

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2023
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NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 714 S EICKHOFF RD EVANSVILLE, IN 47712
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Nursing Home Complaint IN00416986. This visit included the Investigation of Residential Complaint IN00412478.</p> <p>Complaint IN00416986 - Federal/State deficiencies related to the allegations are cited at F684.</p> <p>Complaint IN00412478- No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 6, 7, 8, 2023.</p> <p>Facility number: 012448 Provider number: 155785 AIM number: 201039500</p> <p>Census Bed Type: SNF/NF: 19 SNF: 8 Residential: 55 Total: 82</p> <p>Census Payor Type: Medicare: 3 Medicaid: 16 Other: 8 Total: 27</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on September 20, 2023.</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission by West River Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of West River Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 10/11/23.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Lisa Stallman, RN-BC	TITLE Clinical Support	(X6) DATE 10/05/2023
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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F 0684 SS=D Bldg. 00	<p>483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>Based on interview and record review, the facility failed to ensure physician medication orders were put in place for 1 of 3 residents reviewed. A medication dosage increase was not done. (Resident E)</p> <p>Finding includes:</p> <p>On 9/7/23 at 10:51 a.m., Resident E's clinical record was reviewed. They had diagnoses that included, but were not limited to, dehydration, nausea and vomiting. Resident E admitted to the facility on 8/22/23 and discharged on 8/29/23. A discharge MDS (Minimum Data Set) assessment indicated Resident E's cognition was intact.</p> <p>Physicians orders for August 2023 were reviewed and included but were not limited to: ondansetron(nausea medication) tablet, disintegrating; 4 mg (milligram) amt: 4 mg; oral special instructions: prn (as needed) for N/V (nausea and vomiting), every 6 hours - PRN ; PRN 1, PRN 2, PRN 3, PRN 4, order start date 8/22/23. Basic metabolic panel; CBC w/differential; other test (magnesium level) special instructions: night shift to prepare documents and day shift to await lab results and process any new orders given. Twice a day; 02:00 AM-06:00 AM; -02:00 PM,</p>	F 0684	<p>1 Resident E was discharged from the facility prior to alleged deficiency. All like residents assessed and no adverse effects noted from alleged deficiency.</p> <p>2 All like residents have the potential to be affected by the alleged deficiency. DHS/designee will audit attached documents for any new physician orders to ensure orders are placed in EMAR. Licensed clinical staff educated on the process of documenting physician orders in EMAR.</p> <p>3 As a measure of ongoing compliance, the DHS or designee will audit any new written orders to ensure timely completion. Audit will consist of reviewing any new orders 5 times per week x 6 months.</p> <p>4 As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality</p>	10/11/2023
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	<p>order start date 8/28/23.</p> <p>Resident documents were reviewed and included but were not limited to: Physicians progress notes : date: 8/24/23- Zofran (nausea medication) 8 mg 1 Q (every) 8 hours prn-N/V CBC (complete blood count) & BMP (basic metabolic panel) on Monday (or next lab day). Encourage fluids. * add mag (magnesium) level also. Resident E did not have an active order for Zofran 8 mg prn for August 2023 physician orders.</p> <p>Progress notes were reviewed and included, but were not limited to 8/29/23 at 12:55 p.m., "Therapy was in with resident and noted resident blood pressure when sitting up was significantly higher than when she was laying down. Also resident would have vertigo and throw up. Resident has been throwing up whenever sitting up each time therapy has sat her up. Call placed to (name of Dr. office) and order received for resident to go to (name of hospital) ER to be evaluated and treated per request by family and facility therapy manager."</p> <p>The August 2023 EMAR (Electronic Medication Administration Record) was reviewed and ondansetron 4 mg was given to Resident E on the following dates: 8/22 x 1 8/23 x 1 8/25 x 1 8/26 x 1 8/27 x 1 8/28 x 1</p> <p>On 9/8/23 at 10:25 a.m., the NP (Nurse Practitioner) indicated she visited Resident E at the facility on 8/24/23, Resident H was extremely</p>		<p>Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past the 6 months, if needed, until 100% compliance is met.</p>	

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R 0000 Bldg. 00	<p>nauseated, she did not want her to get dehydrated, the dose of medication she was on for N/V was not enough so she wrote an order to increase the dose. The NP indicated she could not remember if she gave the nurse on the unit the order or laid it down on the desk or medication cart, she may have verbally told the nurse the order also.</p> <p>On 9/8/23 at 11:40 a.m., LPN 1 indicated if the physician comes in the morning to see residents he dictates orders to triage, triage will call the facility nurse with the orders, when the nurse practitioner comes they do the same, everything goes thorough nursing triage on a recorded line.</p> <p>On 9/8/23 at 1:25 p.m., the Clinical Support Nurse indicated there are 3 ways the physician or nurse practitioner gives orders to the licensed nurse, verbal, leave written orders, or triage can give to the licensed facility nurse. It is the licensed nurses responsibility to ensure orders are put into Matrix Care.</p> <p>On 9/8/23 at 1:20 p.m., the Clinical Support Nurse provided the policy on guidelines for medication orders with a review date of 12/31/22. The policy included, but was not limited to: ...telephone or verbal orders shall be recorded in Matrix when received by the nurse receiving the order...</p> <p>This Federal tag relates to Complaint IN00416986.</p> <p>3.1-37(a)</p> <p>This visit was for the Investigation of Residential</p>	R 0000	The submission of this plan of correction does not indicate an	

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R 0052 Bldg. 00	<p>Complaint IN00412478. This visit included the Investigation of Nursing Home Complaint IN00416986.</p> <p>Complaint IN00412478- No deficiencies related to the allegations are cited.</p> <p>Complaint IN00416986- Federal/state deficiencies related to the allegations are cited at F684.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 6, 7, 8, 2023.</p> <p>Facility number: 012448</p> <p>Residential Census: 55</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were free from physical and mental abuse for 1 of 3 residents reviewed for abuse. Staff member threatened to pull residents hair after placing hair in her hand. (Resident H)</p> <p>Findings include:</p>	R 0052	<p>admission by West River Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of West River Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 10/11/23.</p> <p>1 Resident H was assessed and no effects noted from the alleged deficient practice. QMA 1 employment was terminated. 2 All like residents have the potential to be affected from the alleged deficient practice. All</p>	10/11/2023

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	<p>On 9/6/23 at 10:30 a.m., a Indiana Department of Health reportable was reviewed that included, but was not limited to the following:</p> <p>Incident date: 7/10/23 Brief description of incident: 7/10/23 Executive Director was notified on this date of an allegation of care concern regarding QMA (Qualified Medication Aide) (name of employee) that occurred on July 3, 2023. Upon ED (Executive Director) notification QMA (name of employee) was suspended pending investigation. Assisted living memory care resident assessed for psychosocial distress with no concerns. Resident had a head to toe assessment with no concerns. Abuse education initiated. MD, DHS, (Director of Heath Services) , Family Notified.</p> <p>Type of injury added: 7/10/23 No injury</p> <p>Immediate action taken: 7/10/23 Upon ED notification QMA (name of employee) was suspended pending investigation. Resident assessed for psychosocial distress with no concerns. Resident had a head to toe assessment with no concerns. Abuse education initiated. MD, DHS, Family notified.</p> <p>Preventative measures taken: Type of preventative measures added: 7/10/23 Investigation initiated. Employee suspended. All like residents will be assessed for any psychosocial distress and complete .</p> <p>Follow up: 7/12/23 ...Based on investigation campus has substantiated this concern. Employee (name of employee) was terminated from employment based on violation of policy regarding resident rights and abuse...</p>		<p>residents with a BIMS less than 8 have had head to toe assessments completed with no findings. For those residents with a BIMS greater than 8 an interview was conducted with no findings. Staff education completed regarding the abuse policy and reporting requirements.</p> <p>3 As a measure of ongoing compliance, ED or designee will complete interviews with 5 random staff for potential abuse/neglect weekly x 4 weeks, then every other week x 1 month, then monthly x 4 months.</p> <p>4 As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves 100% compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past the 6 months, if needed, until 100% compliance is met.</p>	

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	<p>The following witness statements were reviewed and included but were not limited to:</p> <p>Name of interviewee: ED Summary Statement is given for the following incident: " At 10am (sic) ED was speaking with LND (Legacy Neighborhood Director) (name) regarding the Legacy Assisted Living. During the catch up she mentioned what was told by (name) Q (CNA 1) on Friday eve. 7/7/23. She stated that (CNA 1) told (Legacy Neighborhood Director)) that she reported to (DHS) how (QMA 1) was pulling a resident's hair because the resident was pulling (QMA 1) hair while providing care. At 1030am (sic) ED immediately pulled (QMA 1) off Legacy unit and interviewed about the allegation of concern. (QMA 1) stated that resident (name of resident) was being combative and pulling her hair and ED asked what she did as an intervention and (QMA 1) stated that "I did her like I did toddlers and dogs, I picked up her hair and showed her that we can't do that. I did not pull on her hair just using it as an example. I did not do it in a hateful mean way. " ...</p> <p>Name of interviewee: QMA 1 Ed: Can you tell me about any events that occurred last week. QMA 1: (name of resident was hitting, pitching(sic) and knocked my glasses off my face (name) was in there to. ED: Did you have any other interactions with her that day. QMA 1 : we sent her to the hospital to get labs done because we were unable to attain them at the campus. ED: Did you toilet her at all with anyone else prior to being sent out to the hospital. QMA 1 : I stayed over that day until 6 to help the new girl (CNA 1) out. We were toileting her and</p>			

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	<p>she pulled my hair. ED: What did you do to intervene her pulling your hair. QMA 1 : I did her like I did toddlers and dogs I picked up her hair and showed her that we can't do that you do not pull hair I did not pull I showed her as an example no pulling it. I did not do it in a hateful mean way..."</p> <p>Name of interviewee: DHS "ED: On Monday 7/3/23 did (CNA 1) report anything to you? DHS: Not to my knowledge, I was on the phone with you "ED" regarding another allegation ED: Did (CNA 1) mention anything to you regarding (QMA) and (resident) DHS: No, the only time I spoke with her was regarding the reportable we were currently working on."</p> <p>Name of interviewee: (CNA1) " ED: (CNA 1) can you tell me if any events occurred Monday? (CNA 1) : I thought I told (DHS) about it before I was suspended. I didn't want it to sound like I was trying to get someone in trouble when I was being questioned about another incident myself. ED: Please explain to me the event (CNA 1): I let (DHS) know that when (QMA 1) and I was toileting resident (name of resident) in her room that she was being combative and pulling (QMA 1) hair. ED: What did (QMA 1) or yourself do as an intervention. (CNA 1): (QMA 1) pulled up on residents (name of resident) hair and stated " how does this feel you can't be doing this to us". ED: What did you do when you seen (QMA 1) do that? (CNA1) : I helped get resident ready to be</p>			

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	<p>transferred to the hospital for labs. ED: Who did you report this to and when. (CNA 1) : I told (DHS)..."</p> <p>On 9/6/23 at 2:19 p.m., the Administrator, indicated she was notified on 7/10/23 by the Legacy Neighborhood Director of the incident between Resident H and the QMA 1. The Legacy Neighborhood Director mentioned to her that she was told by CNA 1 on 7/7/23 that during care of Resident H, QMA 1 pulled the resident's hair. The Administrator indicated CNA 1 and the Legacy Neighborhood Director should have reported the allegation immediately, QMA 1 had been terminated from employment.</p> <p>On 9/7/23 at 9:57 a.m., Resident H was sitting in her room, she was unable to answer questions appropriately.</p> <p>On 9/7/23 at 10: 23 a.m., Resident H's clinical record was reviewed. Resident H resided on the locked dementia unit on the Assisted Living Unit. Resident H had diagnoses that included, but were not limited to, vascular dementia, severe, with other behavioral disturbance. Resident H's cognition was severely impaired.</p> <p>On 9/6/23 at at 2:00 p.m., the Executive Director provided the current abuse and neglect policy with a revised date of 8/29/2019. The policy included, but was not limited to: b. physical abuse - includes, but is not limited to, hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping, of hands, flicking, or hitting with an</p>			

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	<p>object.</p> <p>i. Resident to resident abuse with or without cause;</p> <p>ii. Staff to resident abuse with or without injury;...</p> <p>e. Mental/Emotional Abuse- Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation...Identification: ...ii: Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal...iii: The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: IMMEDIATELY notify the Executive Director. If the Executive Director is absent they may appoint a designee...</p>				