STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155854	A. BUILDING 00 B. WING	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIVER HEALTH CAMPUS	811 E BASELINE ROAD EVANSVILLE, IN 47725

(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. Survey dates: April 15, 16, 17, 18, & 19, 2024 Facility number: 013703 Provider number: 155854 AIM number: 300025690 Census Bed Type: SNF/NF: 18 SNF: 30 Residential: 29 Total: 77 Census Payor Type: Medicare: 11 Medicaid: 18 Other: 19 Total: 48 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 29, 2024.	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 **5/10/24.**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessment was completed accurately for 1 of 1 residents reviewed for restraints. (Resident 27)	F 0641	1 Resident 27 was not affected by the alleged deficient practice. No adverse effects noted. 2 All residents have the potential to be affected. Resident	05/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Stallman, RN-BC	Clinical Support	05/08/2024

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	Finding includes: On 4/15/24 at 2:23 P.M., a family member indicated restraints had never been used on Resident 27 that she was aware of. On 4/16/24 at 11:00 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and anxiety disorder. The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident 27 had severe cognitive impairment, had no behaviors, and that physical restraints were used less than daily during the 7-day look back period. The clinical record lacked care plans, orders, assessments, and progress notes related to the use of physical restraints. On 4/17/24 at 9:35 A.M., the MDS Coordinator indicated that restraints used less than daily was marked in error on the 2/16/24 Quarterly MDS Assessment. She further indicated the facility did not use restraints on any resident. On 4/19/24 at 10:51 A.M., the Administrator indicated the facility follows the RAI (Resident Assessment Instrument) manual for guidance on coding MDS Assessments.		27's MDS has been modified to accurately reflect resident's status. Education provided to MDS Coordinator about ensuring accuracy of MDS assessments regarding restraints. 3 As a measure of ongoing compliance, the MDS or designee will complete random audits of completed MDS assessments. Audit will consist of 5 assessments weekly for 2 months, then 3 assessments weekly for 2 months, then 1 assessment weekly for 2 months. 4 As a quality measure, the MDS 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 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			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen equipment was properly labeled and oxygen was administered as ordered for 1 of 2 residents reviewed for respiratory care. (Resident 47) Finding includes: During an observation on 4/15/24 at 1:19 P.M., Resident 47 was observed sitting in a chair in her room with no oxygen being administered. There was an unplugged oxygen concentrator on the opposite side of the room. There was no date or initials observed on the humidification bottle, oxygen tubing, or oxygen tubing bag. During an observation on 4/16/24 at 8:48 A.M., the oxygen concentrator was observed turned off. There was no date or initials observed on the humidification bottle, oxygen tubing, or oxygen tubing bag. There was a portable oxygen concentrator, not in use, attached to the back of Resident 47's wheelchair; there were no dates on the oxygen tubing. On 4/16/24 at 10:06 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 3/23/24. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disorder (COPD), acute and chronic respiratory failure with hypoxia, and bronchopneumonia. The most recent Admission MDS (Minimum Data Set) Assessment, dated 3/39/24, indicated Resident 47 was cognitively intact, required limited assistance of 1 staff member for transfers	F 0695	1 Resident 47 was not affected by the alleged deficient practice. Resident 47 was assessed, and no adverse effects noted. 2 All residents with oxygen therapy orders have been reviewed for proper dating and storage per policy. Nursing personnel will be educated on administration of oxygen policy, including requirements for dating and storage of oxygen tubing. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident with current oxygen orders to ensure proper dating and storage of oxygen tubing. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 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.	05/10/2024

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	and mobility, and was receiving oxygen therapy. Current active physician orders included, but were not limited to: Oxygen at 2L (liters) per nasal cannula continuous, dated 4/1/24. Change oxygen tubing monthly, once a day on the 1st of the month, dated 4/1/24. Current care plans included, but were not limited to: Resident has potential for complications, functional and cognitive status decline related to respiratory disease; Administer oxygen per MD (medical doctor) order, dated 3/25/24. During an interview on 4/17/24 at 09:01 A.M., Registered Nurse (RN) 9 stated that oxygen tubing was changed weekly, and the oxygen tubing was placed in the bag with the resident's name and current date. When the tubing was not in use the equipment was placed in the bag. A current oxygen administration policy was requested on 4/19/24 and was not provided. 3.1-47(a)(6)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge			

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	when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview, and record review, the facility failed to ensure resident records were accurate for 2 of 2 residents reviewed for pressure ulcers and 1 of 1 residents reviewed for dental. (Resident 43, Resident 101, Resident 47) Findings include: 1. On 4/17/24 at 8:42 A.M., Resident 43's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia and morbid obesity. The most recent Admission Minimum Data Set (MDS) Assessment, dated 2/14/24, indicated that Resident 43 was cognitively intact, was at risk for pressure injuries, and had no unhealed pressure injuries. A care plan, initiated 2/29/24, indicated the resident had a pressure area to the bottom of the left lateral foot and to the gluteal fold.	F 0842	1 Residents 43, 101, and 47 were not affected by the alleged deficient practice. Residents 43, 101, and 47 were assessed and no adverse effects noted. 2 All residents have the potential to be affected. Education provided to MDS Coordinator about ensuring plan of care and MDS assessment correlate with each other regarding dental status. Nursing personnel educated on weekly skin assessments and ensuring appropriate documentation completed. Educate wound nurse on appropriate identification and documentation of skin impairment assessments. Skin assessments/audits completed on all residents to validate current wound status and documentation	05/10/2024

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	Physician orders included, but were not limited to: Weekly skin assessment: 0=no impairment, 1=new impairment, 2=old impairment, once a day on Mondays, dated 2/09/24 Cleanse left buttock with soap and water. Apply wound gel to wound bed and cover with dry dressing. May change PRN (as needed) if soiled, once a day, dated 3/21/24 Triad Wound Dressing paste - one application topically, twice a day, dated 3/22/24 Wound 1: A Wound Management Detail report indicated a pressure ulcer was identified on the bottom of the resident's left lateral foot on 2/28/24 at 5:25 P.M.. The wound was unstageable (full thickness tissue loss in which the base of the ulcer cannot be confirmed because the wound bed is obscured by slough and/or eschar), measured 1.9 cm (centimeters) by 2.8 cm, and skin was light purple/green and intact. A wound management detail report, dated 3/7/24 at 7:18 P.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.9 cm by 2 cm, and had necrotic tissue. A progress note, dated 3/14/24 at 11:55 A.M., indicated the pressure ulcer on the resident's left foot continued to show improvement, the purple was fading, with a scant amount of fluid noted under the dermis that appeared to be reabsorbing, and no signs or symptoms of infection. A wound management detail report, dated 3/14/24 at 6:52 P.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.8		accuracy. Dental status audit completed on all residents to ensure plan of care and MDS assessments correlate. 3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident with identified skin impairment to ensure accurate documentation. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 3 months. As a measure of ongoing compliance, the MDSC or designee will complete random audits of MDS assessment and plan of care to ensure that both accurately reflect residents' current oral status. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 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.	

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	cm by 2 cm, and had necrotic tissue. A wound management detail report, dated 3/21/24 at 9:57 P.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.9 cm by 2 cm, and had necrotic tissue. A progress note, dated 3/23/24 at 10:12 A.M., indicated the resident had a "bruised area on bottom L [left] foot". A wound management detail report, dated 3/29/24 at 1:59 P.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.9 cm by 2 cm, and had necrotic tissue. A wound management detail report, dated 4/5/24 at 9:17 A.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.9 cm by 2 cm, and had necrotic tissue. A wound management detail report, dated 4/11/24 at 9:22 A.M., indicated the pressure ulcer on the resident's left foot was unstageable, measured 1.9 cm by 2 cm, and had epithelial tissue. Wound 2: A progress note, dated 3/21/24 at 11:08 A.M., indicated " ... Assessed BLE [bilateral lower extremities]. Remains with purple area to bottom of left foot. Improved from last assessment fading in color ... Noted open area to left buttock. 6.8x5.4<0.1 irregular rashy [sic] dry peeling edges open red with slight bleeding. Notified [name of provider] new order received Cleanse daily apply wound gel and cover with foam dressing. Wound nurse eval [evaluation] treatment effectiveness of treatment". A progress note, dated 3/22/24 at 2:31 P.M.,			

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	indicated "MASD [moisture associated skin damage] noted to bilateral gluteal folds. Areas cleansed and triad paste applied". A progress note, dated 3/27/24 at 12:53 P.M., indicated "treatment done to area on buttocks. Area is healing peri-wound is pink in color". A wound management detail report indicated a pressure ulcer was identified on the left lower buttocks/thigh (gluteal fold) on 3/29/24 at 2:00 P.M.. The wound was unstageable, measured 3.5 cm by 3.2 cm, and had granulation tissue. A wound management detail report, dated 4/5/24 at 9:14 P.M., indicated the pressure ulcer on the resident's gluteal fold was unstageable, measured 3.4 cm by 3.2 cm, and had epithelial tissue. The entry was created on 4/17/24 at 9:17 A.M. A progress note, dated 4/11/24 at 7:24 A.M., indicated "Resident leaving for appointment in [name of city]. Will return this evening". A wound management report dated 4/11/24 at 9:19 A.M., indicated the pressure ulcer on the resident's gluteal fold was unstageable, measured 3.4 cm by 3.1 cm, and had epithelial tissue. The entry was created on 4/17/24 at 9:21 A.M. A progress note, dated 4/11/24 at 7:37 P.M., indicated "Resident has returned from LOA [leave of absence]". A progress note, dated 4/15/24 at 3:07 P.M., indicated "Left foot red intact skin improved almost healed. Moisture associated damage to Buttock has improved". The March 2024 TAR (Treatment Administration			

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	Administration) indicated a weekly skin assessment had been completed: 3/4/24 - old impairment 3/11/24 - no impairment 3/18/24 - no impairment 3/25/24 - "buttocks" The April 2024 TAR indicated a weekly skin assessment had been completed: 4/1/24 - no impairment 4/8/24 - old impairment 4/15/24 - no impairment On 4/17/24 at 11:02 A.M., Certified Nurse Aide (CNA) 11 indicated Resident 43 did not have a dressing covering the wound on her buttocks for at least the past week. On 4/17/24 at 11:04 A.M., Licensed Practical Nurse (LPN) 17 indicated Resident 43 did not have a dressing and Triad paste was used. The wound order for the dry dressing needed to be discontinued. She further indicated if a staff member saw a new wound, they would put in an event and she would check those events daily and assess the new wound at that time. She indicated that the resident was in [name of city] on 4/11/24 and the wound assessment, dated 4/11/24, was completed on 4/10/24 and was dated 4/11/24 in error. She indicated the assessments were entered into the resident's medical record on 4/17/24 because she was behind in putting information into the EHR (electronic health record). On 4/18/24 at 9:39 A.M., the Clinical Support Nurse indicated Resident 43's wounds should have been documented as MASD and not unstageable pressure ulcers. The resident had 1 wound on her buttocks and 1 wound on her left			

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	foot and that the wounds in the progress notes, skin assessments, and wound management reports referred to those wounds. She indicated the wound on Resident 43's bottom was chronic and would come and go. She indicated the wound on the resident's left foot was not nor ever was necrotic. She indicated the wound nurse was new and was confusing bruised tissue with necrotic tissue. She further indicated the skin assessments should reflect the wound detail management reports, and she was unsure why the nurse was charting there was no impairment when there was.2. On 4/17/24 at 2:00 P.M., Resident 101's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified displaced fracture of first cervical vertebra and anterior displaced Type II dens fracture. The current Admission MDS Assessment, dated 4/11/24, indicated Resident 101 was moderately cognitively impaired and needed partial to modified assistance to perform toileting, transferring, and mobility. The MDS Assessment indicated Resident 101 also had an unstageable pressure ulcer. Physician's orders included, but were not limited to: Observe L (left) plantar for any changes, notify MD (medical doctor) if any changes are noted, twice a day, dated 4/17/24. Weekly skin assessment once a day, dated 4/4/24. L plantar skin prep q (every) shift, twice a day, dated 4/17/24. Care plans included, but were not limited to: Resident has a pressure ulcer to left bottom of foot. The goal was that the resident ulcer would heal without complications. Interventions included, but were not limited to, assess and			

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	record the condition of the skin surrounding the pressure ulcer, observe and report signs of infection (localized redness, swelling, tenderness...), and weekly skin assessment, measurement, and observation of the pressure ulcer and record, dated 4/5/24. On 4/17/24 at 12:46 P.M., the Regional Support Nurse provided Resident 101's Wound Management Detail Report. The observation, dated 4/4/24, indicated the observed pressure wound measured 0.5 cm by 0.5 cm and was located on the bottom of the left plantar foot. The wound was unstageable in the deep tissue. The tissue was necrotic with well-defined wound edges and the surrounding skin was pink and normal. The observation dated 4/12/24 indicated the pressure wound measured 0.7 cm by 0.5 cm and was located on the bottom of the left plantar foot. The wound was unstageable in the deep tissue. The tissue was necrotic with well-defined wound edges and the surrounding skin was pink and normal. During an interview on 4/18/24 at 9:34 A.M., the Regional Support Nurse indicated she had seen the wound and it was not necrotic but was blanchable. The person who had been putting in the assessment was new and had put in the wrong entry. It should not be labeled as necrotic. It was more like a bruise.3. During an observation on 4/15/24 at 01:19 P.M., Resident 47 was observed having both missing and broken teeth in the oral cavity. On 4/16/24 at 10:06 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on 3/23/24. Diagnoses included, but were not			

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(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
	limited to, Chronic Obstructive Pulmonary Disorder (COPD), acute and chronic respiratory failure with hypoxia, and type 2 Diabetes Mellitus. The most recent Admission MDS Assessment, dated 3/39/24, indicated Resident 47 was cognitively intact, required limited assistance of 1 staff member for transfers and mobility, and had broken or missing teeth. Current care plans included, but were not limited to: Resident is at risk for malnutrition R/T (related to) no natural teeth or dentures (edentulous), dated 4/1/24. An admission observation, dated 3/23/24 at 3:32 P.M., indicated no oral cavity issues and was not selected for any oral cavity indications including missing or broken teeth, dentures, or edentulous. During an interview on 4/17/24 at 10:05 A.M., the MDS Coordinator indicated the care plan contained incorrect information and was marked in error, was not sure why the admission assessment stated Resident 47 had no oral decays and confirmed Resident 47 did have missing and broken teeth. During an interview on 4/19/24 at 12:58 P.M., the Clinical Support Nurse indicated there was no policy related to documentation, and stated it was company policy to document accurately and timely. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

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	155854	A. BUILDING 00 B. WING	04/19/2024

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	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: (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,			

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	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 its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure the implementation of enhanced barrier precaution (EBP) during a random observation for 1 of 1 resident with a permcath dialysis catheter while changing linen. (Resident 15) Finding includes: During a random observation on 4/18/24 at 10:02	F 0880	1 Resident 15 was not affected by the alleged deficient practice. No adverse effects noted to Resident 15. 2 All residents that are on Enhanced Barrier Precautions have the potential to be affected. Education provided to facility staff on Enhanced Barrier Precautions. 3 As a measure of ongoing compliance, the DHS or designee	05/10/2024

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	A.M., Resident 15's room was identified as following the Enhanced Barrier Precautions. Two CNAs (Certified Nurse Aides) were observed entering Resident 15's room with a Hoyer lift and did not apply PPE (personal protective equipment). The resident was observed to be ready for the transfer with the lift pad in position. While in the resident's room, the CNAs did not have PPE on before or after transferring the resident to a wheelchair. The two CNAs were also observed to change the soiled bed linens and apply new linens. During an interview on 4/19/2 at 9:01 A.M., Resident 15 indicated staff did not wear PPE when doing transfers. During an interview on 4/19/24 at 9:04 A.M., RN (Registered Nurse) 3 indicated the staff wore PPE when doing anything that involved direct contact when residents were on enhanced barrier precautions. On 4/19/24 at 12:49 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, other complications of vascular dialysis catheter and end stage renal disease. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/26/24, indicated the resident was cognitively intact. The resident was dependent for mobility, transfer, and dressing. Physician orders included, but were not limited to: Staff to use enhanced barrier precautions d/t (due to) central line, wearing a gown and gloves at minimum during high-contact care activities twice a day, dated 4/15/24.		will complete random audits of care being given to residents that are currently on Enhanced Barrier Precautions to ensure appropriate PPE being utilized. Audits will consist of 3 residents weekly x 4 weeks, then 3 residents every other week for 2 months, and then 3 residents monthly x 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.	

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	The current care plan indicated the resident had a central line and required enhanced barrier precautions (EBP) during high-contact care related to presence of this line. Interventions included, but were not limited to, risk for transmission of infection will be minimized with use of enhanced barrier precautions, to don/doff and dispose of PPE systematically and appropriately, per policy, and utilize gown and gloves per EBP policy during high contact ADL (Activities of Daily Living) care (e.g. dressing, showering/bathing, hygiene, transfers, toileting/changing briefs) and during linen changes. On 4/19/24 at 1:15 P.M., the Clinical Support Nurse provided a current Enhanced Barrier Precautions (EBP) Standard Operating Procedure policy, dated 4/1/24, that indicated "... Enhanced Barrier Precautions will be in place during high-contact activities for residents with the following conditions...all residents with indwelling medical devices...high-contact activities include but are not limited to...morning and evening ADL care...". 3.1-18(b)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 15, 16, 17, 18, & 19, 2024 Facility number: 013703 Residential Census: 29	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	

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	North River Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.		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 **5/10/24.**	