STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVEROAKS HEALTH CAMPUS	1244 VAIL ST PRINCETON, IN 47670

(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 the Investigation of Complaints IN00444096, IN00440076, and the State Residential Licensure Survey. Complaint IN00440076 - Federal/State deficiencies related to the allegations are cited at an F880. Complaint IN00444096 - No deficiencies related to the allgations are cited. Survey dates: September 30, October 1, 2, 3, and 4, 2024 Facility number: 004130 Provider number: 155732 AIM number: 200491050 Census Bed Type: SNF/NF: 35 SNF: 21 Residential: 35 Total: 91 Census Payor Type: Medicare: 15 Medicaid: 31 Other: 10 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 9, 2024.	F 0000	Assisted Living The submission of this plan of correction does not indicate an admission by River Oaks Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of River Oaks 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted September 30, 2024, through October 4, 2024. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Aaron Stephens	Executive Director	10/25/2024

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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F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure a notice of transfer was completed for 1 of 4 residents reviewed for hospital transfers. (Resident 21) Finding includes: On 10/2/24 at 10:34 A.M., Resident 21's clinical record was reviewed. The diagnosis included, but was not limited, to encephalopathy. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/28/24, indicated Resident 21 was moderately cognitively intact. A nursing progress note, dated 8/16/24 at 2:04 P.M., indicated Resident 21 had returned from the dentist after oral surgery. On 10/3/24 at 1:51 P.M., Regional Support 27 provided transfer discharge paperwork sent with Resident 21 to his appointment on 8/16/24. "Notice of Transfer or Discharge" and "Notice of Transfer Discharge Request for Hearing" were blank and did not include any resident information or reason for transfer. On 10/4/24 at 11:23 A.M., Regional Support 27 provided a document titled "Guidelines for Transfer and Discharge", dated 5/3/17, that indicated to record the reason for, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged in the medical record and on a discharge form. 3.1-12(a)(6)(A)(i)	F 0623	1. Resident 21 was affected, with no adverse effects as a result of the incomplete notice of transfer/discharge. Resident 21 returned after his appointment and was not discharged from campus. 2. All residents transferred from the facility have the potential to be affected. Social Service Director and nursing staff educated on completion and process for sending notice of transfer/discharge paperwork for residents leaving the campus. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 transfers/discharges, as available, for completion of notice of transfer and discharge three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then every other week x 4 weeks, then monthly x 2 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	10/31/2024

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F 0635 SS=D Bldg. 00	483.20(a) Admission Physician Orders for Immediate Care Based on observation, record review, and interview, the facility failed to ensure a newly admitted resident had immediate orders for an indwelling urinary catheter for 1 of 1 residents reviewed for urinary catheters. (Resident D) Findings include: On 9/30/24 at 9:40 A.M., staff was observed to be transferring Resident D. Resident D was observed to have a urinary catheter at that time. On 10/1/24 at 3:00 P.M., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, facial/skull fracture, subdural hemorrhage (type of brain bleed), and subarachnoid hemorrhage (type of brain bleed). Resident D was admitted 9/20/24 Resident D's clinical record lacked orders for an indwelling urinary catheter and/or catheter care. On 10/3/24 at 10:30 A.M., Resident D's clinical record was reviewed. A Nursing Assessment, dated 10/2/24 at 12:37 A.M., indicated Resident D did not have an indwelling urinary catheter. On 10/3/23 at 12:39 P.M., Regional Support RN indicated catheters would have been assessed upon the initial admission nursing assessment. The orders and care plans were not always put in immediately as the facility allowed time for physician's to assess medical indication for the catheter. A policy provided by the Administrator on 10/3/24 at 12:00 P.M., on indwelling catheter use	F 0635	1. Resident D was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Physician updated with orders to discontinue foley catheter received. Catheter was discontinued on 10/2/24; urinary status monitored post removal with no adverse effects. 2. All residents with indwelling urinary catheters have the potential to be affected. Audit completed for all residents with catheters to ensure appropriate physician orders are in place. Nursing staff educated on admission process with checklist and ~~foley~~ indwelling urinary catheter orders/maintenance. IDT (Interdisciplinary team) educated to monitor admission checklist for newly admitted residents daily in Clinical Care Meeting (CCM). 3. As a measure of ongoing compliance, the DHS or designee, will: a) audit 3 residents with indwelling urinary catheters for appropriate orders three times weekly x 4 weeks, then twice times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. b) audit 3 newly admitted residents for admission checklist completion three times weekly x 4 weeks, then twice times weekly x	10/31/2024

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	indicated a resident who enters the campus with an indwelling urinary catheter, or subsequently receives one is assessed for removal as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. 3.1-30(a)		4 weeks, then weekly x 4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure care plans were revised quarterly for 1 of 5 residents reviewed for unnecessary medications. (Resident 36) Findings include: On 10/2/24 at 1:04 P.M., Resident 36's clinical record was reviewed. The diagnoses included, but were not limited to, major depressive disorder, restlessness and agitation, and mild cognitive impairment. The current Annual MDS (Minimum Data Set) assessment, dated 9/18/24, indicated Resident 36 was mildly cognitively impaired and did not receive hypnotic medications during the assessment period. The record lacked an order for a hypnotic medication. A current care plan for psychotropic drug use	F 0657	1. Resident #36 suffered no adverse effects. Resident #36's care plan included a high-risk medication care plan active for hypnotic medication. The resident did not have a hypnotic medication coded on the most recent MDS on 9/18/24 and did not have an active order for a hypnotic medication. The MDS nurse was educated, and the care plan was modified to reflect the resident's current status. 2. All residents have the potential to be affected. All current resident's care plans have been reviewed for accuracy related to high-risk medications. The MDS coordinator and Social Service Coordinator have been educated on accurate care plan development and modification. 3. As a measure of ongoing	10/31/2024

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	indicated the resident was at risk for adverse consequences related to receiving a hypnotic medication for insomnia, initiated 11/6/23. During an interview on 10/3/24 at 9:18 A.M., the MDS Coordinator indicated when a medication was discontinued the care plan needed to be updated. On 10/4/24 at 11:23 A.M., the Regional Support Nurse provided a current policy "Comprehensive Care Plan Guidelines" revised 12/31/18. The policy indicated "... the purpose of the comprehensive care plan was to ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions...in accordance with state and federal guidelines...comprehensive care plans should be reviewed no less than quarterly and revised to reflect changes in the resident's condition as they occur. 3.1-35(d)(2)(B)		compliance, the MDSC or designee will conduct an audit of three residents for correct care planning related to high-risk medications weekly x 4 weeks, then twice per month x 2 months, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on interview, observation, and record review, the facility failed to ensure professional standards of practice were implemented for a PICC (Peripherally Inserted Central Catheter) for 1 of 1 residents reviewed for a PICC line. Physician orders were not followed and a care plan was not developed. (Resident T) Finding includes: During an interview on 9/30/24 at 10:50 A.M., Resident T indicated he had a PICC line for a while	F 0694	1. Resident T was assessed with no findings and suffered no ill physical or psychosocial effects from the alleged deficient practice. The PICC (Peripherally Inserted Central Catheter) was removed on 10/9/24 per physicians order and the resident was monitored post removal with no adverse effects. 2. All residents with PICC lines have the potential to be affected. An audit was completed to ensure all orders for intravenous	10/31/2024

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	but was unsure why he had it. Resident T pulled back the sleeve of his shirt and revealed a PICC on the right side of his chest. The insertion site of the catheter was distal to the right subclavian and appeared to be in the location of a central venous catheter. On 10/2/24 at 9:53 A.M., Resident T's clinical record was reviewed. The diagnoses included, but were not limited to, bacteremia and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 7/30/24, indicated Resident T was cognitively intact and did not have IV (intravenous) access. Physician orders included, but were not limited to: - Change end caps every 96 hours every four days, start date 7/28/23. - Monitor IV site for signs/symptoms of infiltration twice a day, start date 7/28/23. - PICC line flush five mL (milliters) of normal saline every 12 hours, start date 7/28/23. - PICC dressing change every five days, measure external catheter length, enter in measurement note once a day every five days, start date 11/14/23. The clinical record lacked care plans related to IV/PICC. A nursing progress note, dated 7/28/23 at 5:00 P.M., indicated Resident T returned to the facility from the hospital with a PICC line placed centrally to right clavicle. A nursing progress note, dated 9/8/23 at 1:18 P.M., indicated a call was made to infectious disease regarding future lab work and if the line		access device maintenance are following professional standards of nursing practice. Education provided to nursing staff for intravenous access device professional standards of practice. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents with intravenous access, as available, for compliance with professional standards three times weekly x 4 weeks, then twice times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	was to remain in place. No further labs were needed, and the physician indicated the facility could remove the line per infectious disease. A nursing progress note, dated 9/27/24 at 2:04 P.M., indicated Resident T's suture site on PICC line was red, warm, and purulent drainage noted. A nursing progress note, dated 9/30/24 at 4:55 P.M., indicated the nurse attempted to remove the PICC line and met resistance when removing line. A nursing progress note, dated 9/30/24 at 5:16 P.M., indicated the physician was notified with order to arrange an appointment with the hospital for PICC line removal. During an observation on 10/3/24 at 10:38 A.M., Resident T's PICC line insertion site and suture sites were observed to be red. During an interview on 10/3/24 at 1:33 P.M., the DON and Clinical Support 25 indicated Resident T received the PICC line July 2023 for osteomylitis. They indicated a PICC line was typically removed after the course of antibiotics were finished. Resident T should have been marked as having IV access on the MDS assessment and should have had a care plan for the PICC line. During an interview on 10/4/24 at 11:35 A.M., Regional Clinical Support 29 stated there was no documentation of Resident T's refusal to remove the PICC line, education provided after a refusal of removal, or why the physician order to remove the PICC line was not followed. On 10/3/24 at 11:59 A.M., a policy related to IV care and a PICC line care skills check off were requested and were not provided.			

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F 0759 SS=D Bldg. 00	3.1-47(a)(2) 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure residents were free of a medication error rate greater than 5 percent for 2 of 35 opportunities, resulting in a medication error rate of 5.71 percent. (Resident W) Finding includes: On 10/2/24 at 7:02 A.M., Registered Nurse (RN) 17 was observed administering medication to Resident W. Two and a half milliliters of liquid famotidine (antacid medication) mixed with water was administered via the resident's gastric tube. Carboxymethylcellulose (eye lubricant) eye drops were administered to each of the resident's eyes. RN 17 lifted the upper eyelids with a gloved finger and dropped one drop onto each eye. On 10/2/24 at 8:07 A.M., Resident W's clinical record was reviewed. The diagnoses included, but were not limited to, malignant neoplasm of colon and chronic duodenal ulcer with hemorrhage. The most current Quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated Resident W was not assessed for cognitive ability due to rarely or never being understood and had a feeding tube. Physician orders included, but were not limited to: - Famotidine suspension for reconstitution 40 milligrams (mg)/5 milliliters (ml) - Give 2.5 ml by gastric tube twice a day, dated 8/28/24 and discontinued on 9/24/24.	F 0759	1. Resident W was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. MD, resident and family notifications completed. All medication carts were immediately checked for discontinued medications and removed as appropriate. Nurse immediately educated on professional standards for eye drop administration. 2. All residents have the potential to be affected. Nursing staff educated on removal/destruction of discontinued medication and eye drop administration procedure. DHS/ADHS completed eye drop administration competency check off for all nurses and QMA's. 3. As a measure of ongoing compliance, the DHS or designee will: a) audit 3 medication carts for expired medications five times weekly x 4 weeks, then three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. b) observe 3 nurses administer eye drops correctly per policy three times weekly x 4 weeks,	10/31/2024

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	- Lubricant Eye Drops (carboxymethylcellulose sodium) 0.5 percent, give one drop per eye for dry eyes four times a day as needed, dated 9/25/23. A progress note, dated 9/24/24 at 1:34 A.M., indicated that the physician discontinued the famotidine. On 10/3/24 at 11:22 A.M., RN 23 indicated eye drops are administered by pulling down on the lower eyelid and dropping the medication in the pouch in the lower eyelid. At that time, she indicated discontinued medications were removed from the cart and destroyed. On 10/3/24 at 1:34 P.M., the Director of Nursing indicated Resident W's liquid famotidine was discontinued on 9/24/24. On 10/3/24 at 10:53 A.M., Regional Support 27 provided a current Specific Medication Administration Procedures: Eye Drop Administration policy, revised 11/2018, that indicated "With a gloved finger, gently pull down lower eyelid to form "pouch", while instructing resident to look up ... Hold inverted medication bottle between the thumb and index finger, and press gently to instill prescribed number of drops into "pouch" near outer corner of eye". On 10/4/24 at 12:15 P.M., Regional Support 25 provided a current Disposal of Medications and Medication-Related Supplies policy, revised 11/2018, that indicated "Medications are removed from the medication cart or active supply upon receipt of an order to discontinue". 3.1-48(c)(1)		then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure clinical records were accurate and complete for 1 of 1 residents reviewed for falls. Neurological checks were not documented. (Resident 36) Findings include: On 10/2/24 at 1:04 P.M., Resident 36's clinical record was reviewed. The diagnoses included, but were not limited to, unsteadiness on feet, abnormalities of gait and mobility, and history of falling. The current Annual MDS (Minimum Data Set) assessment, dated 9/18/24, indicated Resident 36 was mildly cognitively impaired. Resident 36 needed substantial assistance with transfer and hygiene and had recent falls. An Event Report from an unwitnessed fall on 7/31/24, indicated Resident 36 did not have neurological checks documented after the fall. An Event Report from an unwitnessed fall on 8/11/24, indicated Resident 36 did not have neurological checks documented after the fall. An Event Report from an unwitnessed fall on 8/25/24, indicated Resident 36 did not have neurological checks documented after the fall. During an interview on 10/4/24 at 10:21 A.M., the Regional Support Nurse indicated there were no neurological checks documented after 11:15 A.M. on 7/31/24. There were no order sets initiated for neurological checks initiated for falls on 7/31/24,	F 0842	1. Resident 36 was assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Assessment revealed no change in neurological status baseline. 2. All residents experiencing a fall have the potential to be affected. Audit completed for all residents with fall in last 30 days; any resident identified to have missing or incomplete documentation of neuro checks assessed and MD notified as indicated. No changes in any baseline neurological status identified. Nurses educated on neurological check indications, physicians orders, documentation and thorough completion. IDT educated to monitor neurological check completion per policy in Clinical Care Meeting daily. 3. As a measure of ongoing compliance, the DHS or designee will audit 3 residents who experience a fall for neurological check completion, as warranted, 3 times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure	10/31/2024

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	8/11/24, and 8/25/24. On 10/4/24 at 11:23 A.M., the Regional Support Nurse provided a current policy "Guidelines for Neurological Checks", revised 12/31/23. The policy indicated "...neuro-checks for 24 hours should be completed within the Fall Event Form..." 3.1-50(a)(1) 3.1-50(a)(2)		substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to implement infection control practices for 6 of 6 residents reviewed for EBP (Enhanced Barrier Precautions). Signs were not posted, orders were not initiated, and gowns were not worn during high contact activities. (Resident T, Resident S, Resident D, Resident L, Resident W, Resident V) Findings included: 1. On 9/30/24 at 1:48 P.M., during a random observation there was no EBP sign on Resident L's door. On 10/1/24 at 9:00 A.M., during a random observation there was no EBP sign on Resident L's door. On 10/02/24 at 10:28 A.M., during a random observation there was no EBP sign on Resident L's door. On 10/2/24 at 10:11 A.M., Resident L's clinical record was reviewed. The diagnoses included, but were not limited to, anemia, COPD (Chronic	F 0880	1. Residents T, S, D, L, W and V were assessed with no findings and suffered no ill physical or psychosocial effects from the deficient practice. Residents reviewed for indications and continued need for Enhanced Barrier Precautions (EBP). MD updated with orders added and EBP initiated as appropriate. Nursing staff educated immediately regarding EBP indications and process. 2. All residents have the potential to be affected. Audit completed for all residents to identify residents requiring EBP. MD notified, orders updated and EBP initiated for any resident without EBP currently in place. Staff educated regarding EBP indication, implementation and execution. IDT educated to monitor all residents for EBP indications daily during CCM. 3. As a measure of ongoing	10/31/2024

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	155732	A. BUILDING 00 B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Obstructive Pulmonary Disease), and generalized edema. Current Physician included but were not limited to: - Staff to use enhanced barrier precautions, wearing a gown and gloves at minimum during high-contact care activities twice a day, initiated 9/28/24. The Care Plans included, but were not limited to: Enhanced barrier protocol initiated on 9/30/24. The goal was to minimize the transmission of infection from wound by utilizing EBP. Interventions included, but were not limited to: Utilize gown and gloves per EBP policy during wound care/dressing changes, initiated on 9/30/24. 2. On 9/30/24 at 9:45 A.M., Resident W's door was observed without an EBP sign on the door. During a confidential interview during the survey from 9/30/24 to 10/4/24, it was indicated that staff do not wear gowns while providing care for Resident W. On 10/2/24 at 8:49 A.M., Resident W's clinical record was reviewed. The diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and malignant neoplasm of colon. The most current Quarterly Minimum Data Set (MDS) assessment, dated 7/10/24, indicated Resident W was not assessed for cognitive ability due to rarely or never being understood, was dependent on staff for toileting, and had a feeding tube and an indwelling urinary catheter. Physician orders included, but were not limited to: - Resident requires EBP during high-contact care		compliance, the Infection Preventionist or designee will: a) audit 5 residents for EBP indication and implementation five times weekly x 4 weeks, then three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. b) observe 3 staff providing care for residents in EBP to ensure proper source control five times weekly x 4 weeks, then three times weekly x 4 weeks, then twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	related to presence of indwelling catheter, dated 5/1/24. - Staff to use EBP, wearing a gown and gloves at minimum during high-contact care activities due to indwelling catheter and g-tube, dated 8/28/24. An EBP care plan, dated 5/1/24, included an intervention to utilize gown and gloves per EBP policy during high contact Activities of Daily Living (ADL) care and during linen changes. 3. On 9/30/24 at 11:50 A.M., Resident V's door was observed without an EBP sign on the door. On 10/2/24 at 6:56 A.M., Resident V indicated that the sign was not there before that morning and was not sure why it was hung up. On 10/1/24 at 2:33 P.M., Resident V's clinical record was reviewed. The diagnosis included, but was not limited to, pressure ulcer of left buttock. The most current Quarterly MDS assessment, dated 7/12/24, indicated Resident V was cognitively intact and had one stage four pressure ulcer. Current physician orders included, but were not limited to: - Staff to use EBP, wearing a gown and gloves at minimum during high-contact care activities, dated 10/1/24. The clinical record lacked physician orders for EBP prior to 10/1/24. A current EBP care plan, dated 5/1/24, included an intervention to utilize gown and gloves per EBP policy during high-contact care related to presence of wound with dressing change and			

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	colostomy. 4. On 9/30/24 at 9:40 A.M., staff was observed to be transferring Resident D. Resident had a urinary catheter at that time. No enhanced barrier precaution sign was observed and staff were not wearing protective gowns. During an observation on 9/30/24 at 2:40 P.M., a staff member was observed assisting Resident D transferring to bed. Resident D was observed to have a urinary catheter. There was no enhanced barrier precaution sign in Resident D's room or on the door and the staff member was not wearing a gown. On 10/1/24 at 3:00 P.M. Resident D's clinical record was reviewed and indicated they had diagnoses that included, but were not limited to facial/skull fracture, subdural hemorrhage (type of brain bleed), and subarachnoid hemorrhage (type of brain bleed). Resident D's clinical record lacked an order for enhanced barrier precautions. On 10/1/24 at 3:40 P.M., an enhanced barrier precaution sign was observed on Resident D's door. Regional Support 27 indicated the precaution was most likely due to a wound because the resident did not have a catheter. On 10/1/24 at 4:45 P.M. the ADON indicated that Resident D was on enhanced barrier precautions due to having a catheter. 5. During an observation on 9/30/24 at 10:43 A.M., there was not an enhanced barrier precaution sign in Resident S's room or on the door and no cart containing gowns or gloves near Resident S's room.			

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	On 10/2/24 at 12:59 P.M., Resident S's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The most recent Quarterly MDS assessment, dated 9/20/24, indicated Resident S was severely cognitively impaired, required substantial assistance (staff does more than half the help) for toileting, bathing, and transfers, and had an unhealed wound. 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, started on 10/1/24. 6. During an observation on 9/30/24 at 10:48 A.M., there was not an enhanced barrier precaution sign in Resident T's room or on the door and no cart containing gowns or gloves near Resident T's room. On 10/2/24 at 9:53 A.M., Resident T's clinical record was reviewed. The diagnosis included, but was not limited to, obstructive and reflux uropathy. The most recent Quarterly MDS assessment, dated 7/30/24, indicated Resident T was cognitively intact, required substantial assistance (staff does more than half the help) for bathing, toileting, and transfers, and had a urinary catheter. 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, started on 10/1/24. During an interview on 10/4/24 at 9:38 A.M.,			

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	Regional Clinical Support 29 indicated resident's were missing enhanced barrier precautions and orders because the facility was not consistent. On 10/3/24 at 12:00 P.M., the Administrator provided a document titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated 4/1/24, that indicated EBP would 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 and all residents with indwelling medical devices. 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 activities. This citation related to complaint IN00440076. 3.1-18(b)(1)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP had not received specialized training in infection prevention and control when starting as the IP. This had the potential to affect 56 of 56 residents residing in the facility. Finding includes: On 10/4/24 at 9:38 A.M., the Assistant Director of Nursing (ADON) indicated that she was currently responsible for the infection prevention and control program in the facility. She indicated she	F 0882	1. No residents were affected by the alleged deficient practice. The current Infection Preventionist has completed required specialized training and maintains responsibility for the facility Infection Control program. 2. All residents have the potential to be affected. Executive Director and Director of Health Services educated regarding facility requirements for designation of certified Infection Preventionist (IP) and program	10/31/2024

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	was able to dedicate approximately 5-10 hours per week on the infection control program. On 10/4/24 at 11:25 A.M., the ADON's employee record was reviewed. The ADON had begun the role as IP on 6/4/24, prior to obtaining her IP certification on 6/17/24. On 7/17/24 the ADON was promoted from IP to ADON. The lack of a dedicated Infection Preventionist resulted in Enhanced Barrier Precautions not being implemented. Cross Reference F880. On 10/4/24 at 12:25 P.M., the Administrator provided a document titled Infection Prevention and Control Program, dated 11/10/17, that indicated the campus shall designate a member of the clinical team to monitor the campus infection prevention and control program.		requirements/responsibility. Interdisciplinary Team educated on requirements and two additional nursing staff members enrolled for specialized training in Infection Prevention. IP Log created and added to Infection Control binder with person responsible for program, certification date and specific dates of oversight to ensure no break in trained personnel. 3. As a measure of ongoing compliance, the DHS or designee will audit Infection Control binder for completed log identifying appropriate program oversight weekly x 4 weeks, then every other week x 4 weeks, then monthly x 4 months. 4. The results of the audit observations will be reported, reviewed and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00444096 and IN00440076.	R 0000	Assisted Living The submission of this plan of correction does not indicate an admission by River Oaks Health Campus that the findings and	

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	Complaint IN00444096 - No deficiencies related to the allegations are cited. Complaint IN00440076 - Federa/State deficiencies related to the allegations are cited at F880. Survey dates: September 30, October 1, 2, 3, and 4, 2024 Facility number: 004130 Residential Census: 35 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.		allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of River Oaks 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 the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted September 30, 2024, through October 4, 2024. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by Qualified Medication Aides (QMA) were authorized by a licensed nurse for 5 of 6 resident records reviewed. (Resident 4, Resident 6, Resident 7, Resident 1, Resident 2) Findings include:	R 0246	1. Residents #4,6,7,1 and 2 assessed/monitored with no findings and suffered no ill physical or psychosocial effects. Medication orders reviewed by physician with no changes indicated. Staff immediately educated related Qualified	10/31/2024

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	1. On 10/3/24 at 1:18 P.M., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to, rheumatoid bursitis. Current physician orders included, but were not limited to: - Hydrocodone-acetaminophen (an opioid) 7.5-325 milligrams (mg) - Give 1 tablet by mouth every 6 hours as needed (PRN) for pain, dated 9/20/24 Resident 4's September 2024 Medication Administration Record (MAR) included, but was not limited to, the following dates that hydrocodone-acetaminophen 7.5-325 mg PRN was administered by a Qualified Medication Aide (QMA) without prior authorization from a licensed nurse: 9/21/24 at 12:13 P.M. (given by QMA 15) 9/22/24 at 4:18 P.M. (given by QMA 15) 9/22/24 10:20 P.M. (given by QMA 7) 9/23/24 3:36 P.M. (given by QMA 3) 9/24/24 8:24 A.M. (given by QMA 15) 9/25/24 5:28 A.M. (given by QMA 7) 9/26/24 2:28 P.M. (given by QMA 3) 9/26/24 10:04 P.M. (given by QMA 3) 9/30/24 6:14 P.M. (given by QMA 3) 2. On 10/3/24 at 2:25 P.M., Resident 6's clinical record was reviewed. The diagnosis included, but was not limited to, osteoarthritis. Current physician orders included, but were not limited to: - Clonazepam (an antianxiety medication) 0.5 milligrams (mg) - Give 1/2 tablet (0.25 mg) by mouth every night as needed (PRN) for sleep, dated 9/25/23. - Hydrocodone-acetaminophen (an opioid) 5-325 mg - Give 1 tablet by mouth three times a day PRN		Medication Aides (QMA) administration of prn medications. 2. All residents have the potential to be affected. Education completed with licensed nursing staff regarding QMA administration of prn medications. Random observations completed by nursing leaders during rounding to ensure prn medication administration compliance. 3. As a measure of ongoing compliance, the Director of Assisted Living or designee will audit prn medication administration by QMA's to ensure procedure is followed for compliance with professional standards 5 weekly x 4 weeks, 3 x weekly x 4 weeks, twice weekly x 4 weeks then twice monthly x 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings until 100% compliance achieved. The plan will be reviewed and updated as warranted.	

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	for pain, dated 4/4/24. - Tramadol (an opioid) 50 mg - Give 1 tablet by mouth three times a day PRN for pain, dated 12/28/23 Resident 6's Medication Administration Record (MAR) from 3/1/24 through 4/30/24 included, but was not limited to, the following dates that clonazepam 0.25 mg PRN was administered by a Qualified Medication Aide (QMA) without prior authorization from a licensed nurse: 3/8/24 at 5:07 P.M. (given by QMA 37) 3/25/24 at 11:52 P.M. (given by QMA 5) 4/9/24 at 12:27 A.M. (given by QMA 5) Resident 6's April 2024 MAR included, but was not limited to, the following dates that hydrocodone-acetaminophen 5-325 mg PRN was administered by a QMA without prior authorization from a licensed nurse: 4/8/24 at 12:13 A.M. (given by QMA 5) 4/9/24 at 11:56 P.M. (given by QMA 5) Resident 6's April 2024 MAR included, but was not limited to, the following dates that tramadol 50 mg PRN was administered by a QMA without prior authorization from a licensed nurse: 4/5/24 at 5:51 P.M. (given by QMA 37) 4/19/24 at 7:41 A.M. (given by QMA 7) 3. On 10/4/24 at 10:18 A.M., Resident 7's clinical record was reviewed. The diagnosis included, but was not limited to, hypertension. Current physician orders included, but were not limited to: - Clonidine (a blood pressure medication) 0.1 milligrams (mg) - Give 1 tablet by mouth every 8 hours as needed (PRN) for systolic blood pressure (SBP) above 160, dated 2/20/24 with a			

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	discontinuation date of 6/5/24. - Clonidine 0.1 mg - Give 1 tablet by mouth every 8 hours PRN for SBP above 160, dated 6/5/24. - Hydrocodone-acetaminophen (an opioid) 5-325 mg - Give 1 tablet by mouth twice a day PRN for pain, dated 2/7/24. - Polyethylene glycol powder (stool softner) 17 grams (g) - Give 17 g by mouth PRN for constipation, dated 11/25/23. Resident 7's June 2024 Medication Administration Record (MAR) included, but was not limited to, the following dates that clonidine 0.1 mg PRN was administered by a Qualified Medication Aide (QMA) without prior authorization from a licensed nurse: 6/2/24 at 7:16 P.M. (given by QMA 5) 6/12/24 at 7:04 A.M. (given by QMA 9) 6/19/24 at 7:00 A.M. (given by QMA 9) 6/21/24 at 9:20 A.M. (given by QMA 9) Resident 7's June 2024 MAR included, but was not limited to, the following dates that hydrocodone-acetaminophen 5-325 mg PRN was administered by a QMA without prior authorization from a licensed nurse: 6/12/24 at 6:49 P.M. (given by QMA 7) 6/18/24 at 6:33 P.M. (given by QMA 7) Resident 7's June 2024 MAR included, but was not limited to, the following dates that polyethylene glycol powder 17 g PRN was administered by a QMA without prior authorization from a licensed nurse: 6/19/24 at 7:00 A.M. (given by QMA 9)4. On 10/3/24 at 1:30 P.M., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, Parkinsonism and chronic kidney disease.			

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	Current physician orders included, but were not limited to: - Allegra Allergy tablet, 60 mg (milligrams) at bedtime as needed, dated 9/6/24. - Coricidin HBP cold and flu (chlorpheniramine-acetaminophen) tablet, 2-325 mg every 6 hours as needed, dated 4/27/23. - Hyland's Restful Legs 3 tablets every 4 hours as needed, dated 11/10/23. - Hyland's Restful Legs 3 tablets at bedtime as needed, dated 11/8/23. - Melatonin (supplemental sleep aid) 5 mg at bedtime as needed, dated 4/27/23. - Tylenol arthritis pain, 650 mg every 6 hours as needed, dated 4/27/23. Resident 1's Medication Administration Record (MAR) for September 2024 indicated the following as needed medications were administered by a Qualified Medication Aide (QMA) without prior authorization from a licensed nurse: Allegra Allergy tablet 60mg: 9/9/24 at 7:48 P.M. given by QMA 3 9/10/24 at 8:08 P.M. given by QMA 5 9/12/24 at 8:33 P.M. given by QMA 3 9/14/24 at 8:43 P.M. given by QMA 5 9/20/24 at 7:37 P.M. given by QMA 5 (followed up for effectiveness dated 9/21/24 at 3:08 P.M. by QMA 15) Coriciden HBP cold and flu 2-325mg: 9/3/24 at 3:40 A.M. given by QMA 5 9/8/24 at 11:34 P.M. given by QMA 7 Hyland's Restful Legs: 9/8/24 at 6:44 P.M. given by QMA 7 9/18/24 at 7:20 P.M. given by QMA 7 Melatonin 5mg:			

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RIVEROAKS HEALTH CAMPUS	1244 VAIL ST PRINCETON, IN 47670

(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
	9/10/24 at 8:08 P.M. given by QMA 5 Tylenol arthritis pain 650mg: 9/2/24 at 8:47 P.M. given by QMA 5 9/8/24 at 9:32 A.M. given by QMA 9 (followed up for effectiveness dated 9/8/24 at 4:01 P.M. by QMA 15) 9/8/24 at 6:44 P.M. given by QMA 7 9/10/24 at 9:43 A.M. given by QMA 15 9/10/24 at 8:08 P.M. given by QMA 5 9/12/24 at 8:33 P.M. given by QMA 3 9/14/24 at 8:43 P.M. given by QMA 5 9/20/24 at 7:37 P.M. given by QMA 7 9/22/24 at 8:14 A.M. given by QMA 15 9/23/24 at 3:31 A.M. given by QMA 7 9/23/24 at 1:37 P.M. given by QMA 9 9/25/24 at 1:42 A.M. given by QMA 7 9/26/24 at 2:28 P.M. given by QMA 3 9/27/24 at 10:57 A.M. given by QMA 9 Resident 1's clinical record lacked an observation form for prn (as needed) meds for QMAs, or any other documentation that prior authorization was obtained from a licensed nurse prior to a QMA administering prn medications. 5. On 10/3/24 at 2:00 P.M., Resident 2's clinical record was reviewed. The diagnoses included, but were not limited to, autism and diabetes. Current physician orders included, but were not limited to: - Ondansetron (anti nausea medication) tablet 8 mg (milligrams) every 8 hours as needed, dated 2/7/24. - Ubrelvy (medication used to treat migraines) 100 mg tablet twice a day as needed, dated 2/7/24. Resident 2's Medication Administration Record (MAR) for September 2024 indicated the following			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING 00 B. WING	10/04/2024

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	as needed medications were administered by a Qualified Medication Aide (QMA) without prior authorization from a licensed nurse: Ondansetron 8mg: 9/6/24 at 6:19 A.M. given by QMA 3 9/10/24 at 2:59 P.M. given by QMA 15 Ubrelvy 100mg: 9/3/24 at 1:42 P.M. given by QMA 3 9/6/24 at 6:19 A.M. given by QMA 3 Resident 2's clinical record lacked an observation form for prn (as needed) meds for QMAs, or any other documentation that prior authorization was obtained from a licensed nurse prior to a QMA administering prn medications. On 10/4/24 at 8:28 A.M., Licensed Practical Nurse (LPN) 21 indicated prior to a QMA administering an as needed medication to a resident, they should fill out an observation form in the resident's chart to include a nurse to QMA co-signature as well as request authorization from a licensed nurse prior to administration. LPN 21 indicated the QMA should let the licensed nurse know about the requested medication and describe the resident's signs and symptoms. The licensed nurse would then sign off on administration on the observation form with the date and time of contact. On 10/4/24 at 11:30 A.M. Regional Support 27 provided a current Administration of PRN Medications policy, dated 12/31/23, that indicated "Prior to administration of PRN medication, the nurse shall review the physician orders and note any parameters for administration ... If PRN medication is to be administered by a QMA the Standards of Practice for PRN, medication			

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	administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse"			