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	155854	A. BUILDING 00 B. WING	01/23/2023

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NORTH RIVER HEALTH CAMPUS	811 E BASELINE ROAD EVANSVILLE, IN 47725

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included State Residential Licensure Survey. Survey dates: January 17, 18, 19, 20, 23, 2023 Facility number: 013703 Provider number: 155854 AIM number: 300025690 Census Bed Type: SNF/NF: 20 SNF: 25 Residential: 30 Total: 75 Census Payor Type: Medicare: 12 Medicaid: 18 Other: 15 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 30, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by North 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 North 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 2/14/23.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer	F 0554	1. Resident #37 has been discharged from the facility no adverse effects noted from the alleged deficient practice.	02/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Stallman, RN-BC	Clinical Support	02/13/2023

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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	medications for 2 of 2 residents observed with medications in their rooms. (Resident 24, Resident 37) Findings include: 1. On 1/17/23 at 8:55 A.M., Resident 24 was observed sitting in her chair with a bedside table next to her that had a clear medicine cup with 2 (two) capsules in it. Resident 24 indicated she did not know what the capsules were. At that time, Qualified Medication Aide (QMA) 22 indicated Macrobid and a multivitamin was in the medicine cup, and Resident 24 did not self administer medications. On 1/18/23 at 1:19 P.M., Resident 24's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent quarterly Minimum Data Set (MDS) assessment on 12/30/22, indicated Resident 24 was severely cognitively impaired. Current physician orders included, but were not limited to, Macrobid 100mg (milligrams) oral twice a day, dated 1/13/23 (to be given between 6:00 A.M. and 10:00 P.M. and again from 6:00 P.M. to 10:00 P.M.) and Multivitamin 0.25mg oral once a day, dated 12/8/22 (to be given from 6:00 A.M. to 10:00 A.M). Current physician orders lacked an order to self administer medications, or to keep medications in room. Resident 24's record lacked any care plans related to self administration of medications or storage of medications in room. Resident 24's record lacked any self administration		Resident #24 was assessed and identified as unable to self-administer medication due to cognitive deficit. Resident assessed and no affects noted from the alleged deficient practice. 2. All residents have the potential to be affected from the alleged deficient practice. All residents requesting to self-administer medications have completed self-administration assessments to validate competency. All identified residents were verified to have care plans in place for self-administration. Nursing staff have been provided education regarding medication administration, self-administration, assessments, and care planning. 3. As a measure of ongoing compliance, the DHS or designee will audit/observe adherence to medication administration policy for self-administration. Audit to consist of 5 residents weekly x4 weeks, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 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 Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will	

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	of medication assessments. During an interview on 1/20/23 at 10:33 A.M., Licensed Practical Nurse (LPN) 23 indicated Resident 24 required staff to be in the room when receiving medications. 2. On 1/17/23 at 1:04 P.M., Resident 37 was observed sitting in a chair with a bedside table next to him with a bottle that was labelled glucose pills. On 1/19/23 at 8:45 A.M., Resident 37's clinical record was reviewed. Diagnoses included but were not limited to, acidosis and metabolic acidosis. A current quarterly MDS Assessment dated 12/16/22 indicated the resident was mildly cognitive impaired. He was independent with eating and toileting, and needed supervision with dressing, mobility,an dressing. Resident 37 lacked a physician's order for glucose pills and self administration of such pills. Resident 37 lacked a current care plan for the use of glucose pills. Resident 37 lacked a self medication assessment. During on interview on 1/20/23 09:03 A.M., Nurse 6 indicated she was not aware that resident had glucose pills until they were taken away from him. On 1/23/23 at 10:07 A.M., a current Medication Administration General Guidelines policy, revised 11/18 was provided and indicated "...The person who prepares the dose for administration is the person who administers the dose...The resident is		continue past 6 months, if needed, until 100% compliance met.	

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	always observed after administration to ensure that the dose was completely ingested..." 3.1-11(a)			
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. 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 the resident received necessary respiratory care and services in accordance with professional standards of practice for 1 of 1 residents reviewed for respiratory care. (Resident 197) Findings included: On 1/17/23 at 10:40 A.M., Resident 197 was observed with a CPAP (continuous positive airway pressure) machine on the bedside table. On 1/18/23 at 10:41 A.M., Resident 197's clinical record was reviewed. The resident was admitted on 1/6/23. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and sleep apnea. Resident 197's record lacked a current physician's order for use of a CPAP machine.	F 0695	1. Resident #197 was not affected by the alleged deficient practice. Resident #197 has received a Physician Order for use of CPAP and residents' care plan updated. No adverse effects noted. 2. All residents have the potential to be affected by the alleged deficient practice. All residents with Respiratory Care needs were reviewed to validate appropriate physician orders and care plans were accurately reflected. All nurses educated regarding physician orders and care planning of Respiratory/Tracheostomy Care and Suctioning. 3. As a measure of ongoing compliance, the DHS or designee will audit physician orders, respiratory equipment, and care	02/14/2023

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	A personal possessions inventory form, dated 1/6/23, listed a CPAP machine. During an interview on 1/20/23 8:25 A.M., Resident 197 indicated his wife maintained the care of the CPAP machine such as filling the water. During an interview on 1/20/23 8:46 A.M., CNA (Certified Nurse Aide) 10 indicated care for a CPAP machine should have been located on the resident's MAR (medication administration record), as well as the CNA computer screen. CNA 10 indicated that Resident 197 lacked that notice. During an interview on 1/23/23 at 11:44 A.M., Clinical Support 32 indicated the facility did not have a policy for the use of CPAP machines. 3.1-47(a)(6)		plans to ensure Respiratory Care is accurately reflected. Audit to consist of 5 residents weekly x4 week, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 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 Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			

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	(iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure food was prepared in a sanitary manner. Staff was observed with hair not completely covered by a hairnet for 1 of 1 meal preparations observed. Staff fed residents with bare hands, and reached over a resident's plate of food to assist another resident during 2 of 2 dining observations. (Dietary 12, Resident 16, Resident 17) Findings include: 1. On 1/19/23 during lunch preparation at 11:15 A.M., Dietary 12 was observed in the food preparation area of the kitchen pouring ketchup into containers. Her hair was not contained in the hairnet, hair was exposed and loose at the forehead area. 2. During an observation on 1/17/23 from 12:04 P.M. to 12:32 P.M., the following was observed: Certified Nurse Aide (CNA) 3 reached over Resident 17's plate of food to assist Resident 16 with cutting her food. CNA 3 then reached over Resident 17's plate with her right hand to help Resident 16 obtain food on her fork. CNA 3 walked over to clean Resident 16's hands with a white paper towel. CNA 3 then performed hand hygiene for a 9 (nine) second lather. CNA 3 reached over Resident 17's plate to adjust Resident 16's plate, then reached over Resident 17's plate with her right arm to provide Resident 16 her drink. CNA 3 walked over to clean Resident	F 0812	1. Residents #16 & #17 were assessed for affects of the alleged deficient practice. No adverse effects identified. 2. All residents have the potential to be affected from the alleged deficient practice. All staff have been educated regarding proper donning of hair nets, hand hygiene, proper food handling, and proper methods when assisting residents with eating. 3. As a measure of ongoing compliance, the DHS or designee will audit practices to ensure that methods are accurately reflected. Audit to consist of 5 staff weekly x4 week, then 5 staff every other week for 2 months, then 5 staff monthly for 3 months. 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 Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. Ongoing monitoring will continue past 6 months, if needed, until 100% compliance met.	02/14/2023

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	16's hands with a white paper towel. CNA 3 then performed hand hygiene for an 8 (eight) second lather. CNA 3 then reached over Resident 17's plate to provide Resident 16 her drink. During an interview on 1/23/23 at 8:47 A.M., CNA 1 indicated if she was helping 2 (two) residents, she would sit in the middle of the two residents in order to not reach over the resident's food to assist. 3. On 1/19/23 at 9:46 A.M., CNA 1 was observed to pick up a piece of toast with her bare hand and feed it to Resident 17. That was observed to be done twice while CNA 1 was feeding Resident 17 breakfast. On 1/23/23 at 8:47 A.M., CNA 1 indicated that gloves should be worn to touch food , not bare hands when feeding a resident. During an interview on 1/23/23 at 11:50 A.M., the Dietary Manager indicated that hair was to be completely covered by a hairnet. On 1/23/23 at 1:17 P.M., Clinical Support 32 indicated the facility does not have a policy indicating to not reach over a resident's plate to feed another resident, but staff should not reach over another resident's food to assist another resident. At that time, the Clinical Support 32 indicated staff were not supposed to touch food with bare hands when assisting residents to eat, the facility did not have a policy regarding this. A current policy "Yellow Lines/Hair Restraint Policy" dated 12/31/18 provided by Nurse 14 on 1/23/23 at 11:30 A.M., indicated: "Entering food production areas... requires the proper use of hair restraints to prevent the chance of hair contaminating food for the consumption. No one			

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	is permitted in these areas without the proper hair-restraint equipment being worn... 1. All [name of facility] team members are required to follow signage and wear proper hair restraint equipment such as hair nets... before entering food production areas." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained in 3 of 6 residents observed for care and 1 random observation. Staff did not change gloves from dirty to clean tasks during incontinence care and a catheter bag was observed dragging the floor. (Resident 5, Resident 29, Resident 13, Resident 195) Findings include: 1. On 1/17/23 at 9:10 A.M., RN (Registered Nurse) 21 was observed to provide catheter care to Resident 5. RN 21 wore gloves and used a peri-wipe to cleanse the skin in the folds of the resident's groin and around his pubis, after which she used the same wipe to cleanse the opening to his urethra, which was red. She then disposed of the wipe and her gloves in a plastic trash bag and removed it from the room. 2 .On 1/17/23 at 1:49 P.M., Resident 29's catheter leg bag was observed to be draining cloudy yellow urine. CNA 1 came in to straighten out the pillow case that was wrapped around the resident's right leg and secured with elastic bands. She took the pillow case off his leg and laid it on the floor, then got new elastic bands and wrapped the same pillow case around his leg and placed a new leg bag. At that time, Resident 29 indicated it burned when he urinated. CNA 1 did not acknowledge Resident 29's remark about burning on urination. 3. On 1/18/23 at 9:57 A.M., CNA (Certified Nurse Aide) 3 and CNA 5 were observed to perform incontinence care for Resident 13. CNA 3 washed her hands and donned (put on) a pair of gloves.	F 0880	1. Residents #5, #29, #13 and #195 have been assessed for effects of the alleged deficient practices. All residents were reviewed and no adverse effects identified related to the alleged deficient practices. 2. The facility QAA Committee conducted a root cause analysis to identify the problem(s) that resulted in the indicated infection control deficiency regarding Infection control practices, including but not limited to hand hygiene, indwelling catheter care, donning/doffing PPE. This RCA was completed on 2/9/2023 by the QAA Committee. The QAA Committee developed an action plan to prevent recurrence as part of the QAPI program. The root cause of the indicated deficiencies was determined by the QAA Committee to be lack of continued ongoing education regarding donning and doffing PPE, hand hygiene, and indwelling catheter care. The DHS/Designee provided training to staff. The training included hand hygiene with return demonstration, indwelling catheter care and proper infection control practices regarding indwelling catheters, donning and doffing PPE with return demonstration. 3. As a measure of ongoing compliance, the DHS or designee, will audit practices to ensure	02/14/2023

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	CNA 5 washed her hands with a 4 (four) second lather, and donned gloves. CNA 3 then closed the resident's blinds, and touched the bed control to raise the bed and lower the head of the bed. Both CNA 3 and CNA 5 then removed the blankets from the resident. CNA 3 then opened the cabinet door by the bed, obtained a clean brief and a package of incontinence wipes, and laid them on the bed. CNA 5 removed the soiled brief, and CNA 3 removed an old dressing from the resident's coccyx before cleaning the resident with the incontinence wipe. After cleaning the resident, CNA 3 placed her gloved hands on the resident's legs to assist with turning from side to side to place the new brief. CNA 3 then replaced the package of wipes in the cabinet, and touched the bed control to lower the bed. CNA 3 and CNA 5 then removed their gloves. No glove changes were observed during care. CNA 3 then washed her hands with a 6 (six) second lather, and CNA 5 washed her hands with an 11 second lather. During an interview at that time, CNA 3 indicated hands should be washed for 20 to 30 seconds. 4. On 1/19/23 at 9:37 A.M., during a random observation, Resident 195 was observed sitting in a wheelchair by the 400 Hall nurses station. A catheter bag was observed under the wheelchair resting on the floor. At that time, the resident indicated he was waiting on transportation. PT (Physical Therapist) 7 was observed speaking with the resident, then went to his room, obtained a jacket, and brought it back to assist the resident with putting it on. The driver for the transportation was then observed to push the resident's wheelchair down the hall with the catheter bag dragging the floor. Staff did not address the catheter bag. During an interview on 1/23/23 at 10:17 A.M., the		Infection Control practices are accurately reflected. IP/Designee will conduct daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control practices and will offer additional training as warranted. Infection Control Rounds will be completed daily x 6 weeks and then randomly thereafter. Audits of Indwelling Catheter Infection Control Practices, Hand Hygiene will be completed with 5 residents weekly x4 weeks, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months. 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 6 months, if needed, until 100% compliance met.	

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	IP (Infection Preventionist) indicated if and when a resident's catheter bag was observed on the floor, staff should pick it up. A current catheter care policy, dated 12/1/2021, was provided on 1/23/23 and indicated "Keep drainage bag be covered with an appropriate device ...may utilize drainage bags that have a built-in cover, i.e. "The Fig Leaf"...Cover needs to be replaced when it becomes soiled, urinary drainage bags are to be changed as ordered or as needed...Urinary drainage bags and catheter tubing should be kept from touching the floor surface" On 1/23/23 at 9:37 A.M., a current hand hygiene policy, dated 2/9/17, was provided and indicated "Health Care Workers shall use hand hygiene at times such as ... Before/after having direct physical contact with residents ... Wash well for 15-20 seconds, using a rotary motion and friction" 3.1-18(b) 3.1-18(l)			
F 0888 SS=C Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a			

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	155854	A. BUILDING 00 B. WING	01/23/2023

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	single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or			

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	those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting			

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	within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;			

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	Based on interview and record review, the facility failed to ensure staff COVID-19 vaccination medical exemptions specified a clinically recognized contraindication for 1 of 2 staff medical exemptions reviewed, and the policy lacked additional precautions related to being unvaccinated. (Staff 10) Finding includes: On 1/17/23 at 2:13 P.M., Staff 10's medical exemption was reviewed. The medical exemption, signed 5/16/22, indicated Staff 10 should not receive the COVID-19 vaccine related to multiple neurological issues. During an interview on 1/20/23 at 10:35 A.M., Staff 10 indicated she had a medical exemption and is required to wear a surgical mask as an additional precaution. At that time, Staff 10 was observed working on the resident unit. On 1/23/23 at 9:15 A.M., a current Covid-19 Health Care Staff Vaccination policy, revised 9/28/22, was provided and indicated "...Senior Clinical Staff reserves the right to seek clarification from the employee for medical statements not reflecting the Centers for Disease Control (CDC) recognized contraindications..Must always wear a well-fitting face mask (loop or N95), regardless of whether they are providing direct care to a resident..." The policy lacked the specific contraindication to receiving the vaccine and additional precautions for unvaccinated individuals. 3.1-18(b)	F 0888	1. Employee #10 was identified in the alleged deficient practice. Employee 10 had an approved medical exemption. Alleged deficient practice that company policy does not specify additional precautions imposed to facility staff that are not vaccinated with COVID-19 vaccines. 2. All employees have the potential to be affected. Company policy regarding non-vaccinated facility staff reviewed for compliance. Staff education completed regarding change in vaccination policy. 3. As a measure of ongoing compliance, the Executive Director (ED) or designee, will complete random audits to ensure appropriate precautions are being maintained by vaccinated and unvaccinated facility staff 3x weekly for 4 weeks, weekly for 4 weeks, bi-weekly for 4 months. 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 6 months, if needed, until 100% compliance met.	02/14/2023
R 0000				

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 17, 18, 19, 20, 23, 2023 Facility number: 013703 Residential Census: 30 North River Health Campus was found to be in compliance with 410 IAC 16.2-5 in regards to the State Residential Licensure Survey.	R 0000	The submission of this plan of correction does not indicate an admission by North 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 North 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 2/14/23.	