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
	155165		06/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00202436 and IN00202917. Complaint IN00202436 -- Unsubstantiated. Complaint IN00202917 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: June 26, 27, 28, 2016 Facility number: 000082 Provider number: 155168 AIM number: 100289640 Census bed type: SNF/NF: 98 Total: 98 Census payor type: Medicare: 24 Medicaid: 66 Other: 8 Total: 98 Sample: 5 This deficiency reflects State findings cited in accordance with 410 IAC	F 0000	The creation and submission ofthe Plan of Correction does notconstitute an admission by thisprovider of any conclusion setforth in the statement ofdeficiencies, or of any violation orregulation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 06/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	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
	16.2-3.1. Quality review completed by #02748 on June 30, 2016.			
F 0323 SS=D Bldg. 00	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. Based on interview and record review the facility failed to ensure adequate or new immediate, effective interventions were provided to prevent falls for 1 of 3 residents reviewed for falls. (Resident C) Findings include: The clinical record of Resident C was reviewed on 6/27/16 at 1:31 P.M. The record indicated Resident C had been admitted to the facility on 10/26/12. The diagnoses of Resident C included, but were not limited to, psychosis, heart failure, anxiety, and diabetes. The Quarterly Admission MDS	F 0323	F323-Free of accident hazards/Supervision/Devices **What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?** ·Residents C, affected by the alleged deficient practice no longer resides in the facility **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. ·100%audit completed by DNS/ADNS/Unit Managers/Designee to identify	07/18/2016

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 06/28/2016
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
	(Minimum Data Set) assessment dated 1/6/16 indicated Resident C 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. The Quarterly MDS (Minimum Data Set) assessment dated 4/4/16 indicated Resident C 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. A Care Plan for Falls dated 12/11/14 and updated on 3/2/16 included, but was not limited to, "Problem...Falls:...Resident is at risk for fall due to: general weakness, recieves [sic] high risk medications, complicated by attempt to stand unassisted..." Initial interventions dated 12/31/15 included, but were not limited to, "...call light in reach...Environmental changes as needed...encourage walker use when ambulating...non skid footwear...Personal items in reach...Therapy as ordered..." Care Plan for Falls updated on 3/02/16 - DC (discontinued) ON: 5/23/16...included, but was not limited to, interventions of "...Do not store walker in		residents currently at risk for fall and ensure interventions on resident care plans are clinically indicated and in place. Interventions, care plans and resident profiles will be updated if indicated. Audit completed 07/18/16. **What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur?** ·All clinical staff will be in serviced on fall prevention and fall management by CEC/Designee 07/18/16. ·Nursing staff have been instructed to contact DNS and/or designee when a fall occurs to ensure appropriate interventions are discussed and implemented ·Any resident identified as a fall risk on admission, readmission, or with significant change in health status, will be discussed in IDT meeting to ensure care plan and C.N.A profiles are revised with the appropriate interventions and initiated timely. This process will be ongoing. ·Customer care representatives will conduct random audits of fall interventions 5-7 times per week during rounds and report findings during the morning meeting. This process will be ongoing ·ASC Nurse Consultants will provide additional support 3 days per week for 4 weeks and complete fall management tool during these visits as additional	

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 06/28/2016
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
	room...DC reason: no longer ambulating removed walker..." Care Plan for Falls updated on 5/23/16 included, but was not limited to, "...personal bed and chair alarms, check for placement and function each shift..." Care Plan for Falls updated on 6/13/16 included, but was not limited to, "...Scoop Mattress to bed." Fall 1. A Fall Event report indicated Resident C experienced an unwitnessed fall on 2/29/16 at 10:06 A.M., and read as follows,"...resident was self transferring, sitting on bottom with walker on the floor...shoes were off, incontinent at time of fall...What intervention (s) was put into place to prevent another fall...remove walker from resident room. Resident is not care planned for walker..." A Progress Note dated 2/29/16 10:15 A.M., read as follows: "...Pt [patient] was found sitting on bottom with walker next to pt had shoes halfway on..." Fall 2. A Fall Event report indicated Resident C experienced an unwitnessed fall on 5/21/16 at 8:17 P.M. The Event Report read as follows: "...Resident was lying in bed prior to fall...Resident was found lying on right side on floor, next to bed...Resident fully dressed with slipper		monitoring. ·Nursing administration hours have been extended in the evening hours to allow for extra supervision, this process will be ongoing **How the corrective action(s) will be maintainedto ensure the deficient practice will not recur,i.e., what quality assuranceprogram will be put into place?** ·DNS/ADNS/Designee will complete the Fall Management tool weekly times 4 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?** **7/18/16**	

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 06/28/2016
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
	socks on...location of fall... residents [sic]room...Is the resident a diabetic...No...Resident unable to describe incident, it appears she was trying to transfer self...What intervention (s) was put into place to prevent another fall...Chair alarm placed on residents [sic] wheelchair..." A Progress Note dated 5/21/16 8:20 P.M., read as follows, "...Resident had unwitnessed fall. Resident was found next to bed, it appears she was attempting to self transfer self into chair..." Fall 3. A Fall Event report indicated Resident C experienced an unwitnessed fall on 5/21/16 at 8:40 P.M. The Event Report read as follows: "...Res [resident] was sitting in wheelchair...Res found lying on right side...location of fall Res bed room ...Is resident a diabetic...Yes (accu-check at time of fall 407...injuries...Hematoma ...What intervention (s) was put into place to prevent another fall...Res sent to ...hospital for eval [evaluation] and tx [treatment]..." Documentation was lacking to indicate if the chair alarm was sounding. A Progress Note dated 5/23/16 at 1:01 P.M., read as follows, "...IDT Fall Review...Resident was noted to have two			

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 06/28/2016
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
	falls on 5/21/16 at 8:17 pm and 8:40 pm...Res refused to be put back in bed. so [sic] staff x 2 transferred res to wheelchair...New intervention: Bed alarm...prior to fall res was sitting in wheelchair...Res new intervention: Bed alarm and Wheelchair alarms to alert staff when attempting to self ambulate..." Documentation was lacking to indicate if the chair alarm was sounding. Fall 4. A Fall Event report indicated Resident C experienced an unwitnessed fall on 6/12/16 at 1:07 A.M. The Event Report read as follows: "...Res was lying on her right side, bed alarm sounding...had a brief and socks on...Is the resident a diabetic...No...injuries...Res has scratches to R [right] side of face.....New intervention: Resident to remain 1:1 until EMS arrives. Wheelchair kept within [sic] at all times and brakes locked on bedside table to prevent rolling..." A Progress Note dated 6/12/16 2:19 A.M., read as follows, "...This nurse was at the med [medication] cart when aid walked into residents room and found resident laying by her bed on her right side... Resident stated, 'I hurt,' but could not localize pain. Resident received scratches to the right side of neck and face..."			

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 06/28/2016
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
	During an interview on 6/28/16 at 11:45 A.M., the Director of Nursing (DON) indicated Resident C needed the assistance of two staff for transfers and should not have been self-transferring to the wheelchair. The Policy and procedure for "Fall Management Program" 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." 3.1-45(a)(2)			