

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  10/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
---	--

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaints IN00155346 and IN00154999.</p> <p>Complaint IN00155346- Substantiated. No Federal/State deficiencies cited related to the allegations.</p> <p>Complaint IN00154999- Substantiated. Federal/State deficiency related to the allegations is cited at F-223.</p> <p>Survey dates: October 01 and 02, 2014</p> <p>Facility number: 000082 Provider number: 155165 AIM number: 100289640</p> <p>Survey Team: Trudy Lytle, RN-TC Gwen Pumphrey, RN</p> <p>Census bed type: SNF/NF: 111</p> <p>Census payor type: Medicare: 24 Medicaid: 64 Private: 13 Other: 10 Total: 111</p>	F000000	I respectfully request a paper review IDR for deletion of F223.	
---------	---	---------	---	--

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.

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  10/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
---	--

(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
F000223 SS=E	<p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 7, 2014 by Randy Fry RN.</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 interview and record review, the facility failed to ensure residents were free from verbal abuse from staff. This deficient practice affected 1 of 6 residents reviewed for abuse.</p> <p>Findings include:</p> <p>On 10/04/14 at 1:30 the reportable incidents from July 2014 through September 2014, to the Indiana State Department of Health (ISDH) were reviewed. Nineteen incidents were reported to ISDH, 5 involved allegations of staff to resident abuse and 2 of the</p>	F000223	We respectfully request deletion of F223 for reasons stated in attached paper review IDR.F223 - The facility does ensure residents are free from verbal abuse from staff.1. Without an identifier list, after inquiring with the surveyors, we are unsure of who made the allegations/comments quoted in the 2567, however, every known allegation is thoroughly investigated and reported per policy. Social service follows up with every resident for any known allegation of abuse, neglect or misappropriation of property.2. All residents have the potential to be affected by the alleged deficient	10/31/2014

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  10/02/2014
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
(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>allegations involved Certified Nurse Aide (CNA)#1.</p> <p>The most recent reportable dated 9/22/14 indicated CNA #1 had been rude to three residents. CNA #1 was suspended as of 9/22/14 pending the investigation.</p> <p>A confidential interview during the investigation indicated, "Residents have told me staff have been rude to them. Some of the staff will make the residents wait to get showers, and to take them to the bathroom. It's like they don't understand this is their home. This is the worse that I have seen it here. The managers don't do anything to fix it really."</p> <p>A confidential interview during the investigation indicated, "I have had residents tell me that CNA's have been rude to them. I made sure they were safe and reported that to the DON (Director of Nursing)."</p> <p>A confidential resident interview during the investigation indicated a CNA "had been rude while bathing and called me a name. I didn't want to get her in trouble but I told the nurse."</p> <p>On 10/2/14 at 8:45 a.m., the Administrator indicated the charge nurses</p>		<p>practice. SSD and MCF conducted interviews with all interviewable/available residents on October 3, 2014 to ensure there were no concerns or allegations of verbal abuse.3. SSD/MCF/designee will conduct a minimum of 5 residents and 5 staff members interviews each week to maintain open communication with residents and staff members to ensure that all allegations or concerns related to verbal abuse are addressed immediately.Staff inserved on abuse protocol by CEC on 10/28/14 emphasizing prohibition of abuse and reporting requirements and that there will be no reprisals or retaliation associated with any allegations or concerns reported.During routine Care Plan and Road 2 Recovery meetings where residents attend, both residents and families will be encouraged to voice any concerns with emphasis on no reprisals or retaliation.ED attended Resident Council meeting on 10/17/14 with permission and will continue to attend monthly with permission to encourage residents to voice concerns immediately to staff to ensure prompt follow up without reprisals or retaliation associated with any allegations or concerns reported.4. To ensure compliance, the CEC/designee is responsible for completion of the Abuse CQI tool weekly times 4 weeks, bi-monthly times 2</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  10/02/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129
---	--

(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>and unit managers monitor staff all the time to ensure abuse does not occur. She indicated the Resident Council routinely communicates to the residents to voice concerns without fear of reprisal.</p> <p>On 10/2/14 at 9:30 a.m., the Director of Nursing was interviewed. She indicated when she is notified of an allegation of abuse, she immediately reports to ISDH, initiates an investigation, and conducts interviews with all residents deemed interviewable. She indicated staff are inserviced regularly on abuse.</p> <p>The DON indicated the reportable involving CNA #1 was substantiated. CNA #1 would be terminated.</p> <p>On 10/2/14 at 10:15 a.m., the Assistant Director of Nursing indicated staff are educated on abuse regularly with online training and classroom training.</p> <p>On 10/1/14 at 9:45 a.m., the Administrator provided a copy of the policy titled, "Abuse Prohibition, Reporting, and Investigation. This policy was last revised October 2013. The policy indicated, "...It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the residents is maintained if abuse is identified or</p>		<p>months, monthly times 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed to ensure compliance.5. 10/31/14.</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  10/02/2014
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129		
(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	
	suspected.  3.1-27(b)				