STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riveroaks Health Campus	1244 Vail St Princeton, IN 47670

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130 Based on observation, interview, and record review, the facility failed to provide assistance with bathing and oral hygiene for 4 of 7 residents reviewed for activities of daily living (ADLs). Residents did not receive a complete bed bath, shower, and/or daily oral hygiene according to the plan of care and residents preferences. (Resident F, Resident G, Resident H, Resident J) Findings include: 1. During an observation on 5/16/24 at 10:20 A.M., Resident F was sitting up in his room, dressed, with his hair combed back. His hair appeared to be oily. During record review on 5/16/24 at 11:00 A.M., Resident F's diagnoses included, but were not limited to, heart failure, kidney failure, reduced mobility, and weakness. Resident F's most recent Admission MDS (Minimum Data Set) assessment, dated 5/8/24, indicated that the resident had moderate cognitive impairment, required an assistive device including a walker or wheelchair for mobility, was dependent for oral hygiene and bathing. Resident F's care plan included, but was not limited to, showers on Wednesdays and Saturdays (first shift) (initiated 5/1/24), Resident has potential for mouth pain due to: natural teeth - offer and provide mouth care as needed (initiated 5/3/24). Resident F's documented bathing and provided mouth care reviewed from the admitted [DATE] through 5/16/25 included no documented showers or complete bed baths and no documentation of daily mouth care. 2. During record review on 5/16/24 at 12:00 P.M., Resident G's diagnoses included, but were not limited to, pulmonary disease, obesity, and obstructive and reflux uropathy. Resident G's most recent Admission MDS assessment, dated 5/9/24, indicated that the resident had severe cognitive impairment and was dependent for oral hygiene, toileting, and bathing. Resident G's care plan included, but was not limited to, showers on Wednesdays and Saturdays (second shift) (initiated 5/6/24), Resident has potential for mouth pain due to: wears upper dentures - offer and provide mouth care as needed (initiated 5/6/24). (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident G's documented bathing and provided mouth care reviewed from the admitted [DATE] through 5/10/25 (discharge date) included no documented showers or complete bed baths and no documentation of daily mouth care. 3. During record review on 5/17/24 at 10:30 A.M., Resident H's diagnoses included, but were not limited to, neurocognitive disorder, dementia, altered mental status, polyneuropathy, and repeated falls. Resident H's most recent Admission MDS assessment, dated 4/23/24, indicated that the resident had severe cognitive impairment, used a walker or wheelchair for mobility and was dependent for oral hygiene and bathing. Resident H's care plan included, but was not limited to, showers on Wednesdays and Saturdays (second shift), Resident has potential for mouth pain - offer and provide mouth care as needed. Resident H's documented bathing and provided mouth care reviewed from the admitted [DATE] through 5/16/24 included showers on 4/22/24, 4/27/24, and 5/9/24. No documentation of daily mouth care was found in Resident G's record. 4. During an observation and interview on 5/17/24 at 12:09 P.M., Resident J was sitting up in her room dressed. Resident J's hair appeared to be uncombed. Resident J indicated that she required assistance from staff to stand up and to bathe and that she is not provided at least two showers or complete bed baths per week. During record review on 5/17/24 at 12:30 P.M., Resident J's diagnoses included, but were not limited to, acute kidney failure, heart failure, diabetes, and chronic pain. Resident J's most recent Admission MDS assessment, dated 4/30/24, indicated that the resident had no cognitive impairment, used a walker or wheelchair for mobility, and was dependent for bathing. Resident J's care plan included, but was not limited to, showers on Mondays and Thursdays (second shift). Resident J's documented bathing reviewed from 4/23/24 through 5/16/24 included one shower on 4/30/24. 5. During a review of the facility's grievance log on 5/16/24 at 11:45 A.M., the following grievances were made: - On 3/29/24 - [Resident] having issues with nursing not coming to help her with showers and toileting in a reasonable amount of time . - On 4/9/24 - [Resident] is very tearful. Had shower today but was not offered her razor to shave and has facial hair. - On 4/21/24 - .[Resident] is only being [sic] receiving his showers per his requests. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/5/24 - States that [Resident] is not getting showers. Wants showers on (Monday/Thursday) evenings. During an interview on 5/16/24 at 9:25 P.M., CNA 4 indicated that staff are not always able to provide a complete bed bath or shower in the evenings on a resident's scheduled shower day due to being short-staffed. During an interview on 5/17/24 at 11:40 A.M., RN 5 indicated that staff should document provided oral care in the point of care charting system. On 5/17/24 at 3:20 P.M., the Administrator supplied a facility policy titled, Guidelines for Bathing Preference, dated 12/31/22. The policy included, .4. Bathing shall occur at least twice a week unless resident preference states otherwise. On 5/17/24 at 3:45 P.M., the Administrator supplied a facility policy titled, Nursing ADL Documentation Guidelines, dated 12/31/23. The policy included, .2. ADL services will be conducted and documented by the CNA each shift at the 'point of care' or as reasonably possible after care . This citation relates to Complaint IN00434456. 3.1-38(b)(1) 3.1-38(b)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39130 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was provided to maintain residents quality of life and to ensure residents' activities of daily living (ADL's) were completed for 2 of 2 days during the survey. Findings include: On 5/16/24 at 10:00 a.m., the Facility Census Form indicated there were 57 residents residing on the health center. 1. During the survey from 5/16/24 through 5/17/24, the following interviews were conducted. - The staff could use more help. - Call lights take a long time to be answered and it was frustrating. - Waiting 20 minutes for call lights to be answered. - The facility is short staffed. - It was difficult to complete tasks for residents due to staffing. - She needed staff assistance to stand up out of her chair and that staff hardly answered her call light at all. She may have to wait up to an hour or hour and a half to have a call light answered. One night shift she turned her light on at 2:45 A.M. and staff didn't come until 5:00 A.M. Staff had told her when answering her light that they only had two CNA's for 50 people. She didn't receive her showers. Sometimes the supper trays are still in the resident room in the morning. 2. During a review of the facility's grievance log on 5/16/24 at 11:45 A.M., the following grievances were made: - On 3/27/24 - Angry about call light/waiting. - On 3/27/24 - Upset about call light/waiting, waiting for an extended period of time. - On 4/2/24 - Upset about call light/waiting, stated she had a long wait time for call light during evening supper time hours. - On 4/4/24 - Upset about call light/waiting - Resident stated that on Monday night she had to wait too long for staff to answer the call light. When they finally came, she was wet from urine. She was continent but when she had to wait and just needed stand by assist to ambulate to the bathroom, she had an accident. - On 4/2/24 - Angry about call light/waiting - CNA staff left the floor. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/4/24 - Upset about call light/waiting - light was not answered timely on evening shift. - On 4/9/24 - Angry about call light/waiting. - On 4/21/24 - Upset about call light/waiting. - On 4/21/24 - Upset about not having enough help. - On 4/21/24 - Upset about not having enough staff. - On 4/23/24 - Upset about call light/waiting - Resident had to wait long time on someone to answer light for assistance with using restroom. - On 5/3/24 - Upset about call light/waiting - Resident ended up toileting self because no one answered the call light. - On 5/3/24 - Concerned about call light/waiting - Had issues over the weekend with call light not being answered. On 5/16/24 at 8:50 P.M., two licensed nursing staff and three CNAs were working on the 100, 200, and 300 halls. A stack of resident meal trays were on the nursing station desk between the 100 and 200 halls containing dirty dishes and food scraps left over from supper that evening. On 5/16/24 at 8:55 P.M., the 300 hall was observed to have a nurse passing medications from a medication cart and no CNA was observed. A push cart was left in the hall containing three left over supper trays with dirty dishes and food scraps. Rooms 313, 317, 318, 322, and 323 had call lights on. On 5/16/24 at 9:00 P.M., Resident B was observed lying in bed with a bed side table extended out over her lap with a dirty dishes and a plate of leftovers resting on the table. Resident B indicated the plate was from the supper meal. On 5/16/24 at 9:03 P.M., room [ROOM NUMBER] turned their call light on. At 9:04 P.M., CNA 4 was observed on the 300 hall and entered room [ROOM NUMBER]. At 9:14 P.M., CNA 4 was observed to enter room [ROOM NUMBER]. Call lights in Rooms 315, 317, 322, and 323 were still on. On 5/16/24 at 9:25 P.M., CNA 4 indicated that most evening shifts are scheduled with one CNA per hall and two nurses. CNA 4 indicated the goal was to have two CNAs per hall. CNA 4 indicated that the 200 hall had several resident that required an assist of two staff with mechanical lifts for transfers and that she had just came from helping on the 200 hall when she saw the residents lights on the 300 hall. 3. On 5/17/24 at 2:30 P.M., a review of the facility's list of residents requiring two assist or greater for transfers indicated that 8 of 24 residents on the 100 hall needed 2 assist, 7 of 15 residents on the 200 hall required 2 assist, and 4 of 18 resident required 2 assist on the 300 hall. 4. On 5/17/24 at 3:15 P.M., during a review of daily posted staffing from 5/5/24 through 5/15/24 included the following staffing patterns: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Licensed nursing staff worked 12 hour shifts) 5/5/24 - Day shift - 3 licensed nursing staff, 6 nurse aides Evening shift - 3 nurse aides Night shift - 1 licensed nursing staff, 2 nurse aides 5/6/24 - Day shift - 1 licensed nursing staff, 8 nurse aides Evening shift - 4 nurse aides Night shift - 1 licensed nursing staff, 4 nurse aides 5/7/24 - Day shift - 3 licensed nursing staff, 10 nurse aides Evening shift - 4 nurse aides Night shift - 1 licensed nursing staff, 3 nurse aides 5/8/24 - Day shift - 4 licensed nursing staff, 11 nurse aides Evening shift - 4 nurse aides Night shift - 3 licensed nursing staff, 3 nurse aides 5/9/24 - Day shift - 3 licensed nursing staff, 12 nurse aides Evening shift - 6 nurse aides Night shift - 2 licensed nursing staff, 5 nurse aides 5/10/24 - Day shift - 2 licensed nursing staff, 9 nurse aides Evening shift - 7 nurse aides Night shift - 1 licensed nursing staff, 2 nurse aides 5/11/24 - Day shift - 3 licensed nursing staff, 10 nurse aides Evening shift - 2 nurse aides Night shift - 1 licensed nursing staff, 3 nurse aides 5/12/24 - Day shift - 3 licensed nursing staff, 11 nurse aides Evening shift - 2 nurse aides (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Night shift - 1 licensed nursing staff, 3 nurse aides 5/13/24 - Day shift - 3 licensed nursing staff, 9 nurse aides Evening shift - 5 nurse aides Night shift - 2 licensed nursing staff, 3 nurse aides 5/14/24 - Day shift - 4.5 licensed nursing staff, 9 nurse aides Evening shift - 7 nurse aides Night shift - 2 licensed nursing staff, 3 nurse aides 5/15/24 - Day shift - 4 licensed nursing staff, 9 nurse aides Evening shift - 7 nurse aides Night shift - 1 licensed nursing staff, 2 nurse aides 5. The lack of sufficient nursing staff resulted in the lack of ADL services provided including bathing and oral care. Cross reference F677. On 5/17/23 at 3:45 P.M., the Administrator supplied a facility policy titled, Scheduling Standards Policy, dated 1/2024. The policy included, Each schedule should be developed and planned to ensure adequate staffing levels to meet resident needs, to manage staff efficiently, to align the schedule with a census adjusted staffing budget, and to improve employee engagement and retention . Schedules should be developed in a manner that promotes efficient staffing in each Health Campus area for all shifts, weekdays, and weekends . This citation relates to Complaint IN00434456. 3.1-17(a)