

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00197965.</p> <p>Complaint IN00197965 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225, F226, F312, F314, F323, F371.</p> <p>Unrelated deficiency are cited.</p> <p>Survey dates: April 20, 21, 25, 26, 2016</p> <p>Facility number: 000082 Provider number: 155168 AIM number: 100289640</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 11 Medicaid: 65 Other: 20 Total: 96</p> <p>Sample: 13</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.	
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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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F 0223 SS=D Bldg. 00	<p>Quality review completed by#02748 on May 4, 2016.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview, and record review, the facility failed to prevent staff to resident physical and verbal abuse for 1 of 3 allegations of abuse involving staff to resident abuse reviewed. (Resident D, Resident G, Resident S)</p> <p>Findings include: On 4/21/16 at 9:55 A.M., Resident D was interviewed. Resident D was observed to be in bed, calm with in no apparent</p>	F 0223	<p>F223– Free from abuse/Involuntary seclusion. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Residents D, G and S affected by the alleged deficient practice have been identified by the interdisciplinary team. Residents D,G and S have had their follow up for emotional and psychosocial distress. No negative outcomes were identified. CNA #20 has been</p>	05/20/2016

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	<p>distress. During the interview Resident D indicated last Friday during a bed bath a CNA #20 had pushed her head. Resident D explained she could hold her head up herself during her bed bath. Resident D also indicated the CNA #20 told Resident D not to talk to her during care. Resident D indicated she did not know the CNA's name. Resident D indicated a facility Social Service Staff member and a nurse came to talk to her about the incident. Resident D indicated the CNA #20 was moved to a different floor to work.</p> <p>On 4/21/16 at 10:40 A.M., the Director of Nursing (DON) provided a facility documentation entitled, "Incident Number: 114..." that had been reported to the State Department of Health. The documentation indicated, incident date and time of 4/15/16 at 6:01 A.M. The report indicated, "... 4/15/16 at 2:50 pm, DNS [Director of Nursing Services] was alerted to an incident that occurred at the end of third shift during AM care. Resident G [Resident's first and last initial] stated CNA was rude to her, got in her face and yelled at her. Resident stated she did not report incident until this time as she was out of facility for dialysis Investigation started. Aide suspended pending investigation..." "... Follow up added--4/20/16 Investigation complete. Interviewable residents on the</p>		<p>terminated. All staff educated on abuse and reporting policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> ·All residents have potential to be affected by the alleged deficient practice. ·All staff educated on abuse policy and reporting What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·All staff inserviced on abuse and reporting policy by 05/20/16. ·Weekly and monthly audits done by Executive Director and DNS/Designee ·Monthly Resident Interview Questions related to Abuse by customer care REPS initiated by 05/20/16. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Executive Director/Designee will complete the Abuse-Staff Interview CQI tool weekly times four and then monthly times six. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. ·Executive Director will also track the Resident Interview 		

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	<p>halls were questioned and upon investigation, additional residents had complaints related to the care provided by CNA #20 (last name of CNA in abuse allegation).</p> <p>The Follow Up Incident Report #114-4/20/16 also included, but was not limited to, an interview from Resident D who had indicated, "...the aide was rude and stated 'do not speak to me while I am in here with you' and the aide was a little rough with care. When I asked to be specific... Resident D indicated, 'The aide was a little rough when she raised my head.' Staff was interviewed and an LPN (LPN#18) provided a statement about an event she witnessed. The LPN (LPN #18) indicated the aide took the residents out for a smoke break and when she walked outside to check on them, she witnessed the aide and Resident S (Resident's initials) arguing. The aide stated the resident accused her of taking his cigarettes and she was telling him she did not. The LPN (LPN#18) indicated both, the resident and the aide were 'loud' to each other. This was reported to the DNS [Director of Nursing Service] by the LPN (LPN #18) on the same date as the allegation from Res G (resident's initials). The aide was suspended on 4/15/16 and was brought in to meet with the ED [Executive Director] DNS and ADNS</p>		<p>questions monthly times 6. By what date will the systemic changes be completed? 05/20/2016</p>		

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	<p>[Assistant Director of Nursing] on 4/19/16. Aide CNA #20 [CNA's last name] was terminated at that time for allegations of inconsiderate treatment..."</p> <p>On 4/21/16 at 2:15 P.M., the Executive Director of the facility provided a facility file related to the investigation of Incident Number 114 that had been reported to the Indiana State Department of Health. The file included a form entitled "Employee Communication Form" addressing CNA #20 (CNA's last name) dated 4/15/16. The documentation indicated under the section of "What policy/procedure was violated?" Information handwritten in the section was "... (Verbal Abuse)." Details of the incident : "Residents complained about CNA #20 [CNA's last name] being rough with care & alleged that CNA #20[last name of CNA] yelled at them... "... Upon investigation, further allegations surfaced regarding CNA #20 [CNA's last name] being rough with care and yelling at residents. Statements were provided by residents and/or staff. Yelling & rough care was confirmed by interviews with residents & staff..."</p> <p>Another form (undated) in the facility Incident 114 file included, "Reason For Communication (Check the appropriate box(s) below)." The documentation</p>			

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F 0225 SS=E Bldg. 00	<p>included, but was not limited to, "...Workplace Conduct/Work Performance...The following list is intended to be representative of serious actions and gross misconduct as indicated on page 34-35 of the Facility/Community Employee Handbook that will subject you to immediate discharge..." A checkmark had been placed in front of "Resident Abuse/Inconsiderate Treatment."</p> <p>On 4/26/16 at 10:34 A.M., the Administrator was made aware the facility failed to ensure residents were free of abuse in regard to CNA #20's treatment of yelling and rough care.</p> <p>3.1-27(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged</p>			
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	<p>violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure allegations of staff to resident abuse had been reported to the Administrator for 1 of 3 allegations of abuse reviewed. (Resident D, Resident G, Resident S, Resident Y)</p> <p>Findings include:</p> <p>1. On 4/21/16 at 9:55 A.M., Resident D was interviewed. During the interview Resident D was observed to be in bed in no apparent distress. Resident D indicated last Friday during a bed bath a</p>	F 0225	<p>F225– Investigate/Report Allegations/Individuals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Residents D, G, S, and Y affected by the alleged deficient practice have been identified by the interdisciplinary team. Resident Y no longer resides in the facility. Residents D, G and S have had their follow up for emotional and psychosocial distress. No negative outcomes were identified. CNA #20 has been terminated. All staff</p>	05/20/2016

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	<p>CNA had pushed her head. Resident D explained she could hold her head up herself during her bed bath. Resident D also indicated the CNA told Resident D not to talk to her during care. Resident D indicated she did not know the CNA's name. Resident D indicated a facility Social Service Staff member and a nurse came to talk to her about the incident. Resident D indicated the CNA was moved to a different floor to work.</p> <p>On 4/21/16 at 10:40 A.M., the Director of Nursing (DON) provided a facility documentation entitled, "Incident Number: 114..." that had been reported to the State Department of Health. The documentation indicated, incident date and time of 4/15/16 at 6:01 A.M. The report indicated, "... 4/15/16 at 2:50 pm, DNS [Director of Nursing Services] was alerted to an incident that occurred at the end of third shift during AM care. Resident G [Resident's first and last initial] stated CNA was rude to her, got in her face and yelled at her. Resident stated she did not report incident until this time as she was out of facility for dialysis Investigation started. Aide suspended pending investigation..." "... Follow up added--4/20/16 Investigation complete. Interviewable residents on the halls were questioned and upon investigation, additional residents had</p>		<p>educated on abuse and reporting policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? ·All residents have potential to be affected by the alleged deficient practice. ·All staff educated on abuse policy and reporting What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·All staff inserviced on abuse and reporting policy by 05/20/16. ·Weekly and monthly audits done by Executive Director and DNS/Designee How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·Executive Director/Designee will complete the Abuse-Staff Interview CQI tool weekly times four and then monthly times six. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. By what date will the systemic changes be completed? ·05/20/2016</p>	

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	<p>complaints related to the care provided by CNA # 20 (last name of CNA in abuse allegation).</p> <p>The Follow Up Report of incident #114-4/20/16 also included but was not limited to, an interview from Resident D who had indicated, "... the aide was rude and stated 'do not speak to me while I am in here with you' and the aide was a little rough with care. When I asked to be specific... Resident D indicated, 'The aide was a little rough when she raised my head.' Staff was interviewed and an LPN (LPN #18) provided a statement about an event she witnessed. The LPN (LPN#18) indicated the aide took the residents out for a smoke break and when she walked outside to check on them, she witnessed the aide and resident S (Resident's initials) arguing. The aide stated the resident accused her of taking his cigarettes and she was telling him she did not. The LPN (LPN#18) indicated both, the resident and the aide were 'loud' to each other. This was reported to the DNS [Director of Nursing Service] by the LPN (LPN#18) on the same date as the allegation from Res G (resident's initials). The aide was suspended on 4/15/16 and was brought in to meet with the ED [Executive Director] DNS and ADNS [Assistant Director of Nursing] on 4/19/16. Aide [CNA #20] CNA's [last</p>			

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	<p>name] was terminated at that time for allegations of inconsiderate treatment..."</p> <p>On 4/21/16 at 2:15 P.M., the Executive Director of the facility provided a facility file related to the investigation of Incident Number 114 that had been reported to the Indiana State Department of Health. The file included a form entitled "Employee Communication Form" addressing CNA #20 (CNA's last name) dated 4/15/16. The documentation indicated under the section of "What policy/procedure was violated?..." Information handwritten in the section was (Verbal Abuse)." Details of the incident : "Residents complained about CNA #20 [Last name] being rough with care & alleged that CNA #20 [last name of CNA] yelled at them... "... Upon investigation, further allegations surfaced regarding CNA #20 [CNA's last name] being rough with care and yelling at residents. Statements were provided by residents and/or staff. Yelling & rough care was confirmed by interviews with residents & staff..."</p> <p>On 4/25/16 at 11:35 A.M., the Director of Nurses (DON) was interviewed regarding the Incident 114/allegation of abuse and the facility investigation of the allegation. The DON was made aware the facility investigation file also</p>			

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	<p>contained an "Employee Communication Form" in regard to CNA #20. The documentation listed the dates of 3/16/16 and 3/17/17 (sic). The form included, but was not limited to, "... 1) Points of care compliance not completed for multiple shifts despite being requested to do so by nurse. 2) Poor quality of care. Ice not passed timely, tasks not being done timely despite request of nurse 3) Verbal threatening of a resident..." The Employee Communication Form (3/16/16, 3/17/16) had been signed on 3/21/16 by CNA # 20, DON, the Administrator, and a witness.</p> <p>On 4/25/16 at 11:55 A.M., the written statement from the 4/15/16 allegation investigation from LPN #18 regarding CNA #20 was reviewed with the DON. The statement included, "On or about April 11 th CNA #20 [CNA's name] was outside with the smokers. Resident S [resident's name] became upset over missing a pack of cigarettes. CNA called and stated that she needed help she was getting cussed out. When arrived at smoking area CNA was & resident were both yelling at each other. I separated them and asked CNA to calm down and not be yelling at me. I was trying to help her. Explained that the more she yelled the more the resident was yelling to please calm down and stop it. Finally she</p>			

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	<p>calmed down and so did the resident."</p> <p>2. The DON during interview on 4/25/16 at 11:35 A.M., indicated she completed the Employee Communication form for 3/16/16, 3/17/17 (sic) on CNA # 20 from documentation dated 3/17/16 from LPN #19. The report from LPN #19 indicated CNA #20 wasn't getting her assigned work done and had told Resident Y that "... she best not lie to the nurse & say the CNA didn't want to put her bed (sic)..." The DON indicated she had talked to Resident Y and the resident was unable to remember exactly what had happened. The DON was made aware, at that time, that a verbal threat to a resident was an allegation of abuse and should have been reported to the state agency.</p> <p>On 4/25/16 at 11:55 A.M., the DON was made aware at that time, LPN #18 should have reported the above yelling allegation on 4/11/16 immediately to the Administrator. The DON agreed the allegation should have been reported . The DON indicated the facility had then provided a facility wide inservice regarding abuse and the reporting of abuse.</p> <p>On 4/25/16 at 12:23 P.M., the Administrator was made aware of a verbal threat from a CNA to a resident in</p>			

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F 0226 SS=E Bldg. 00	<p>a nursing report dated 3/17/16 had not been reported to the state agency . The Administrator was also made aware an incident of verbal yelling to a resident by a CNA on 4/11/16 had not been reported to the facility/administrator until an investigation on 4/15/16. The Administrator agreed these allegations should have been reported.</p> <p>The facility abuse policy entitled, ABUSE PROHIBITION, REPORTING, AND INVESTIGATION POLICY AND PROCEDURE (revised July 2015) was reviewed on 4/25/16 at 8:58 A.M. The policy included but was not limited to, "...POLICY/PROCEDURE: ...5. All abuse allegations/abuse must be reported to the Executive director [sic] immediately ..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview and record review, the facility failed to ensure</p>	F 0226	F226– Develop /Implement Abuse/Neglect policies What	05/20/2016

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>the facility abuse policy was followed in regard to reporting allegations of abuse to the Administrator of the facility and to the State Department of Health for 1 of 3 allegations of abuse reviewed. (Resident D, Resident G, Resident S, Resident Y)</p> <p>Findings include:</p> <p>1. On 4/21/16 at 9:55 A.M., Resident D was interviewed. Resident D was observed to be in bed in no apparent distress. Resident D indicated last Friday during a bed bath a CNA had pushed her head. Resident D explained she could hold her head up herself during her bed bath. Resident D also indicated the CNA told Resident D not to talk to her during care. Resident D indicated she did not know the CNA's name. Resident D indicated a facility Social Service Staff member and a nurse came to talk to her about the incident. Resident D indicated the CNA was moved to a different floor to work.</p> <p>On 4/21/16 at 10:40 A.M., the Director of Nursing (DON) provided a facility documentation entitled, "Incident Number: 114..." that had been reported to the State Department of Health. The documentation indicated, incident date and time of 4/15/16 at 6:01 A.M. The report indicated, "... 4/15/16 at 2:50 pm,</p>		<p>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Residents D, G, S, and Y affected by the alleged deficient practice have been identified by the interdisciplinary team. Resident Y no longer resides in the facility. Residents D, G and S have had their follow up for emotional and psychosocial distress. No negative outcomes were identified. CNA #20 has been terminated. All staff educated on abuse and reporting policy. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> ·All residents have potential to be affected by the alleged deficient practice. ·All staff educated on abuse policy and reporting. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·All staff inserviced on abuse and reporting policy by 05/20/16. ·Executive Director and DNS inserviced on ISDH incident reporting policy by 05/20/16. ·Weekly and monthly audits done by Executive Director and DNS/Designee. How the corrective action(s) will be maintained to ensure the deficient 	

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	<p>DNS [Director of Nursing Services] was alerted to an incident that occurred at the end of third shift during AM care. Resident G [Resident's first and last initial] stated CNA was rude to her, got in her face and yelled at her. Resident stated she did not report incident until this time as she was out of facility for dialysis Investigation started. Aide suspended pending investigation..." "... Follow up added--4/20/16 Investigation complete. Interviewable residents on the halls were questioned and upon investigation, additional residents had complaints related to the care provided by CNA # 20 (last name of CNA in abuse allegation).</p> <p>The Follow Up Report for Incident #114-4/20/16 also included but was no limited to, an interview from Resident D who had indicated, "... the aide was rude and stated 'do not speak to me while I am in here with you' and the aide was a little rough with care. When I asked to be specific... Resident D indicated,'The aide was a little rough when she raised my head.' Staff was interviewed and an LPN (LPN#18) provided a statement about an event she witnessed. The LPN (LPN#8) indicated the aide took the residents out for a smoke break and when she walked outside to check on them, she witnessed the aide and resident (Resident's initials)</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Executive Director/Designee will complete the Abuse Prohibition and Investigation CQI tool weekly times four and then monthly times six. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changes be completed?</p> <p>·05/20/2016</p>		

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	<p>arguing. The aide stated the resident accused her of taking his cigarettes and she was telling him she did not. The LPN (LPN #18) indicated both, the resident and the aide were 'loud' to each other. This was reported to the DNS [Director of Nursing Service] by the LPN on the same date as the allegation from Res #1 (MD). The aide was suspended on 4/15/16 and was brought in to meet with the ED [Executive Director] DNS and ADNS [Assistant Director of Nursing] on 4/19/16. Aide [CNA #20] [last name] was terminated at that time for allegations of inconsiderate treatment..."</p> <p>On 4/21/16 at 2:15 P.M., the Executive Director of the facility provided a facility file related to the investigation of Incident Number 114 that had been reported to the Indiana State Department of Health. The file included a form entitled "Employee Communication Form" addressing CNA # 20 dated 4/15/16. The documentation indicated under the section of "What policy/procedure was violated?..." Information handwritten in the section was...(Verbal Abuse)." Details of the incident : "Residents complained about CNA #20[CNA's last name] being rough with care & alleged that CNA #20 [CNA's last name] yelled at them... "...</p>			

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	<p>Upon investigation, further allegations surfaced regarding CNA #20 [CNA's last name] being rough with care and yelling at residents. Statements were provided by residents and/or staff. Yelling & rough care was confirmed by interviews with residents & staff..."</p> <p>On 4/25/16 at 11:55 A.M., the written statement from the 4/15/16 allegation investigation from LPN #18 regarding CNA #20 was reviewed with the DON. The statement included, "On or about April 11 th CNA #20 [CNA's name] was outside with the smokers. Resident S [resident's name] became upset over missing a pack of cigarettes. CNA called and stated that she needed help she was getting cussed out. When arrived at smoking area CNA was & resident were both yelling at each other. I separated them and asked CNA to calm down and not be yelling at me. I was trying to help her. Explained that the more she yelled the more the resident was yelling to please calm down and stop it. Finally she calmed down and so did the resident."</p> <p>2. On 4/25/16 at 11:35 A.M., the Director of Nurses (DON) was interviewed regarding the Incident 114/allegation of abuse and the facility investigation of the allegation. The DON was made aware</p>			

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	<p>the facility investigation file also contained an "Employee Communication Form" in regard to CNA #20. The documentation listed the dates of 3/16/16 and 3/17/17 (sic). The form included, but was not limited to, "... 1) Points of care compliance not completed for multiple shifts despite being requested to do so by nurse. 2) Poor quality of care. Ice not passed timely, tasks not being done timely despite request of nurse 3) Verbal threatening of a resident..." The Employee Communication Form for 3/16/16, 3/17/17 (sic) had been signed on 3/21/16 by CNA # 20, DON, the Administrator, and a witness.</p> <p>The DON during interview on 4/25/16 at 11:35 A.M., indicated she completed the Employee Communication form (3/16/16, 3/17/17 (sic) on CNA # 20 from documentation dated 3/17/16 from LPN #19. The report from LPN #19 indicated CNA #20 wasn't getting her assigned work done and had told a Resident Y that "... she best not lie to the nurse & say the CNA didn't want to put her bed (sic)..." The DON indicated she had talked to Resident Y and the resident was unable to remember exactly what had happened. The DON was made aware, at that time, that a verbal threat to a resident was an allegation of abuse and should have been reported to the state</p>			

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	<p>agency.</p> <p>On 4/25/16 at 11:55 A.M., the DON was made aware at that time, LPN #18 should have reported the above yelling allegation on 4/11/16 immediately to the Administrator. The DON agreed the allegation should have been reported on 4/11/16. The DON indicated the facility had then provided a facility wide inservice regarding abuse and the reporting of abuse.</p> <p>On 4/25/16 at 12:23 P.M., the Administrator was made aware of a verbal threat from a CNA to a resident in a nursing report dated 3/17/17 (sic) had not been reported to the state agency. The Administrator was made aware an incident of verbal yelling at a resident by a CNA on 4/11/16 had not been reported to the facility/Administrator until an investigation on 4/15/16. The Administrator agreed these allegations should have been reported.</p> <p>On 4/26/16 at 10:34 A.M., the Administrator was made aware the facility abuse policy had not been followed in regard to the above allegations of abuse not being reported immediately to the Administrator and the State Department of Health.</p>			

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F 0312 SS=D Bldg. 00	<p>The facility abuse policy entitled, ABUSE PROHIBITION, REPORTING, AND INVESTIGATION POLICY AND PROCEDURE (revised July 2015) was reviewed on 4/25/16 at 8:58 A.M. The policy included but was not limited to, "...POLICY/PROCEDURE: ...5. All abuse allegations/abuse must be reported to the Executive director [sic] immediately ..." "... 7. The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, neglect, misappropriation of property and injuries of unknown origin immediately, to the Long Term Care Division of the Indiana State Department of Health..."</p> <p>3.1-28(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents received effective incontinence care for 2 of 3 residents who met the</p>	F 0312	F312- ADL care provided for dependent resident What corrective action(s) will be accomplished for those residents found to have been	05/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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	<p>criteria for review of incontinence care. (Resident E, Resident F, Resident Q)</p> <p>Findings include:</p> <p>1. On 4/20/16 at 6:20 P.M., during initial tour, Resident E was observed to be sitting in a padded geri-chair in the 2nd floor common lounge. Resident E was observed to have a strong odor of urine.</p> <p>During an interview on 4/20/16 at 6:40 P.M., during initial tour, LPN #10 indicated Resident E was not interviewable, required staff assistance for transfers and bed mobility, and was incontinent of bladder.</p> <p>On 4/20/16 at 7:10 P.M., Resident E was observed to be sitting in a padded geri-chair in the 2nd floor common lounge. Resident E was observed to have a strong odor of urine.</p> <p>On 4/20/16 at 8:20 P.M., Resident E was observed to be sitting in a padded geri-chair in the 2nd floor common lounge. Resident E was observed to have a strong odor of urine.</p> <p>On 4/21/16 at 9:55 A.M., Resident E was observed in an activity, sitting in a padded geri-chair in the 2nd floor common lounge. Resident E was</p>		<p>affected by the deficientpractice?</p> <ul style="list-style-type: none"> ·There is not a Resident Q identified in the finding. Residents E and F, affected by the alleged deficient practice have been identified by the interdisciplinary team and are provided with proper incontinent care. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> ·All residents dependent for incontinent care have potential to be affected by the alleged deficient practice. ·Audit will be completed by 5/20/16 to identify all residents requiring incontinent care. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·All Clinical staff inserviced on incontinent care protocol by 5/20/16. ·All Clinical staff will complete incontinent care skills validation with DNS/ADNS/Unit Managers/CEC/Designee by 05/20/2016. <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/ADNS/Designee will complete the Bladder Program CQI tool weekly times four and 	

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	<p>observed to have a strong odor of urine.</p> <p>During an observation on 4/21/16 at 11:30 A.M., CNA #11 was observed to transport Resident E from the common lounge to the dining room. During an interview, at that time, CNA #11 indicated Resident E was being taken to the dining room for lunch.</p> <p>During an interview on 4/21/16 at 11:35 A.M. CNA #5 indicated Resident E had been gotten up by night shift staff and was in the padded geri-chair upon her arrival to the unit at 6:30 A.M. CNA #5 further indicated Resident E would be transferred to bed and provided incontinence care after lunch.</p> <p>On 4/21/16 at 12:30 P.M. Resident E was observed sitting in a padded geri-chair in the 2nd floor dining room. Resident E was observed to have a strong odor of urine.</p> <p>On 4/21/16 at 12:40 P.M., Resident E was observed lying in bed without a strong odor of urine. During an interview, at that time, CNA #11 indicated Resident E had just been transferred from the geri-chair to the bed and incontinence care had been provided. (6 hours 10 minutes)</p>		<p>then monthly times six. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changes be completed? 05/20/2016</p>	

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	<p>The clinical record of Resident E was reviewed on 4/21/16 at 1:38 P.M. The record indicated the diagnoses of Resident E included, but were not limited to, dementia.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 12/25/15 indicated Resident E experienced moderate cognitive impairment, required the extensive assistance of two staff for bed mobility, required the total assistance of two staff for transfers, was not on a toileting program, and was always incontinent of urine.</p> <p>The most recent Quarterly MDS dated 2/27/16 indicated Resident E experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility and transfers, was not on a toileting program, and was always incontinent of urine.</p> <p>A Care Plan dated 11/5/15 for "Resident is incontinent due to: weakness and decreased cognition" included, but was not limited to, interventions of, "...assist with incontinent care as needed, check every 2 hours for incontinence..."</p> <p>During an interview on 4/21/16 at 2:00 P.M., the DON (Director of Nursing) indicated Resident E should have been</p>			

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	<p>checked for incontinence every 2 hours and changed if necessary.</p> <p>2. On 4/20/16 at 6:45 P.M., during initial tour, Resident F was observed lying in bed with the head of bed elevated. Resident F was observed to have a strong BM (bowel movement) odor.</p> <p>During an interview on 4/20/16 at 6:56 P.M., during initial tour, LPN #10 indicated Resident F was not interviewable, required staff assistance for transfers and bed mobility, and was incontinent of bowel.</p> <p>On 4/21/16 at 9:55 A.M., Resident F was observed in an activity, sitting in a wheelchair in the 2nd floor common lounge. Resident F was observed to have a strong BM odor.</p> <p>During an observation of care on 4/21/16 at 10:30 A.M., Resident F was observed lying in bed in a right-sided position. CNA #5 and CNA #6 were observed to remove an incontinence brief and indicated Resident F had been incontinent of BM. CNA #5 was observed to wipe a moderate amount of BM from the peri-anal area. A dried ring of BM was observed on the bilateral buttocks of Resident F. CNA #5 indicated, at that time, Resident F had</p>			

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	<p>been gotten up by night shift staff and was in a wheelchair upon her arrival to the unit at 6:30 A.M. CNA #5 further indicated, at that time, Resident F had been checked at 9:15 A.M. and was continent of BM.</p> <p>The clinical record of Resident F was reviewed on 4/21/16 at 11:00 A.M. The record indicated the diagnoses of Resident F included, but were not limited to, dementia.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 11/4/15 indicated Resident F experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility, was not on a toileting program, and was always incontinent of BM.</p> <p>A Significant change MDS assessment dated 2/16/16 indicated Resident F experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility, was not on a toileting program, and was always incontinent of BM.</p> <p>A Resident Profile provided by the DON (Director of Nursing) on 4/20/16 at 8:00 P.M. indicated Resident F should be checked for incontinence every two hours.</p>			

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F 0314 SS=G Bldg. 00	<p>An "11-7 [night shift] Get Up List" provided by UM [Unit Manager] #1 on 4/21/16 at 11:45 A.M. indicated Resident E and Resident F were to be gotten up by night shift.</p> <p>A Policy and Procedure for "Bladder Program" provided by the DON on 4/26/16 at 11:20 A.M. indicated, "...if a resident is totally incontinent and unable to be placed on a toilet or bed pan resident should be checked and changed every two hours..."</p> <p>3.1-38(a)(3)(c)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident without pressure ulcers, developed pressure ulcers for 3 of 5 who met the criteria for review of pressure ulcers. This deficient practice resulted in</p>	F 0314	F314-Treatment/Services to prevent/heal pressure sores What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	05/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
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	<p>Resident F experiencing Stage 3 wounds to the coccyx, left buttock, and right buttock, Resident Q experiencing a Stage 3 wound to the coccyx, and Resident Z experiencing a Stage 3 wound to the left heel. (Resident F, Resident Q, Resident Z)</p> <p>Findings include:</p> <p>1. On 4/20/16 at 6:45 P.M., Resident F was observed lying in bed on his/her back with the head of bed raised.</p> <p>During an interview on 4/20/16 at 6:56 P.M., LPN #10 indicated Resident F was not interviewable, required staff assistance for bed mobility, was incontinent of bowel, and experienced a small area of pressure on the coccyx.</p> <p>A Resident Profile provided by the DON (Director of Nursing) on 4/20/16 at 8:00 P.M., indicated pressure interventions of, "...assist as needed to turn and reposition at least every 2 hours, preventative treatment as ordered..." The Profile lacked any documentation to indicate Resident F experienced pressure related skin impairment to the coccyx, left buttock, and right buttock and lacked any documentation to indicate Resident F had a pressure reducing mattress.</p>		<p>·Residents F, Q and Z, affected by the alleged deficient practice, have been identified by the interdisciplinary team. Resident Q no longer resides in the facility. Residents F and Z are provided with proper wound care and dressing changes and have clinically indicated interventions in place to prevent new or worsening areas of skin breakdown.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>·All dependent residents have potential to be affected by the alleged deficient practice.</p> <p>·Audit will be completed by 5/20/16 to identify all residents at risk for new or worsening skin areas. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>·All Clinical staff inserviced on skin management protocol by 5/20/16</p> <p>·Wound Care Nurse will register for enrollment in an ASC wound care course by 05/20/16.</p> <p>·IDT will meet weekly and as indicated for a Wound meeting to ensure appropriate interventions are in place, care plans and resident profiles are updated for all identified residents. This process will be ongoing</p> <p>How the corrective action(s) will</p>		

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	<p>During an observation of care on 4/21/16 at 10:25 A.M., CNA #5 and CNA #6 were observed to reposition Resident F to a right side-lying position and remove an incontinence brief. Resident F was observed to not have any dressings on the coccyx or bilateral buttocks and to have wounds with white slough on the coccyx, left buttock, and right buttock. RN #9 was observed to enter the room of at 10:45 A.M. and indicated she was going to provide wound care to Resident F. At that time, RN #9 indicated Resident F experienced facility acquired wounds on the coccyx, left buttock, and right buttock and further indicated the following:</p> <p>Wound #1 (coccyx) measured 1.0 cm (centimeter) L (length) X (by) 1.7 cm W (width) X < (less than) 0.1 cm D (depth) and the wound bed contained 97% white slough.</p> <p>Wound #2 (left buttock) measured 4.2 cm L X 1.5 cm W X undetermined D and the wound bed contained 98% white slough.</p> <p>Wound #3 (right buttock) measured 3.0 cm L X 1.0 cm W X undetermined D and the wound bed contained 97% slough.</p> <p>The clinical record of Resident F was reviewed on 4/21/16 at 11:00 A.M. The record indicated the diagnoses of</p>		<p>be maintained to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?</p> <p>·DNS/ADNS/Designee will complete the Skin Management Program tool weekly times four and then monthly times six. The results of these auditswill be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changesbe completed?</p> <p>·05/20/2016</p>	

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	<p>Resident F included, but were not limited to, muscle weakness and dementia.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 11/4/15 indicated Resident F experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility, was at risk to develop pressure, and experienced no skin impairment.</p> <p>A Significant Change MDS assessment dated 2/16/16 indicated Resident F experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility, was at risk to develop pressure, and experienced no skin impairment.</p> <p>The most recent care plan dated 4/13/16 lacked any documentation to indicate Resident F experienced actual skin impairment to the coccyx, left buttock, and right buttock.</p> <p>The clinical record lacked any documentation to indicate Resident F was thoroughly assessed for the risk of pressure ulcer development.</p> <p>The April 2015 Physician's Order Recap included, but was not limited to, an order for, "Remedy Nutrashield [a skin protection cream]...apply to bilateral</p>			

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	<p>buttocks, coccyx...every shift..." The recap lacked any documentation related to a dressing to the wounds on the coccyx, left buttock, or right buttock.</p> <p>A Weekly Nursing Summary dated 4/11/16 at 6:42 A.M., indicated Resident F did not experience skin impairment to the coccyx, left buttock, or right buttock. The Summary lacked any documentation to indicate Resident F was thoroughly assessed for pressure ulcer development risk and lacked any documentation to indicate pressure ulcer prevention interventions were implemented.</p> <p>Wound #1: A New Skin Event assessment dated 4/16/16 at 4:10 A.M. indicated, "...coccyx...1 x 1 x 0.5 [sic]...open area...pink..." The assessment lacked any documentation to indicate an immediate, new pressure relieving intervention was implemented.</p> <p>A Non-Pressure Wound Skin Evaluation Report dated 4/18/16 at 2:06 P.M. indicated, "...coccyx...moisture associated skin damage...partial thickness wound...1 x 1.5 x < [less than] 0.1[sic]...wound color white with pink..."</p> <p>A Non-Pressure Wound Skin Evaluation Report dated 4/20/16 at 1:26 P.M. indicated, "...coccyx...moisture associated</p>			

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	<p>skin damage...partial thickness wound...1 x 1.5 x<0.1 [sic]...wound color pink red..."</p> <p>Wound #2</p> <p>The Nursing notes from 4/16/16 were reviewed and lacked any documentation to indicate Resident F experienced skin impairment on the left buttock.</p> <p>A Non-Pressure Wound Skin Evaluation Report dated 4/18/16 at 2:07 P.M. indicated, "...originally noted 4/16/16...left buttock...moisture associated skin damage...partial thickness wound...3 x 1.0 x < 0.1...wound color pink/flesh tone..."</p> <p>A Non-Pressure Wound Skin Evaluation Report dated 4/20/16 at 1:24 P.M. indicated, "...left buttocks...moisture associated skin damage...partial thickness wound...2.8 x 1.2 x<0.1 [sic]...wound color pink/red..."</p> <p>Wound #3</p> <p>The Nursing notes from 4/16/16 were reviewed and lacked any documentation to indicate Resident F experienced skin impairment on the right buttock.</p> <p>A Non-Pressure Wound Skin Evaluation</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>Report dated 4/18/16 at 2:09 P.M. indicated, "originally noted 4/16/16...right buttock...moisture associated skin damage...partial thickness wound...1 x 0.8 x < 0.1...wound color pink..."</p> <p>A Physician's Telephone Order dated 4/20/16 at 3:28 P.M., indicated a new order was received for "Cleanse coccyx and buttocks with wound cleanser pat dry. Apply Exuderm (a hydrocolloid wound dressing) q [every] 3 days..."</p> <p>During an interview on 4/21/16 at 11:30 A.M., the WCN (Wound Care Nurse) indicated Resident F did not experience pressure related wounds to the coccyx, left buttock, and right buttock. The WCN further stated Resident F experienced, "...moisture associated damage to the to the buttocks and center of buttocks due to incontinence, significant decline, poor nutrition, and not getting up like...used to" The WCN further indicated all 3 areas of skin impairment were facility acquired, discovered as "pinkish red diaper rash" on 4/16/16, and were not pressure-related because the wounds were located "in the buttocks". The WCN then indicated skin assessments were completed weekly, skin sweeps were completed monthly, but no assessments were done related to a</p>			

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	<p>resident's risk to develop pressure ulcers. The WCN then indicated all residents were at risk to develop pressure ulcers and a new pressure ulcer prevention interventions were implemented if a resident developed a Stage 2 wound.</p> <p>A Pressure Wound Report provided by the WCN on 4/21/16 at 11:45 A.M. indicated, "Stages of pressure wounds/definitions...Stage II-Partial thickness loss of skin layers that present clinically as an abrasion, blister or shallow crater. Stage III-Full thickness of skin is lost, exposing the subcutaneous tissue-presents as a deep crater with/without undermining tissue..."</p> <p>During an interview on 4/21/16 at 2:00 P.M. the DON indicated residents were not assessed for their risk to develop pressure ulcers because all residents were at risk to develop pressure ulcers and every resident received a pressure reducing mattress upon admission to the facility. The DON further indicated the ulcers on the coccyx, left buttock, and right buttock were moisture associated skin damage and not pressure related.</p> <p>A Policy and Procedure for Skin Management Program provided by 4/21/16 at 2:30 P.M., lacked any documentation related to pressure ulcer</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>prevention or pressure ulcer staging.</p> <p>A Policy and Procedure for Pressure Ulcer Prevention and Pressure Ulcer Staging was requested of the DON (Director of Nursing) on 4/21/16 at 2:30 P.M. and was not provided as of 4/26/16 at 9:00 A.M.</p> <p>During an interview on 4/26/16 at 9:30 A.M., the HFA (Health Facilities Administrator) indicated the facility did not have specific policies for Pressure Ulcer Prevention and Pressure Ulcer Staging.</p> <p>2. The clinical record for Resident Q was reviewed on 4/21/16 at 1:10 P.M. The diagnoses included, but were not limited to, Diabetes Mellitus, Multiple Sclerosis, and Paraplegia of the lower extremities.</p> <p>An Admission assessment dated 3/17/16 indicated Resident Q was alert and oriented, and is unable to move from a seated to standing position, turn, and perform surface to surface transfers. The assessment further indicated Resident Q was admitted with a condom catheter (an external catheter) is incontinent of bowel and bladder function. The Admission assessment indicated Resident Q had no skin impairment when he was admitted to the facility, but has a history of pressure ulcers.</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>A New Skin Event form dated 3/24/16 included, "...3/24/16...Wound/Area present on admission No...6 x 4.6 x 0.1...open area...Wound /Area color bright red...LEFT BUTTOCK...Wound/Area appearance Red/Warm/Hot around the wound/area..."</p> <p>An IDT Weekly Update Skin Event form dated 3/30/16 included "....New area...Wound present on admission No...Stage II...Most Severe tissue type granulation... right buttock bottom...Describe measurements 1.8 x 1.2 x <0.1..."</p> <p>An IDT Weekly Update Skin Event form dated 3/30/16 included "...New Area...Wound present on admission No... Stage II...Most Sever Tissue type Granulation...Site Right top buttock..2.3 x 1.5 x <0.1 [centimeters]</p> <p>An IDT note dated 3/30/16 included, ...Resident noted to have three Stage II areas to bilateral buttock, two on the right and one on the left...Current treatment is to apply Venalex [a skin protectant ointment] to buttock q [every] shift and cover with dry dressing...Resident is incontinent of bowel and bladder and has a Foley catheter at this time...Resident has Roho overlay [A pressure reducing</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129			
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	<p>overlay] to bed and cushion to wheel chair..."</p> <p>A New Skin Event dated 4/3/16 included, "...right heel.... Wound/Area present on admission No...3.0 x 4.0 x U [undetermined]... Wound/Area type blister... Wound/Area color White Waxy..."</p> <p>A New Skin Event dated 4/3/16 included, "...left heel.... Wound/Area present on admission No...3.0 x 4.0 x U [undetermined]... Wound/Area type blister... Wound/Area color White Waxy..."</p> <p>An IDT note dated 4/6/16 included "Resident noted to have three worsening Stage II areas to bil [bilateral] buttock two on the right and one on the left, resident also has new Stage II areas to bilateral heels. Current treatment is to apply santyl [sic] [a debridment agent] to buttock, cover with fluffed gauze, then cover with Abd [an absorbent dressing] pad q shift. Treatment to heels is to cleans areas with wound cleanser, pat dry. Then apply Silvadene [an antimicrobial ointment used for burns] and wrap with kerlix. Buttocks wound contains approximately 25% yellow slough... Resident is incontinent of bowel and bladder and has a catheter at this</p>						

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>time..."</p> <p>National Pressure Ulcer Advisory Panal (NPUAP), Pressure Ulcer Treatment Quick Referance guide dated 2009, define a Stage II pressure ulcer as a "Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister."</p> <p>The NPUAP further defines a Stage III pressure ulcer as a "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling."</p> <p>A IDT Weekly Update Skin Events form included, but was not limited to, "... Existing area...Stage II, Most Severe tissue type Slough (yellow or white tissue adhering to ulcer bed)...Site RIGHT TOP BUTOTOCK [sic]...measurements 2.3 x 1.5 x <0.1....Describe wound drainage YELLOW SLOUGH....Current treatment cleanse area to buttock pat dry and apply nickel thick layer of santyl only to open area on buttock cover with fluffed gauze then cover with ABD dressing indications :area on buttock..."</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>A IDT Weekly Update Skin Events form included, but was not limited to, "... Existing area...Stage II, Slough (yellow or white tissue adhering to ulcer bed)...Site RIGHT TOP BUTOOCK [sic]...measurements 1.8 x 1.2 x <0.1....Describe wound drainage YELLOW SLOUGH....Current treatment cleanse area to buttock pat dry and apply nickel thick layer of santyl only to open area on buttock cover with fluffed gauze then cover with ABD dressing indications :area on buttock..."</p> <p>A IDT Weekly Update Skin Events form included, but was not limited to, "... Existing area...Stage II, Slough (yellow or white tissue adhering to ulcer bed)...Site RIGHT TOP BUTOOCK [sic]...measurements 7.6 x 5.3 x <0.1....Describe wound drainage YELLOW SLOUGH....Current treatment cleanse area to buttock pat dry and apply nickel thick layer of santyl only to open area on buttock cover with fluffed gauze then cover with ABD dressing indications :area on buttock..."</p> <p>An IDT Weekly Update Skin Event dated 4/3/16 included, but was not limited to, "...Existing area...Stage II...Most severe tissue type granulation...Site RIGHT HEEL...measurements 3.0 x 4.0 x < 0.1</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>....Current treatment CLEANSE AREA TO BILATERAL HEELS PAT DRY AND APPLY SILADENE [sic] TO BOTH HEELS AND WRAP WITH KERLIX Q SHIFT..."</p> <p>An IDT Weekly Update Skin Event dated 4/3/16 included, but was not limited to, "...Existing area...Stage II...Most severe tissue type epithelial...Site LEFT HEEL...measurements 3.0 x 4.0 x < 0.1</p> <p>....Current treatment CLEANSE AREA TO BILATERAL HEELS PAT DRY AND APPLY SILADENE [sic] TO BOTH HEELS AND WRAP WITH KERLIX Q SHIFT...</p> <p>A IDT Weekly Update Skin Events form dated 4/13/16 included, but was not limited to, "... Existing area...Stage II, most severe tissue type granulation...Site BUTTOCK [sic]...measurements 9 x 6 x 1.5....Describe wound drainage YELLOW SLOUGH....Current treatment DAKINS [a disinfecting/debridment agent]..."</p> <p>An IDT note dated 4/13/16 included, "...Unstagable area to buttock which had previously identified as two separate areas...Current treatment changed to soak gauze in Dakins solution, loosely pack wound and then cover with ABD dressing q shift....Buttock wound</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>contains approximately 20% yellow slouth [sic]....Resident is incontinent of bowel and bladder...FMH Wound center appointment scheduled...."</p> <p>During an interview with the WCN (Wound care nurse) on 4/25/16 at 11:10 A.M., she indicated Resident Q entered the facility on 3/17/16 with no areas of skin impairment. She indicated Resident Q was on was at risk to develop pressure because of this incontinence of bowel and bladder and immobility related to paraplegia and multiple sclerosis. She indicated on 3/34/26 a stage 2 pressure ulcer was observed on on Resident Q's left buttock that was treated with a barrier cream. The WCN further indicated on 3/30/16 Resident Q had developed the two new stage 2 pressure ulcers to his right buttock that were treated with a barrier cream as well. She indicated on 4/13/16 the 3 pressure areas were combined into one large pressure ulcer as the tissue separating them had broken down. The WCN indicated Resident Q did not resist care. The WCN indicated she was unaware why Santyl [a debridment agent] was used on the Stage 2 pressure ulcers on Resident Q.</p> <p>The care plans were reviewed and included, but were not limited to:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>A care plan for ADL Functional/Rehabilitation dated 3/18/16. The interventions included, Resident to have 2 1/2 side rails. AM Cares including bathing, dressing oral care, hair care.</p> <p>A care plan for incontinence dated 3/31/16. The interventions included, but were not limited to, assessed and monitor skin condition weekly and PRN, assist with elimination, assist with incontinence care as needed, and check regularly for incontinence.</p> <p>A care plan for an indwelling Foley catheter dated 3/31/16. The interventions included, change catheter per MD order, do not allow tubing or any part of drainage system to touch floor, help resident choose new clothing that will not constrict catheter system.</p> <p>A care plan for impaired mobility dated 3/31/16. The interventions include, assess and document skin condition weekly and as needed, assist with incontinence care as needed, encourage resident to participate in transfers and bed mobility, notify therapy, side rail as enabler to promote independence, turn and reposition regularly.</p> <p>A care plan for self care deficit dated 3/31/16. The interventions included,</p>			

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	<p>encourage resident to do as much for self as possible, incontinent care as needed.</p> <p>A care plan for impaired skin integrity dated 3/30/16 related to "Unstagnable to left and right buttock now merged (prev was 1 area to left buttock and 2 areas to right buttock)..." interventions included, but was not limited to, FMH wound care clinic apt per order (4/13/16), Incontinence care as needed with peri wash and moisture barrier (3/30/16), Stage IV (4) air mattress on bed (3/30/16), treatment as ordered (3/30/16), Turn and reposition regularly (3/30/16).</p> <p>During an interview with the DNS on 4/26/16 at 9:25 A.M., she indicated Resident Q was incontinent of bowel and bladder when he entered the facility and utilized a condom catheter (external catheter) by choice. The DNS indicated Resident Q did not refuse care but was very conscientious of they way he was turned as he had a fear of falling. She indicated while Resident Q had an order for Cloraseptine (a skin protectat) starting on 3/18/16 . The DNS further indicated when Resident Q was up doing therapy the and condom catheter would leak and his skin would become exposed for long periods of time so she did not believe his skin impairments were not pressure but a result of Resident Q sitting in urine when</p>			

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	<p>the condom catheter would leak.</p> <p>3. On 4/20/16 at 6:40 P.M., Resident Z was observed to be sitting up in a wheel chair in the memory care dining room wearing boots on her feet. The MCF (Memory Care Facilitator) indicated Resident Z had developed 2 unstagable areas to her heels. The MCF indicated the area on Resident Z's left heel had formed 1st and then an area on her Right heel had formed later from her heels rubbing on the floor when she was pushed or propelled herself.</p> <p>On 4/21/16 Resident Z was observed to be propelled by by CNA #26 to her room, during the observation Resident Z's feet and boots were observed to be rubbing on the floor as she was pushed. The heel area in the boots was observed to be open.</p> <p>The clinical record for Resident Z was reviewed on 4/21/16 at 10:15 A.M., diagnoses included, but were not limited to depression, hypertension, and dementia.</p> <p>A New Skin Event form dated 1/8/16 at 6:15 P.M. indicated a 1.4 cm (centimeters) by 1.2 cm, red and purple blood blister was found on Resident Z's left heel. The treatment put into place</p>			

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	<p>was to monitor area.</p> <p>An IDT (Interdisciplinary Team) note dated 1/13/16 included "Resident is noted with stage II to left heel 1.4 x [by] x 1.2. x 0. Wound is the result of improper fitting shoes. treatment is granule heel q [every] shift.</p> <p>An IDT Weekly Update Skin Event dated 2/24/16 included "...Existing area...left heel...Unstagable...Most severe tissue type...Necrotic/eschar (Black, brown or tan tissue adheres to wound bed)...describe wound color black</p> <p>An IDT not dated 3/2/16 included "Resident is noted with unstable area to left heel...Resident continues not wearing shoes and but [sic] wearing non skid socks...".</p> <p>A New Skin Event dated 3/24/16 included "...3/24/16...right heel blister 1.7 cm x 2 cm.... blood filled blister... Wound/Area color...red/yellow clear...". The new order put into place was Venelex ointment to right heel blister, apply a non adherent pad and wrap with kerlix (gauze roll).</p> <p>An IDT note dated 3/30/16 included "Resident is noted with a healing unstagable to left heel and a new Stage II</p>			

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	<p>to the right heel....current treatment is Venelex to heels and cover with a non adherent pad..."</p> <p>An IDT Weekly Update Skin Event dated 4/8/16 included "...Existing area...Unstageable...Right Heel measuring 1.0 x 1.0 x 0cm...Describe wound color Black.</p> <p>An IDT note dated 4/13/16 included, Unstagabele to left and right heel...current treatment is Venelex to heels and cover with a non adherent pad then wrap with kerlix every shift... Resident has new order for zero gravity boots for pressure relief when up in wheel chair..."</p> <p>The care plans for Resident Z was reviewed and included, but were not limited to the following:</p> <p>A care plan for a risk for skin breakdown or further skin breakdown dated 11/6/14, the interventions included, but were not limited to Assess and document skin condition (11/6/14), Pressure reducing/redistribution cushion in chair/wheelchair (11/6/14), and Turn and reposition at least every 2 hours (11/6/14).</p> <p>A care plan for impaired skin integrity,</p>			

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	<p>unstagable blister to left heel and an unstagable flat blister visualized as a stage II to right heel.- no shoes to be worn, resident uses non-skid socks for wound healing...Interventions included, but were not limited to, zero gravity boots all times when up out of bed (4/21/16),</p> <p>An observation of the wounds to Resident Z's bilateral heels were observed on 4/26/16 at 10:44 A.M., with LPN #23. The Right heel had a closed purple area approximately 1 cm x 1 cm. The Left heel was observed to have a quarter sized open area with yellow and white wound bed. LPN #23 indicated the area was open and contained slough.</p> <p>During an interview with the MCF (Memory Care Facilitator) on 4/26/16 at 10:10 A.M., she indicated the area on Resident Z's left heel was from a tight shoe and the intervention was to remove her shoes and place gripper socks on her. She indicated at that time the unstagable pressure area on her right heel had formed formed from friction caused when Resident Z's foot would rub when being propelled in her wheel chair. She indicated the zero gravity boots were added as an intervention to assist with friction in April following the formation of the second pressure area.</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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F 0323 SS=G Bldg. 00	<p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision or new immediate, effective interventions were provided to prevent falls for 2 of 3 residents who met the criteria for the review of accidents. This deficient practice resulted in Resident P experiencing 2 fractured ribs. (Resident P, Resident E)</p> <p>Findings include:</p> <p>1. During an observation on 4/21/16 at 9:25 A.M., Resident P was observed sitting in a wheelchair in his room. CNA #32 was observed wiping up a large amount of liquid from the floor around the base of the commode in Resident P's bathroom. At that time, CNA #32</p>	F 0323	<p>F323-Free of accident hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Residents E and P, affected by the alleged deficient practice, have been identified by the interdisciplinary team and have appropriate interventions in place regarding fall prevention. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? ·All residents have potential to be affected by the alleged deficient practice. ·Audit will be completed by DNS/ADNS/Unit Managers/Designee to identify residents currently at risk for a fall 	05/20/2016

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
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	<p>indicated Resident P would get up by himself and go to the bathroom and miss the commode when urinating. CNA #32 further indicated Resident P should call for assistance.</p> <p>The clinical record of Resident P was reviewed on 4/21/16 at 10:31 A.M. The record indicated Resident P had been admitted to the facility on 12/31/15. The diagnoses of Resident P included, but were not limited to, atrial fibrillation, cerebrovascular accident, anxiety, and diabetes.</p> <p>A "Comprehensive Admission Assessment" completed on 12/29/16 was provided by the DON on 4/25/16 at 11:30 P.M., and the assessment for musculoskeletal read as follows: "...Balance: moving from seated to standing position...Not steady, but able to stabilize without human assistance..." "...Balance: walking...did not attempt..." "...Balance: surface to surface transfer...did not attempt..."</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/5/16 indicated Resident P experienced severe cognitive impairment and needed the assistance of one person for transfers, ambulation, toileting and was unable to balance without the assistance of a staff person.</p>		<p>and ensure interventions on resident careplans are clinically indicated and in place. Interventions, care plans and resident profiles will be updated if indicated. Audit will be completed by 05/20/16.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·All clinical staff will be inserviced on fall prevention and fall management by CEC/Designee by 05/20/16. ·Any new residents identified as a fall risk on admission, readmission, or with significant change in health status, will be discussed in IDT meeting the following business day to ensure appropriate interventions and care plans will be updated and/or initiated. This process will be ongoing.</p> <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·DNS/ADNS/Designee will complete the Fall Management tool weekly times four and then monthly times six. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic</p>		

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>The Admission MDS (Minimum Data Set) assessment dated 4/ 6/16 indicated Resident P experienced severe cognitive impairment and needed the assistance of 2 persons for transfers, ambulation, and toileting, and was unable to balance without the assistance of a staff person.</p> <p>A Care Plan for Falls dated 12/31/15 and updated on 3/8/16 included, but was not limited to, "Problem...Falls:...Resident is at risk for fall due to: weakness h/o [history of] left foot metatarsal fx [fracture], complicated by arthritis and high risk meds [medications]..." Initial interventions dated 12/31/15 included, but were not limited to, "...call light in reach...Environmental changes as needed...keep rollator walker near bed during periods of rest...non skid footwear...Personal items in reach...Therapy screen..."</p> <p>Care Plan for Falls updated on 1/25/16 included, but was not limited to, interventions of "...may align bed along the wall for open floor space..."</p> <p>Care Plan for Falls updated on 3/8/16 included, but was not limited to, "...educate resident to ask for assistance in obtaining items from the refrigerator..."</p>		<p>changesbe completed? ·05/20/2016</p>	
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>Care Plan for Falls updated on 4/6/16 included, but was not limited to, "...non skid strip in front of the bed."</p> <p>A "RADIOLOGY REPORT" dated 3/7/16 read as follows: "...Results: There is a fracture involving the lateral portion of the right 7th - 9th ribs with minimal displacement..."</p> <p>A Progress Note by the Nurse Practioner dated 3/9/16 read as follows: "...Pt [patient]...fall with new rib fractures. lateral 7th - 9th ribs..."</p> <p>Fall 1. A Fall Event report indicated Resident P experienced an unwitnessed fall on 1/22/16 at 11:54 A.M. Resident P was found on his knees in front of his electric wheelchair and stated that his legs, "gave ou. [sic]" The Event Report read as follows: "...What intervention (s) was put into place to prevent another fall...IDT to review..."</p> <p>A Progress Note dated 1/25/16 3:35 P.M., read as follows: "...IDT review of falls...Resident was found on knees in front of his electric wheelchair...resident was self transferring and his legs gave out. New intervention is to move bed along wall to provide for additional space for transferring...Current interventions:</p>			

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---	--

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	<p>Call light in reach, personal items in reach, rollator within reach..."</p> <p>Fall 2. A Fall Event report indicated Resident P experienced an unwitnessed fall on 3/7/16 at 11:00 A.M. The Event Report read as follows: "...Resident was getting into the fridge and getting ice cubes...Resident found laying [sic] on his back...What intervention (s) was put into place to prevent another fall...Residents skin tears where cleaned and dressed, resident assisted from floor to bed..."</p> <p>A Progress Note dated 3/8/16 12:19 P.M., read as follows, "...IDT REVIEW OF FALL...Resident was up getting ice out of fridge...resident was noted to have 3 S/T's [skin tears] to right hand, wrist and elbow. resident was noted to have a small laceration on the top of his head. Resident did c/o pain to right side ribs. A [sic] x-ray was ordered at that time...New Intervention: Reeducate resident to use call light when he needs assistance..." Documentation was lacking concerning the results of the x-ray.</p> <p>Fall 3. A Fall Event report indicated Resident P experienced an unwitnessed fall on 4/5/16 at 1:47 P.M. The Event Report read as follows: "...attempting to change seats...lying on side...What intervention (s) was put into place to</p>			

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---	--

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	<p>prevent another fall...educate resident to call for help when transferring; reminder of call light use..."</p> <p>A Progress Note dated 4/5/16 4:29 P.M., read as follows, "...IDT REVIEW OF FALL...Resident was attempting to change seats. resident was found lying on his side...Resident is not a diabetic...Residents [sic] walker was not next to his bed. NEW INTERVENTIONS: add non skid strips next to bed. All other interventions in place, bed along wall, ask for assistance when needed, resident walker next to bed, to make transfers easier for resident..."</p> <p>Fall 4. A Fall Event report indicated Resident P experienced an unwitnessed fall on 4/8/16 at 7:42 A.M. The Event Report read as follows: "...sitting on the floor talking...res [resident] stating sliding his self off the bed into [sic] floor, and wanted staff to pick him up...res room is cluttered. drinks and urinal were out of reach of the resident...What intervention (s) was put into place to prevent another fall...educate staff on importance of keeping resident items within reach of the resident..."</p> <p>A Progress Note dated 4/8/16 4:29 P.M., read as follows, "...IDT REVIEW OF</p>			

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	<p>FALL...Resident was found sitting on his buttocks...NEW INTERVENTION: resident to wear non skid socks at all times..."</p> <p>During an interview on 4/25/16 at 10:20 P.M., the Director of Nursing (DON) indicated Resident P was assessed at admission to be at a high risk to experience a fall. The DON further indicated Resident P had experienced 2 rib fractures as a result of a fall on 3/7/16. The DON further indicated Resident P's subsequent hospitalization for pneumonia on 3/13/15 was a result of Resident P not moving much and not deep breathing due to pain from the fractures.</p> <p>2. The clinical record of Resident E was reviewed on 4/21/16 at 1:38 P.M. The record indicated the diagnoses of Resident E included, but were not limited to, dementia, history of left hip replacement, osteoporosis, history of left elbow and distal humerus (upper arm bone) fracture.</p> <p>The Significant Change MDS (Minimum Data Set) assessment dated 12/25/15 indicated Resident E experienced moderate cognitive impairment, required the extensive assistance of two staff for bed mobility, required the total assistance of two staff for transfers, had a history of</p>			

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	<p>fall with fracture, and had experienced one fall since the previous assessment period.</p> <p>The most recent Quarterly MDS dated 2/27/16 indicated Resident E experienced severe cognitive impairment, required the extensive assistance of two staff for bed mobility and transfers, and had experienced no falls since the previous assessment period.</p> <p>A Care Plan for "Resident is at risk for fall due to: weakness and decreased cognitive status" dated 3/21/16 indicated the following interventions: "Comfort care foam chair when up out of bed, place dycem [an anti-slip device] between w/c [wheelchair] seat and cushion, and between alarm and bottom, 15 min [minute] personal checks when in bed, Keep resident in common area, in view of staff when not in bed, toilet after meals before laying down, add wedge cushion under back to support side laying position when in bed, may align bed along the wall for addition floor space, scoop mattress on bed, call light in reach, non skid footwear, personal items in reach,</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
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	<p>therapy screen"</p> <p>Fall #1 A Fall Event assessment dated 4/9/16 at 12:00 A.M. indicated Resident E experienced an unwitnessed fall from the bed. The assessment further indicated, "...The resident was sitting on the floor, leaning against...bed..." and an immediate intervention of "When restless on HS [hour of sleep] assist res [resident] up in to [sic] wheelchair" was implemented.</p> <p>A Nursing Progress note dated 4/9/16 at 2:00 A.M. indicated, "Resident was checked on around 11:30 pm [P.M.], when an aid [sic] checked her call light. Resident was found sitting on the edge of...bed stating...'wanted to go home.' Resident was placed back down in bed and a wedge was placed on...left side. At approximately 12 am [A.M.], resident was found sitting beside...bed. Resident again stated...'wanted to, 'go home,' and to 'please get...out of here.' Resident was assessed and placed in...chair for a little while to monitor for awhile..."</p> <p>An IDT (Interdisciplinary Team) progress note dated 4/11/16 at 4:07 P.M. indicated, "...un-witnessed [sic] fall on 4/9/16 at 12AM [sic]...New intervention: When restless on HS gwet [sic] res up in Wheelchair [sic]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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	<p>Fall #2</p> <p>A Fall Event assessment dated 4/13/16 at 10:36 P.M., indicated Resident E experienced an unwitnessed fall from the bed. The assessment further indicated, "...lying on L [left] side beside bed" and an immediate intervention of, "Placed Wedge [sic] cushion in bed to prevent res from rolling" was implemented.</p> <p>A Nursing Progress note dated 4/13/16 at 10:54 P.M. indicated, "Cna [sic] called this nurse to res room at approx [approximately] 10:30 pm [sic]. Res was found lying on...left side in floor beside...bed..." The note lacked any documentation to indicate a new, immediate intervention to ensure the safety of Resident E was implemented.</p> <p>An IDT progress note dated 4/14/16 at 11:09 A.M. indicated, "...un-witnessed [sic] fall on 4/13/16 at 10:36pm [sic]...New Intervention: Fall mat to open side of bed..."</p> <p>Fall #3</p> <p>A Fall Event assessment dated 4/14/16 at 6:47 P.M. indicated Resident E experienced an unwitnessed fall from the bed. The assessment further indicated, "...lying on L side in floor" and an immediate intervention of, "...Ensure</p>			
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	<p>wedge cushion in firmly in place, fall mat in floor to side of bed" was implemented.</p> <p>A Nursing Progress note dated 4/14/16 at 9:50 P.M. indicated, "At approx 6:47pm [sic], this nurse went into res room to check res vital signs, and res was on the floor beside...bed. his nurse called for help, and immediately assessed res for injuries. No injuries found. Assisted staff in getting res back into bed. Ensured that fall mat was in place, wedge cushion was in place, and call light within reach. Neuro [neurological] checks already in place from earlier unwitnessed fall..."</p> <p>Fall #4</p> <p>A Fall Event assessment dated 4/14/16 at 7:32 P.M. indicated Resident E experienced an unwitnessed fall from the bed. The assessment further indicated, "...lying on R [right] side in floor beside bed" and an immediate intervention of, "...Fall mat in floor to side of bed, wedge cushion firmly in place. Place res in geri chair" was implemented. The assessment lacked any documentation to indicate a new, immediate intervention to ensure the safety of Resident E was implemented.</p> <p>A Nursing Progress note dated 4/14/16 at 9:50 P.M. indicated, "...At approx 7:32</p>			

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	<p>pm [sic], this nurse was going into res room again to check on res and administer evening medications when res was found on fall mat beside bed. Assisted staff in getting res into...chair to ensure res safety. Placed chair in front of nurses station to be able to monitor res closely..." The note lacked any documentation to indicate a new, immediate intervention to ensure the safety of Resident E was implemented.</p> <p>An IDT progress note dated 4/15/16 at 10:42AM [sic] indicated, "...Res was noted to have 2 un-witnessed [sic] fall on 4/14/16...New Intervention: Med [medication] review..."</p> <p>During an interview on 4/21/16 at 2:00 P.M., the DON (Director of Nursing) indicated the immediate intervention implemented after Fall #1 was to transfer the resident in a chair to the nursing station for closer supervision when he/she experienced restlessness at night. The DON then indicated the immediate intervention implemented after Fall #2 was to place a fall mat beside the bed and the immediate intervention implemented after Fall #3 was to educate staff to make sure the wedge cushion was placed firmly. The DON further indicated the immediate intervention implemented after Fall #4 was to complete a</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
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	<p>medication review.</p> <p>During an interview on 4/21/16 at 2:15 P.M., the DON indicated every resident in the building was at risk to experience a fall. The DON further indicated no documentation could be provided to indicate the fall risk of Resident P and E was thoroughly assessed.</p> <p>During an interview on 4/26/16 at 10:50 A.M., the Regional DON indicated no documentation could be provided to indicate any resident's risk to fall was thoroughly assessed.</p> <p>The Policy and procedure for "Fall Management Program" was provided by the DON [Director of Nursing] on 4/25/16 at 2:00 P.M., and read as follows: "...It is the policy...to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls."</p> <p>3.1-45(a)(2)</p>				

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food temperatures were checked and documented before serving residents, temperatures of the refrigeration units were monitored according to the facility's policy, sanitation solution was at the correct strength, food sitting out was covered, and the back door to the kitchen remained closed. for 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>The following observations occurred on 4/21/16 at 8:40 A.M.:</p> <ol style="list-style-type: none"> The outside exit door was propped open with a large, black plastic milk crate. The Food Service Manager (FSM) indicated she could not find the thermometer in Walk-in Refrigerator Cooler #2. The FSM questioned Cook #2 how she read the temperature of the 	F 0371	<p>F371– Food Procure, Store/Prepare/Serve - Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·No residents were identified in the alleged deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? ·All residents have potential to be affected by the alleged deficient practice. ·Walk-in refrigerator units have been serviced ·Alarm has been added to kitchen back door and door remains closed ·All dietary staff to be inserviced on alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·Dietary staff to be inserviced on food preparation and covering of food, refrigerator temperatures, temperature testing of food items</p>	05/20/2016

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	<p>Walk-in that morning and Cook #2 indicated she used the exterior thermometer. The FSM placed her hand over the exterior thermometer and stated, "No, we do not use this."</p> <p>3. The "Equipment Temperature Monitoring" logs were reviewed. The forms indicated that for 20 of 21 days during the month of April 2016, the morning and evening temperatures recorded for Walk-in Cooler (Refrigerator) #1 and Walk-in Cooler (Refrigerator) #2 were below 32 degrees Fahrenheit (below freezing).</p> <p>4. The "Weekly Temperature Record" (form used by the facility to document the temperatures of the food before serving) for the first floor kitchen was reviewed. The form lacked documentation the food temperatures had been taken and recorded on Thursday morning 4/21/16 before serving the residents. During an interview, at that time, the FSM indicated the staff had forgotten to take the temperatures of the food because they were in a new routine. The FSM further indicated the facility used to have 3 cooks, now there were only 2, and the CNA's just forgot to take and record the temperatures Thursday morning 4/21/16.</p>		<p>prior to meal service, and using sanitation solution at proper strength by 05/20/16.</p> <p>·New thermometers, larger in size, have been purchased for refrigerator units and are in use. Staff inserviced on how to read new thermometers. How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·To ensure compliance, the Dietary Manager/designee is responsible for the completion of a Food Temperatures and Preparation CQI tool weekly times 4 and monthly times 6 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed. By what date will the systemic changes be completed?</p> <p>·05/20/2016</p>	

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	<p>5. One compartment of a 3 compartment dish sink was filled with blue water. Soaking in the blue water were scoops, ladles, whisks, tongs, and spoons. During an interview, at that time, the FSM indicated the utensils had been used to serve breakfast that morning and were soaking in sanitizing solution. The FSM checked the concentration of the sanitizer and it was 175 ppm (parts per million). The FSM indicated the correct level should have been between 200 to 400 ppm.</p> <p>6. Three square pizza crusts were observed on two sheet pans located on top of the steam table. The pizza crusts were not covered. During an interview at that time, Cook #1 indicated she had placed them on the steam table so that the crusts could rise. Cook #1 further indicated the pizza crusts should have been covered.</p> <p>During an interview on 4/21/16 at 12:53 P.M., and 1:05 P.M., the Health Care Administrator (HCA) indicated the back door of the kitchen should not be left propped open and the dumpster lid should always be closed. The HCA further indicated he had purchased new thermometers for the Walk-in refrigeration.</p>			

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	<p>7. During a record review and an interview on 4/25/16 at 12:00 P.M., the "Weekly Temperature Record" for the second floor kitchen was reviewed. There were no evening meal temperatures documented for Wednesday 4/20/16, Thursday 4/21/16, Saturday 4/23/16 and Sunday 4/24/16. During an interview, at that time, the FSM indicated the staff took and recorded the temperatures of the food on the 1st floor kitchen, but forgot to check and record food temperatures in the upstairs kitchen.</p> <p>The Policy and Procedure for "Food Temperatures" was provided by the HCA on 4/21/16 at 12:08 P.M., and the policy read as follows: "...The facility will prepare and serve food at the proper temperature to prevent food borne illness...Temperatures should be recorded at the beginning of meal service to ensure hot food is served at or above 135 [sign for degrees] F and cold food is served below 41 degrees F. If a portable steam table is used...food temperatures should be taken and recorded at each location before meal service begins.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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F 0372 SS=E Bldg. 00	<p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure trash was disposed of according to the facility's policy for 2 of 2 kitchen observations.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. During an observation on 4/20/16 at 6:10 P.M., the dumpster located behind the kitchen was observed to have the lid open and refuse was observed to be above the rim of the dumpster. 2. During an observation on 4/21/16 at 8:40 A.M. of the Walk-in Freezer, which was located outside behind the kitchen, the dumpster lid was observed open and refuse was overflowing from the top of the dumpster. 3. Outside the back exit door of the kitchen were 12 black milk cartons scattered about, a hose, a mop bucket and a mop. <p>During an interview on 4/21/16 at 12:53</p>	F 0372	<p>F372-Dispose of garbage and refuse properly What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·No residents were identified in the alleged deficient practice How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? ·All residents have potential to be affected by the alleged deficient practice ·Dumpster is routinely checked and remains closed ·Area outside of back kitchen door has been cleared of debris What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ·Staff inserviced on keeping dumpster lid closed and area outside of back kitchen door free of debris ·ED ordered new dumpster with sliding doors on side ·ED ordered an extra dumpster so the facility now has 2 trash and one recycling to be emptied daily <p>How the corrective action(s)</p>	05/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2016
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F 0441 SS=E Bldg. 00	<p>P.M., the Heath Care Administrator indicated the dumpster lid should always be closed.</p> <p>3.1-21(i)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>		<p>will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the Maintenance supervisor/designee is responsible for the completion of a Waste Management CQI tool weekly times 4 and monthly times 6 months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p> <p>By what date will the systemic changes be completed?</p> <p>05/20/2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure a c-diff. (Clostridium Difficile) contact isolation room was sanitized appropriately, gloves were change by staff, and adequate handwashing was not preformed as per facility policy for 4 of 4 observations. (Resident C, Resident M, Resident P, Resident Z)</p> <p>Findings include:</p> <p>1. On 4/21/16 at 9:15 A.M., Resident C's clinical record was reviewed. Resident C had been admitted to the facility on 2/11/16. His current diagnoses included, but were not limited to, vascular dementia with behavioral disturbance and chronic obstructive pulmonary disease.</p>	F 0441	<p>F441-Infection control, prevent spread, linens What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Residents C, M, P, and Z, affected by the alleged deficient practice, have been identified by the interdisciplinary team. Residents C, M, P, and Z did not have a negative outcome related to the alleged deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>·All residents have potential to be affected by the alleged deficient practice.</p>	05/20/2016	

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	<p>His current physician's orders included, but were not limited to, an order initiated 3/3/16 for contact isolation for signs and symptoms of C-Diff (Clostridium Difficile).</p> <p>On 4/21/16 at 11:10 A.M., CNA #15 and CNA #16 applied gowns, gloves, and masks and entered the room of Resident C whose physician's orders indicated he had been placed in contact isolation.</p> <p>During care observation on 4/21/16 at 11:10 A.M., CNA #16 cleaned between the buttocks of Resident C and then discarded the BM (bowel movement) soiled wash cloth into a plastic bag. CNA # 16 continued care by fastening Resident C's brief on one side and then positioned Resident C's gown before removing gloves and applying new gloves without handwashing. CNA # 16 then assisted Resident C with the assistance of CNA #15 into a Broda [a pressure redistribution chair] chair.</p> <p>On 4/21/16 at 11:20 A.M., after assisting Resident C into the Broda chair, CNA #16 removed her gloves, gown, and mask and exited the isolation room without handwashing.</p> <p>On 4/21/16 at 2:46 P.M., A facility policy (review date July 2015) entitled,</p>		<p>·All Clinical staff will be inserviced on proper hand washing and glove use by 05/20/16.</p> <p>·All housekeeping staff and housekeeping supervisor will be inserviced on proper cleaning of rooms occupied by residents in isolation precautions for clostridium difficile by 05/20/16.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>·All Clinical staff will complete a hand washing skills validation with DNS/ADNS/Unit Managers/CEC/Designee by 05/20/16.</p> <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Housekeeping supervisor will verify the proper cleaning of resident rooms used for isolation related to clostridium difficile once per week times four weeks and one time monthly for 6 months to ensure compliance.</p> <p>·To ensure compliance, the DNS/ADNS/Unit Managers/Designee is responsible for the completion of the Infection Control Review CQI tool weekly times 4 weeks and monthly times 6 months. The results of these audits will be reviewed by the CQI committee</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>"Clostridium Difficile (CDI, C.diff)" was received and reviewed. The policy included, but was not limited to,"...4. CONTACT PRECAUTIONS...i. Gloves-gloves must be put on before entering room and worn by all staff during care and when in contact with resident's environment. Gloves should be changed when contaminated or torn. Gloves should be removed when leaving the resident's room. Hand washing should be done after removing gloves..."</p> <p>2. On 4/21/16 at 9:40 A.M., Housekeeper #5 was interviewed regarding resident isolation rooms on Hall F. She indicated she was housekeeper on F Hall (where Resident C resided) today and she was unaware of any isolation rooms on the F Hall. She indicated if she was to clean an isolation room she would have to apply gown, gloves, and a mask. Housekeeper #5 indicated she would clean the floor of an isolation room with the facility disinfectant cleaner. She indicated bleach was not used in the cleaning of isolation room floors due to residents were unable to tolerate the smell of the bleach.</p> <p>On 4/21/16 at 10:10 A.M., the Housekeeping Supervisor was interviewed in regard to the cleaning of</p>		<p>overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed.</p> <p>By what date will the systemic changes be completed?</p> <p>05/20/2016</p>				

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	<p>isolation rooms such as in regard to C.Diff (Clostridium Difficile). The Housekeeping Supervisor indicated the disinfectant cleaner QUAT [cleaning solution] was used for cleaning/ mopping the floors of all resident rooms including isolation resident rooms. The Housekeeping Supervisor indicated in isolation rooms, the bed frames, chests, bedside tables, for example were cleaned with a bleach solution. She indicated no bleach was used in the cleaning of the floor in an isolation room with C.Diff.</p> <p>On 4/25/16 at 9:40 A.M., a Material Safety Data Sheet for the disinfectant, QUAT was reviewed. The composition of the disinfectant did not include the ingredient, hypochlorite (Ingredient of bleach).</p> <p>On 4/21/16 at 2:46 P.M., A facility policy entitled, "Clostridium Difficile (CDI, C.diff)" was received and reviewed. The policy included, but was not limited to, "...7. CLEANING a. solution -10% hypochlorite solutions (one part chlorine bleach mixed with 9 parts tap water) mixed fresh daily or commercial brand hypochlorite solutions. b. Contact time-Surface being disinfected should come into contact with the solution (stay wet after cleaning) for 10 minutes. Follow manufacture</p>			

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	<p>directions on the commercial brand hypochlorite solutions for contact time..."</p> <p>On 4/26/16 at 10:32 A.M., during interview the Administrator indicated the Housekeeper Supervisor had indicated staff were not using a bleach solution to clean the floors of isolation rooms with C.Diff. The Housekeeper Supervisor had indicated to the Administrator she was concerned about a bleach solution doing harm to resident room floors. The Administrator indicated the facility had already started inservicing on day shift staff today regarding the use of a bleach solution to clean isolation room floors with C.Diff. The Administrator indicated the facility had been using the disinfectant, QUAT to clean C.Diff isolation room floors. The Administrator indicated he was not aware of any cleaner except a bleach solution that would kill the C.Diff. bacteria.</p> <p>The following hand washing was observed on 4/21/16:</p> <p>3. Incontinence care was provided to Resident M by LPN #6 and CNA #32 at 9:17 A.M. After incontinence care was completed, LPN #6 went into the resident's bathroom and washed her hands for 10 seconds.</p> <p>4. During an observation at 9:25 A.M.,</p>			

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	<p>CNA #32 was observed wiping up a large amount of fluid around the base of the commode with a white towel in Resident P's bathroom. CNA #32 placed the towel in a plastic bag and then washed her hands for 10 seconds.</p> <p>5. During an observation at 9:35 A.M., LPN #6 was observed to wash her hands for 12 seconds before a dressing change for Resident Z. LPN #17 was observed to wash her hands for 6 seconds before a dressing change.</p> <p>During an interview on 4/26/16 at 9:25 A.M., the DON [Director of Nursing] indicated it was the facility's policy to wash hands vigorously for 20 to 25 seconds.</p> <p>3.1-18(b) 3.1-18(l) 3.1-18(j)</p>			