STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00405930. Complaint IN00405930 - Federal/State deficiencies related to the allegations are cited at F656. Survey dates: April 20 and 21, 2023 Facility number: 012448 Provider number: 155785 AIM number: 201039500 Census Bed Type: SNF: 14 SNF/NF: 17 Residential : 54 Total: 85 Census Payor Type: Medicare: 8 Medicaid: 16 Other: 7 Total: 31 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 25, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by West River 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 West River Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by **05/08/23.**	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Stallman, RN-BC	Clinical Support	05/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

(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
	(iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure the plan of care was followed for 1 of 3 residents reviewed. A fall intervention was not in place. (Resident D) Finding includes: On 4/21/23 at 7:35 a.m., Resident D was observed lying in bed. Resident D was not interviewable. On 4/21/23 at 7:56 a.m., Resident D's clinical record was reviewed. Resident D diagnoses included, but were not limited to, unspecified dementia and other lack of coordination. A Quarterly MDS (Minimum Data Set) assessment, dated 2/8/23, indicated Resident D's was not cognitively intact, required extensive assistance of 2 persons for bed mobility, and was dependent on 2 staff for transfers. Care plans were reviewed and included, but were not limited to: Resident is at risk for falling related to a history of falls, cognitive impairment, weakness, unsteadiness/balance issues, poor eyesight, and adult failure to thrive. The interventions included, but were not limited to, dycem to air mattress, approach start date 2/6/23. The current April physicians orders were reviewed and included, but were not limited to: fall intervention: dycem to air mattress below draw sheet, frequency 3 three times a day: 6:00 AM - 2:00 PM, 2:00 PM - 10:00 PM, 10:00 PM - 6:00 AM. Start date 2/4/23.	F 0656	1. Resident D was assessed for effects of the alleged deficient practice. Dycem was placed to low air loss mattress as ordered. No adverse effects identified. 2. All residents have the potential to be affected by the alleged deficient practice. Residents were reviewed to validate current safety interventions were in place, orders and care plans correlate. Clinical staff educated regarding care planning and following physician orders/plan of care. 3. As a measure of ongoing compliance, the DHS or designee will audit safety interventions as stated on care plan and physician orders to ensure in place. Audit to consist of 5 residents weekly x4 week, 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 continue past 6 months, if needed, until 100% compliance met.	05/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

(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
	An IDT (Interdisciplinary Team) progress note, dated 2/6/23 at 11:16 a.m., indicated "Met to discuss fall on 2/3/23 Root cause: Self transferring from bed Intervention: Dycem to air mattress Will continue to monitor". On 4/21/23 at 9:18 a.m., a treatment to Resident D's skin was observed. The dycem was not observed to be on Resident D's mattress. On 4/21/23 at 9:53 a.m., CNA 1 was observed to make Resident D's bed. A draw sheet, incontinence pad, and top sheet were observed to be put on the mattress. The dycem was not observed to be placed on the mattress. CNA 1 indicated the linens that had been taken off the bed before new linens were applied were, a draw sheet, incontinence pad, and Resident D's blanket. CNA 1 indicated Resident D's fall interventions in place in his room were bed in lowest position, fall mat beside bed, and call light in reach. On 4/21/23 at 9:56 a.m., CNA 2 indicated a draw sheet, incontinence pad, blanket and pillows were applied when making Resident D's bed. The fall interventions in his room were bed in low position and a fall mat. On 4/21/23 at 2:00 p.m., the Clinical Support Nurse provided the current policy titled, "Fall Management Program Guidelines", reviewed 3/16/22. The policy included, but was not limited to, care plan interventions should be implemented that address the resident's factors. Any orders received from the physician should be noted and carried out. Discuss risks and interventions with resident and/or responsible party and communicate interventions during shift report. This Federal tag relates to Complaint IN00405930.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WEST RIVER HEALTH CAMPUS	714 S EICKHOFF RD EVANSVILLE, IN 47712

(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
	3.1-35(g)(2)			