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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/30/2025 |
| NAME OF PROVIDER OR SUPPLIER West River Health Campus | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on the interview and record review, the facility failed to complete a physician's order to obtain a urine sample timely for 1 of 3 residents reviewed for urinary tract infections (UTIs). A urine sample was not obtained for five (5) days, with two documented attempts to obtain the sample before the physician was notified, and an order to obtain the sample via catheterization was received. (Resident C) Findings include: On 12/29/25 at 10:35 A.M., Resident C's clinical record indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, and a disorder of the kidney and ureter. Resident C's most recent Significant Change Minimal Data Set (MDS) assessment, dated 6/25/25, indicated the resident had severe cognitive impairment, was frequently incontinent of bladder and bowel, and required partial to moderate assistance with activities of daily living (ADL's). Resident C's physician orders included but were not limited to: culture, urine; urinalysis one time (started and discontinued 7/25/25) and urinalysis with culture and sensitivity due to signs and symptoms of infection, may in-and-out catheter to obtain (started and discontinued 7/30/25). Resident C's nurse's progress notes included, but were not limited to: 7/25/25 at 11:51 A.M. - Resident initially had difficulty urinating. The hospice nurse suspected the resident had a UTI. 7/25/25 at 4:26 P.M. - Hospice nurse spoke to the physician and wanted to get a urinalysis and culture for the resident due to increased urgency. Order placed. 7/28/25 at 10:30 A.M. - Resident toileted at this time. Urine sample collection hat was placed in the toilet to collect urine for urinalysis; however, the resident missed the hat. Will attempt at the next void. Spoke with hospice nurse who stated she will be in on Tuesday for a visit and will obtain an order for an in-and-out catheter if needed. 7/30/25 at 11:54 A.M. - New order, may in-and-out catheterize to obtain a urine sample for urinalysis with culture & sensitivity for possible UTI. 7/31/25 at 7:57 A.M. - Urinalysis results faxed, awaiting response. 07/31/25 at 12:27 P.M. - New orders to start Keflex 250 milligrams (mg) three times a day for seven (7) days UTI Urine was cloudy and odorous. Resident C's MAR/TAR from 7/25/25 to 7/31/25 indicated that an order to obtain a urine sample on 7/25/25 was attempted, and Resident C had refused. No other documented attempts were included in the MAR/TAR until the new order on 7/31/25 for the in-and-out catheter was obtained and completed successfully. Resident C's urinalysis dated 7/30/25 indicated a trace (abnormal) amount of blood in the urine, a high amount of white blood cells, many bacteria, and had a turbid appearance. During an interview on 12/30/25 at 9:15 A.M., the Assistant Director of Nursing (ADON) indicated that when an order to obtain a urine sample is received, staff should document when an attempt is made, and if unsuccessful, should document that an attempt was made the following shift, until the sample is obtained. If a urine sample cannot be obtained or if symptoms worsen, staff should notify the physician. During an interview on 12/30/25 at 9:50 A.M., RN 8 indicated the facility did not have a policy for following physician orders, but when an order to obtain a urinalysis was received, and the urine could not be obtained, the physician should be notified, and typically, an in-and-out catheter order would be obtained. This citation relates to intake 2696361.3.1-41(a)(2)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 155785 |
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