| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155165 | A. BUILDING 00<br>B. WING | 06/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RIVERVIEW VILLAGE | 586 EASTERN BLVD<br>CLARKSVILLE, IN 47129 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: June 10, 11, 12, 13, and 14, 2024.<br><br>Facility number: 000082<br>Provider number: 155165<br>AIM number: 100289640<br><br>Census Bed Type:<br>SNF/NF: 85<br>Total: 85<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 57<br>Other 24<br>Total: 85<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on June 19, 2024. | F 0000 | Please accept this plan of correction as facilities' credible allegation of compliance. Please note this facility respectfully request paper review for this survey. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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 comprehensive person-centered care plan, and the residents' choices.<br>Based on observation, record review, and | F 0684 | **F684**- Residents 6 and 18 did not | 07/12/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tina Martin | Executive Director | 07/01/2024 |

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| | interview, the facility failed to ensure the nursing staff followed procedure during 2 of 3 observations of the administration of insulin related to Quality of Care. (Residents 6 and 18)<br><br>Findings include:<br><br>1. During an observation on 6/12/24 at 10:45 a.m., LPN (Licensed Practical Nurse) 3 prepared the lispro flexpen for administration to Resident 6 by applying the needle. The LPN failed to prime the needle prior to dialing the prescribed dosage of lispro. The LPN dialed the flexpen to 10 units and entered the resident's room and administered the insulin into the resident's abdomen. The LPN indicated the resident's blood sugar was 155 mg/dL (milligrams per deciliter).<br><br>The record for Resident 6 was reviewed on 6/13/24 at 8:40 a.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus.<br><br>The physician's order, dated 5/17/23, indicated the staff were to administer 10 units of the lispro flexpen to the resident subcutaneously, three times a day.<br><br>The Annual MDS (Minimum Data Set) assessment, dated 4/9/24, indicated the resident was cognitively intact. She received 7 injections of insulin in the last 7 days prior to the assessment.<br><br>The June MAR (Medication Administration Record) indicated the resident had received the lispro three times daily.<br><br>2. During an observation on 6/12/24 at 10:46 a.m., LPN 3 prepared the Admelog flexpen for administration to the resident by applying the | | have any ill effects related to alleged deficient practice. Residents 6 and 18 received ordered/scheduled insulin per physician orders without incident.<br>All residents who receive insulin pen have the potential to be affected by the deficient practice.<br>100 % audit of residents who receive flex-pen administration will be completed.<br>-Education on administration of insulin pen and skills validations completed with all licensed nurses.<br>Observational rounds by DNS/Designee daily to ensure insulin administration is completed per physician orders.<br>Diabetic Monitoring QAPI tool will be completed by DNS/Designeeweekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. | |

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| | needle. The LPN dialed the flexpen to 25 units and entered the resident's room and administered the insulin into the resident's abdomen. The LPN failed to prime the needle prior to dialing the prescribed dose of the insulin. The LPN indicated the resident's blood sugar was 144 mg/dL.<br><br>The record for Resident 18 was reviewed on 6/13/24 at 8:53 a.m. The diagnosis included, but was not limited to, type 2 diabetes mellitus with diabetic neuropathy.<br><br>The Quarterly MDS assessment, dated 4/18/24, indicated the resident was cognitively intact. She received 7 injections of insulin in the last 7 days prior to the assessment.<br><br>The physician's order, dated 5/31/24, indicated staff were to administer 25 units of the Admelog SoloStar flexpen to the resident subcutaneously, three times a day.<br><br>The June MAR indicated the resident received the Admelog three times daily except for low blood sugar or a change in condition.<br><br>During an interview on 6/14/24 at 9:35 a.m., LPN 3 indicated that during the administration of an insulin flexpen, she should dial up the insulin and administer the insulin in the location the resident chose. She should prime the needle when she placed the needle on the insulin flexpen. She had not done that prior to dialing up the dose of insulin on 6/12/24. She thought about not having done that after she had completed the insulin administrations.<br><br>The Insulin Pen Administration procedure, reviewed October 2019, included, but was not limited to, " ... 9. Pull off and remove outer pen | | | |

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| | needle protective cap and cover. 10. Prime the pen by dialing 2 units. 11. Push the end of the pen to push out the 2 units. (A small drop of insulin should be visible. If insulin does not appear, repeat). 12. Dial desired insulin dosage to be administrated to resident ..."<br><br>3.1-37(a) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>Based on observation, record review, and interview, the facility failed to ensure oxygen concentrator filters were placed and maintained for 3 of 9 residents reviewed for respiratory care. (Residents 41,14, and 31)<br><br>Findings include:<br><br>1. During an observation on 6/10/24 at 9:37 a.m., Resident 41's oxygen concentrator filter was 100% lightly covered with a white powdery substance and multiple small chunks of a white substance.<br><br>During an observation on 6/11/24 at 10:52 a.m., Resident 41's oxygen concentrator filter was 100% lightly covered with a white powdery substance and multiple small chunks of a white substance. | F 0695 | **F695**-Residents 14, 41 and 31 did not have any ill effects related to alleged deficient practice.<br>Residents 14, 41 and 31 concentrator filters were immediately cleaned and/or replaced<br>All residents who receive oxygen have the potential to be affected by<br>the<br><br>deficient practice. 100% audit was completed on all residents who utilize oxygen with filters cleaned/or replaced.<br>-Education on placing and maintaining oxygen concentrator | 07/12/2024 |

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| | The record for Resident 41 was reviewed on 6/12/24 at 11:16 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hospice care.<br><br>The care plan, dated 1/14/21, indicated the resident was at risk for impaired gas exchange related to COPD with shortness of breath while lying flat and at times with physical exertion. The interventions, dated 1/14/21, indicated staff were to administer oxygen as ordered, assess vital signs, and lung sounds as needed, monitor oxygen saturation rates as needed and ordered.<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 3/29/24, indicated the resident was severely cognitively impaired. She received oxygen treatments.<br><br>The care plan, dated 4/11/24 and last revised on 4/26/24, indicated the resident had symptoms of decreased oxygenation related to COPD and wore continuous oxygen. The interventions, dated 4/11/24, included but were not limited to, administer oxygen as ordered, monitor oxygen saturations as ordered, and observe for continued or worsening symptoms of decreased oxygenation.<br><br>The physician's order, dated 11/26/23, indicated staff were to change the oxygen tubing and humidity, and clean the concentrator and filters on Sundays.<br><br>The physician's order, dated 11/20/23, indicated staff were to provided oxygen at 2 liters per nasal cannula and to monitor every shift.<br><br>The nurse's note, dated 7/23/23 at 9:45 a.m., indicated the resident was resting abed with O2 | | filters was completed with all licensed nurses.<br>Observational rounds by DNS/Designee daily to ensure placement and maintenance of oxygen concentrator filters.<br>Oxygen storage QAPI tool will be completed by DNS/Designeeweekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. | |

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| | (oxygen) per physician's order with O2 saturation of 98% without any SOA (shortness of air).<br><br>2. During an observation on 6/10/24 at 9:18 a.m., Resident 14's bilateral oxygen concentrator filters on the oxygen tank sides were 100% covered with a white powdery substance. A finger test indicated the white powdery substance could be wiped away.<br><br>During an observation on 6/11/24 at 10:09 a.m., Resident 14's bilateral oxygen concentrator filters were 100% covered with a white powdery substance. RN 4 swiped his finger across the left filter, removing the white powdery substance where his finger swiped.<br><br>During an interview at this time, RN 4 indicated he didn't even know that oxygen tanks had the filter on both sides like that. The staff should do weekly cleaning of the oxygen concentrator filters.<br><br>The record for Resident 14 was reviewed on 6/13/24 at 9:21 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and shortness of breath.<br><br>The physician's order, dated 3/14/21, indicated staff were to change the oxygen tubing and humidity, and clean the concentrator and filter once a day on Sundays.<br><br>The nurse's note, dated 12/9/23 at 6:07 p.m., indicated the resident had a nonproductive cough, lung sounds were diminished, but CTA (clear to auscultation). The O2 saturation was 97-98% on O2 per order per NC (nasal cannula).<br><br>The nurse's note, dated 12/10/23 at 12:40 p.m., indicated the resident's O2 was at 2 liters per NC, | | | |

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| | continuously with saturations in the high 90's. The lungs had rhonchi of the upper lobes bilaterally and diminished at the bases with no signs or symptoms of respiratory distress at 17 breaths per minute.<br><br>The care plan, dated 2/5/24 and last revised on 5/23/24, indicated the resident had symptoms of decreased oxygenation related to COPD and utilized 2 liters of oxygen continuously. The interventions, dated 2/5/24, included but were not limited to, administer oxygen as ordered, monitor oxygen saturations as ordered, and observe for continued or worsening symptoms of decreased oxygenation. On 4/15/24 the resident preferred no humidification on her O2 (oxygen).<br><br>The physician's order, dated 4/25/24, indicated staff were to provide oxygen to the resident at 2 liters per nasal cannula continuously, twice daily.<br><br>The Quarterly MDS assessment, dated 5/6/24, indicated the resident was cognitively intact. The resident received continuous oxygen treatments.<br><br>During an interview on 6/11/24 at 10:18 a.m., RN 4 indicated the oxygen concentrator filters should be cleaned. The staff may not have known the filters were there to clean.<br><br>During an interview on 6/14/24 at 9:28 a.m., LPN (Licensed Practical Nurse) 5 indicated the resident had no issues with breathing, other than just having COPD. They were not allowed to spray aerosols in the resident's room<br><br>3. During an observation on 6/10/24 at 9:17 a.m., Resident 31's oxygen concentrator had no filter to the back of the oxygen tank. A slight amount of dust was visible in the louvers. | | | |

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During an observation on 6/11/24 at 8:29 a.m., Resident 31's oxygen concentrator still had no filter.

During an observation on 6/11/24 at 10:11 a.m., Resident 31's oxygen concentrator still had no filter.

At this time, RN 4 indicated he would have to get on that to obtain a filter for the tank. It may have fallen off and housekeeping swept it up, not knowing what it was.

The record for Resident 31 was reviewed on 6/13/24 at 9:33 a.m. The diagnoses included, but were not limited to, COPD, dependence on supplemental oxygen, and seasonal allergic rhinitis.

The physician's order, dated 3/1/23, indicated staff were to change the oxygen tubing, humidity and clean the concentrator and filters on Sundays.

The physician's order, dated 5/1/23, indicated staff were to administer oxygen at 2 liters per nasal cannula to the resident.

The Quarterly MDS assessment, dated 2/24/24, indicated the resident was cognitively intact. The resident received oxygen treatments.

The care plan, dated 4/11/24 and last revised on 5/28/24, indicated the resident had symptoms of decreased oxygenation related to COPD and she wore continuous oxygen. The interventions, dated 4/11/24, included but was not limited to, administer oxygen as ordered, monitor oxygen saturations as ordered, and observe the resident for continued or worsening symptoms of

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| | decreased oxygenation. On 4/22/24 the resident preferred no humidification on the O2.<br><br>During an interview on 6/11/24 at 10:22 a.m., the DON (Director of Nursing) indicated cleaning the filter would result in better output of the oxygen and cleaner air.<br><br>The current Oxygen Concentrator policy included, but was not limited to, " ... 1) DO NOT operate the oxygen concentrator without the filter or with a dirty filter ... Daily Maintenance ... 3) Clean the air inlet filter PRN [as needed] and weekly ... b. Grasp filter and pull out. c. Wash the filter in warm sudsy water and rinse thoroughly. d. Dry filter by removing excess water with a lint free towel. e. Replace filter and turn the power on."<br><br>3.1-47(a)(6) | | | |