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	08/19/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00437352. This visit included a State Residential Licensure Survey. Complaint IN00437352 - No deficiencies related to the allegations are cited. Survey dates: August 12, 13, 14, 15, 16, and 19, 2024 Facility number: 012448 Provider number: 155785 AIM number: 201039500 Census Bed Type: SNF/NF: 22 SNF: 13 Residential: 56 Total: 91 Census Payor Type: Medicare: 11 Medicaid: 18 Other: 6 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 28, 2024.	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 **9/9/24.**	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on interview, record review, and observation, the facility failed to ensure residents	F 0677	1 Residents 32, 11, 148, and 6 were assessed and no adverse	09/09/2024

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

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	dependent on staff for ADL (activities of daily living) were bathed for 4 of 4 residents reviewed for ADL care. (Resident 11, Resident 32, Resident 148, Resident 6) Findings include: 1. During an interview on 8/12/24 at 11:01 A.M., Resident 32's family indicated Resident 32 was not receiving showers as often as he should be. On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on 3/16/24. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired and was completely dependent on staff for bathing, toileting, and transfers. Current care plans included, but were not limited to: Resident requires staff assistance to complete self-care and mobility functional tasks completely and safely; Showers: per shower schedule. Dated 4/27/24. On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 7/1/24 through 8/16/24; Resident 32 received a shower or complete bed bath four times in July and one time in August. No shower schedule was available for review when requested. 2. On 8/14/24 at 12:02 P.M., Resident 11's clinical record was reviewed. Resident 11 was admitted on 2/28/22. Diagnoses included, but were not limited		effects noted from alleged deficient practice. 2 All residents have the potential to be affected. Education provided to nursing personnel on completion of bathing per resident preferences. Audit completed of all current residents to ensure bathing preferences are addressed, care planned, and being completed and documented. 3 As a measure of ongoing compliance, the DHS or designee will audit to ensure bathing is being completed per the resident preference and documented appropriately. 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 continue past 6 months, if needed, until 100% compliance met.	

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	to, dementia and hemiplegia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident 11 was moderately cognitively impaired and was completely dependent on staff for bathing and transfers. Current care plans included, but were not limited to: Showers: per shower schedule. Dated 3/13/22. On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 7/1/24 through 8/16/24; Resident 11 received a shower or complete bed bath two times in July and had not received a shower or complete bed bath in August. No shower schedule was available for review when requested. 3. On 8/13/24 at 8:44 A.M., Resident 148's clinical record was reviewed. Resident 148 was admitted on 8/7/24. Resident 148's clinical record lacked diagnoses and a completed MDS Assessment. Current care plans included, but were not limited to: Showers: per shower schedule. Dated 8/12/24. On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 8/7/24 through 8/16/24; Resident 148 had not received a shower or complete bed bath since admission to the facility. No shower schedule was available for review when requested. 4. On 8/12/24 at 11:21 A.M., Resident 6 indicated she was supposed to get showers every other day but didn't get them very often. She indicated if she refused a shower, she was not offered a bed bath as an alternative. At that time, white flakes of skin			

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	were observed on Resident 6's blanket and chair. On 8/13/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Resident 6 was admitted to the facility on 7/3/24. Diagnoses included, but were not limited to, hypertensive heart disease, major depressive disorder, and urge incontinence. The most current Admission Minimal Data Set (MDS) Assessment, dated 7/8/24, indicated Resident 6 was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care. A Point of Care (POC) History report indicated Resident 6 received a shower or complete bed bath two times in July and one time in August. On 8/14/24 at 11:15 A.M., the Assistant Director of Nursing (ADON) indicated CNAs (Certified Nursing Assistants) should be charting all showers and bed baths in POC Responses (a charting system for CNAs). If a resident refused a shower, staff should offer an alternative. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current "Guidelines for Bathing Preference" policy, dated 12/31/23, that indicated "Bathing shall occur at least twice a week...". 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record	F 0689	1 Residents 30 and 32 were	09/09/2024

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	review, the facility failed to ensure residents had supervision and interventions in place to prevent accidents for 2 of 2 residents reviewed for Accidents. A resident's fall intervention was out of place, care plans were not updated with new interventions, and a resident's diet orders were not followed or supervised during a group activity. (Resident 30 and Resident 32) Findings include: 1. On 8/13/24 at 11:25 A.M., nonskid strips were observed in the shower and in front of sink in Resident 30's bathroom. Nonskid strips were not observed in front of the toilet. On 8/13/24 at 9:25 A.M., Resident 30's clinical record was reviewed. Resident 30 was admitted to the facility on 10/29/23 following left hip surgery. Diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, and unspecified fall. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/21/24, indicated Resident 30 had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half) for transferring and toileting, and had one fall without injury and one fall with injury since the prior assessment on 3/28/24. A fall risk assessment, dated 8/2/24, indicated Resident 30 was at high risk for falls. The admission comprehensive falls care plan, dated 11/2/23, included the following interventions: Assure the floor is free of liquids and foreign objects		assessed, and no adverse effects noted related to the alleged deficient practice. 2 All residents have the potential to be affected by the alleged deficiency. Audit completed of current residents fall interventions to ensure interventions are in place. Education completed with nursing personnel regarding resident fall interventions and ensuring items in place. Education completed with employees and residents to ensure during activities involving food that residents receive correct diet order. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident rooms to ensure appropriate/ordered fall interventions are in place. 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. As a measure of ongoing compliance, the LED (Life enrichment director) or designee will complete random audits during activities that involve food to ensure appropriate/ordered diets are given. Audit will consist of at least 1 activity weekly for 1 month, then 1 activity every other week for 2 months, and then 1 activity monthly for 3 months. 4 As a quality measure, the DHS/designee and LED/designee	

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	Encourage/assist resident to assume a standing position slowly Keep call light in reach Keep personal items and frequently used items within reach Provide nonskid footwear Staff to assist resident with transfers as needed Therapy evaluation and treatment as needed The clinical record indicated Resident 30 had fallen 10 times since admission to the facility. Fall 1 On 11/1/23 at 11:20 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident complained of pain in his left hip and was sent to the Emergency Room (ER) for evaluation and treatment. Hospital discharge papers indicated the x-rays were negative for a hip fracture. The intervention "Staff to assist resident with toileting prior to bed and then throughout the night" was added to the care plan on 11/2/23. Fall 2 On 11/13/23 at 4:57 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident had a laceration to his left elbow and was sent to the ER for evaluation and treatment. Hospital discharge papers, dated 11/13/24, indicated x-rays were negative for an elbow fracture. The intervention "Nursing staff to offer and assist with toileting upon rounds" was added to the care plan on 11/22/23. Fall 3 On 11/24/23 at 4:53 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention "antiroll back to wheelchair" was added to the care plan on 11/27/23.		will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	Fall 4 On 11/25/23 at 3:00 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident's previous laceration on the left elbow had reopened and his eye was dark pink and swollen. The resident was sent to the ER for evaluation and treatment. Hospital discharge paperwork, dated 11/27/23, indicated x-rays were negative for facial and elbow fractures. The intervention "Wake frequently at night and assist with toileting needs" was added to the care plan on 11/27/23. Fall 5 On 12/8/23 at 7:00 A.M., Resident 30 had a witnessed fall while attempting to self transfer out of bed. The intervention "Encourage resident to wear non skid socks in bed" was added to the care plan on 12/11/23. Fall 6 On 12/21/23 at 3:06 A.M., Resident 30 had an unwitnessed fall while sitting on the couch in the day room. The intervention "Dycem to couch" was added to the care plan on 12/21/23. Fall 7 On 1/25/24 at 1:32 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention "Therapy referral for trunk control" was added to the care plan on 1/26/24. Fall 8 On 5/7/24 at 2:46 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident sustained abrasions to his right knee and right elbow and a knot to the back of his head. The interventions "Bed in lowest position" and "Offer resident to toilet between 1am-2am" was added to the care plan on 5/7/24.			

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Fall 9
On 5/18/24 at 9:06 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention "non skid strips in front of toilet" was added to the care plan on 5/20/24.

Fall 10
On 7/28/24 at 8:00 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. A nursing progress note, dated 7/28/24 at 8:45 P.M., indicated the floor in the bathroom was "very slick". An x-ray on the resident's left hip and left ankle was ordered. Results indicated the left ankle and left hip were negative for fracture and dislocation. The intervention "assist to toilet with each round" was added to the care plan on 7/29/24.

On 8/14/24 at 9:10 A.M., the Assistant Director of Nursing (ADON) indicated that maintenance placed nonskid strips in front of Resident 30's toilet on 8/13/24 around noon.

On 8/16/24 at 9:10 A.M., Clinical Support 5 indicated after a resident sustained a fall, the IDT (Interdisciplinary Team) would meet to determine a root cause for the fall and a new intervention related to the fall would be placed in the care plan and implemented that day.
2. On 08/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on 3/16/24. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia.

The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, required moderate assistance from staff with eating, and required a modified diet due to

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	choking, coughing, and difficulty swallowing. Physician orders included, but were not limited to: Diet: Fortified foods/puree/thin liquids Special Instructions: Built up utensils and divided plate. Start date 8/8/24. Diet: Puree, Thin liquids, Resident to be feed all meals. Go to dining room for all meals. Date 5/15/24 - 6/20/24. Care plan included, but was not limited to: Resident has potential for complications, functional and cognitive status decline. Diet as ordered. Date initiated: 4/27/24. A progress note, dated 6/2/24 at 11:26 A.M., indicated Resident 32 had choked on banana bread while in activities. The progress note indicated by the time staff saw Resident 32 choking, he was blue/purple and the nurse performed the Heimlich maneuver to dislodge food stuck in Resident 32's throat. Resident 32 was sent to the emergency department. A chest X-ray report obtained in the hospital emergency department, dated 6/2/24 at 1:33 P.M., indicated resident 32 was admitted for aspiration and the X-ray indicated infiltrates in the lungs. A progress note, dated 6/2/24 at 6:09 P.M., indicated Resident 32 returned to the facility from the hospital with an order for Augmentin (antibiotic) with a diagnosis of pneumonia. During an interview on 8/16/24 at 2:22 P.M., Clinical Support 5 indicated Resident 32 was in the activities room when staff were making banana bread and provided it to residents, Resident 32 was given banana bread by another resident, and that Resident 32 was on a puree diet at the time he			

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	choked in activities. On 8/16/24 at 11:30 A.M., Clinical Support 5 indicated there was no facility policy on resident supervision or following diet orders, but staff were expected to follow all physician orders. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current "Falls Management Program Guidelines" policy, dated 12/31/23, that indicated "Should the resident experience a fall the attending nurse shall complete the "Fall Event" This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possibly contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions ... The resident care plan should be updated to reflect any new or change in interventions". On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current "Comprehensive Care Plans" policy, dated 12/31/23, that indicated "Comprehensive care plans need to remain accurate and current. New interventions will be added and updated during or directly following CCM [continuity of care meeting] meeting". 3.1-25(a)(1) 3.1-45(a)(2)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure services were provided to a	F 0690	1.Resident 32 was assessed, and no adverse effects noted by alleged deficient practice.	09/09/2024

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	resident with an indwelling urinary catheter to prevent the development of infection for 1 of 1 resident reviewed for a catheter-associated urinary tract infection (CAUTI). (Resident 32) This deficient practice resulted in Resident 32 developing a CAUTI with septic shock and pneumonia. Resident 32 required artificial ventilation and treatment at a hospital-based intensive care unit. (Resident 32) Finding includes: On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on 3/16/24. Diagnoses included, but were not limited to, Parkinson's disease, obstructive uropathy, dementia. An Admission MDS (Minimum Data Set) Assessment, dated 3/20/24, indicated Resident 32 was moderately cognitively impaired, was completely dependent on staff for bathing, toileting, and transfers, and had an indwelling catheter. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, was completely dependent on staff for bathing, toileting, and transfers, and had an indwelling catheter. The clinical record lacked current orders related to indwelling catheter care or documentation of physician notification for clarification of indwelling catheter use. Current comprehensive care plan included, but was not limited to: Resident uses a Foley (brand of indwelling) catheter for diagnosis of obstructive uropathy; Observe for any signs of complication such as		2 All residents with a change of condition have the potential to be affected. All residents with current indwelling urinary catheters were assessed for any change of condition with none noted. All residents with current indwelling urinary catheters ordered reviewed to ensure monitoring of indwelling urinary catheter is in place and being completed. During CCM (clinical care meeting) review of residents in house for any s/s of change of condition and ensuring appropriate action/notifications completed. Nursing personnel educated on change of condition policy and monitoring of indwelling urinary catheter output for any change. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident records of residents with indwelling urinary catheters to review for any s/s of change of condition and physician notification is documented as warranted. 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. As a measure of ongoing compliance, the DHS or designee will monitor to ensure monitoring orders for indwelling urinary catheter are in place and being completed . Audit will consist of 5 residents weekly for 1 month, then	

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	UTI, urethral trauma, strictures, bladder calculi or silent hydronephrosis notify my doctor. Date initiated: 4/27/24. Resident is at risk for excessive bleeding and bruising related to medications; Notify MD (doctor) of abnormal bruising and or bleeding. Date initiated: 4/27/24. A progress note, dated 7/28/24 at 1:30 A.M., indicated Resident 32 had blood in his urine. The clinical record lacked any further urinary or catheter assessment or notification to the physician related to any abnormal urinary symptoms. A progress note, dated 7/30/24 at 12:39 A.M., indicated Resident 32 was experiencing blood in his urine and a catheter flush was performed. Documentation did not include specific information to determine technique used to perform the catheter flush, further assessment after the catheter flush, or notification to the physician prior to flush the catheter, of findings during the catheter flush. A progress note, dated 7/30/24 at 1:31 A.M., indicated Resident 32 was found with abnormal vitals: labored wheezing respirations at 22 per minute, an oxygen saturation of 86%, a pulse of 139 beats per minute, a blood pressure of 94/54, and temperature of 101.3 degrees Fahrenheit. Resident 32 had thick and clotted blood noted in his indwelling catheter tubing and decreased urinary output. The physician was notified through triage and Resident 32 was sent to the hospital. A hospital document titled Patient Summary Report, dated 7/30/24 at 4:48 A.M., indicated Resident 32 was admitted to the hospital with		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. On behalf of Trilogy Health Services at West River Health Campus and in accordance with Administrative 42 CFR 488.331, we respectfully request an Informal Dispute Resolution for F690 SS=G Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3). We at Trilogy Health Services note West River Health Campus would like to provide supportive documentation to demonstrate the F690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) should not have been cited at the scope and severity of G level. To follow the requirements to meet the IDR process, West River Health Campus has referred to the **CMS State Operations Manual Chapter 7- 7212.3- Mandatory Elements of Informal Dispute Resolution Pg. 37-38. (Exhibit**	

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	155785	A. BUILDING 00 B. WING	08/19/2024

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	septic shock secondary to a urinary tract infection and pneumonia. Resident 32 was intubated and placed in intensive care. A late entry progress note, entered by nursing staff at the facility dated 8/2/24 at 7:16 P.M. for 7/28/24 at 7:06 P.M, indicated Resident 32 had passed a blood clot, urine was clear and non-odorous, and vital signs were in "normal range". The clinical record lacked notification to the physician the resident had passed a blood clot. A progress note dated 8/7/24 at 3:15 P.M., indicated Resident 32 had returned to the facility from the hospital. During an interview on 8/16/24 at 10:16 A.M., the Clinical Support 5 indicated there was no catheter assessment tool to monitor indwelling catheters but Resident 32 should have had an indwelling catheter order set entered upon return from the hospital stay and did not, and that if a nurse noticed abnormalities with an indwelling catheter such as bleeding, the physician should be notified. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a policy titled Guidelines for the Use of Indwelling Catheter, dated 12/31/23, that indicated "Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible; A resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible." The policy did not address indwelling catheter flushing or indwelling catheter associated urinary tract infections.		**A)** **Please see uploaded detailed document**	

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F 0692 SS=D Bldg. 00	3.1-41(a)(2) 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview, record review, and observation, the facility failed to ensure a resident's decline in nutritional status was addressed and recommendations were followed for 1 of 1 residents reviewed for significant weight loss. (Resident 32) Finding includes: On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on 3/16/24. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, required moderate assistance from staff with eating, was completely dependent on staff for bathing, toileting, and transfers, and required a modified diet due to choking, coughing, and difficulty swallowing. Physician orders included, but were not limited to: Diet: Fortified foods/puree/thin liquids Special Instructions: Built up utensils and divided plate. Start date 8/8/24. Order Set Admission - Weekly Weight. Start date 3/16/24. Dietary supplement: Ensure may substitute if available. Dated 5/5/24 - 6/11/24. Dietary supplement: Medpass 120 mL (milliliters) TID (three times a day). Dated 6/11/24 - 7/9/24. Care plan included, but was not limited to:	F 0692	1 Resident 31 and Resident 32 was not affected by the alleged deficient practice. No adverse effects noted. 2 All residents have the potential to be affected. Nursing personnel educated on following residents physician orders regarding completing weekly weights timely. IDT (Interdisciplinary team) educated on identifying, tracking, and monitoring residents for weight changes per policy. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident records to ensure weekly weights completed per orders and weight changes have appropriate notifications to provider. 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	09/09/2024

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	Resident is malnourished/at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. Date initiated 3/18/24. Resident has experienced a significant weight loss. Date initiated 7/8/24. Obtain a dietary consult as needed. Follow recommendations as required. Date initiated 5/14/24 Hospital discharge documents, dated 3/15/24, indicated Resident 32 had a weight recorded of 218 pounds. The following vitals indicated "date taken" by nursing staff in the facility: 3/19/24 (admission) 230 lbs (pounds) Height: 5 feet 11 inches No weekly weight taken the week of 3/24/24-3/30/24 No weekly weight taken the week of 3/31/24-4/6/24 4/12/24 (11:25 AM) 231 lbs 4/15/24 (10:54 AM) 231 lbs No weekly weight taken the week of 4/21/24-4/27/24 No weekly weight taken the week of 5/5/24-5/11/24 No weekly weight taken the week of 5/12/24-5/18/24 5/20/24 (2:51 PM) 253.8 lbs 5/27/24 (3:54 PM) 175.4 lbs 6/3/24 (3:08 PM) 184.6 lbs 6/6/24 (2:54 AM) 183 lbs No weekly weight taken the week of 6/9/24-6/15/24 6/18/24 (12:07 PM) 183.5 lbs 6/24/24 (1:36 PM) 185.8 lbs 7/1/24 (8:39 AM) 181.6 lbs 7/5/24 (12:07 PM) 181.6 lbs No weekly weight taken the week of 7/7/24-7/13/24 No weekly weight taken the week of 7/14/24-7/20/24		warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	

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	No weekly weight taken the week of 7/21/24-7/27/24 8/7/24 (3:30 PM) 177 lbs 8/12/24 (1:42 PM) 178 lbs A progress note, dated 5/13/24 at 9:26 A.M., indicated Resident 32 had no edema noted. A progress note, dated 5/22/24 at 5:22 P.M., indicated Resident 32 had a weight gain in the last 30 days, weekly weights should continue, and no increased edema was noted. A weight monitoring nutrition assessment progress note created by the registered dietitian on 5/30/24 at 4:13 P.M. indicated Resident 32's weight of 175.4 lbs on 5/27/24 was likely an error and Resident 32 should be re-weighed. A weight was not recorded until the next weekly weight was due. A weight monitoring nutrition assessment progress note created by the registered dietitian, dated 6/10/24 at 10:43 A.M., indicated Resident 32's weight Inconsistencies were likely how inconsistently Resident 32 was being weighed by staff; staff to ensure resident is weighed the exact same every time day, continue weekly weights. During an observation on 8/16/24 at 2:09 P.M., CNA 6 weighed Resident 32's wheelchair by itself (52.8 lbs), then weighed Resident 32 while sitting in the wheelchair (235.6 lbs), for a final weight for Resident 32 of 182.8 lbs. During an interview on 8/15/24 at 9:28 A.M., the ADON (assistant director of nursing) indicated the large fluctuation in Resident 32's weight was due to staff not weighing Resident 32 correctly,			

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	and was unsure where the actual weight loss occurred because residents clothes still fit the same. The ADON indicated Resident 32 was put on nutritional supplement and fortified foods after the significant weight loss. The ADON indicated the weight machine was not reading right and needed to be calibrated and that may have caused the significant weight differences, and was unsure if Resident 32 was reweighed after the weight machine was recalibrated. During an interview on 8/16/24 at 10:16 A.M. the Regional Clinical indicated weekly weights documented in physician orders and POC (point of care) responses populate in vitals, if weekly weights were not there, they were not completed, and that the order for weekly weights order is a nurse task to be completed but sometimes CNA (certified nurses aide) may take the weight and give the weight to the nurse to enter. The Regional Clinical indicated she believed Resident 32's weight entered on 5/20/24 and 5/27/24 should have been marked invalid, and the 46.4 pound weight loss from 4/15/24 to 6/3/24 was due to Resident 32 having diarrhea and edema. Documents indicating diarrhea and edema during this time was requested but not provided. The clinical record lacked documentation in medical record of thorough assessment of resident 32's condition for recorded weight loss. A document provided by Clinical Support 5 on 8/16/24 at 1:52 P.M., titled Work History Report indicated the weight scale had been calibrated weekly from 8/5/23 through 8/17/24. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a document titled Guidelines for Weight Tracking, dated 12/31/23, that indicated "Scales shall be properly maintained and calibrated to			

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	ensure accuracy of weight. Residents who have a weight that seems out of normal range shall be re-weighed to determine the accuracy of the original weight. The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days." 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and oxygen services were provided according to physician order for 1 of 3 residents reviewed for respiratory care. (Resident 6) Finding includes: On 8/12/24 at 11:30 A.M., Resident 6 was observed to receive 5 Liters (L) of oxygen via nasal cannula. The humidification bottle was empty and not dated and the tubing was not dated. At that time, Resident 6 indicated she was supposed to be getting 3L of oxygen but was not sure why. On 8/13/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, non-ST elevation (NSTEMI) myocardial infarction and shortness of breath. The most current Admission Minimum Data Set (MDS) Assessment, dated 7/8/24, indicated Resident 6 was cognitively intact, received partial to moderate assistance of staff (staff does less than half) for transfers, and was not receiving	F 0695	1 Resident 6 was not affected by the alleged deficient practice. Resident 6 was assessed, and no adverse effects noted. 2 All residents with oxygen therapy orders have been reviewed for proper dating, storage, humidification bottle filled per policy, and oxygen is administered at liters per minute as ordered. Nursing personnel will be educated on administration of oxygen policy, including requirements for dating, storage of oxygen tubing, humidification and ensuring oxygen is being administrated as ordered. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident with current oxygen orders to ensure proper dating of oxygen tubing. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 3 months.	09/09/2024

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	oxygen. Physician orders included, but were not limited to: Oxygen at 3L per nasal canula continuous, dated 7/30/24 Change oxygen tubing monthly once a day on the 1st of the month, dated 7/30/24 A Profile Care Guide care plan, dated 7/16/24, indicated Resident 6 received 3L of continuous oxygen. On 8/14/24 at 11:10 A.M., Licensed Practical Nurse (LPN) 12 indicated she was unsure who was supposed to change oxygen tubing and humidification bottles. On 8/14/24 at 11:15 AM., the Assistant Director of Nursing (ADON) indicated tubing and humidification bottles were changed out according to physician's order or as needed by the night shift nursing staff. On 8/16/24 at 11:39 A.M., Clinical Support 5 indicated the facility did not have a policy for following physician orders, but staff were expected to follow orders. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a "Respiratory Equipment" policy, dated 12/31/23 that indicated "Use sterile distilled water for humidification over 4LPM [liters per minute] ... Change prefilled humidifier when water level becomes low ... Change oxygen cannula and tubing monthly and as necessary". 3.1-47(a)(6)		As a measure of ongoing compliance, the DHS or designee will complete random audits of resident with current oxygen orders to ensure proper storage of oxygen tubing. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 3 months. As a measure of ongoing compliance, the DHS or designee will complete random audits of resident with current oxygen orders to ensure proper Oxygen amount is being administrated as ordered. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents 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 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.	
F 0812 SS=E	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner in accordance with professional standards for food service safety for 2 of 2 observations of the kitchen and 1 of 1 observations of unit refrigerators. Food was not labeled, floors were soiled, and equipment was soiled. (Kitchen, Certified Locked Dementia Unit) Findings include: On 8/12/24 at 6:58 A.M., the following was observed in the kitchen: 1. walk in cooler - 2 bags of lunch meat, one open to air, no labels. 2. walk in freezer - clear bag of cookies no label, container of individually sealed frozen pork chops, no label. 3. soiled shelves under the grill and steamer, sides of the stove soiled, floors with debris build up under equipment and storage racks, dishwasher area, around edges of walls, sides of ice machine calcium build up, dusty vents. On 8/14/24 at 9:43 A.M., the refrigerator on the locked dementia unit was observed to have a bowl of purple pureed food, no label, 3 muffins in individual bowls, no label, a tray containing 8 individual bowls of macaroni salad and two bowls of orange pureed food, no label, and an unopened can of an energy drink no label. On 8/14/24 at 12:05 P.M., the lunch meat in the walk in cooler was observed with a label. On 8/15/24 at 9:21 A.M., the same was observed for all other areas observed on 8/12/24 at 6:58 A.M.	F 0812	1 No residents were affected by the alleged deficient practice. 2 All residents have the potential to be affected. Dietary staff educated on proper storage, dating, and labeling food items. Dietary staff educated on cleaning schedules and completion of cleaning of kitchen. 3 As a measure of ongoing compliance, the DFS (director of food service) or designee will complete random audits of food storage areas to ensure appropriate labeling and dating. Audit will be weekly for 1 month, then every other week for 2 months, then monthly for 3 months. As a measure of ongoing compliance, the DFS or designee will complete random audits of kitchen environment to ensure cleaning schedule being followed and kitchen in sanitary conditions. Audit will be weekly for 1 month, then every other week for 2 months, then monthly for 3 months. 4 As a quality measure, the DFS 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	09/09/2024

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	On 8/15/24 at 9:26 A.M., the Dietary Manager indicated the pork chops were delivered last week and should have been labeled, after food was opened it was put in a two gallon bag and labeled, floors were mopped nightly, usually once a week under tables, equipment, etc. There was a weekly cleaning schedule. On 8/15/24 at 12:10 p.m., the Administrator provided the current policy on food labeling and dating with a revised date of 2019. The policy included but was not limited to: "Any food product removed from its original container, has a broken seal, has been processed in any way must have a label...1. Item name. 2. Date and time the food was label. 3. Use by date. 4. Initials of the person labeling the item. 4. Securely cover the food item...". 3.1-21(i)(2) 3.1-21(i)(3)		continue past 6 months, if needed, 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 ensure staff performed proper hand hygiene and sanitation practices while providing care for 3 of 3 residents observed receiving care and 1 of 1 residents observed receiving blood glucose level checks. (Resident 11, Resident 19, Resident 32, Resident 9) Findings include: 1. On 8/12/24 at 9:07 A.M., LPN (Licensed Practical Nurse) 4 was observed getting supplies out of the medication cart. She knocked on Resident 11's door, entered the room, donned gloves, and obtained Resident 11's blood glucose	F 0880	1 Residents 11, 19, 32, and 9 were not affected by the alleged deficient practice. No adverse effects noted to Resident 11, 19, 32, and 9. 2 All residents have the potential to be affected. Education provided to facility staff on Infection control practices, including hand hygiene, mechanical lift cleaning and glove usage. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of	09/09/2024

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	level. LPN 4 removed her gloves, left the room, helped another staff to pull up a resident in their wheelchair by a draw sheet, went to the medication cart, and charted on the computer. No hand hygiene was observed. 2. On 8/14/24 at 9:06 A.M., CNA (Certified Nurse Aide) 6 was observed providing morning care to Resident 19. After care, CNA 6 removed her gloves, gave Resident 19 a drink from a cup, pushed the resident out of the bathroom, gave the call light to the resident, stripped the bed and pillow of linens and put them in a bag, changed the trash bag in the trash can, took personal care supplies to the bathroom, and shut the bathroom door. CNA 6 left the room carrying the bags to the dirty linen room, pushed the buttons on the door to open it, opened the lids to the containers to dispose of the bags, left the room, walked across the hall and opened the door to the bathroom, and washed her hands. 3. During a wound care observation on 8/15/24 at 9:16 A.M., the RN (Registered Nurse) 11 was observed standing in the hall wearing a gown and gloves. RN 11 entered Resident 9's room, shut the door, and opened wound care supplies on Resident 9's bedside table. RN 11 reached around her gown and pulled a marker out of her pants pocket and dated the dressings. RN 11 removed her gloves, applied hand sanitizer, and put new gloves on. RN 11 assisted Resident 9 to roll to his right side. RN 11 sprayed wound cleanser in the wound on Resident 9's coccyx and applied skin prep around the wound. RN 11 used a cotton swab to apply Santyl (ointment used to promote skin healing) to the coccyx wound and covered the wound with a dressing. RN 11 removed her gloves and gown, turned the sink on, and washed her hands for nine (9) seconds.		hand hygiene and resident care to ensure appropriate hand hygiene is conducted appropriately. 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. As a measure of ongoing compliance, the DHS or designee will complete random audits of resident care to ensure appropriate glove usage is 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. As a measure of ongoing compliance, the DHS or designee will complete audit of mechanical lifts to ensure cleanliness weekly x 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 continue past 6 months, if needed, until 100% compliance met.	

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

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	4. During a random care observation on 8/16/24 at 2:13 P.M., CNA (Certified Nurse Aide) 2 and CNA 6 used a sit to stand lift to transfer Resident 32 from the bed to the wheelchair. The footplate of the sit to stand lift was observed to have dirty build up and the grip mat of the footplate was peeling off and sticking up on all sides. On 8/16/24 at 8:44 A.M., CNA 2 indicated hand hygiene should be done before and after glove use and before and after providing care to a resident. On 8/16/24 at 11:29 A.M., LPN 3 indicated hand hygiene needed done when hands were visibly soiled and when passing medications. In between residents, staff could use alcohol gel, and after every couple of residents, staff should wash their hands. On 8/16/24 at 11:30 A.M., the Clinical Support 5 provided the current policy on hand washing/hand hygiene with a revision date of 2/9/17. The policy included but was not limited to: "All health care workers shall utilize hand hygiene frequently and appropriately...3. Health care workers (HCW) shall use hand hygiene at times such as: ...c. before/after having direct physical contact with residents. d. After removing gloves, worn per standard precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc. ...Hand Washing... b) wet hands with running water. Apply liquid soap and work into a lather. c) wash for at least 20 seconds, using rotary motion and friction...". On 8/16/24 at 11:30 A.M., the Clinical Support 5 provided the current policy on standard precautions guidelines with a revision date of			

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	5/11/16. The policy included but was not limited to: "1. Standard precautions include, but are not limited to hand hygiene, safe injection practice, the proper use of PPE (e.g.; gloves, gowns, and masks), resident placement, and care of the environment, textiles, and laundry. Also equipment or items in the resident's room environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents, (e.g.; wear gloves for handling soiled equipment, and properly clean and disinfect or sterilize equipment before use on another resident)...". 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint #IN00437352. Survey dates: August 12, 13, 14, 15, 16, and 19, 2024 Facility number: 012448 Residential Census: 56 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 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	

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			matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by **9/9/24.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were completed every 6 months and signed by residents for 3 of 7 residents reviewed for service plans. (Resident 1, Resident 3, Resident 4) Findings include: 1. On 8/19/24 at 8:49 P.M., Resident 1's clinical record was reviewed. The most current service plan, dated 3/20/24, was not signed by the resident. The clinical record lacked a completed service plan between 5/12/23 and 3/20/24. 2. On 8/19/24 at 9:07 A.M., Resident 3's clinical record was reviewed. The most current service plan, dated 8/14/24, was not signed by the resident. The clinical record lacked a completed service plan between 9/26/23 and 8/14/24. 3. On 8/19/24 at 9:16 A.M., Resident 4's clinical record was reviewed. The most current service plan, dated 3/20/24, was not signed by the resident. The clinical record lacked a completed service plan between 8/9/23 and 3/20/24. On 8/19/24 at 9:17 A.M., Clinical Support 5 indicated Resident 1, 3, and 4's service plans were not signed by the residents. At that time, she indicated service plans were completed every 6	R 0217	1 Resident 1, 3, and 4 were not affected by the alleged deficient practice. No adverse effects noted. 2 All residents have the potential to be affected. Audit completed to ensure all service plans up to date. IDT and DAL educated on service plan guidelines. 3 As a measure of ongoing compliance, the DAL or designee will complete random audits of resident records to ensure service plan up to date and completed semi-annually. 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 DAL 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	09/09/2024

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	months. On 8/19/24 at 10:17 A.M., Clinical Support 5 provided a current "AL-Evaluation and Service Plan Guidelines" policy, dated 12/31/23, that indicated "Upon admission semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs".		continue past 6 months, if needed, until 100% compliance met.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner in accordance with professional standards for food service safety for 2 of 2 observations of the kitchen and 1 of 1 observations of unit refrigerators. Food was not labeled, floors were soiled, and equipment was soiled. (Kitchen) Findings include: On 8/12/24 at 6:58 A.M., the following was observed in the kitchen: 1. walk in cooler - 2 bags of lunch meat, one open to air, no labels. 2. walk in freezer - clear bag of cookies no label, container of individually sealed frozen pork chops, no label. 3. soiled shelves under the grill and steamer, sides of the stove soiled, floors with debris build up under equipment and storage racks, dishwasher area, around edges of walls, sides of ice machine calcium build up, dusty vents. On 8/15/24 at 9:21 A.M., the same was observed for all other areas observed on 8/12/24 at 6:58	R 0273	1 No residents were affected by the alleged deficient practice. 2 All residents have the potential to be affected. Dietary staff educated on proper storage, dating, and labeling food items. Dietary staff educated on cleaning schedules and completion of cleaning of kitchen. 3 As a measure of ongoing compliance, the DFS or designee will complete random audits of food storage areas to ensure appropriate labeling and dating. Audit will be weekly for 1 month, then every other week for 2 months, then monthly for 3 months. As a measure of ongoing compliance, the DFS or designee will complete random audits of kitchen environment to ensure cleaning schedule being followed and kitchen in sanitary conditions. Audit will be weekly for 1 month, then every other week for 2	09/09/2024

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	A.M. On 8/15/24 at 9:26 A.M., the Dietary Manager indicated the pork chops were delivered last week and should have been labeled, after food was opened it was put in a two gallon bag and labeled, floors were mopped nightly, usually once a week under tables, equipment, etc. There was a weekly cleaning schedule. On 8/15/24 at 12:10 p.m., the Administrator provided the current policy on food labeling and dating with a revised date of 2019. The policy included but was not limited to: "Any food product removed from its original container, has a broken seal, has been processed in any way must have a label...1. Item name. 2. Date and time the food was label. 3. Use by date. 4. Initials of the person labeling the item. 4. Securely cover the food item...".		months, then monthly for 3 months. 4 As a quality measure, the DFS 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.	