

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/03/2012
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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R0000	<p>This visit was for the Investigation of Complaint IN00110049.</p> <p>Complaint IN00110049 - Substantiated. A state residential deficiency related to the allegations is cited at R217.</p> <p>Survey dates: July 2 and 3, 2012</p> <p>Facility number: 011274 Provider number: 011274 AIM number: N/A</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: Residential: 90 Total: 90</p> <p>Census payor type: Other: 90 Total: 90</p> <p>Sample: 13</p> <p>This state residential deficiency is cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/5/12 Cathy Emswiller RN</p>	R0000		

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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R0217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure services were revised to assist staff to meet the needs of a resident with behaviors. The deficient practice affected 1 of 3 residents reviewed related to behaviors in a sample of 13. (Resident C) The deficient practice affected 3 of 9 residents interviewed</p>	R0217	<p>R217 All residents have the potential to be affected. A specific resident service plan has been developed for resident C on using effective approaches for violent and verbally abusive behaviors. The service plan will be signed and dated by resident C.</p>	07/31/2012			

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	<p>related to behavior of other residents in the sample of 13. (Residents H, I, and M)</p> <p>Findings include:</p> <p>1. During observation at the Nurse's Station on 7/2/12 at 3:15 p.m., a notation on the marker board indicated Resident C was listed for "alert charting" every shift related to behaviors. During interview at this time, LPN #5 indicated Resident C "sometimes says off-color things," which need to be charted in his record.</p> <p>During confidential interview on 7/2/12, Resident M indicated fearfulness related to another resident. Resident M indicated the interviewee was "afraid of the big guy - [name of Resident C] - he tried to come in my room. My door was locked - he tried to open the locked door....I've heard he's rowdy....He's so big." Resident M indicated the event happened "Sunday before last."</p> <p>During confidential interview on 7/3/12 related to whether any residents at the facility frightened the interviewee, Resident H named Resident C as a resident who frightened the interviewee. The interviewee stated, "He don't [sic] like black people," and "I think he has threatened staff."</p>		<p>Resident C may request a copy of the service plan. A copy of service plan has been placed and will be kept on resident's C chart. All employees will be in-serviced on resident's C service plan on how to effectively approaching resident C when dealing with violent and verbally abusive behavior of resident C.</p> <p>Completion date 7/31/2012</p> <p>Daily behavior charting will be done for four weeks, then weekly for four weeks, then monthly for four months, then quarterly. The DON or his designee will audit behavior charting weekly for effectiveness of service plan and make revisions as needed on service plan.</p> <p>Completion date 7/31/2012</p>				

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	<p>During confidential interview on 7/3/12, Resident I indicated the interviewee was afraid of some residents. The interviewee indicated not understanding why the facility housed "the mental people" on the same floors with other residents.</p> <p>The clinical record for Resident C was reviewed on 7/2/12 at 5:15 p.m. The record indicated the resident was admitted 5/1/12 with diagnoses including, but not limited to, bleeding around the tracheostomy site, chronic obstructive pulmonary disease, alcoholism, mood disorder with bipolar component, and severe depression.</p> <p>The Evaluation for Residential Care, dated 5/1/12, indicated with a check mark in the section for "Behavior: No problems, deals appropriately with emotions, people, and staff; moves about with purposeful direction." Another check mark in the same "Date" (5/1/12) column of the form, but with the date of 5/29/12, indicated, "Behavior managed by increased staff time, moderate more than three times per week. Exhibits inappropriate behavior, i.e., disrobes, takes others' belongings, wanders aimlessly."</p> <p>The Service Plan, dated 5/1/12, with no updates indicated with check marks for</p>						

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	<p>"Behavior: Monitor for early warning signs of problem behavior; Keep family informed of resident's behaviors; Other: [handwritten] Mental Health Services." The Service Plan indicated no updates since 5/1/12.</p> <p>A Transfer Form, dated 5/24/12, indicated Resident C was transferred to the local hospital emergency room with "Reason for Transfer/Other Information: Has become violent to others haullucinating [sic], talking to people who are not there, delugenial [sic]."</p> <p>The Antibiotic Therapy Documentation X [times] 48 Hours form, dated 5/29/12, indicated, "Return from hospital [with] order for Levaquin [antibiotic]...."</p> <p>Nurse's Notes included, but were not limited to, the following:</p> <p>5/30/12 at 10:55 a.m., "Resident has been exhibiting anxious and abrupt behavior towards staff & other residents...." Notes indicated the Director of Nursing was contacted, and the nurse was instructed to seek alternate placement for the resident, and placement was refused by the other facility.</p> <p>6/2/12 at 9:30 a.m., "Has been outside door of room this a.m. [morning] talking</p>						

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	<p>very loudly and making inapprop [inappropriate] comments to staff, residents, and visitors, at times sl [slightly] aggressive. Removed large stick from resident's room. Called Admin [Administrator], DON [Director of Nursing] et [and] nursing supervisor re: behavior. Nrsrg [nursing] Supervisor ret [returned] call et discussed situation [with] her. Refusing to take Abilify [medication for schizophrenia] et does not want to take meds [medications] at scheduled times."</p> <p>6/2/12 at 2:30 p.m., "Reached admin on phone - explained events to her states to follow [name of local police department] instructions.</p> <p>A Transfer Form, dated 6/2/12, indicated the resident was transferred to the local hospital emergency room with "Reason for Transfer/Other Information, "Having psychotic episode - making threats and racial slurs at visitors and staff - yelling threats out window. Removed 5" long knife et sharp phillips head screwdriver from room stated he need 'protection' from dietary workers. Removed large stick earlier."</p> <p>6/2/12 at 3:45 p.m., "Returned to facility...."</p>						

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	<p>6/3/12 at 10:00 a.m., "Began a restless morning - has hung a blanket over window on door to room so 'they' (meaning dietary) can [sic] see me - 'they want to trade me my methadone and morphine for a girl.' Also states there are people outside yelling at him - taken to window and shown there was no one outside. Becoming increasingly anxious. Requested to take a walk to 'cool off' was gone approx [approximately] 1/2 hour. Sl. calmer but still very suspicious and guarded....</p> <p>6/3/12 at 6:00 p.m., "...Not as anxious when spoken to in calm manner...."</p> <p>6/3/12 at 10:00 p.m., "Continues to have suspicious behavior tonight. States these is a black man in the building that should not be here. Tried to assure resident that there is no one here that shouldn't be...."</p> <p>6/4/12 at 6:30 a.m., "Res [resident] [arrows pointing up and down] freq [frequently] tonight still cussing & talking to self & wall still saying there are people here that shouldn't be."</p> <p>6/4/12 at 1:00 p.m., "Resident talking and cursing to self while standing in hallway outside of his room...."</p> <p>Notes indicated the resident was</p>						

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	<p>hospitalized from 6/7 to 6/11/12 related to a respiratory infection, and on 6/14/12, the resident had appointments at the behavioral health clinic and his attending physician. Buspar [anxiety medication] was added to the medication regimen on that date.</p> <p>6/14/12 at 10:00 p.m., "Pacing up and down hall. Talking to self. Has window open in room d/t [due to] states claustrophobic...."</p> <p>6/17/12 at 9:00 p.m., "Pacing up et down calling staff members racial names & regarding his possible sexual orientation . Res has went [sic] outside @ this time to take a walk...."</p> <p>Notes indicated on 6/19/12 the resident was transferred to the pain clinic to receive an epidural pain injection.</p> <p>6/19/12 at 10:30 a.m., after return from the epidural injection, "...seems very angry, up & down hallway, cussing aloud, redirected to rm [room], refused to have VS [vital signs] done at this time 1:15 p.m. Resident continues to curse a lot, got mad at lunch, threw food in trash can...denies any pain."</p> <p>6/21/12 at 10:30 a.m., "Anxious this a.m. [morning] - standing in hallway talking</p>						

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	<p>loudly to self...."</p> <p>Notes indicated the resident attended an appointment at the pain clinic on 6/21/12, and his Methadone dose was increased.</p> <p>6/23/12 at 10:00 a.m., "Resident is highly agitated today - in hallway outside room - yelling racial slurs and profanity in loud tone of voice. When told by QMA [Qualified Medication Assistant] to go to room and not stand in hallway yelling he began asking her 'where her track marks are' and calling her very foul names - had hands balled into fist et was taking steps toward her - another QMA guided him into room and he slammed the door. QMA and this nurse called administrator et left two voice mails regarding incident."</p> <p>6/23/12 at 10:00 p.m., "Has been pacing in hallways tonight talking to self no inappropriate behavior towards staff noted."</p> <p>6/25/12 at 5:15 a.m., "Resident in room [with] window open yelling obscenities out the window."</p> <p>Notes indicated the resident attended an appointment at the behavioral health clinic on 6/28/12.</p>			

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	<p>6/30/12 at 6:50 a.m., "CNA reports resident wanting ice & she was in the middle of helping another resident. Resident started cursing @ employee when employee would not stop what she was doing."</p> <p>Notes indicated the resident attended an appointment at the behavioral health clinic on 6/28/12.</p> <p>During interview on 7/3/12 at 10:45 a.m., LPN #11 indicated she thought staff approach with Resident C had a lot to do with his behaviors. She indicated she was not present on the day police came and sat the resident down and talked to him. She indicated she had contacted police on a week-end when the resident was yelling out his window to people on the street. She indicated she was told by the police that they could nothing when the resident was yelling out the window.</p> <p>During interview on 7/3/12 at 11:30 a.m., RN #13 indicated she had just started employment at the facility about three weeks ago, and Resident C "has never done anything around me," but she had heard about him. She indicated, "Now watch it happen."</p> <p>During interview on 7/3/12 at 12:00 noon, QMA #18 indicated there was not a plan</p>						

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	<p>related to managing Resident C's behaviors, which she indicated had been directed at her. She indicated the Administrator had told her to be direct with the resident. She indicated she has not called the police about Resident C, because unless he is physically aggressive, the police cannot help. She indicated "today" she received inservice paperwork to read and sign. The inservice record indicated the Director of Nursing was the inservice presenter, and the attachment indicated, "Handling Aggression can be a challenge but dealing with it assertively can make all the difference to the end result. Please find below some ideas on different responses, which could give a more positive outcome, and a range of techniques to add to your portfolio of skills....I do hope you have found the above information of interest. These techniques can be very powerful used in the right context. If you would like to explore his subject more, do check out my workshop on being assertive listed on the training page of this website. Please contact me if you would like to discuss this or any other workshop further. Don't forget all my workshops are very interactive and can be personalized to suit business/individual needs."</p> <p>During interview on 7/2/12 at 6:00 p.m.,</p>						

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	<p>the Administrator indicated the facility did not have full information about Resident C at the time of admission. She indicated alternate placement was being sought for the resident.</p> <p>During interview on 7/3/12 at 1:20 p.m., the Director of Nursing indicated the service plan had not been revised related to the on-going behaviors exhibited by Resident C. He indicated staff was assisted "by word of mouth" and "staff sharing with others" the best way to manage the resident's behaviors. He indicated there was not a specific behavior plan for the resident. He indicated he had distributed the inservice information about dealing with aggression "today." He indicated the resident had no family or friends to coordinate care with, and no facility had agreed to accept the resident at this point. He indicated he had no documentation related to the incidents when the police were called in regard to the resident's behavior.</p> <p>This state residential deficiency relates to Complaint IN00110049.</p>				

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