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	12/22/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified during a change in condition for 1 of 1 residents reviewed for closed records. (Resident 57)Finding includes: On 12/16/25 at 2:23 P.M., Resident 57's clinical record was reviewed. Resident 57 was admitted on [DATE]. Diagnoses included, but were not limited to, encephalopathy. The most recent admission Minimum Data Set (MDS) Assessment, dated 9/10/25, indicated Resident 57 was cognitively intact. Physician orders included, but were not limited to: lactulose solution 45mL (milliliters) oral three times a day; Start date 9/12/25 The electronic medication administration record (eMAR) indicated the following dates Resident 57 refused lactulose medication:10/3/25 12:21 P.M.10/4/25 11:55 A.M.10/8/25 8:26 A.M.10/8/25 12:20 P.M.10/10/25 3:42 P.M.10/10/25 6:48 P.M.10/11/25 7:31 A.M. The clinical record lacked physician notification of refusal of medications for the above attempted medication administrations. A physician note, dated 10/10/25, indicated resident does take medicines and has been using lactulose. During an interview on 12/19/25 at 1:15 P.M., Clinical Registered Nurse 3 indicated staff had previously contacted the physician when Resident 57 was refusing medications but did not contact the physician each time. On 12/22/25 at 9:43 A.M., the Administrator provided a policy titled Self Determination of Care, dated 5/16, that indicated Should a resident refuse his/her medications service recommendation, appropriate documentation relative to this decision shall be recorded in the resident's EMR. Documentation pertaining to a resident's care decision shall include, as a minimum: Open a self determination of care observation form in the electronic health record . b. The resident's response and reasons for denial . f. the date and time the physician was notified as well as the physician's response. 3.1-5(a)(2)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for 1 of 4 residents reviewed for pressure ulcers and 2 of 5 residents reviewed for unnecessary medications. (Resident 4, Resident 3, and Resident 42)Findings include: 1. On 12/16/25 at 10:33 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on [DATE]. Diagnoses included, but were not limited to, generalized anxiety disorder. The most recent Annual Minimum Data Set (MDS) Assessment, dated 9/19/25, indicated Resident 4 was cognitively impaired and received antianxiety medication during the 7-day lookback period. Physician orders included, but were not limited to: lorazepam (antianxiety medication) tablet 0.5 mg (milligrams) one tablet oral at bedtime; Start date 12/12/24 The electronic Medication Administration Record (eMAR) from 9/13/25 to 9/19/25 was reviewed. The resident received lorazepam 0.5 mg seven out of seven days. 2. On 12/16/25 at 2:03 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 10/4/25, indicated Resident 3 was cognitively intact, received an anticonvulsant medication, and did not receive an antianxiety medication during the 7-day lookback period. Physician orders included, but were not limited to:clonazepam (an antianxiety medication) 0.5 milligrams (mg) - Give one tablet by mouth four times a day for anxiety, dated 9/28/25. Pharmacological classifications listed for this medication were antianxiety, hypnotic, and anticonvulsant. The electronic Medication Administration Record (eMAR) from 9/30/25 to 10/4/25 was reviewed. Resident 3 received clonazepam 0.5 mg seven out of seven days. 3. On 12/16/25 at 1:28 P.M., Resident 42's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 10/31/25, indicated Resident 42 had severe cognitive impairment, received an anticonvulsant medication, and did not receive an antianxiety medication during the 7-day lookback period. Physician orders included, but were not limited to:clonazepam (an antianxiety medication) 0.5 milligram (mg) tablet - Give 0.25 mg by mouth twice a day for anxiety, dated 6/17/25 and discontinued on 12/16/25. Pharmacological classifications listed for this medication were antianxiety, hypnotic, and anticonvulsant. The electronic Medication Administration Record (eMAR) from 10/25/25 to 10/31/25 was reviewed—resident 42 received clonazepam 0.25 mg seven out of seven days. During an interview on 12/19/25 at 9:04 A.M., MDS Coordinator 5 indicated that clonazepam was coded as an anticonvulsant. During an interview on 12/19/25 at 10:15 A.M., MDS Coordinator 5 indicated she was not aware that clonazepam was also classified as an antianxiety medication and a hypnotic medication. She indicated medications should be coded for all pharmacological classifications on the MDS Assessment. She indicated that she used the facility's charting system drug classifications for coding medications. At that time, she indicated the facility followed guidelines set in the Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment Instrument (RAI) Manual. On 12/19/25 at 10:27 A.M., the RAI Manual, dated October 2024, was reviewed. It indicated Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 of 5 residents reviewed for medications. (Resident 3) A resident receiving a long-term prophylactic antibiotic did not have a care plan in place to address the antibiotic medication.Finding includes: On 12/16/25 at 2:03 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive chronic kidney disease and urinary retention. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 10/4/25, indicated Resident 3 was cognitively intact and received an antibiotic medication during the 7-day lookback period. Physician orders included, but were not limited to:ciprofloxacin (an antibiotic medication) 250 milligram (mg) - Give one tablet by mouth once a day on the 24th of the month, dated 9/30/25ciprofloxacin 500 mg tablet - Give one tablet by mouth twice a day, dated 9/28/25 and discontinued on 9/30/25ciprofloxacin 500 mg tablet - Give one tablet by mouth twice a day, dated 9/30/25 and discontinued on 10/2/25A care conference was completed on 10/24/25 with Resident 3's family member in attendance. Care plans were reviewed.The clinical record lacked a care plan related to the long-term use of an antibiotic.During an interview on 12/19/25 at 9:06 A.M., the Director of Nursing (DON) indicated that residents who received an antibiotic would also have a care plan that addressed the antibiotic.During an interview on 12/19/25 at 10:25 A.M., the DON indicated that there was not a care plan in place in the clinical record that addressed Resident 3's antibiotic medication prior to 12/19/25.On 12/22/25 at 9:43 A.M., the Administrator provided a current Comprehensive Care Plan Guideline policy, dated 5/22/18, that indicated Should new identified areas of concern arise during the resident's stay, they should be addressed on the care plan . Address problems that become ongoing or chronic with a new comprehensive care plan . Comprehensive care plans need to remain accurate and current .3.1-35(a)3.1-35(b)(1)

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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. Based on interview and record review, the facility failed to ensure care plan interventions were revised following a fall for 1 of 4 residents reviewed for falls. (Resident 12) A resident's care plan was not updated with a new intervention after a fall.Finding includes:On 12/16/25 at 12:55 P.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and dementia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/20/25, indicated Resident 12 had mild cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) with toileting and transferring, and had two or more falls without injury since the prior assessment. A care plan conference was completed on 12/3/25 with Resident 12's representative attending via phone call. Care plans were reviewed.A risk for falling care plan, initiated 1/2/25, included, but was not limited to, the following interventions:Therapy evaluation and treatment as needed, dated 1/2/25Ensure Dycem (a non-slip pad) is in place in wheelchair, dated 1/3/25Staff to assist resident to bed after p.m. meals, dated 2/10/25Dycem placed to wheelchair and staff to ensure placement and replace as needed, dated 6/3/25Therapy referral, dated 7/15/25Staff to assist resident to bed after supper if resident declines to stay in common area, dated 10/27/25An Occurrence clinical note, dated 1/2/25 at 9:59 A.M., indicated Resident 12 had an unwitnessed fall in her room while attempting to pick items up off the floor. Ensure Dycem is in place in wheelchair was added to the care plan on 1/3/25.A nursing progress note, dated 2/7/25 at 9:43 P.M., indicated Resident 12 had an unwitnessed fall in the common area while attempting to stand unassisted. Staff to assist resident to bed after p.m. meal was added to the care plan on 2/10/25.An Occurrence clinical note, dated 6/2/25 at 3:10 P.M., indicated Resident 12 had an unwitnessed fall in her room while attempting to pick an item up off the floor. Dycem placed to wheelchair and staff to ensure placement and replace as needed was added to the care plan on 6/3/25.A nursing progress note, dated 7/13/25 at 6:28 P.M., indicated Resident 12 had an unwitnessed fall in her room while attempting to walk unassisted. Therapy referral was added to the care plan on 7/15/25.A therapy referral report, initiated 7/14/25 and completed by therapy staff on 7/15/25, indicated that therapy was not recommended at that time.The clinical record did not indicate that the Interdisciplinary Team (IDT) met to follow up on the therapy report or that another relevant intervention was implemented following Resident 12's fall on 7/13/25.An Occurrence clinical note, dated 10/25/25 at 5:22 P.M., indicated that Resident 12 and an unwitnessed fall while attempting to self-transfer from her wheelchair to her bed. Staff to assist resident to bed after supper if resident declines to stay in common area was added to the care plan on 10/27/25.During an interview on 12/19/25 at 9:06 A.M., the Director of Nursing (DON) indicated that after a resident sustained a fall, the IDT would review the fall and initiate a new intervention appropriate to the situation.During an interview on 12/19/25 at 10:55 A.M., Clinical Registered Nurse (RN) 3 indicated that if an intervention such as a therapy referral did not end up being appropriate for the resident, a new intervention would be added to the care plan depending on the situation. After the therapy evaluation on 7/15/25 determined Resident 12 was not a candidate for therapy at that time, nothing else was added to the care plan.On 12/22/25 at 9:43 A.M., the Administrator provided a current Fall Management Program Guidelines policy, last reviewed on 11/19/25, that indicated Should the resident experience a fall the attending nurse shall complete .interventions to reduce risk of repeat episode and a review by the IDT to evaluate .appropriateness of the interventions . The resident care plan should be updated to reflect any new or change in interventions.On 12/22/25 at 9:43 A.M., the Administrator provided a current Comprehensive Care Plan Guideline policy, dated 5/22/18, that indicated Comprehensive care plans need to remain accurate and current. New interventions will be added and updated during or directly following CCM meeting.3.1-35(b)(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure residents were monitored for side effects of high-risk medications for 1 of 5 residents reviewed for medications. (Resident 3) A resident was not monitored for side effects of antibiotic, antiplatelet, diuretic, and antianxiety medications.Finding includes:On 12/16/25 at 12:03 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, urinary retention, congestive heart failure, and anxiety disorder. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 10/4/25, indicated Resident 3 was cognitively intact and received an antibiotic, diuretic, antiplatelet, and anticonvulsant medication and did not receive an antianxiety medication during the 7-day look back period.A care conference was completed on 10/24/25 with the resident's family member in attendance. Care plans were reviewed.The clinical record included, but were not limited to, the following care plans:Resident receives diuretic medication related to congestive heart failure, dated 6/6/25Resident is at risk for excessive bleeding and bruising related to medications, dated 6/6/25Resident has diagnosis of anxiety and demonstrated the following symptoms: fidgeting about, talking quickly, undecisive, dated 9/28/25Physician orders included, but were not limited to:aspirin (an antiplatelet medication) 81 milligrams (mg) chewable tablet - Give one tablet by mouth once a day, dated 9/28/25ciprofloxacin (an antibiotic medication) 250 mg tablet - Give one tablet by mouth once a day on the 24th of the month, dated 9/30/25furosemide (a diuretic medication) 20 mg table - Give one tablet by mouth once a day, dated 9/28/25clonazepam (an antianxiety medication) 0.5 mg tablet - Give one tablet by mouth four times a day, dated 9/28/25The clinical record lacked monitoring orders for side effects of the antiplatelet, antibiotic, diuretic, and antianxiety medication.During an interview on 12/19/25 at 9:04 A.M., MDS Coordinator 5 indicated that she coded the clonazepam as an anticonvulsant.During an interview on 12/19/25 at 9:06 A.M., the Director of Nursing (DON) indicated that when a resident was prescribed a high-risk medication, they also got an order to monitor for side effects of that medication. During an interview on 12/19/25 15 10:15 A.M., MDS Coordinator 5 indicated that she was unaware that clonazepam was also an antianxiety medication.During an interview on 12/19/25 at 10:25 A.M., the DON indicated that there was not a monitoring order for the antibiotic or the antiplatelet. Nursing staff monitored the side effects of the antianxiety medication with the anticonvulsant monitoring order. The diuretic medication was monitored through an intervention in the care plan.During an interview on 12/19/25 at 11:23 A.M., Registered Nurse (RN) 16 indicated that they monitored side effects of medication by using the monitoring orders and that they were not sure how to access the care plan. They indicated since there was not an antianxiety monitoring order for the clonazepam, she would use the hypnotic medication monitoring order to monitor for side effects of that medication.During an interview on 12/22/25 at 10:28 A.M., Clinical RN 3 indicated that there were some important side effects listed in the antianxiety monitoring order that were not listed in the anticonvulsant monitoring order such as sedation, vomiting, confusion, headache, and skin rash, and that the anticonvulsant monitoring order would not be completely appropriate for monitoring for side effects of clonazepam.On 12/22/25 at 10:34 A.M., Clinical RN 3 provided a current Specific Medication Administration Procedures policy, revised 11/2018, that indicated Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration . Monitor for side effects of adverse drug reactions immediately after administration and throughout each shift . Monitoring of side effects of medication-related problems occurs continually, but particularly after medication administration .3.1-48(a)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation was complete or accurate for 1 of 3 residents reviewed for closed records. (Resident 57) Finding includes: On 12/16/25 at 2:23 P.M., Resident 57's clinical record was reviewed. Resident 57 was admitted on [DATE]. Diagnoses included, but were not limited to, encephalopathy. The most recent admission Minimum Data Set (MDS) Assessment, dated 9/10/25, indicated Resident 57 was cognitively intact. Physician orders included, but were not limited to: lactulose solution 45mL oral three times a day; Start date 9/12/25 The electronic medication administration record (eMAR) indicated the following dates lactulose medication was recorded as unavailable:10/1/25 11:07 A.M.10/1/25 6:48 P.M.10/6/25 8:35 P.M.10/7/25 7:51 A.M.10/7/25 11:22 A.M.10/7/25 7:45 P.M. During an interview on 12/9/25 at 10:28 A.M., the Director of Nursing indicated staff could not remember Resident 57's lactulose medication being unavailable, and believe the missed medication administrations were documented in error. On 12/22/25 at 9:43 A.M., the Administrator provided a policy titled Medication Orders, dated 11/18, that indicated The prescriber is contacted by the facility personnel for direction when delivery of a medication will be delayed or the medication is not or will not be available. 3.1-50(a)(2)