STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155732	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVEROAKS HEALTH CAMPUS	1244 VAIL ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00413599. Complaint IN00413599 - No deficiencies related to the allegations are cited. Survey dates: July 23, 24, 25, 26, 27, & 28, 2023 Facility number: 004130 Provider number: 155732 AIM number: 2241301 Census Bed Type: SNF/NF: 36 SNF: 21 Residential: 33 Total: 90 Census Payor Type: Medicare: 11 Medicaid: 24 Other: 22 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 2, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by River Oaks Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of River Oaks 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 the requirements of participation for residential care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted July 23, 2023. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Lucas	Executive Director	08/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen services were provided according to physician orders for 1 of 2 residents reviewed for respiratory care. A resident's humidification bottle was not filled with water. (Resident 34) Finding includes: On 7/24/23 at 8:35 A.M., Resident 34's oxygen concentrator was observed to have no water in the humidification bottle. On 7/25/23 at 9:02 A.M., Resident 34's oxygen concentrator was observed to have no water in the humidification bottle. At that time, the resident indicated she was unsure if it was ever filled with water. On 7/25/23 at 9:51 A.M., Resident 34's clinical record was reviewed. Resident 34's diagnoses included, but were not limited to, acute respiratory failure with hypoxia (low levels of oxygen in body tissue) and COPD (chronic obstructive pulmonary disease). The most recent quarterly MDS (Minimum Data Set) assessment, dated 6/20/23, indicated Resident 34 was cognitively intact, required extensive assistance of 2 staff for transfers and bed mobility, and was on oxygen.	F 0695	1. Resident #34 suffered no ill effects from the alleged deficient practice. Resident assessed and monitored for adverse effects with no findings. All oxygen tubing was replaced, physician orders verified, and humidification bottle replaced then filled immediately. Nursing department staff were immediately educated on respiratory equipment monitoring and process for maintaining humidification. 2. All residents with humidified respiratory equipment have the potential to be affected. Nursing staff educated by the DHS on the respiratory care/oxygen use policy. Nursing leaders will complete visual observation during daily rounds to ensure that humidifier bottles are filled with water. 3. As a measure of ongoing compliance, the DHS, or designee, will complete an audit of 2 residents to ensure that humidifier bottles are filled with water 3 x per week for 4 weeks, then 2 x weekly for 4 weeks, then weekly for 4 weeks, then monthly	08/29/2023

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	Current physician orders included, but were not limited to: - Oxygen at 2L (liters) per nasal cannula continuous, dated 5/30/23. - Add water to humidifier Q (every) HS (night) at bedtime, dated 6/1/23. Current care plans included, but were not limited to: Potential for complications, functional and cognitive status decline related to respiratory disease that included the intervention, but was not limited to, administer oxygen per orders, dated 5/1/21. On 7/26/23 at 8:57 A.M., Resident 34's oxygen concentrator was observed to have no water in the humidification bottle. At that time, RN (Registered Nurse) 5 indicated the oxygen concentrator was supposed to be filled with distilled water nightly by night shift staff. On 7/26/23 at 2:20 P.M., a current Administration of Oxygen policy, dated 12/31/22, indicated "be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through". 3.1-47(a)(6)		for 3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 8/29/23	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to store medications in a safe manner for 2 of 3 medication carts and 1 of 1 medication rooms. Narcotic medications not locked, loose pills were in the medication carts, the refrigerator was not within the temperature range, and resident money was stored in the medication carts. (Medication Room, 200 Hall Medication Cart, 300 Hall Medication Cart) Findings include: 1. During an interview with LPN (Licensed Practical Nurse) 9 and observation on 7/24/23 at 8:30 A.M., the medicine refrigerator on the skilled unit was found to have 2 permanently affixed drawers inside that were unlocked. One drawer contained full bottles of liquid morphine sulfate (an opiod pain medication), 30 ml (milliliters) each, labeled for Resident 20 (unopened), Resident 30	F 0761	F761A – Medication room (narcotic box and refrigerator temperature) Plan of Correction Text: 1. No residents suffered no ill effects from the alleged deficient practice. The lock on narcotic box in medication room refrigerator was immediately repaired and locked. The temperature of the refrigerator was checked 5 minutes after shutting the door and the temperature returned to within limits. It was determined that the amount of time the door had been opened investigating the lock on the narcotic drawer contributed to the temperature discrepancy. The temperature was checked at routine intervals	08/29/2023

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	(unopened) and Resident 37 (opened). The other drawer contained liquid Lorazepam (an anti-anxiety medication) for Resident 30 (unopened) and Ativan (an anti-anxiety medication) for Resident 27 (unopened). The thermometer in the medicine refrigerator was observed to be 49 degrees F (Fahrenheit). LPN 9 indicated the temperature should be between 36 degrees F and 46 degrees F. During an interview with the DON on 7/24/23 at 8:55 A.M., she indicated the key to the locked narcotic/anxiolytic drawers in the medication room had broken off, so the drawers were unlocked. 2. On 7/26/23 at 10:30 A.M., during an observation of the medication administration with RN 13 on the 200 hall, there were 4 loose pills in the top drawer of the medicine cart - 1 round brown pill, 1 small round pink pill, 1 small round white pill, and 1 oblong white pill. 3. On 7/26/23 at 11:00 A.M., during an observation of medication administration on the 300 hall with RN 14, there were 26 dollars in cash in the bottom of the drawer. There was a 20 dollar bill, which RN 14 indicated had been found in a resident's room and the staff were not sure whose it was. There was a bundle of six, one dollar bills wrapped with a rubber band and a note around it with a resident's name. RN 14 indicated the resident was on the Assisted Living Unit now. During an interview on 7/26/23 at 12:38 P.M., the Business Office Manager indicated that when money was found, the staff were supposed to give it to their supervisor, who took it to the business office. If they knew who it belonged to, they return it. If not, they kept the money for 30 days and if not claimed they donated it to the		throughout the day and maintained appropriate temperature. Nursing staff were immediately educated on narcotic medication storage in refrigerator and refrigerator temperature requirements. 2. All residents have the potential to be affected. Nursing staff educated by the Director of Health Services (DHS) on the medication storage policy. Nursing leaders will complete visual observation of medication room refrigerator during daily rounds to ensure that narcotic drawer is locked, and refrigerator temperature is within required parameters. 3. As a measure of ongoing compliance, the DHS, or designee, will complete an audit of medication room refrigerator narcotic storage and temperature 3 x per week for 4 weeks, then 2 x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	activities fund. 3.1-25(m) 3.1-25(n)		Completion Date: 8/29/23 F761B – Medication cart (loose pills and money) Plan of Correction Text: 1. No residents suffered no ill effects from the alleged deficient practice. Loose pills and resident money were immediately removed from the medication cart drawers. Nursing department staff were immediately educated on medication storage. 2. All residents have the potential to be affected. Nursing staff educated by the DHS on the medication storage policy. Nursing leaders will complete visual observation of medication carts during daily rounds to ensure that there are no loose pills or money in the drawers and that all items are stored appropriately. 3. As a measure of ongoing compliance, the DHS, or designee, will complete an audit of medication carts to ensure there are no loose pills or resident money 3 x per week for 4 weeks, then 2 x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance	

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			in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 8/29/23	
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure that waste was properly contained in dumpster's with lids covered for 1 of 1 garbage storage areas observed. Findings include: On 7/23/23 at 9:05 A.M., the garbage storage area was observed with the Food Service Director. There were 2 dumpsters. One was open, surrounded by trash on the ground, 1 large smashed cardboard box was under it, and 3 old mattresses with tears in their coverings were piled on top of each other beside it. The Food Service Director indicated it would be cleaned up. The policy for the garbage storage area was requested and not received. 3.1-21(i)(5)	F 0814	1. No residents suffered no ill effects from the alleged deficient practice. The dumpster area was immediately cleared, and all waste was properly contained within the dumpster. Dietary and environmental staff immediately educated regarding proper disposal of waste in the dumpster. 2. All residents have the potential to be affected. Facility staff educated by the Executive Director (ED) on proper disposal of garbage and refuse. Campus leaders will complete visual observation of dumpster area during daily rounds to ensure that any garbage or refuse is properly contained in the dumpster. 3. As a measure of ongoing compliance, the Director of Food Service (DFS), or designee, will complete an audit of the dumpster area to ensure that any garbage or refuse is properly contained in the dumpster. 3 x per week for 4 weeks, then 2 x weekly for 4	08/29/2023

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			weeks, then weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DFS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 8/29/23	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00413599. Complaint IN00413599 - No deficiencies related to the allegations are cited. Survey dates: July 23, 24, 25, 26, 27, & 28, 2023 Facility number: 004130 Residential Census: 33 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000	The submission of this plan of correction does not indicate an admission by River Oaks Health Campus that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, or living environment provided to the residents of River Oaks 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 the requirements of participation for residential care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state	

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			requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted July 23, 2023. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure semiannual evaluations were completed for 3 of 7 residents reviewed. (Resident 9, Resident 11, Resident 17) Findings include: 1. On 7/26/23 at 2:24 P.M., Resident 9's clinical record was reviewed. The semiannual evaluations were completed on 7/13/22 and 5/14/23. 2. On 7/27/23 at 9:50 A.M., Resident 11's clinical record was reviewed. The semiannual evaluations were completed on 7/12/22 and 4/26/23. 3. On 7/27/23 at 10:23 A.M., Resident 17's clinical record was reviewed. The most recent semiannual evaluation was completed on 8/30/22.	R 0214	1. Residents #9, #11 and #17 suffered no ill effects from the alleged deficient practice. Residents assessed with no findings. Semi Annual evaluations were completed on all three residents. Nursing staff were immediately educated on semiannual evaluation policy. 2. All residents the potential to be affected. Director of Assisted Living (DAL) educated by the Director of Health Services (DHS) on the semiannual evaluation (service plan) policy and completion process. An audit was conducted, and semiannual service plans were completed for	08/29/2023

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	On 7/27/23 at 1:32 P.M., the MDS coordinator indicated semiannual evaluations should be completed twice a year. On 7/27/23 at 1:44 P.M., a current Assisted Living Evaluation and Service Plan Guidelines policy, dated 3/24/22, indicated "upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial function and care needs".		all residents who had not had an evaluation within the previous 6 months. 3. As a measure of ongoing compliance, the DAL, or designee, will complete an audit to ensure service plans are completed for 2 residents semiannual evaluation frequency 3 x per week for 4 weeks, then 2 x weekly for 4 weeks, then weekly for 4 weeks, then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and required corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Completion Date: 8/29/23.	