

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 08/14/2015
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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 IN00179560.</p> <p>Complaint IN00179560 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: August 13 and 14, 2015</p> <p>Facility Number: 000082 Provider Number: 155165 AIM Number: 100289640</p> <p>Census bed type: SNF/NF: 98 Total: 98</p> <p>Census payor type:</p> <p>Medicare: 14 Medicaid: 70 Other: 14 Total: 98</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from physical abuse from a staff member. This deficient practice affected 1 of 1 resident reviewed for abuse. (Resident #E)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #E on 8/14/15 at 10:45 a.m., indicated the resident had diagnoses which included, but were not limited to, episodic mood disorder, depressive disorder, and dementia with behavioral disturbances. The clinical record indicated the resident had frequent episodes of combative behaviors with care and was biting and resistive to care during the incident on 4/11/15. The Minimum Data Set (MDS) Quaterly assessment dated 7/15/15, indicated the</p>	F 0223	<p>F223</p> <p>1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? Resident #E, there was no adverseeffects to the identified resident.</p> <p>1.How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken? Social Services will follow up withthe initial psycho-social well-being of the resident. No residents wereidentified.</p> <p>1.What measures will be put into place or whatsystemic changes will you make to ensure that the deficient practice does notoccur? All staff were in-serviced on AbusePolicy and Procedures by the CEC and was completed 8/17 through 8/20/15. TheCustomer Care round managers will talk with</p>	09/13/2015	

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	<p>resident required extensive assist of one to two staff persons with her Activities of Daily Living.</p> <p>Interview with LPN (Licensed Practical Nurse) #2 on 8/13/15 at 3:15 p.m., indicated the resident was very confused and could be combative with care and that one had to take it moment by moment in providing care depending on how much she would allow. She indicated staff would usually have to back away and let the resident calm before proceeding.</p> <p>On 8/13/15 at 11:00 a.m., the Administrator provided a copy of an investigative report to the Indiana State Department of Health (ISDH). It indicated CNA (Certified Nursing Assistant) #1 was observed holding Resident #E's wrists and laying on top of her to prevent her from striking out at staff during care. The CNA was also heard to be cursing and yelling at the resident.</p> <p>The incident report indicated the facility did not initiate an investigation into the incident until the next day and only completed some staff interviews and resident interviews were done only on C and F halls.</p>		<p>residents to insure no evidence of abuse not being reported immediately. Weekend supervisor will also monitor for any signs or allegations of abuse.</p> <p>1. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assurance program will be put into place?</p> <p>Executive Director will use CQI Tool for the Abuse Prohibition and investigation which will be done weekly X4, monthly X3 and then quarterly X6 and will be reviewed in CQI meetings monthly thereafter. Plan will be revised as needed.</p> <p>Compliance Date: September 13, 2015</p>	

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	<p>The written statement by CNA #2, dated 4/11/15 (untimed), indicated the following, "On Saturday 4-11-15 I witnessed CNA (name of CNA #1) on 'C' hall physically and verbally abuse residents! A resident in (Resident E's room) needed a brief change. We entered the room, resident was asleep, (name of CNA #1) grabbed her by the wrists & (and) began yelling for her to get up. The resident became combative & verbal, she attempted to hit & bite (name of CNA #1), at that point (name of CNA #1) yelled 'calm the (expletive curse word) down'. As the resident was laying on her right side, (name of CNA #1) threw her entire upper torso onto the resident's left side, in an attempt to stop the resident's movements. At that point I removed (name of CNA#1) from the resident, I calmed her, & we proceeded to change the brief. (Name of CNA #1) removed old brief & placed a clean one in position. The resident needed to be rolled over to finish putting the clean brief on, (name of CNA #1) grabbed the resident's knees & just flipped her completely over, crashing the resident's face into my thigh. (Name of CNA #1) was yelling & cursing again, so I finished putting the brief on. I then rolled the resident back to her right side, covered her & told her good night."</p> <p>In an interview with CNA #2 on 8/14/15</p>			
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	<p>at 10:40 a.m., she indicated that CNA #1 was very angry that night [date of incident] because the third shift staff would not let them leave and told them they had to finish changing all their residents first. She indicated CNA #1 was still cursing and yelling when they walked into Resident #E's room to change her and continued to do so while caring for the resident. CNA #2 indicated that because CNA #1 was so angry and upset, she had told her repeatedly to just leave the room and go do something else while she and CNA #3 finished the care, but CNA #1 refused saying she had to stay and finish the care of the resident. CNA #1 continued to remain angry and was cursing while CNA #2 and #3 finished the care of the resident. CNA #2 also indicated that she left the room at one point during the care while CNA #3 remained in the room with CNA #1 and the resident in order to report to the nurse what was happening. She indicated that the nurse never came into the room to check on the resident or to remove the CNA during the care.</p> <p>In an interview with CNA #3 on 8/14/15 at 9:45 a.m., she indicated she was also present during and witnessed the incident on 4/11/15. She indicated she witnessed CNA #1 holding and leaning on Resident #E and being verbally abusive also. CNA</p>			

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	<p>#3 indicated that because of CNA#1's actions, CNA #2 went out to the desk to find a nurse to report CNA #1's actions while she stayed in the room with CNA #1 and the resident.</p> <p>In an interview on 8/14/15 at 1:00 p.m. with LPN #1 who was the nurse on the night of 4/11/15, she indicated she could not really remember the incident very well as it was 4 months ago, but she thinks CNA #2 did come out in a "dramatic" manner yelling about what CNA #1 had done. She indicated that she did talk to CNA #1 and told her it was not proper care to hold a resident's hands while providing care to the resident and then let the CNA continue her rounds. LPN #1 indicated that she did not think CNA #1's actions were intentional and not meant to harm the resident. She also indicated that she thinks she assessed the resident, but did not document it as she was still new and did not know where to document it.</p> <p>Review of the Social Services notes, dated 4/13/15, 4/15/15 and 4/17/15, indicated the resident displayed no emotional distress.</p> <p>On 8/13/15 at 11:00 a.m., the Administrator presented a copy of the facility's current policy titled, "Abuse</p>			

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F 0226 SS=D Bldg. 00	<p>Prohibition, Reporting, and Investigation". Review of this policy at this time included, but was not limited to: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse...verbal abuse, mental abuse...Resident Abuse - - Staff Member...Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected..."</p> <p>3.1-27(a)(1)</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 record review and interviews, the facility failed to implement their policy to protect a resident when an incident of physical abuse by a staff member occurred in that, a thorough investigation was not completed, including missing staff interviews, local authorities were not notified,</p>	F 0226	<p>F226 1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice? Resident #E, there was no adverseeffects to the identified resident. 1.How will you identify other residents having thepotential to</p>	09/13/2015

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	<p>administrative staff was not notified immediately and the staff member was not immediately removed from the situation when it occurred. This deficient practice affected 1 of 1 resident reviewed for an allegation of abuse. (Resident #E)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #E on 8/14/15 at 10:45 a.m., indicated the resident had diagnoses which included, but were not limited to, episodic mood disorder, depressive disorder, and dementia with behavioral disturbances.</p> <p>On 8/13/15 at 11:00 a.m., the Administrator provided a copy of an investigative report to the Indiana State Department of Health (ISDH). It indicated CNA (Certified Nursing Assistant) #1 was holding Resident #E's wrists and laying on top of her to prevent her from striking out at staff during care. The CNA was also heard to be cursing and yelling at the resident.</p> <p>The incident report indicated the facility did not initiate an investigation into the incident until the next day and only completed some staff interviews and resident interviews were only done on C and F halls. Documentation showed no</p>		<p>be affected by the same deficient practice and what correctiveaction will be taken? Social Services will follow up withthe initial psycho-social well-being of the resident. No residents wereidentified. 1.What measures will be put into place or whatsystemic changes will you make to ensure that the deficient practice does notoccur? All staff were in-serviced on AbusePolicy and Procedures by the CEC and was completed 8/17 through 8/20/15. TheCustomer Care round managers will talk with residents to insure no evidence ofabuse not being reported immediately. Weekend supervisor will also monitor forany signs or allegations of abuse. 1.How will the corrective action be monitored to ensure the deficient practice does not recur, i.e, what quality assuranceprogram will be put into place? Executive Director will use CQI Tool for the Abuse Prohibition and investigation which will be done weekly X4, monthly X3 and then quarterly X6 and will be reviewed in CQI meetings monthlythereafter. Plan will be revised as needed. CEC in-serviced nurses on head-to-toeassessments and how to complete investigations, how and when to do weeklysummary events in computer by 9/4/15. DNS/designee will follow up</p>	

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	<p>indication that the local authorities had been contacted regarding the incident that occurred on 4/11/15.</p> <p>During an interview with the Administrator on 8/14/15 at 2:30 p.m., he indicated that he was notified by the former Director of Nursing (DON) the next morning when she had been told by her staff, instead of immediately after the incident occurred. He indicated the nurse should have removed and escorted the CNA out of the building when informed of her actions. He also indicated the investigation by the former DON was not as thorough nor handled the way it should have been.</p> <p>The written statement by CNA #2, dated 4/11/15 (untimed), indicated the following, "On Saturday 4-11-15 I witnessed CNA (name of CNA #1) on 'C' hall physically and verbally abuse residents! A resident in (Resident E's room) needed a brief change. We entered the room, resident was asleep, (name of CNA #1) grabbed her by the wrists & (and) began yelling for her to get up. The resident became combative & verbal, she attempted to hit & bite (Name of CNA #1), at that point (name of CNA #1) yelled 'calm the (expletive curse word) down'. As the resident was laying on her right side, (name of CNA #1) threw her</p>		<p>with investigations to make sure they are complete. Medical Records prints out report daily Monday through Friday to ensure summaries completed and weekends supervisor will ensure head-to-toe assessments complete if allegations of abuse occur on weekend. Executive Director will be called immediately. Medical Records will print out compliance report weekly X4 and monthly X6. Compliance Date: September 13, 2015</p>				

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	<p>entire upper torso onto the resident's left side, in an attempt to stop the resident's movements. At that point I removed (name of CNA#1) from the resident, I calmed her, & we proceeded to change the brief. (name of CNA #1) removed old brief & placed a clean one in position. The resident needed to be rolled over to finish putting the clean brief on, (name of CNA #1) grabbed the resident's knees & just flipped her completely over, crashing the resident's face into my thigh. (Name of CNA #1) was yelling & cursing again, so I finished putting the brief on. I then rolled the resident back to her right side, covered her & told her good night."</p> <p>In an interview with CNA #2 on 8/14/15 at 10:40 a.m., she indicated that CNA #1 was very angry that night because the third shift staff would not let them leave and told them they had to finish changing all their residents first. She indicated CNA #1 was still cursing and yelling when they walked into Resident #E's room to change her and continued to do so while caring for the resident. CNA #2 indicated that because CNA #1 was so angry and upset, she had told her repeatedly to just leave the room and go do something else while she and CNA #3 finished the care, but CNA #1 refused saying she had to stay and finish the care of the resident. CNA #1 continued to</p>			

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	<p>remain angry and was cursing while CNAs #2 and #3 finished the care of the resident. CNA #2 also indicated that she left the room at one point during the care while CNA #3 remained in the room with CNA #1 and the resident in order to report to the nurse what was happening. She indicated that the nurse never came into the room to check on the resident or to remove the CNA during the care.</p> <p>In an interview with CNA #3 on 8/14/15 at 9:45 a.m., she indicated she was also present during and witnessed the incident on 4/11/15. She indicated she witnessed CNA #1 holding and leaning on Resident #E and being verbally abusive also. CNA #3 indicated that because CNA#1's actions, CNA #2 went out to the desk to find a nurse to report CNA #1's actions while she stayed in the room with CNA #1 and the resident.</p> <p>In an interview on 8/14/15 at 1:00 p.m. with LPN (Licensed Practical Nurse) #1, who was the nurse on the night of 4/11/15, she indicated she could not really remember the incident very well as it was 4 months ago, but she thinks CNA #2 did come out in a "dramatic" manner yelling about what CNA #1 had done. She indicated that she did talk to CNA #1 and told her it was not proper care to hold a resident's hands while providing care to</p>			

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	<p>the resident and then let the CNA continue her rounds. LPN #1 indicated that she did not think CNA #1's actions were intentional and not meant to harm the resident. She also indicated that she thinks she assessed the resident, but did not document it as she was still new and did not know where to document it.</p> <p>On 8/13/15 at 11:00 a.m., the Administrator presented a copy of the facility's current policy titled, "Abuse Prohibition, Reporting, and Investigation". Review of the policy at this time included, but was not limited to: "...Resident Abuse - Staff member...: Policy: It is the policy of American Senior Communities to assure interventions are in place and followed to assure safety of the resident (s) is maintained if abuse is identified or suspected. Procedure: if resident abuse is identified or suspected, the following guidelines will be followed: 1. The resident (s) involved in the incident will be protected and/or removed from the situation immediately..3. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed...4. The Executive Director and/or the Director of Nursing will be immediately notified of the report and the initiation of the</p>			
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	<p>investigation. 5. The resident (s) involved in the incident will be assessed for injuries...8. An incident report will be initiated, following the guidelines for 'Unusual Occurrence Reporting' along with a narrative description in the nurses' notes....11. The investigation will include: * Facts and observations by involved employees; * Facts and observations by witnessing employees;... * Facts and observations by the supervisor or individual whom the initial report was made. 12. Follow up assessments will be completed/documented during every shift... and the resident safety is maintained...16. The Executive Director or the Director of Nursing is responsible to coordinate all investigation, processes, assures an accurate and complete written record of the incident and investigation,..."</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d)</p>			