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	08/19/2024

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

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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 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** 48057 Based on interview, record review, and observation, the facility failed to ensure residents dependent on staff for ADL (activities of daily living) were bathed for 4 of 4 residents reviewed for ADL care. (Resident 11, Resident 32, Resident 148, Resident 6) Findings include: 1. During an interview on 8/12/24 at 11:01 A.M., Resident 32's family indicated Resident 32 was not receiving showers as often as he should be. On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired and was completely dependent on staff for bathing, toileting, and transfers. Current care plans included, but were not limited to: Resident requires staff assistance to complete self-care and mobility functional tasks completely and safely; Showers: per shower schedule. Dated 4/27/24. On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 7/1/24 through 8/16/24; Resident 32 received a shower or complete bed bath four times in July and one time in August. No shower schedule was available for review when requested. 2. On 8/14/24 at 12:02 P.M., Resident 11's clinical record was reviewed. Resident 11 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia and hemiplegia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident 11 was moderately cognitively impaired and was completely dependent on staff for bathing and transfers. Current care plans included, but were not limited to: Showers: per shower schedule. Dated 3/13/22. (continued on next page)

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 7/1/24 through 8/16/24; Resident 11 received a shower or complete bed bath two times in July and had not received a shower or complete bed bath in August. No shower schedule was available for review when requested. 3. On 8/13/24 at 8:44 A.M., Resident 148's clinical record was reviewed. Resident 148 was admitted on [DATE]. Resident 148's clinical record lacked diagnoses and a completed MDS Assessment. Current care plans included, but were not limited to: Showers: per shower schedule. Dated 8/12/24. On 8/16/24 at 10:59 A.M., Clinical Support 5 provided bathing performed from 8/7/24 through 8/16/24; Resident 148 had not received a shower or complete bed bath since admission to the facility. No shower schedule was available for review when requested. 48147 4. On 8/12/24 at 11:21 A.M., Resident 6 indicated she was supposed to get showers every other day but didn't get them very often. She indicated if she refused a shower, she was not offered a bed bath as an alternative. At that time, white flakes of skin were observed on Resident 6's blanket and chair. On 8/13/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Resident 6 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, hypertensive heart disease, major depressive disorder, and urge incontinence. The most current Admission Minimal Data Set (MDS) Assessment, dated 7/8/24, indicated Resident 6 was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care. A Point of Care (POC) History report indicated Resident 6 received a shower or complete bed bath two times in July and one time in August. On 8/14/24 at 11:15 A.M., the Assistant Director of Nursing (ADON) indicated CNAs (Certified Nursing Assistants) should be charting all showers and bed baths in POC Responses (a charting system for CNAs). If a resident refused a shower, staff should offer an alternative. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current Guidelines for Bathing Preference policy, dated 12/31/23, that indicated Bathing shall occur at least twice a week . 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on observation, interview, and record review, the facility failed to ensure residents had supervision and interventions in place to prevent accidents for 2 of 2 residents reviewed for Accidents. A resident's fall intervention was out of place, care plans were not updated with new interventions, and a resident's diet orders were not followed or supervised during a group activity. (Resident 30 and Resident 32) Findings include: 1. On 8/13/24 at 11:25 A.M., nonskid strips were observed in the shower and in front of sink in Resident 30's bathroom. Nonskid strips were not observed in front of the toilet. On 8/13/24 at 9:25 A.M., Resident 30's clinical record was reviewed. Resident 30 was admitted to the facility on [DATE] following left hip surgery. Diagnoses included, but were not limited to, Alzheimer's disease, muscle weakness, and unspecified fall. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 6/21/24, indicated Resident 30 had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half) for transferring and toileting, and had one fall without injury and one fall with injury since the prior assessment on 3/28/24. A fall risk assessment, dated 8/2/24, indicated Resident 30 was at high risk for falls. The admission comprehensive falls care plan, dated 11/2/23, included the following interventions: Assure the floor is free of liquids and foreign objects Encourage/assist resident to assume a standing position slowly Keep call light in reach Keep personal items and frequently used items within reach Provide nonskid footwear Staff to assist resident with transfers as needed Therapy evaluation and treatment as needed The clinical record indicated Resident 30 had fallen 10 times since admission to the facility. Fall 1 (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/1/23 at 11:20 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident complained of pain in his left hip and was sent to the emergency room (ER) for evaluation and treatment. Hospital discharge papers indicated the x-rays were negative for a hip fracture. The intervention Staff to assist resident with toileting prior to bed and then throughout the night was added to the care plan on 11/2/23. Fall 2 On 11/13/23 at 4:57 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident had a laceration to his left elbow and was sent to the ER for evaluation and treatment. Hospital discharge papers, dated 11/13/24, indicated x-rays were negative for an elbow fracture. The intervention Nursing staff to offer and assist with toileting upon rounds was added to the care plan on 11/22/23. Fall 3 On 11/24/23 at 4:53 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention antiroll back to wheelchair was added to the care plan on 11/27/23. Fall 4 On 11/25/23 at 3:00 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident's previous laceration on the left elbow had reopened and his eye was dark pink and swollen. The resident was sent to the ER for evaluation and treatment. Hospital discharge paperwork, dated 11/27/23, indicated x-rays were negative for facial and elbow fractures. The intervention Wake frequently at night and assist with toileting needs was added to the care plan on 11/27/23. Fall 5 On 12/8/23 at 7:00 A.M., Resident 30 had a witnessed fall while attempting to self transfer out of bed. The intervention Encourage resident to wear non skid socks in bed was added to the care plan on 12/11/23. Fall 6 On 12/21/23 at 3:06 A.M., Resident 30 had an unwitnessed fall while sitting on the couch in the day room. The intervention Dycem to couch was added to the care plan on 12/21/23. Fall 7 On 1/25/24 at 1:32 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention Therapy referral for trunk control was added to the care plan on 1/26/24. Fall 8 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 2:46 A.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The resident sustained abrasions to his right knee and right elbow and a knot to the back of his head. The interventions Bed in lowest position and Offer resident to toilet between 1am-2am was added to the care plan on 5/7/24. Fall 9 On 5/18/24 at 9:06 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. The intervention non skid strips in front of toilet was added to the care plan on 5/20/24. Fall 10 On 7/28/24 at 8:00 P.M., Resident 30 had an unwitnessed fall while attempting to self toilet. A nursing progress note, dated 7/28/24 at 8:45 P.M., indicated the floor in the bathroom was very slick. An x-ray on the resident's left hip and left ankle was ordered. Results indicated the left ankle and left hip were negative for fracture and dislocation. The intervention assist to toilet with each round was added to the care plan on 7/29/24. On 8/14/24 at 9:10 A.M., the Assistant Director of Nursing (ADON) indicated that maintenance placed nonskid strips in front of Resident 30's toilet on 8/13/24 around noon. On 8/16/24 at 9:10 A.M., Clinical Support 5 indicated after a resident sustained a fall, the IDT (Interdisciplinary Team) would meet to determine a root cause for the fall and a new intervention related to the fall would be placed in the care plan and implemented that day. 48057 2. On 08/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, required moderate assistance from staff with eating, and required a modified diet due to choking, coughing, and difficulty swallowing. Physician orders included, but were not limited to: Diet: Fortified foods/puree/thin liquids Special Instructions: Built up utensils and divided plate. Start date 8/8/24. Diet: Puree, Thin liquids, Resident to be feed all meals. Go to dining room for all meals. Date 5/15/24 - 6/20/24. Care plan included, but was not limited to: Resident has potential for complications, functional and cognitive status decline. Diet as ordered. Date initiated: 4/27/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 6/2/24 at 11:26 A.M., indicated Resident 32 had choked on banana bread while in activities. The progress note indicated by the time staff saw Resident 32 choking, he was blue/purple and the nurse performed the Heimlich maneuver to dislodge food stuck in Resident 32's throat. Resident 32 was sent to the emergency department. A chest X-ray report obtained in the hospital emergency department, dated 6/2/24 at 1:33 P.M., indicated resident 32 was admitted for aspiration and the X-ray indicated infiltrates in the lungs. A progress note, dated 6/2/24 at 6:09 P.M., indicated Resident 32 returned to the facility from the hospital with an order for Augmentin (antibiotic) with a diagnosis of pneumonia. During an interview on 8/16/24 at 2:22 P.M., Clinical Support 5 indicated Resident 32 was in the activities room when staff were making banana bread and provided it to residents, Resident 32 was given banana bread by another resident, and that Resident 32 was on a puree diet at the time he choked in activities. On 8/16/24 at 11:30 A.M., Clinical Support 5 indicated there was no facility policy on resident supervision or following diet orders, but staff were expected to follow all physician orders. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current Falls Management Program Guidelines policy, dated 12/31/23, that indicated Should the resident experience a fall the attending nurse shall complete the Fall Event This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possibly contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions . The resident care plan should be updated to reflect any new or change in interventions. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a current Comprehensive Care Plans policy, dated 12/31/23, that indicated Comprehensive care plans need to remain accurate and current. New interventions will be added and updated during or directly following CCM [continuity of care meeting] meeting. 3.1-25(a)(1) 3.1-45(a)(2)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure services were provided to a resident with an indwelling urinary catheter to prevent the development of infection for 1 of 1 resident reviewed for a catheter-associated urinary tract infection (CAUTI). (Resident 32) This deficient practice resulted in Resident 32 developing a CAUTI with septic shock and pneumonia. Resident 32 required artificial ventilation and treatment at a hospital-based intensive care unit. (Resident 32) Finding includes: On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, obstructive uropathy, dementia. An Admission MDS (Minimum Data Set) Assessment, dated 3/20/24, indicated Resident 32 was moderately cognitively impaired, was completely dependent on staff for bathing, toileting, and transfers, and had an indwelling catheter. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, was completely dependent on staff for bathing, toileting, and transfers, and had an indwelling catheter. The clinical record lacked current orders related to indwelling catheter care or documentation of physician notification for clarification of indwelling catheter use. Current comprehensive care plan included, but was not limited to: Resident uses a Foley (brand of indwelling) catheter for diagnosis of obstructive uropathy; Observe for any signs of complication such as UTI, urethral trauma, strictures, bladder calculi or silent hydronephrosis notify my doctor. Date initiated: 4/27/24. Resident is at risk for excessive bleeding and bruising related to medications; Notify MD (doctor) of abnormal bruising and or bleeding. Date initiated: 4/27/24. A progress note, dated 7/28/24 at 1:30 A.M., indicated Resident 32 had blood in his urine. The clinical record lacked any further urinary or catheter assessment or notification to the physician related to any abnormal urinary symptoms. A progress note, dated 7/30/24 at 12:39 A.M., indicated Resident 32 was experiencing blood in his urine and a catheter flush was performed. Documentation did not include specific information to determine technique used to perform the catheter flush, further assessment after the catheter flush, or notification to the physician prior to flush the catheter, of findings during the catheter flush. (continued on next page)

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	155785	A. Building B. Wing	08/19/2024

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A progress note, dated 7/30/24 at 1:31 A.M., indicated Resident 32 was found with abnormal vitals: labored wheezing respirations at 22 per minute, an oxygen saturation of 86%, a pulse of 139 beats per minute, a blood pressure of 94/54, and temperature of 101.3 degrees Fahrenheit. Resident 32 had thick and clotted blood noted in his indwelling catheter tubing and decreased urinary output. The physician was notified through triage and Resident 32 was sent to the hospital. A hospital document titled Patient Summary Report, dated 7/30/24 at 4:48 A.M., indicated Resident 32 was admitted to the hospital with septic shock secondary to a urinary tract infection and pneumonia. Resident 32 was intubated and placed in intensive care. A late entry progress note, entered by nursing staff at the facility dated 8/2/24 at 7:16 P.M. for 7/28/24 at 7:06 P.M, indicated Resident 32 had passed a blood clot, urine was clear and non-odorous, and vital signs were in normal range. The clinical record lacked notification to the physician the resident had passed a blood clot. A progress note dated 8/7/24 at 3:15 P.M., indicated Resident 32 had returned to the facility from the hospital. During an interview on 8/16/24 at 10:16 A.M., the Clinical Support 5 indicated there was no catheter assessment tool to monitor indwelling catheters but Resident 32 should have had an indwelling catheter order set entered upon return from the hospital stay and did not, and that if a nurse noticed abnormalities with an indwelling catheter such as bleeding, the physician should be notified. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a policy titled Guidelines for the Use of Indwelling Catheter, dated 12/31/23, that indicated Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible; A resident with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible. The policy did not address indwelling catheter flushing or indwelling catheter associated urinary tract infections. 3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview, record review, and observation, the facility failed to ensure a resident's decline in nutritional status was addressed and recommendations were followed for 1 of 1 residents reviewed for significant weight loss. (Resident 32) Finding includes: On 8/13/24 at 11:20 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and dysphagia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/26/24, indicated Resident 32 was significantly cognitively impaired, required moderate assistance from staff with eating, was completely dependent on staff for bathing, toileting, and transfers, and required a modified diet due to choking, coughing, and difficulty swallowing. Physician orders included, but were not limited to: Diet: Fortified foods/puree/thin liquids Special Instructions: Built up utensils and divided plate. Start date 8/8/24. Order Set Admission - Weekly Weight. Start date 3/16/24. Dietary supplement: Ensure may substitute if available. Dated 5/5/24 - 6/11/24. Dietary supplement: Medpass 120 mL (milliliters) TID (three times a day). Dated 6/11/24 - 7/9/24. Care plan included, but was not limited to: Resident is malnourished/at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. Date initiated 3/18/24. Resident has experienced a significant weight loss. Date initiated 7/8/24. Obtain a dietary consult as needed. Follow recommendations as required. Date initiated 5/14/24 Hospital discharge documents, dated 3/15/24, indicated Resident 32 had a weight recorded of 218 pounds. The following vitals indicated date taken by nursing staff in the facility: 3/19/24 (admission) 230 lbs (pounds) Height: 5 feet 11 inches No weekly weight taken the week of 3/24/24-3/30/24 No weekly weight taken the week of 3/31/24-4/6/24 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/12/24 (11:25 AM) 231 lbs 4/15/24 (10:54 AM) 231 lbs No weekly weight taken the week of 4/21/24-4/27/24 No weekly weight taken the week of 5/5/24-5/11/24 No weekly weight taken the week of 5/12/24-5/18/24 5/20/24 (2:51 PM) 253.8 lbs 5/27/24 (3:54 PM) 175.4 lbs 6/3/24 (3:08 PM) 184.6 lbs 6/6/24 (2:54 AM) 183 lbs No weekly weight taken the week of 6/9/24-6/15/24 6/18/24 (12:07 PM) 183.5 lbs 6/24/24 (1:36 PM) 185.8 lbs 7/1/24 (8:39 AM) 181.6 lbs 7/5/24 (12:07 PM) 181.6 lbs No weekly weight taken the week of 7/7/24-7/13/24 No weekly weight taken the week of 7/14/24-7/20/24 No weekly weight taken the week of 7/21/24-7/27/24 8/7/24 (3:30 PM) 177 lbs 8/12/24 (1:42 PM) 178 lbs A progress note, dated 5/13/24 at 9:26 A.M., indicated Resident 32 had no edema noted. A progress note, dated 5/22/24 at 5:22 P.M., indicated Resident 32 had a weight gain in the last 30 days, weekly weights should continue, and no increased edema was noted. A weight monitoring nutrition assessment progress note created by the registered dietitian on 5/30/24 at 4:13 P.M. indicated Resident 32's weight of 175.4 lbs on 5/27/24 was likely an error and Resident 32 should be re-weighed. A weight was not recorded until the next weekly weight was due. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weight monitoring nutrition assessment progress note created by the registered dietitian, dated 6/10/24 at 10:43 A.M., indicated Resident 32's weight Inconsistencies were likely how inconsistently Resident 32 was being weighed by staff; staff to ensure resident is weighed the exact same every time day, continue weekly weights. During an observation on 8/16/24 at 2:09 P.M., CNA 6 weighed Resident 32's wheelchair by itself (52.8 lbs), then weighed Resident 32 while sitting in the wheelchair (235.6 lbs), for a final weight for Resident 32 of 182. 8 lbs. During an interview on 8/15/24 at 9:28 A.M., the ADON (assistant director of nursing) indicated the large fluctuation in Resident 32's weight was due to staff not weighing Resident 32 correctly, and was unsure where the actual weight loss occurred because residents clothes still fit the same. The ADON indicated Resident 32 was put on nutritional supplement and fortified foods after the significant weight loss. The ADON indicated the weight machine was not reading right and needed to be calibrated and that may have caused the significant weight differences, and was unsure if Resident 32 was reweighed after the weight machine was recalibrated. During an interview on 8/16/24 at 10:16 A.M. the Regional Clinical indicated weekly weights documented in physician orders and POC (point of care) responses populate in vitals, if weekly weights were not there, they were not completed, and that the order for weekly weights order is a nurse task to be completed but sometimes CNA (certified nurses aide) may take the weight and give the weight to the nurse to enter. The Regional Clinical indicated she believed Resident 32's weight entered on 5/20/24 and 5/27/24 should have been marked invalid, and the 46.4 pound weight loss from 4/15/24 to 6/3/24 was due to Resident 32 having diarrhea and edema. Documents indicating diarrhea and edema during this time was requested but not provided. The clinical record lacked documentation in medical record of thorough assessment of resident 32's condition for recorded weight loss. A document provided by Clinical Support 5 on 8/16/24 at 1:52 P.M., titled Work History Report indicated the weight scale had been calibrated weekly from 8/5/23 through 8/17/24. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a document titled Guidelines for Weight Tracking, dated 12/31/23, that indicated Scales shall be properly maintained and calibrated to ensure accuracy of weight. Residents who have a weight that seems out of normal range shall be re-weighed to determine the accuracy of the original weight. The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. 3.1-46(a)(1)

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	08/19/2024

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48147 Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and oxygen services were provided according to physician order for 1 of 3 residents reviewed for respiratory care. (Resident 6) Finding includes: On 8/12/24 at 11:30 A.M., Resident 6 was observed to receive 5 Liters (L) of oxygen via nasal cannula. The humidification bottle was empty and not dated and the tubing was not dated. At that time, Resident 6 indicated she was supposed to be getting 3L of oxygen but was not sure why. On 8/13/24 at 1:04 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, non-ST elevation (NSTEMI) myocardial infarction and shortness of breath. The most current Admission Minimum Data Set (MDS) Assessment, dated 7/8/24, indicated Resident 6 was cognitively intact, received partial to moderate assistance of staff (staff does less than half) for transfers, and was not receiving oxygen. Physician orders included, but were not limited to: Oxygen at 3L per nasal canula continuous, dated 7/30/24 Change oxygen tubing monthly once a day on the 1st of the month, dated 7/30/24 A Profile Care Guide care plan, dated 7/16/24, indicated Resident 6 received 3L of continuous oxygen. On 8/14/24 at 11:10 A.M., Licensed Practical Nurse (LPN) 12 indicated she was unsure who was supposed to change oxygen tubing and humidification bottles. On 8/14/24 at 11:15 AM., the Assistant Director of Nursing (ADON) indicated tubing and humidification bottles were changed out according to physician's order or as needed by the night shift nursing staff. On 8/16/24 at 11:39 A.M., Clinical Support 5 indicated the facility did not have a policy for following physician orders, but staff were expected to follow orders. On 8/16/24 at 11:30 A.M., Clinical Support 5 provided a Respiratory Equipment policy, dated 12/31/23 that indicated Use sterile distilled water for humidification over 4LPM [liters per minute] . Change prefilled humidifier when water level becomes low . Change oxygen cannula and tubing monthly and as necessary. 3.1-47(a)(6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35733 Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner in accordance with professional standards for food service safety for 2 of 2 observations of the kitchen and 1 of 1 observations of unit refrigerators. Food was not labeled, floors were soiled, and equipment was soiled. (Kitchen, Certified Locked Dementia Unit) Findings include: On 8/12/24 at 6:58 A.M., the following was observed in the kitchen: 1. walk in cooler - 2 bags of lunch meat, one open to air, no labels. 2. walk in freezer - clear bag of cookies no label, container of individually sealed frozen pork chops, no label. 3. soiled shelves under the grill and steamer, sides of the stove soiled, floors with debris build up under equipment and storage racks, dishwasher area, around edges of walls, sides of ice machine calcium build up, dusty vents. On 8/14/24 at 9:43 A.M., the refrigerator on the locked dementia unit was observed to have a bowl of purple pureed food, no label, 3 muffins in individual bowls, no label, a tray containing 8 individual bowls of macaroni salad and two bowls of orange pureed food, no label, and an unopened can of an energy drink no label. On 8/14/24 at 12:05 P.M., the lunch meat in the walk in cooler was observed with a label. On 8/15/24 at 9:21 A.M., the same was observed for all other areas observed on 8/12/24 at 6:58 A.M. On 8/15/24 at 9:26 A.M., the Dietary Manager indicated the pork chops were delivered last week and should have been labeled, after food was opened it was put in a two gallon bag and labeled, floors were mopped nightly, usually once a week under tables, equipment, etc. There was a weekly cleaning schedule. On 8/15/24 at 12:10 p.m., the Administrator provided the current policy on food labeling and dating with a revised date of 2019. The policy included but was not limited to: Any food product removed from its original container, has a broken seal, has been processed in any way must have a label .1. Item name. 2. Date and time the food was label. 3. Use by date. 4. Initials of the person labeling the item. 4. Securely cover the food item . 3.1-21(i)(2) 3.1-21(i)(3)

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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. 35733 Based on observation, record review, and interview, the facility failed to ensure staff performed proper hand hygiene and sanitation practices while providing care for 3 of 3 residents observed receiving care and 1 of 1 residents observed receiving blood glucose level checks. (Resident 11, Resident 19, Resident 32, Resident 9) Findings include: 1. On 8/12/24 at 9:07 A.M., LPN (Licensed Practical Nurse) 4 was observed getting supplies out of the medication cart. She knocked on Resident 11's door, entered the room, donned gloves, and obtained Resident 11's blood glucose level. LPN 4 removed her gloves, left the room, helped another staff to pull up a resident in their wheelchair by a draw sheet, went to the medication cart, and charted on the computer. No hand hygiene was observed. 2. On 8/14/24 at 9:06 A.M., CNA (Certified Nurse Aide) 6 was observed providing morning care to Resident 19. After care, CNA 6 removed her gloves, gave Resident 19 a drink from a cup, pushed the resident out of the bathroom, gave the call light to the resident, stripped the bed and pillow of linens and put them in a bag, changed the trash bag in the trash can, took personal care supplies to the bathroom, and shut the bathroom door. CNA 6 left the room carrying the bags to the dirty linen room, pushed the buttons on the door to open it, opened the lids to the containers to dispose of the bags, left the room, walked across the hall and opened the door to the bathroom, and washed her hands. 48057 3. During a wound care observation on 8/15/24 at 9:16 A.M., the RN (Registered Nurse) 11 was observed standing in the hall wearing a gown and gloves. RN 11 entered Resident 9's room, shut the door, and opened wound care supplies on Resident 9's bedside table. RN 11 reached around her gown and pulled a marker out of her pants pocket and dated the dressings. RN 11 removed her gloves, applied hand sanitizer, and put new gloves on. RN 11 assisted Resident 9 to roll to his right side. RN 11 sprayed wound cleanser in the wound on Resident 9's coccyx and applied skin prep around the wound. RN 11 used a cotton swab to apply Santyl (ointment used to promote skin healing) to the coccyx wound and covered the wound with a dressing. RN 11 removed her gloves and gown, turned the sink on, and washed her hands for nine (9) seconds. 4. During a random care observation on 8/16/24 at 2:13 P.M., CNA (Certified Nurse Aide) 2 and CNA 6 used a sit to stand lift to transfer Resident 32 from the bed to the wheelchair. The footplate of the sit to stand lift was observed to have dirty build up and the grip mat of the footplate was peeling off and sticking up on all sides. On 8/16/24 at 8:44 A.M., CNA 2 indicated hand hygiene should be done before and after glove use and before and after providing care to a resident. On 8/16/24 at 11:29 A.M., LPN 3 indicated hand hygiene needed done when hands were visibly soiled and when passing medications. In between residents, staff could use alcohol gel, and after every couple of residents, staff should wash their hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/16/24 at 11:30 A.M., the Clinical Support 5 provided the current policy on hand washing/hand hygiene with a revision date of 2/9/17. The policy included but was not limited to: All health care workers shall utilize hand hygiene frequently and appropriately .3. Health care workers (HCW) shall use hand hygiene at times such as: .c. before/after having direct physical contact with residents. d. After removing gloves, worn per standard precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc.Hand Washing . b) wet hands with running water. Apply liquid soap and work into a lather. c) wash for at least 20 seconds, using rotary motion and friction . On 8/16/24 at 11:30 A.M., the Clinical Support 5 provided the current policy on standard precautions guidelines with a revision date of 5/11/16. The policy included but was not limited to: 1. Standard precautions include, but are not limited to hand hygiene, safe injection practice, the proper use of PPE (e.g.; gloves, gowns, and masks), resident placement, and care of the environment, textiles, and laundry. Also equipment or items in the resident's room environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents, (e.g.; wear gloves for handling soiled equipment, and properly clean and disinfect or sterilize equipment before use on another resident) . 3.1-18(b) 3.1-18(l)