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	10/04/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50827 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)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 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 [DATE] 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 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)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46758 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 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)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 50827 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 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 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. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 3.1-47(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48147 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. - 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. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46758 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, 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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46758 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 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. 48147 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: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident requires EBP during high-contact care 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 colostomy. 50827 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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., 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This citation related to complaint IN00440076. 3.1-18(b)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50827 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 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.