STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155785	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West River Health Campus	714 S Eickhoff Rd Evansville, IN 47712

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's plan of care was followed by providing assistance during transfers for 1 of 1 residents reviewed for falls. (Resident F) Finding includes: On 8/13/25 at 10:38 A.M., Resident F's clinical record was reviewed. Resident F was admitted on [DATE]. Diagnoses included, but were not limited to, dementia. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 6/25/25, indicated Resident F was severely cognitively impaired, required partial assistance from staff for bathing and toileting (staff do half of the work), and required supervision from staff for transfers. During an anonymous interview on 8/12/25 at 8:15 A.M., it was indicated that Resident F had fallen on 8/2/25 where family viewed the fall through a camera and called the facility to notify staff of the fall, and staff were not assisting the resident during toileting or transfers. Physician orders included, but were not limited to: Macrobid (antibiotic medication) capsule; 100 mg (milligrams) oral, take one capsule by mouth twice a day for seven days for urinary tract infection (UTI); start date 8/1/25 Current care plan included, but was not limited to: Resident is at risk for falling related to weakness and immobility, staff to assist resident with transfers as needed; start date 6/22/24 A nursing progress note, dated 7/25/25 at 10:28 A.M., indicated Resident F had trouble transferring out of bed. After several minutes resident was transferred to wheelchair with assistance from two staff members. An event report, dated 7/31/25, indicated Resident F experienced confusion and falling as symptoms of a UTI. Point of care (POC) responses in the medical record were reviewed. The following indicated staff's responses to assisting Resident F with toileting and transfers the day of the fall: 8/2/25 at 10:41 A.M.: How did resident use the toilet? Independent; Staff support provided for toileting? No setup or physical help from staff 8/2/25 at 10:41 A.M. How did the resident transfer? Independent; Staff support provided for transferring? No setup or physical help from staff;What appliances or assistive devices were used for transferring? None During an interview on 8/14/24 at 11:15 A.M., Certified Nurses Aide 4 (CNA) indicated that Resident F required assistance of one for transfer and toileting. During an interview on 8/15/25 at 9:13 A.M., The Director of Nursing (DON) indicated Resident F was typically independent, only required staff assistance while having a UTI, and the care plan level of assistance was accurate in stating Resident F needed assistance with transfers. On 8/15/25 at 11:55 A.M., the Administrator provided a policy titled Comprehensive Care Plan Guidelines, dated 5/18, that indicated Goals should be measurable and attainable, interventions should be reflective of the individual's needs; Comprehensive care plans need to remain current and accurate 3.1-35(a)

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