STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155854	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North River Health Campus	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medication for 3 of 3 medication carts observed. Loose pills, employee drinks, and unlabeled medications were observed in the medication carts. (Medication Cart 200 Hall, Medication Cart 300 Hall, Medication Cart 400 Hall) Findings include: 1. On 5/6/26 at 9:00 A.M., the following loose pills and unlabeled medications were observed in the 200 Hall Medication Cart:2 medium-sized orange pills 1 blue capsule 1 small white oval bill1 bottle of eye drops with no open date 2. On 5/6/26 at 9:10 A.M., the following unlabeled medications and food were observed in the 300 Hall Medication Cart:1 open can of soda4 bottles of cough medicine with no open date1 bottle of antacid pills with no label or open date 3. On 5/6/26 at 9:20 A.M., the following unlabeled medications were observed in the 400 Hall Medication Cart:1 tube of ointment with no open date1 bottle of lactulose with no open date1 bottle of nasal spray with no open date2 bottles of extra strength acetaminophen with no open date2 bottles of cough medicine with no open date1 bottle of antacid pills with no label or open date1 bottle of antacid pills with no open date During an interview on 5/6/26 at 9:15 A.M., Registered Nurse (RN) 3 indicated she should not have had the drink in the medication cart. She also indicated that the medications should have a label and an open date. During an interview on 05/12/26 9:08 A.M., the Director of Nursing (DON) indicated there should be no employee food in the medication carts. Medications should have a label and an open date. On 5/11/26 at 10:50 A.M., the Regional Support Nurse provided a current Medication Storage in the Facility policy, dated 11/2028. The policy indicated .outdated, contaminated, and deteriorated medications, and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory and disposed of according to medical procedures .a date opened sticker will be placed on medications . medications are kept in closed and labeled containers .separate from fruit juices, applesauce, and other food used for administrating medications .other food .is not stored there . 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to treat residents with dignity for 1 of 1 random observations. Staff members stood up to feed a resident and had personal conversations in the dining area with residents present. (Resident 3) Finding includes:On 5/6/25 at 11:46 A.M., Certified Nurse Aide (CNA) 5 was observed feeding Resident 3 lunch in the restorative dining area. CNA 5 was standing up. At 11:50 A.M., CNA 6 took over feeding Resident 3. CNA 6 was standing up. At that time, CNA 5 and CNA 6 engaged in conversation about the difficulties of their job and how burnt out they were.On 5/7/26 at 12:39 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and dysphagia.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 4/15/26, indicated Resident 3 was assessed by staff to have severe cognitive impairment and was dependent on staff (staff does all the work) for eating.A care plan conference was completed on 2/10/26 with the resident's representative in attendance. The care plan was reviewed. A risk for malnutrition care plan, dated 2/22/24, included an intervention to assist with meals as needed.A profile care guide, dated 2/22/24, included an intervention to assist with eating as needed.During an interview on 5/11/26 at 10:22 A.M., CNA 7 indicated that staff should sit down next to the resident while assisting them to eat. Staff were not supposed to stand over the residents for dignity reasons.On 5/12/26 at 10:15 A.M., the Administrator provided an undated Your Rights and Protections as a Nursing Home Resident policy that indicated You have the right to be treated with dignity and respect.410 Indiana Administrative Code (IAC) 16.2-3.1-3(a)

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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 observation, record review, and interview, the facility failed to revise a residents care plan after a change in condition occurred for 1 of 2 residents reviewed for fall resulting in major injury. (Resident 8) Finding includes:On 5/7/26 at 1:44 P.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, hypotension.A Quarterly Minimum Data Set (MDS) Assessment, dated 2/4/26, indicated Resident 8 was cognitively intact, required supervision for bathing and toileting, and was independent in transfers.The most recent Significant Change MDS Assessment, dated 4/22/26, indicated Resident 8 was moderately cognitively impaired and required substantial assistance (staff does more than half of the work) for bathing, toileting, and transfers. Care plan included, but was not limited to:Resident at risk for falling related to impaired mobility, history of syncope, atrial fibrillation, pulmonary fibrosis; Start date 11/15/24Interventions included, but were not limited to:Encourage proper footwear; Start date 11/15/24Provide nonskid footwear; Start date 11/15/24A nursing progress note, dated 4/4/26 at 10:12 A.M., indicated Resident 8 sustained a fall while attempting to self-toilet. The resident was sent to the emergency room (ER) with injury to her left temple, left upper arm, left hip, and left knee.During an observation on 5/8/26 at 1:42 P.M., Resident 8 was lying in bed awake with black tube socks on that were not non-skid. During an interview on 5/12/26 at 10:19 A.M., the Regional Support Nurse indicated Resident 8's fall care plan intervention should have been revised after the resident's change in condition due to the resident no longer walking. On 5/12/26 at 10:15 A.M., the Administrator provided a policy titled Comprehensive Care Plan Guideline, dated 12/13/24, that indicated Comprehensive care plans need to remain accurate and current.410 Indiana Administrative Code (IAC) 16.2-3.1-35(d)(2)(B)

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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. Based on observation, record review, and interview, the facility failed to ensure insulin was properly administered for 1 of 2 residents observed for insulin administration. The insulin pen was not primed before administration. (Resident 68)Finding includes:On 5/8/26 at 9:10 A.M., Licensed Practical Nurse (LPN) 2 was observed administering insulin to Resident 68. LPN 2 attached the needle to the Glargine insulin pen, dialed the pen to 32 units, and administered the insulin. LPN 2 did not prime the pen prior to administering the insulin to Resident 68. On 5/8/26 at 9:30 A.M., Resident 68's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus.Physician orders included, but was not limited to: Insulin glargine 100 units per milliliter (unit/mL) Injectable Solution (long acting insulin) - 32 units subcutaneously (SQ) twice a day, dated 5/5/26. During an interview on 5/11/26 at 9:36 A.M., the Regional Support Nurse indicated that insulin pens should be primed with two units of insulin prior to dialing in the amount needed. On 5/11/26 at 10:46 A.M., the Administrator provided a current insert for Kwik-Pen Insulin dated July/2023. The instructions indicated . prime the pen with 2 units .if you do not prime before each injection, you may give too much or too little insulin . 410 Indiana Administrative Code (IAC) 16.2-3.1-35(g)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to provide infection control practices during 2 of 2 insulin administrations. The rubber injectable port for insulin was not cleaned prior to placing the needle on the insulin pen. (Resident 68, Resident 37) Findings include:1. On 5/8/26 at 6:45 A.M., Licensed Practical Nurse (LPN) 2 was observed not using an alcohol swab to prepare the rubber injectable port of a Lantus pen prior to placing the needle on the pen to administer insulin to Resident 68. 2. On 5/8/26 at 11:49 A.M., Registered Nurse (RN) 3 was observed not using an alcohol swab to prepare the rubber injectable port of a Lispro pen prior to placing the needle on the pen to administer insulin to Resident 37. During an interview on 5/11/26 at 9:36 A.M., the Regional Support Nurse indicated the rubber injectable ports of the insulin pens should be prepped with an alcohol swab prior to placing a needle on the pen. On 5/11/26 at 10:46 A.M., the Administrator provided a current insert for Kwik-Pen Insulin dated 7/2023. The instructions indicated .wipe the port with an alcohol prep . 410 Indiana Administrative Code (IAC) 16.2-3.1-18(b)(1)