

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2024
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NAME OF PROVIDER OR SUPPLIER  RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP COD 1244 VAIL ST PRINCETON, IN 47670
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00426756.</p> <p>Complaint IN00426756 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 23, 2024</p> <p>Facility number: 004130 Provider number: 155732 AIM number: 200491050</p> <p>Census Bed Type: SNF: 21 SNF/NF: 34 Residential: 33 Total: 88</p> <p>Census Payor Type: Medicare: 10 Medicaid: 26 Other: 19 Total: 55</p> <p>Riveroaks Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00426756.</p> <p>Quality review completed Janaury 23, 2024.</p>	F 0000	<p>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 licensed residential health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey IN00426756 conducted January 23, 2024. The facility respectfully requests from the department a desk review for substantial compliance.</p>	
R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint</p>	R 0000	<p>The submission of this plan of</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Lucas	Executive Director	02/05/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R 0052 Bldg. 00	<p>IN00426756.</p> <p>Complaint IN00426756 - State deficiencies related to the allegations are cited at R0052.</p> <p>Survey date: January 23, 2024</p> <p>Facility number: 004130</p> <p>Residential Census: 33</p> <p>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and</p>		<p>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 licensed residential health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey IN00426756 conducted January 23, 2024. The facility respectfully requests from the department a desk review for substantial compliance.</p>	

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	<p><b>(6) involuntary seclusion.</b> Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident was free from staff-to-resident sexual abuse for 1 of 3 residents reviewed for abuse. (Resident C) This deficient practice resulted in Resident C being assaulted by a male staff member. (Housekeeping 13)</p> <p>Finding includes:</p> <p>During a review of facility reported incidents on 1/23/24 at 11:05 A.M., an incident report, dated 1/22/23, involving Resident C and Housekeeping 13 indicated " ...upon staff member entering assisted living resident's room, staff observed floor tech (Housekeeping 13) with inappropriate behavior of [sic] towards resident ..."</p> <p>On 1/23/24 at 10:30 A.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified dementia and major depressive disorder.</p> <p>Resident C's nursing progress notes included, but were not limited to, the following:</p> <ul style="list-style-type: none"> <li>- On 1/22/24 at 11:00 A.M., Upon staff member entering assisted living resident's room, staff observed floor tech with inappropriate behavior towards resident. Resident safety maintained, staff member removed from resident room.</li> <li>- On 1/22/24 at 12:59 P.M., Order received to send resident to ER (emergency room) for evaluation by SANE (Sexual Assault Nurse Examiner).</li> </ul> <p>A hospital triage assessment, dated 1/22/24 at 3:04 P.M., indicated that Resident C was sent to ER via EMS (Emergency Medical Services) for a reported sexual assault. Resident with a history of</p>	R 0052	<p>1. Director of Assisted Living remained with Resident C from time of incident until family arrival at the emergency room to provide support and reassurance. Resident C was assessed in facility and at hospital with no findings or trauma identified. Resident has diagnosis of dementia and has no recollection of incident. Serial trauma trigger assessments completed, lab work negative for findings in emergency room and ongoing monitoring in place to identify physical, emotional, or psychosocial effects. Resident returned to the facility after emergency room evaluation and resumed her usual routine with support of staff and family. Resident transferred to specialized Memory Care unit on 2/2/24 per family request. Care coordinated with receiving facility for continued support to resident/family. Employee was removed from campus by law enforcement, suspended then subsequently terminated and did not return to the campus.</p> <p>2. All residents have the potential to be affected. All residents in the facility with BIMs of 8 or below had skin assessment completed with no findings. All residents with BIMs 9 or greater interviewed for any experienced or witnessed abuse with no findings. Staff</p>	01/24/2024

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	<p>dementia. Resident denies complaints of pain. She was awake, disoriented, and confused. She was pleasantly demented. A final result included, a reported sexual assault of adult by bodily force by caregiver.</p> <p>A Hospital ED (Emergency Department) provider note, dated 1/22/24 at 5:32 P.M., included that Resident C " ...denies any complaints of pain... She is awake. She is not in acute distress ...She is disoriented and confused ... Patient pleasantly demented ... Final Impression: 1. Reported sexual assault of adult by bodily force by caregiver..."</p> <p>During an interview on 1/23/24 at 11:10 A.M., the Administrator indicated Resident C was in the facility but usually not in her room. The resident often walked around the facility but had severe cognitive impairment.</p> <p>During an observation on 1/23/24 at 11:15 A.M., Resident C was sitting on a couch in a common area of the facility with her eyes closed.</p> <p>During an interview on 1/23/24 at 11:25 A.M., LPN 24 indicated she was the second staff member to witness the incident on 1/22/23 involving Resident C and Housekeeping 13. Activities 6 had seen Housekeeping 13 and Resident C walking together towards the resident's room. When Activities 6 and LPN 24 went to check on the resident Activities 6 and LPN 24 heard voices coming from Resident C's room and then the sound of Velcro being pulled apart. When Activities 6 and LPN 24 got to Resident C's door LPN 24 and Activities 6 heard something being placed against the door. Admission Staff 4 then pushed the door in and found Housekeeping 13 naked from the waist down. Resident C was also naked from the waist down and had her shirt</p>		<p>education provided related to abuse and neglect policy. Campus investigation into incident coordinated with law enforcement and area ombudsman.</p> <p>3. As a measure of ongoing compliance, 5 residents with BIMs of 8 or below will have skin assessment completed at random 3 x weekly for 4 weeks, 1 x weekly for 4 weeks and then monthly for 4 months. As a measure of ongoing compliance, 5 residents with BIMs of 9 or greater will be interviewed at random for any experienced or witnessed abuse 3 x weekly for 4 weeks, 1 x weekly for 4 weeks and then monthly for 4 months.</p> <p>4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.</p>	

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	<p>pulled up above her chest. Housekeeping 13 was on top of Resident C on her bed. Admission Staff 4 yelled at Housekeeping 13 to get off of Resident C. Housekeeping 13 then picked his pants up off the floor to cover himself and went to the resident's bathroom. LPN 24 stayed with the resident and Activities 6 contacted the Administrator. The police arrived and arrested Housekeeping 13.</p> <p>During an interview on 1/23/24 at 11:35 A.M., Activities 6 indicated she was sitting in her office and could see Resident C from her window. Resident C was watching television when Housekeeping 13 had walked up to Resident C and was talking to Resident C in a hushed tone, which seemed odd due to Housekeeping 13 typically being loud when he spoke. Activities 6 then noticed Resident C got up and walked toward the dining room with Housekeeping 13. Activities 6 felt something was odd about the two of them walking off together so she notified her nurse, LPN 24 and they both went to her room to check on her. The door was closed when Activities 6 and LPN 24 got to Resident C's room. LPN 24 and Activities 6 heard voices in the room and the sound of Velcro being pulled apart. LPN 24 and Activities 6 grabbed Admission Staff 4, who pushed the door in. There was a chair placed in front of the door from the inside. Admission Staff 4 broke the wooden chair when pushing the door open enough to look inside the room. Admissions Staff 4 yelled at Housekeeping 13 to get off of the resident. Activities 6 saw Housekeeping 13 in the residents restroom with his pants off and Resident C was on her bed. Staff immediately notified the Administrator who came to the room quickly and they called the police.</p> <p>On 1/23/24 at 11:50 a.m., the Administrator</p>			

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	<p>provided the facility investigation report. The report included a typed statement from Admission Staff 4, signed and dated 1/22/24. The statement indicated, "I was in my office when [staff] came to the doorway and stated that [Activities 6 and LPN 24] need our assisted [sic] on the 400 hall. I immediately got up and went down the 400 hall to provide assistance. [LPN 24] had come up the hall to get us and as we walked to the room I saw that [Activities 6] had her hand on the handle of [Resident C's] room with her ear on the door. I asked [Activities 6] what was going on and she stated that she believed [Housekeeping 13] was in the room with [Resident C]. I attempted to open the door at that time and found that it was blocked by an object as the door nob [sic] did not have a locking mechanism on it. At that time I asked [Activities 6] to move out of the way and knocked on the door. I stated '[Resident C] are you in here' and I broke into the room approximately 3 inches showing that a chair was up under the door knob. I pushed again against the door and was able to stick my head into the room. From my vantage point I was able to see [Housekeeping 13] partially on top of [Resident C] with his left leg on the floor pushing himself up. I saw that he was pushing himself up by shifting his weight with his right hand on the mattress where [Resident C] was laying. He reached down to grab his pants off of the floor and stood up covering his privates with his pants. I was shouting '[Housekeeping 13] what are you doing? Get off of her' Once he was standing I was able to fully enter the room and I stated 'Get in the bathroom now' to separate staff member and resident. I ensured that the resident and staff member were separated. I checked to see how [Resident C] was doing and ensured [Housekeeping 13] did not have access to resident. I then remained with resident until Executive Director entered and directed staff to</p>			

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

PRINTED: 02/09/2024

FORM APPROVED

OMB NO. 0938-039

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	<p>escort [Housekeeping 13] to conference room and [LPN 24] to remain with resident."</p> <p>On 1/23/24 at 10:10 A.M., the Administrator supplied the most recent facility policy titled, Abuse and Neglect Procedural Guidelines, dated 6/2023. The policy included, but was not limited to, "...[Facility] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse... Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse... (d) Sexual Abuse - is non-consensual sexual contact of any type with a resident..."</p> <p>This citation relates to Complaint IN00426756.</p>				