

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155854	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER North River Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 811 E Baseline Road Evansville, IN 47725	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure skin injuries did not happen during routine care for 1 of 3 resident's reviewed for ADL (activities of daily living) care. A resident received skin shearing during care. The deficient practice was corrected on July 15, 2026, prior to the start of the survey, and was therefore past noncompliance. Finding includes: On 7/28/26 at 9:41 a.m., Resident B's clinical record was reviewed. Diagnoses included but were not limited to, central cord syndrome at unspecified level of cervical spinal cord, arthrodesis status, spinal stenosis, cervical region, wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing. An admission Minimum Data Set (MDS) assessment dated [DATE], indicated cognition intact, toileting dependent (helper completed the activities for the resident), roll left and right, dependent, skin- surgical wound, no pressure ulcers on admission. Resident B was admitted to the facility on [DATE]. Care plans were reviewed and included, but were not limited to: Skin integrity at risk for skin breakdown r/t (related to) Foley catheter placement, need for assistance with mobility, ADL's toileting, hygiene, positioning off of pressure areas, altered skin integrity d/t (do to) shearing, start date 7/6/26. Approach included but was not limited to, avoid shearing skin during positioning, turning, and transferring, treatments/preventative treatments as or when ordered, start date 7/6/26. Resident has shearing injury: L) buttock & R buttock, start date 7/15/26. Approach included but was not limited to, treatment per MD order. July 2026 physician's orders were reviewed and included but were not limited to: order set WC (wound care) preventative - apply foam dressing coccyx (be sure to cover both areas) change every 5 days. Special instructions: change PRN (as needed) with soiled, once a day every 5 days, 6:30 p.m.- 11:00 p.m., order date 7/13/26. Order set WC preventative - observe dressing to coccyx every shift. May peel back and view area to monitor if area has opened, twice a day, 6:00 a.m.- 10:00 p.m., order date 7/13/26. Incontinence care- cleanse skin with personal cleanser and apply protective ointment/cream as needed after each incontinence episode twice a day, 6:00 a.m.- 6:00 p.m., 6:00 p.m.- 6:00 a.m., order date 7/3/25. Progress notes were reviewed and included but were not limited to: 7/13/26 at 5:13 p.m., Primary Etiology: Other friction injuryLocation:: L side coccyxLength: 1.6Width: 9Depth: 0Exudate: No ExudateTissue Type: Partial ThicknessDebridement Type: No Debridement Type 7/13/26 at 5:15 p.m., Primary Etiology: Other friction injuryLocation:: R side coccyxLength: 1Width: 3.8Depth: 0Exudate: No ExudateTissue Type: Partial ThicknessDebridement Type: No Debridement Type 7/13/26 at 5:16 p.m., This nurse called to room via hall staff member. Coccyx noted to have purple, red areas to each side. Measurements entered into wound management and skin progress note. The following treatment was recommended by WCC (wound care certification) - apply skin prep to area, periwound and cover with Allevyn Life Sacral dressing- change every 5 days and PRN if becomes soiled or dislodged. LAL(low air loss) mattress applied this day, resident and staff were encouraged to use podus boots while resident is in (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. Use draw sheet for all transfers to prevent friction. NHT(nursing home triage) notified and new orders received for liquacell 30 ml daily X 1 month. Orders transcribed. 7/14/26 at 3:43 p.m., IDT/New onset edema/blister to right medial heel/friction injury to bil(bilateral) buttocks: .[Resident B] has also experienced friction injures to bil buttocks. Areas are elongated length wise across her buttocks (much longer on the left than on the right) and there are areas with what appears to be blood blisters. Areas treated with skin prep and covered with a foam dressing for protection .Education to be done with team regarding shearing injuries .On 7/29/26 at 9:22 a.m., LPN 2 was observed to do a treatment/dressing change to Resident B's shearing wounds to her bilateral buttocks. LPN 2 indicated the wounds were due to shearing, she believed either from staff removing a brief, or pulling Resident B up in bed, education had been done with staff. On 7/29/26 at 9:49 a.m., the DON indicated she thinks Resident B's skin injury was shearing from removing sheets or a brief, you could see a line across buttocks like something had rubbed, reinforcement was done with staff about using draw sheets and what causes friction injuries. On 7/29/26 at 12:24 p.m., the Administrator provided the standard operating procedure for turning and repositioning with a review date of 12/16/24. The procedure guide included but was not limited to: Overview: to identify residents who are unable to turn and reposition themselves or those requiring assistance to reposition while in bed and assist with turning and repositioning as needed to maintain skin integrity, decreased pain, and maintain proper body alignment .2. Turning and repositioning is not routinely documented as this a normal nursing standard of practice that will be performed in accordance with the resident's care plan . 5. Proper turning techniques and body mechanics should be utilized to prevent injury to the resident and care giver . The deficient practice was corrected by July 15, 2026 after the facility implemented a systemic plan that included the following actions: In-service to all nursing staff regarding the Friction Injury Policy. Completed an audit of resident care to ensure turning and repositioning being completed properly to prevent friction injuries. Began the additional audits as follows: 5 random residents and audit will be completed 3 times a week for one month, weekly for one month, every other week for one month, and then monthly for three months. This citation related to Intake 3094983. 410 IAC (Indiana Administrative Code) 3.1-37(a)		