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	155669	A. BUILDING 00 B. WING	08/07/2017

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 1, 2, 3, 4, and 7, 2017 Facility number: 011046 Provider number: 155669 AIM number: N/A Census bed type: SNF/NF: SNF: 8 NF: 0 Total: 8 Census payor type: Medicare: 5 Medicaid: 0 Other: 3 Total: 8 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 10, 2017.	F 0000	This plan of correction is to serve as Riverview TCU credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Riverview TCU or its management company tht the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitue an agreement or admission of the survey allegations. This provider requests "A Desk Review" in lieu of a Post Survey revisit. Our Date of compliance is: September 5, 2017	
F 0203	483.15(c)(3)-(6)(8)			

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

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SS=D Bldg. 00	NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;			

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	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the			

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	agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review the facility failed to notify the ombudsman when residents were discharged to home for 1 of 1 residents reviewed for discharge (Resident 55). Findings include:	F 0203	F203 483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE I. Resident 55 no longer resides in the community.	09/05/2017

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	The clinical record for Resident 55 was reviewed on 8/7/17 at 9:22 a.m. Current signed physician's orders for the resident included, but were not limited to, the following orders: a. May discharge to home with home health care. The order originated on 2/13/17. The clinical record for Resident 55 was reviewed on 8/7/17 at 11:35 a.m. The Notice of Transfer or Discharge form did not indicate the area Ombudsman had been notified of her discharge. During an interview on 8/7/17 at 11:21 a.m., the Administrator indicated the facility had not started notifying the Ombudsman of resident transfers or discharges in January of 2017. During an interview on 8/7/17 a.m., 11:33 a.m., the Administrator indicated the (TCU) Transitional Care Unit had received notice from ISDH (Indiana State Department of Health), and had been made aware of the federal regulation related to the area Ombudsman being notified before Transfer or Discharge, which was implemented on November of 2016. The Administrator indicated		II. All residents discharged between January 1, 2017 and April 28, 2017 had the potential to be affected by the alleged deficient practice. The Ombudsman has received notification of all residents discharged during this time. III. The systemic change includes all residents will have their discharge communicated to the Ombudsman if they meet the notification requirement. Education will be provided to the administrative staff regarding notification of discharge communication to the Ombudsman. IV. The Administrator/designee will audit discharges to determine if notification of discharge was communicated to the Ombudsman when the notification requirement is met. This audit will occur 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months. After 100% compliance is reached the QA committee will determine the	

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	notices of transfers or discharges from the facility had not been sent to the Ombudsman until April of 2017. During an interview on 8/7/17 at 2:20 p.m., the MDS Coordinator indicated the facility did not have a specific policy regarding notification of discharge. She indicated the facility typically would follow the federal guidelines in regard to the long term care ombudsman being notified of transfer or discharge. 3.1-12(a)(6)(A)(iv)		frequency of continued monitoring. COMPLETION DATE 9/05/2017 IDR is being requested for deficiency because we disagree with the findings.	
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review and	F 0279	F279 483.20(d);483.21(b)	09/05/2017

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	interview, the facility failed to develop health care plans for residents with psychoactive medication orders for 3 of 19 residents reviewed for health care plans (Resident 85 and 86). Findings include: 1. Resident 85 was observed calmly in her room or common areas on the following dates and times: 8/1/17 at 10:34 a.m., 8/1/17 at 11:12 a.m., 8/1/17 at 1:15 p.m., 8/2/17 at 7:46 a.m., 8/4/17 at 8:42 a.m., 8/4/17 at 10:55 a.m., 8/7/17 at 8:04 a.m., and 8/7/17 at 10:22 a.m. The clinical record for the resident was reviewed on 8/2/17 at 2:05 p.m. Diagnoses for the resident included, but were not limited to dementia, diabetes, and depression. The resident was admitted to the facility on 7/31/17 with a physician's order for Paxil (anti-depressant medication) 20 mg by mouth daily. Resident 85's clinical record lacked a health care plan for depression which required the use of Paxil. During an interview on 8/7/17 at 9:38 a.m., the MDS (Minimum Data Assessment Set) Coordinator indicated		(10DEVELOP COMPREHENSIVE CARE PLANS I. Resident 86 no longer resides in the community. This patient was discharged before the end of our survey. II. All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. All residents receiving psychotropic medications have care plans in place to address their diagnosis, targeted behaviors and measurable goals. III. The systemic change is that the facility will review residents with new psychotropic medications for placement of a care plan that includes the diagnosis for the medication, targeted behaviors and measurable goals daily during clinical stand up meeting. (Monday through Friday) Education will be provided to all licensed staff regarding comprehensive care planning when residents have psychotropic medications.	

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	the nurses completed the initial health care plans for the residents. She indicated she updated the health care plans after she had completed the MDS admission assessment. During an interview on 8/7/17 at 9:50 a.m., the MDS Coordinator indicated the nurses "should address any new concern that arises between the initial careplan and the admission assessment update careplan." During an interview on 8/7/17 at 10:02 a.m., the DON indicated the "nurses do not typically update the initial careplan." She indicated the "the documentation including orders in the computer are the updates to the care plan." The DON also indicated the nurses were required to review all orders under the "Manage Orders" tab in the electronic medical record when they started their shifts. The DON indicated the nurses for each shift were required to sign the document in the paper medical record in front of the paper health care plans which was titled "SIGNATURE INDICATES ATTENDING NURSE HAS REVIEWED PATIENT'S EXISTING CAREPLANS." During an interview with the Director of Nursing (DON) and the Administrator on		IV. The DON or designee will audit residents with new psychotropic medications for targeted behaviors and measurable goals in the care plan 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. COMPLETION DATE: 9/5/2017	

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	8/7/17 at 10:24 a.m., the DON indicated she completed audits on newly admitted residents within 24 hours of admission. She indicated she would audit the resident's record to make sure each medication had an appropriate diagnosis. She indicated she would let staff know the resident was on the medication and the reason the resident was on the medication. The DON indicated she had not initiated a careplan for Resident 85's depression and her use of Paxil. During a telephone interview on 8/7/17 at 10:58 a.m., the Social Worker indicated no mental health care plans were initiated until the MDS Coordinator had completed the MDS admission assessment. The Social Worker indicated "we do not put any mental health medications on the 48 hour initial care plan." She also indicated she "did not know they needed to put them on the 48 hour initial care plan." 2. The clinical record for Resident 86 was reviewed on 8/4/17 at 9:26 a.m., Diagnoses for the resident included but were not limited to, anxiety, chronic obstruction pulmonary disease, and pneumonia. Current signed physician's orders for the resident included, but were not limited to, the following orders:			

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a. Lorazepam (anxiety medication) 0.5 mg by mouth daily as needed. The order originated on 7/23/17.

b. Melatonin (sleep medication) 3 mg by mouth at bedtime as needed. The order originated on 7/24/17.

The resident had a 7/31/17, quarterly Minimum Data Set (MDS) assessment, which indicated the resident had no cognitive impairment.

Her admission care plan and/or her comprehensive care plan lacked her diagnosis of anxiety, resident specific targeted behaviors, and measurable goals.

During an interview on 08/07/2017 9:37 a.m., the MDS coordinator indicated the floor nurses completed all the admission care plans and she completed all the comprehensive care plans during the residents first MDS assessment. The MDS coordinator indicated if a new problem is identified between when the initial care plan and the comprehensive care plan are completed, the nurses should have addressed the problem on the initial care plan.

During an interview on 08/07/2017 9:55 a.m., the Director of Nursing, indicated

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	we use the comprehensive care plans as a tool. The initial care plan is reviewed daily, but typically we do not update the initial care plans. During an interview on 08/07/2017 10:54 a.m., the Director of Nursing indicated, the nurse will notify the physician for a new or worse condition of a resident. The physician will give an updated order, the nurse typically does not update the care plan. Review of the current facility policy, revised August 2006, titled "Care Plans -Preliminary" provided by the Director of Nursing on 8/7/17 at 2:21 p.m., included, but was not limited to, "Policy Statement: A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission. Policy Interpretation and Implementation:... ...2. The Interdisciplinary Team will review the Attending Physician's order (e.g. dietary needs, medications, and routine treatment, ect.), and implement a nursing care plan to meet the resident's immediate care needs.			

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...3. The preliminary care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan."

Review of the current facility policy, revised October 2009, titled "Care Plans-Comprehensive" provided by the Administrator on 8/7/17 at 1:25 p.m., included, but was not limited to,

"Policy Statement: Individualize comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.

Policy Interpretation and Implementation:...

...2. The comprehensive care plan is based on a through assessment that includes, but is not limited to, the MDS. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.

...3. Each resident's comprehensive care plan is designed to :

...a. Incorporate identified problem

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	areas; ...b. Incorporate risk factors associated with identified problems; ...e. Reflect treatment goals, timetables and objectives in measurable outcomes; ...4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS)." 3.1-35(a)(1) 3.1-35(d)(2)(B) 3.1-35(e)			
F 0309 SS=D Bldg. 00	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to identify resident specific targeted behaviors being treated by the use of an anti-depressant for 1 of 5 residents reviewed for unnecessary medications. (Resident 85) Findings include: Resident 85 was observed calmly in her room or common areas on the following dates and times: 8/1/17 at 10:34 a.m., 8/1/17 at 11:12 a.m., 8/1/17 at 1:15 p.m., 8/2/17 at 7:46 a.m., 8/4/17 at 8:42 a.m., 8/4/17 at 10:55 a.m., 8/7/17 at 8:04 a.m., and 8/7/17 at 10:22 a.m. The clinical record for the resident was reviewed on 8/2/17 at 2:05 p.m.	F 0309	F309 483.24, 483.25 (k) (l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING I. Resident 85 has behavior monitoring for targeted behaviors in place. II. All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. All residents receiving psychotropic medications have behavior monitoring in place for targeted behaviors. III. The systemic change is that the facility will review residents	09/05/2017

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	155669	A. BUILDING 00 B. WING	08/07/2017

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	Diagnosis for the resident included, but were not limited to dementia, diabetes, and depression. The resident was admitted to the facility on 7/31/17 with a physician's order for Paxil (anti-depressant medication) 20 mg by mouth daily. A social services note, dated 8/3/17, indicated the social worker had met with the resident's family member who stated the resident had been "cognitively declining over 2 years now." The resident's clinical record lacked any identified resident specific targeted behaviors for the use of Paxil. During an interview with the Director of Nursing (DON) and the Administrator on 8/7/17 at 10:24 a.m., the Administrator indicated the Social Worker was off today and he "was covering for her." The DON indicated she completed audits on newly admitted residents within 24 hours of admission. She indicated she would audit the resident's record to make sure each medication had an appropriate diagnosis. If a resident was on a medication such as an anti-depressant the DON indicated she would talk to the resident to determine if the resident had been on the medication prior to being		with new psychotropic medications for monitoring of targeted behaviors daily during clinical stand up meeting. (Monday through Friday) Education will be provided to all licensed staff regarding behavior monitoring for targeted behaviors for residents receiving psychotropic medications. IV. The DON or designee will audit residents with new psychotropic medications to determine behavior monitoring for targeted behaviors is in place 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. COMPLETION DATE: 9/5/2017	

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	admitted to the facility. She indicated she would also ask the resident if the medication was effective. The DON indicated if the resident was not cognitively able to be interviewed she would speak with the resident's family and ask the same questions. The DON indicated she did not ask the resident or the resident's family what the resident's signs and symptoms of their depression were, or how the resident exhibited their depression. The DON acknowledged that every resident is different and will exhibit depression differently. The Administrator indicated if the resident was unable to be interviewed he would interview the resident's family. The Administrator indicated the Social Worker also documented her notes in the chart. When asked of the DON and Administrator indicated they did not know where in the resident's clinical record would the resident's specific targeted behaviors for the use of an anti-depressant or a description of how the resident exhibits her depression for Resident 85 were located. During an interview with the Administrator on 8/7/17 at 10:52 a.m., he indicated the Social Worker "will check if medication such as an anti-depressant is being effective during her initial assessment." The Administrator			

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	indicated if the medication was effective then the Social Worker "typically does not chart about the medication." The Administrator indicated the Social Worker would document about a medication if the medication was not being effective for the resident. The Administrator indicated the documentation would be in a social services note. When asked what the Social Worker would do if the resident with depression was not crying and was not able to be interviewed and where the behaviors or the signs and symptoms for a resident being on a psychoactive medication would be documented the Administrator indicated he did not know and attempted to telephone the Social Worker. During a telephone interview on 8/7/17 at 10:58 a.m., the Social Worker indicated "during the first few days of the resident's admission I will talk to the resident about any mental health medications they are on, ask them how long they have been on it at home and if it is effective." She indicated she does not document any discussion unless the medications were not being effective. The Social worker indicated she would speak with the resident's family if the resident was not able to be interviewed and ask the same questions. The Social Worker indicated			

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	she had spoke with Resident 85's granddaughter and the granddaughter indicated the resident's anti-depressant medication was effective and the resident had been on it for a while before admission to the facility. The Social Worker indicated she did not ask Resident's 85 granddaughter how the resident exhibited her depression or the resident's signs and symptoms of her depression. The Social Worker acknowledged every resident would not exhibit depression in the same ways. When asked how she [Social Worker] or the facility staff would know if Resident 85 was showing signs or symptoms of depression, or how she or the facility staff would know if Resident 85's depression had become worse or better, the Social Worker indicated she didn't know. Review of the current, revised 4/2007, facility policy, titled "Behavior Assessment and Monitoring," provided by the Administrator on 8/7/17 at 1:25 p.m., included, but was not limited to, the following: "Policy Statement 1. Problematic behavior will be identified and managed appropriately.... ...3. The facility will comply with regulatory requirements related to the use			

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	of medications to manage problematic behavior. Assessment 1. As part of the initial assessment, the nursing staff and Attending physician will identify individuals with a history of impaired cognition...problematic behavior or mental illness... 2. The nursing staff will identify, document and inform the physician about an individuals' mental status, behavior, and cognition, including: a. Onset, duration and frequency of problematic behaviors or changes in behavior, cognition or mood...." 3.1-37(a)			