| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155854 | A. BUILDING 00<br>B. WING | 03/21/2025 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: March 17, 18, 19, 20, and 21, 2025.<br><br>Facility number: 013703<br>Provider number: 155854<br>AIM number: 300025690<br><br>Census Bed Type:<br>SNF/NF: 48<br>Residential: 27<br>Total: 75<br><br>Census Payor Type:<br>Medicare: 13<br>Medicaid: 18<br>Other: 17<br>Total: 48<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on March 28, 2025. | 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 **4/14/25.** | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, record review, and interview, the facility failed to ensure residents received supervision and consistent implementation of interventions to prevent a fall for 1 of 1 residents reviewed for accidents related to falls. Fall interventions were not consistently | F 0689 | 1 Resident 15 was assessed, and no adverse effects noted related to the alleged deficient practice.<br>2 All residents have the potential to be affected by the | 04/14/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Lisa Stallman | Clinical Support | 04/11/2025 |

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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| | implemented. (Resident 15)<br><br>Findings include:<br><br>On 3/19/25 at 9:35 A.M., during a random observation of Resident 15 transferring from a wheelchair to a shower chair by Certified Nurse Aide 5 (CNA) and CNA 6, the wheelchair was observed lacking a Dycem (Anti-slip mat) in the seat.<br><br>On 3/18/25 at 10:26 A.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease with late onset and Dementia with unspecified severity.<br><br>The Current Annual Minimum Data Set (MDS) Assessment dated 2/26/25 indicated that Resident 15 was severely cognitively impaired. Resident 15 was dependent on transferring, hygiene, and dressing.<br><br>Current physician orders included, but were not limited to, using a Dycem to the wheelchair twice a day from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. dated 6/21/24.<br><br>An Interdisciplinary (IDT) note dated 3/17/25 at 12:24 P.M., indicated Resident 15 had a fall on 3/14/25 while leaning forward trying to pick things off the floor when he toppled out of the chair. The note indicated that a Dycem was in place.<br><br>A Quarterly Resident First Meeting dated 2/21/25 indicated Resident 15 was a high fall risk.<br><br>The most recent care plan indicated the resident was a high fall risk related to altered/impaired mobility and impaired cognition. Interventions included, but were not limited to: | | alleged deficiency. Audit completed of current residents fall interventions to ensure interventions are in place. Education completed with nursing personnel regarding resident fall interventions and ensuring items in place.<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audits of resident rooms to ensure appropriate/ordered fall interventions are in place. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the DHS/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 is met. | |

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| | Dycem to wheelchair cushion dated 6/24/24 and keep personal items and frequently used items within reach dated 2/22/24, the care plan was last reviewed by staff on 3/3/2025.<br><br>During an interview on 3/19/25 at 9:35 A.M., CNA 5 indicated that there should be a Dycem in place for the resident.<br><br>During an interview on 3/21/25 at 8:30 A.M., the Regional Support Nurse indicated that the care plan should be followed and updated after each fall.<br><br>On 3/21/25 at 9:15 A.M., the Regional Support Nurse provided a current policy "Fall Management Program Guidelines" reviewed on 12/17/24. The policy indicated "...the resident care plan should be updated to reflect any new or change in interventions..."<br><br>3.1-45(a)(2) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.<br><br>Survey dates: March 17, 18, 19, 20, and 21, 2025.<br><br>Facility number: 013703<br><br>Residential Census: 27<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5. | 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. | |

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| | | | 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 **4/14/25.** | |
| R 0409<br><br>Bldg. 00 | 410 IAC 16.2-5-12(d)<br>Infection Control - Noncompliance<br><br>Based on interview and record review, the facility failed to ensure physician orders contained an annual health statement for 2 of 5 residents reviewed currently residing in the facility. (Resident 4 and Resident 2)<br><br>Findings include:<br><br>1. On 3/20/25 at 8:50 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. Resident 4 was admitted to the facility on 12/14/24.<br><br>The clinical record lacked an annual health statement for Resident 4.<br>2. On 3/20/25 at 9:44 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, chronic kidney disease. Resident 2 was admitted on 2/12/24.<br><br>The clinical record lacked an annual health statement for Resident 2.<br><br>On 3/20/25 at 1:46 P.M., Regional Support 17 indicated Resident 4 and Resident 2 did not have | R 0409 | 1 Residents 4 and 2 were assessed and no adverse effects noted from alleged deficient practice.<br>2 All residents have the potential to be affected. Education provided to nursing personnel on required annual health assessment/statement requirements. Audit completed of residents to ensure all current residents have the required annual health assessment/statement.<br>3 As a measure of ongoing compliance, the DHS or designee will complete random audit of resident records to ensure the required annual health assessment/statement is present in resident EHR. Audit will consist of 5 residents weekly for 1 month, then 5 residents every other week for 2 months, then 5 residents monthly for 3 months.<br>4 As a quality measure, the | 04/14/2025 |

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| | annual health statements as a part of their physician orders since admission to the residential facility prior to 3/20/25.<br><br>On 3/20/25 at 9:30 A.M., Regional Support 17 indicated the facility followed regulations as set forth by the State in relation to annual health statement requirements. | | 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 is met. | |