	07/10/2024

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	topical, May keep at bedside, every four hours as needed. Start date 4/8/23. Saline Nasal (sodium chloride) aerosol spray 0.65%: 1 spray each nostril, May keep at bedside. Every four hours as needed. Start date 4/8/23. Make sure not to leave resident medications in his room. Watch him take them. Three times a day, start date 4/8/23. The record lacked a physician order for Tylenol (acetaminophen). During an interview on 6/11/23 at 1:09 P.M., The Director of Nursing indicated Resident 153 did not have an approved medication self administration evaluation, should not be self administering medications, and the orders that said "may keep at bedside" were not updated. On 6/11/24 at 4:43 P.M., the Director of Nursing provided a policy titled Guidelines for Self Administration of Medications, dated 12/31/23, that indicated "To ensure the safe administration of medication for residents who request to self-medicate or when self- medication is a part of their plan of care ... Residents requesting to self-medicate or has self- medication ass a part of their plan of care shall be assessed using the observation Trilogy- Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication ... The assessment will be documented in the EHR (electronic health record)".		medications at bedside. Audit will consist of 3 residents weekly for 1 month, then 3 residents every other week for 2 months, then 3 residents monthly for 3 months. ·4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any			

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	actual or potential detrimental effects to the resident. Based on observation, interview, and record review, the facility failed to ensure a resident was administered the correct dose of a medication for 1 of 5 residents observed during medication administration observation. (Resident 157) Finding includes: During a medication administration on 6/11/24 at 7:10 A.M., QMA (Qualified Medication Aide) 12 was observed preparing and administering the following medications for Resident 157: Atorvastatin (used to lower cholesterol) 40 mg (milligrams) one tablet B12 vitamin one gummy Felodipine (medication used to lower blood pressure) 5 mg one tablet Lisinopril (medication used to lower blood pressure) 5 mg one tablet Vitamin D3 one tablet Lorazepam (antianxiety medication) 1 mg one tablet The label located on the bottle of B12 vitamin gummies indicated each gummy was 500 mcg (micrograms); take two gummies per serving size to equal 1000 mcg. On 6/11/24 at 7:45 A.M., Resident 157's clinical record was reviewed. Physician orders included, but were not limited to: Atorvastatin 4 mg once a day, start date 9/30/22 Vitamin B12 1000 mcg, one tablet every other day, start date 5/20/24 Felodipine 5 mg once a day, start date 9/30/22 Lisinopril 5 mg once a day, start date 9/30/22 Vitamin D3 50 mcg once a day, start date 3/21/24 Lorazepam 1 mg twice a day, start date 9/30/22	R 0247	1.p paraid="304691000" paraeid="{2e539fab-ec9d-44dc-9c99-deaab04cc7dc}{193}" >1. Resident 157 was not affected by the alleged deficient practice. Resident 157 was assessed, and no adverse effects noted. ·2. All residents have the potential to be affected. Nursing personnel medication administration and five rights. ·3. As a measure of ongoing compliance, the DHS or will complete random audits of medication administration to ensure five rights being followed. Audit will consist of 3 residents weekly for 1 month, then 3 residents every other week for 2 months, then 3 residents monthly for 3 months. ·4. As a quality measure, the DHS or designee will review any	07/10/2024

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	During an interview on 6/11/24 at 2:36 P.M., the Director of Nursing indicated the pharmacy sometimes did a therapeutic interchange and sent a different form of a medication, but the medication would contain the same dosage. The Director of Nursing indicated the order and the label did not match and would put a sticker over the label to notify staff of the dosage correction. On 6/11/24 at 1:58 P.M., the Administrator provided a policy titled Specific Medication Administration Procedures, dated 11/18, and indicated "Review five rights (3) times. Prior to removing the medication from the container, check the label against the order on the MAR (medication administration record)".		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 past 6 months, if needed, until 100% compliance .	
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on observation, interview, and record review, the facility failed to ensure medications	R 0306	ol class="NumberListStyle1 SCXW19241377 BCX0" role="list"	07/10/2024

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	were properly disposed of for 1 of 5 residents observed during medication administration. (Resident 153) Finding includes: During a medication administration on 6/11/24 at 7:10 A.M., QMA (Qualified Medication Aide) 12 was observed preparing medications for Resident 153. These medications included one tablet of memantine (medication used to treat dementia) 10 mg (milligrams) and one tablet of a multivitamin. QMA 12 entered Resident 153's room, assisted Resident 153 to a sitting position, and handed Resident 153 a medicine cup containing both pills. Resident 153 dropped the memantine 10 mg tablet on the floor. QMA 12 picked the pill up and threw it away in the trash can next to Resident 153's bed. On 6/10/24 at 2:15 P.M., Resident 153's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and neuromuscular dysfunction of the bladder. The most recent service plan, dated 2/19/24, indicated the following: Resident is moderately cognitively impaired. Resident requires assist to administer, organize or store medications- staff provide any medication to resident. Current physician orders included, but were not limited to: Memantine tablet 10 mg twice a day, start date 4/8/23. Multivitamin one tablet once a day, start date 4/8/23. During an interview on 6/11/24 at 2:36 P.M., the Director of Nursing (DON) indicated if		start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" 1. Resident 153 was not affected by the alleged deficient practice. No adverse effects noted to Resident 153. ol class="NumberListStyle1 SCXW19241377 BCX0" role="list" start="2" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" 2. All residents have the potential to be affected. Nursing personnel educated on proper medication destruction and disposable. ·3. As a measure of ongoing compliance, the DHS or designee will complete random audits of medication administration to ensure proper medication destruction and disposable procedures are followed if indicated. Audit will consist of 3 residents weekly for 1 month, then 3 residents every other week for 2 months, then 3 residents monthly for 3 months.	

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	medications are dropped during medication administration, staff should put dropped medications in drug dissolvent solution. On 6/11/24 at 1:17 P.M., the DON provided a policy titled Disposal of Medications and Medication-Related Supplies, dated 11/18, and indicated "Destruction methods should comply with federal and state laws and regulations for medication destruction. Some options to dispose of prescription drugs include ... Mix drugs with an undesirable substance".		·4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	
R 0413 Bldg. 00	410 IAC 16.2-5-12(j) Infection Control - Deficiency (j) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident only to the degree needed to isolate the infecting organism. Based on observation, interview, and record review, the facility failed to ensure infection control precautions were followed for 1 of 1 residents observed for wound care. (Resident 152) Finding includes: During an observation on 6/10/24 at 1:25 P.M., Home Health Nurse (HHN) 17 was observed in Resident 152's room performing wound care on Resident 152's bilateral lower legs. HHN 17 was not wearing a gown.	R 0413	p="" paraid="1867669939" paraeid="{c5ab07af-797e-4ea9-bc88-e0e0a91575bb}{98}">1. Resident 152 was not affected by the alleged deficient practice. No adverse effects noted to Resident 152. 2. Education provided to facility staff/home health company on Enhanced Barrier Precautions. 3. As a measure of ongoing compliance, the DHS or will	07/10/2024

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	During an observation on 6/11/24 at 9:18 A.M., QMA (Qualified Medication Aide) 12 was observed in Resident 152's room assisting Resident 152 in the bathroom with toileting, assisting with ambulating from the bathroom back to the recliner, and assisting with transferring with a walker to sitting position in the recliner. QMA 12 was not wearing gloves or a gown. QMA 12 then asked Resident 152 if he knew where the gloves in his room were. QMA 12 put on a pair of gloves and administered eye drops to Resident 152. A sign was observed on Resident 152's door at that time that indicated "Enhanced Barrier Precautions everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care". During an interview on 6/11/24 at 2:36 P.M., the Director of Nursing (DON) indicated PPE (personal protective equipment) for EBP (enhanced barrier precautions) should be worn during high contact. On 6/11/24 at 1:06 P.M., the DON provided a policy titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated 4/1/24, that indicated "Enhanced barrier precautions will be in place during high-contact care activities for residents with the following conditions: All residents with chronic wounds, including but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Personal protective equipment (PPE) should be used even if blood and body fluid		complete random audits of care being given to residents that are currently on Enhanced Barrier Precautions to ensure appropriate being utilized. Audit will consist of 3 residents weekly for 1 month, then 3 residents every other week for 2 months, then 3 residents monthly for 3 months. 4. As a quality measure, the DHS 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 past 6 months, if needed, until 100% compliance .	

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	exposure is not anticipated. At minimum, staff should wear gloves and gowns during high-contact care activities".			