

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/16/2012
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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R0000	<p>This visit was for the Investigation of Complaint IN00119127 and Complaint IN00119217.</p> <p>Complaint IN00119127 - Substantiated. State findings related to the allegations are cited at R117, R241 and R245.</p> <p>Complaint IN00119217 - Substantiated. No findings related to the allegations are cited.</p> <p>Survey dates: November 15 and 16, 2012</p> <p>Facility number: 011274 Provider number: 011274 AIM number: N/A</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: Residential: 87 Total: 87</p> <p>Census payor type: Other: 87 Total: 87</p> <p>Sample: 6</p>	R0000	All residents have the potential to be effected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/20/12 by Suzanne Williams, RN</p>				

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a CNA did not perform accuchecks and administer insulin injections, for 2 of 4 residents reviewed with orders for accuchecks, in a sample of 6. Residents C and D</p> <p>Findings include:</p> <p>1. On 11/15/12 at 1:30 P.M., Resident D and his roommate, Resident F,</p>	R0117	<p>R 117 All diabetic residents have the potential to be effected. The staff members that where involved with this complaint were reprimanded prior to survey. All nursing staff will be in-serviced on their nursing license'/certifications' scope of practice. Completion Date 12/07/2012 The DON or his designee will audit 10% of the diabetic residents. Daily</p>	12/07/2012			

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	<p>were interviewed. Resident D indicated he was diabetic, and received insulin injections 4 times daily. Resident D indicated nursing staff usually administered his insulin, except for one occasion. Resident F indicated, "A few weeks ago, [CNA # 1] gave [Resident D] his 6 A.M. dose. She checked his blood sugar, and asked him where he wanted his shot. Then she gave it to him. We were both sleeping, and I wasn't paying attention at first. I couldn't believe it. We told [the Administrator and Director of Nursing]. They said the nurse drew the insulin up and then [CNA # 1] gave it. They said they inserviced both of them."</p> <p>The clinical record of Resident D was reviewed on 11/15/12 at 12:50 P.M. Diagnoses included, but were not limited to, diabetes.</p> <p>A Service Plan, dated 4/9/12, indicated, "Staff to adm. [administer] meds."</p> <p>A Physician's order, dated 1/3/12 and on the October 2012 orders, indicated, "Accucheck four times daily [with] Novolog sliding scale...2/28/12 Humalog sliding scale 151-200 = 2 units, 201-250 = 6 units, 251-350 = 10 units...> 400 call MD."</p>		<p>times one week, then weekly times four weeks, then monthly times four months. Results will be forwarded to QA</p> <p>All residents have the potential to be effected.</p> <p>The nursing staff will be in-serviced on leaving any medications at the residents' bedside.</p> <p>Completion Date 12/07/2012</p> <p>The DON or his designee will audit 10% of the residents' rooms for medications left at bedside. Daily times one week, then weekly times four weeks, then monthly times four months. Results will be forwarded to QA.</p>				

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	<p>The Medication Administration Record [MAR], dated 10/21/12 at 6:00 A.M., indicated the resident's blood sugar was 309. The MAR indicated the resident received 10 units of Humalog insulin and 30 units of Lantus insulin subcutaneously.</p> <p>2. On 11/16/12 at 10:25 A.M., Resident C was interviewed. Resident C indicated she received insulin injections daily. Resident C indicated CNA # 1 gave her an insulin shot and her medications approximately one month previously. Resident C indicated she thought it was on Sunday, 10/21/12. Resident C indicated she was sleeping, and CNA # 1 came in, "said who she was, did my accu check and gave me my shot. She left my pills with me."</p> <p>The clinical record of Resident C was reviewed on 11/15/12 at 1:05 P.M. Diagnoses included, but were not limited to, type I diabetes mellitus.</p> <p>A Resident Evaluation, dated 7/11/12, indicated, "Mental Status, Oriented to person/place/time. Medications, Requires complete supervision and administration of all meds."</p> <p>A Service Plan, dated 8/30/12,</p>						

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	<p>indicated, "Medications, Staff to adm. meds."</p> <p>A Physician's order, dated 1/3/12 and on the October 2012 orders, indicated, "Fasting accuchecks daily."</p> <p>A Medication Administration Record, dated 10/21/12 at 6:00 A.M., indicated the resident's accucheck was 201, and the resident received Lantus 10 units subcutaneously.</p> <p>3. On 11/16/12 at 10:35 A.M., the DON indicated that CNAs are not allowed to perform accuchecks. The DON indicated he was unaware the CNA performed accuchecks.</p> <p>This state finding relates to Complaint IN00119127.</p>			

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R0241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on interview and record review, the facility failed to ensure a nurse administered medications to a resident, and instead a CNA left the medications at the bedside, for 1 of 4 residents reviewed for medication administration, in a sample of 6. Resident C</p> <p>Findings include:</p> <p>On 11/16/12 at 10:25 A.M., Resident C was interviewed. Resident C indicated she received insulin injections daily. Resident C indicated CNA # 1 gave her an insulin shot and her medications approximately one month previously. Resident C indicated she thought it was on Sunday, 10/21/12. Resident C indicated she was sleeping, and CNA # 1 came in, "said who she was, did my accu check and gave me my shot. She left my pills with me."</p> <p>The clinical record of Resident C was reviewed on 11/15/12 at 1:05 P.M.</p>	R0241	<p>R 241 All residents have the potential to be effected. The staff members that where involved with this complaint were reprimanded prior to survey. All nursing staff will be in-serviced on their nursing license' / certifications' scope of practice. Completion Date 12/07/2012 The DON or his designee will audit 10% of the residents' rooms for medications left at bedside. Daily times one week, then weekly times four weeks, then monthly times four months. Results will be forwarded to QA.</p>	12/07/2012			

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	<p>Diagnoses included, but were not limited to, type I diabetes mellitus.</p> <p>A Resident Evaluation, dated 7/11/12, indicated, "Mental Status, Oriented to person/place/time. Medications, Requires complete supervision and administration of all meds."</p> <p>A Service Plan, dated 8/30/12, indicated, "Medications, Staff to adm. (administer) meds."</p> <p>A Physician's order, initially dated 3/12/12 and on the October 2012 orders, indicated, "Lantus [insulin], Inject 10u [units] sub-q [subcutaneous injection] every morning." An additional order, dated 1/3/12 and on the October 2012 orders, indicated, "Fasting accuchecks daily."</p> <p>A Medication Administration Record, dated 10/21/12 at 6:00 A.M., indicated the resident received the following meds: Maxzide 25 mg [for high blood pressure], Vesicare 10 mg [for bladder], Zoloft 100 mg 2 tablets [anti-depressant], Zocor 40 mg [for high cholesterol], Synthroid 125 mcg [for thyroid], MS Contin 15 mg [for pain], Glucophage 500 mg [for diabetes], Aggrenox [blood thinner], Neurontin 300 mg [for pain], Colace 100 mg [stool softener], and Lantus</p>						

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	<p>10 units subcutaneously.</p> <p>On 11/16/12 at 10:10 A.M., CNA # 1 was interviewed. CNA # 1 indicated she had been called in as extra help for the CNAs on 10/21/12. CNA # 1 indicated LPN # 1 asked her to help administer some insulins. CNA # 1 indicated she had thought other CNAs gave medications to residents at times also.</p> <p>On 11/16/12 at 10:35 A.M., the Director of Nursing provided an investigation. The investigation, undated, indicated, "It was reported that a CNA gave 3 residents their insulin shots... The nurse drew up the insulin and asked the CNA to give them...When questioning the LPN involved she confirmed that she drew up the insulin and asked the CNA to give the insulin...." The DON indicated he was unaware the CNA had left medications at the bedside for the resident.</p> <p>This state finding relates to Complaint IN00119127.</p>						

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R0245	<p>410 IAC 16.2-5-4(e)(5) Health Services - Offense (5) Injectable medications shall be given only by licensed personnel. Based on interview and record review, the facility failed to ensure residents were administered their insulin injections by a licensed nurse, for 3 of 4 residents reviewed with insulin injections ordered, in a sample of 6. Residents B, C, D.</p> <p>Findings include:</p> <p>1. On 11/15/12 at 11:15 A.M., the Director of Nursing [DON] provided a list of residents, indicating those who were interviewable. Residents B, C, D, and F were listed as being interviewable.</p> <p>On 11/15/12 at 11:30 A.M., Resident B was interviewed. Resident B indicated he was diabetic, and received insulin injections 4 times daily. Resident B indicated the nursing staff usually gave him his insulin injections, except for "one time about one month ago." Resident B indicated a CNA gave him his insulin shot. Resident B indicated he knew who it was, but did not want to name her. Resident B indicated it was his early morning shot. Resident B indicated, "She made a mistake. We</p>	R0245	<p>R 245 All diabetic residents have the potential to be effected. The staff members that where involved with this complaint were reprimanded prior to survey. All nursing staff will be in-serviced on their nursing license' / certifications' scope of practice. Completion Date 12/07/2012 The DON or his designee will audit 10% of the diabetic residents. Daily times one week, then weekly times four weeks, then monthly times four months. Results will be forwarded to QA</p>	12/07/2012			

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	<p>met with [the DON], and he said it wouldn't happen again."</p> <p>The clinical record of Resident B was reviewed on 11/15/12 at 12:25 P.M. Diagnoses included, but were not limited to, diabetes mellitus.</p> <p>A Service Plan, dated 4/9/12, indicated, "Medications, Staff to adm. [administer] meds [medications]."</p> <p>A Resident Evaluation, dated 7/9/12, indicated the resident was oriented to person, place, and time, and "requires complete supervision and administration of all meds."</p> <p>A Physician's order, initially dated 7/15/10 and signed by the physician on 9/27/12, indicated, "Accucheck at 0600 [6:00 A.M.] with Novolog sliding scale." A physician's order, dated 2/28/12, indicated: "Novolog sliding scale... 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units."</p> <p>A Medication Administration Record [MAR], dated 10/21/12, indicated the resident's blood sugar at 6:00 A.M. was 382, and the resident received 10 units of Novolog insulin subcutaneously.</p> <p>2. On 11/15/12 at 1:30 P.M.,</p>						

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	<p>Resident D and his roommate, Resident F, were interviewed. Resident D indicated he was diabetic, and received insulin injections 4 times daily. Resident D indicated nursing staff usually administered his insulin, except for one occasion. Resident F indicated, "A few weeks ago, [CNA # 1] gave [Resident D] his 6 A.M. dose. She checked his blood sugar, and asked him where he wanted his shot. Then she gave it to him. We were both sleeping, and I wasn't paying attention at first. I couldn't believe it. We told [the Administrator and DON]. They said the nurse drew the insulin up and then [CNA # 1] gave it. They said they inserviced both of them."</p> <p>The clinical record of Resident D was reviewed on 11/15/12 at 12:50 P.M. Diagnoses included, but were not limited to, diabetes.</p> <p>A Service Plan, dated 4/9/12, indicated, "Staff to adm. meds."</p> <p>A Resident Evaluation, dated 7/9/12, indicated, "Requires complete supervision and administration of all meds."</p> <p>A Physician's order, dated 1/3/12 and on the October 2012 orders, indicated, "Accucheck four times daily</p>			

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	<p>[with] Novolog sliding scale...2/28/12 Humalog sliding scale 151-200 = 2 units, 201-250 = 6 units, 251-350 = 10 units...> 400 call MD." Physician orders indicated the resident received 30 units of Lantus insulin routinely at 6:00 A.M.</p> <p>The Medication Administration Record [MAR], dated 10/21/12 at 6:00 A.M., indicated the resident's blood sugar was 309. The MAR indicated the resident received 10 units of Humalog insulin and 30 units of Lantus insulin subcutaneously.</p> <p>3. On 11/16/12 at 10:25 A.M., Resident C was interviewed. Resident C indicated she received insulin injections daily. Resident C indicated CNA # 1 gave her an insulin shot and her medications approximately one month previously. Resident C indicated she thought it was on Sunday, 10/21/12. Resident C indicated she was sleeping, and CNA # 1 came in, "said who she was, did my accu check and gave me my shot. She left my pills with me." Resident C indicated she "was so mad," and wouldn't have let CNA # 1 administer the shot if she would have been more awake. Resident C indicated she had a meeting with the DON afterwards and was told it would never happen</p>						

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	<p>again.</p> <p>The clinical record of Resident C was reviewed on 11/15/12 at 1:05 P.M. Diagnoses included, but were not limited to, type I diabetes mellitus.</p> <p>A Resident Evaluation, dated 7/11/12, indicated, "Mental Status, Oriented to person/place/time. Medications, Requires complete supervision and administration of all meds."</p> <p>A Service Plan, dated 8/30/12, indicated, "Medications, Staff to adm. meds."</p> <p>A Physician's order, initially dated 3/12/12 and on the October 2012 orders, indicated, "Lantus [insulin], Inject 10u [units] sub-q [subcutaneous injection] every morning." An additional order, dated 1/3/12 and on the October 2012 orders, indicated, "Fasting accuchecks daily."</p> <p>A Medication Administration Record, dated 10/21/12 at 6:00 A.M., indicated the resident's accucheck was 201, and the resident received Lantus 10 units subcutaneously.</p> <p>4. On 11/16/12 at 10:10 A.M., CNA # 1 was interviewed. CNA # 1 indicated she had been called in as extra help</p>						

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	<p>for the CNAs on 10/21/12. CNA # 1 indicated LPN # 1 was "running behind," and asked her to administer the insulin. CNA # 1 indicated, "It was only 3 residents." CNA # 1 indicated LPN # 1 had drawn up the insulin doses, and had each resident's syringe with the insulin in a wrapper with the resident's name on it. CNA # 1 indicated she did the resident's accuchecks and informed the nurse, and then LPN # 1 handed her the filled syringe. When questioned regarding the sliding scale dosages, CNA # 1 indicated she did not know anything about that, that LPN # 1 already had the insulins drawn up. CNA # 1 indicated she had not been officially trained to administer insulin injections, but that she previously had given a family member injections. CNA # 1 indicated the 3 residents she administered insulin to were Residents B, C, and D.</p> <p>5. On 11/16/12 at 9:30 A.M., during interview with the DON and Administrator, the Administrator indicated a CNA had given 3 residents insulin injections, and both the CNA and nurse were "reprimanded."</p> <p>On 11/16/12 at 10:35 A.M., the DON provided an investigation into the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2012
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	<p>incident. The investigation, undated, indicated, "It was reported that a CNA gave 3 residents their insulin shots...Residents involved: [Resident B, Resident C, and Resident D]. Employees involved: [CNA # 1 and LPN # 1]. The nurse drew up the insulin and asked the CNA to give them...When questioning the LPN involved she confirmed that she drew up the insulin and asked the CNA to give the insulin...."</p> <p>This state finding relates to Complaint IN00119127.</p>			