STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	03/04/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00453349. Complaint IN00453349 - No deficiencies related to the allegations are cited. Unrelated deficiencies cited Survey dates: March 3 and 4, 2025 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Census Bed Type: SNF/NF: 100 Total: 100 Census Payor Type: Medicare: 5 Medicaid: 57 Other: 38 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 10, 2025.	F 0000	Please accept this plan of correction as facilities' credible allegation of compliance. Please note this facility respectfully requests paper review for this survey.	
F 0744 SS=G Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview and record review, the facility failed to ensure the safety of a resident (Resident C), upon return from the hospital, from a resident (Resident D) with escalating behaviors, which resulted in Resident C's head injury/concussion	F 0744	past non compliance POC not required per 2567. Past non-compliance 10/30/24 to 11/10/24. Date indicated for correction is day after surveyors	03/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Martin	Executive Director	03/19/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	without loss of consciousness for 2 of 4 residents reviewed for dementia care. Findings include: 1. The clinical record for Resident D was reviewed on 3/3/25 at 11:15 a.m. The resident's diagnoses included, but were not limited to, dementia with other behavioral disturbance, anxiety, depression, and vascular dementia with agitation. The Behavior Note, dated 10/7/24 at 9:08 p.m., indicated the resident repeatedly attempted to enter the nurse's station. The resident kicked the doors, tried to hit the nurse and asked staff to fight. The interventions were not effective, and the resident would be referred to the psychiatrist. The Behavior Note, dated 10/17/24 at 6:15 a.m., indicated the resident was in the middle of the hall screaming. The staff attempted to help, and the resident threatened to hit staff members. The Progress Note, dated 10/21/24 at 6:52 p.m., indicated the resident had grabbed a butter knife off the table. A staff member asked for the knife and the resident refused to give the knife back. A second staff member asked the resident for the knife because the resident held the knife like he was going to stab someone with it. The nurse attempted to get the knife, and the resident tried to stab the nurse with the knife. The nurse was able to retrieve the knife and calm the resident. The resident was reassured that he was not in harm's way. The resident insisted that he would die and not make it until the morning. On 10/25/24, the resident was seen by the facility nurse practitioner with a new order for risperidone (antipsychotic) 0.25 mg (milligrams) twice daily for		exited as system does not allow a date prior to exit to be input.	

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	physical aggression and agitation. The Behavior Note, dated 10/28/24 at 9:07 p.m., indicated the patient screamed at the nurse and attempted to hit the nurse in the face. The nurse explained to the resident the treatment orders for bandage changes to his right upper extremity. The resident appeared to become more agitated which resulted in his attempt to hit the nurse in the face. The Behavior Note, dated 10/29/24 at 12:28 a.m., indicated the resident had moved the trash can, a walker and a wheelchair in front of the room door, which blocked staff from entering the room. A staff member was able to get into the room through an adjoining bathroom. When asked if everything was ok, the resident responded no and that someone was trying to kill him. The resident was unable to be re-directed and continued to place more things in front of the door to hinder staff entrance. The Care Plan, dated 10/29/24, Indicated the resident may experience paranoia thoughts such as "someone trying to kill me". Resident will place personal items such as wheelchair, trash can and walker in front of the door which doesn't allow staff to enter. Resident takes an ordered antipsychotic. The interventions included, but were not limited to, offer snack or drink, resident to see in house psych provider, and staff to ensure residents' room door remained open when not providing care. The Behavior Note, dated 10/29/24 at 12:43 p.m., indicated the resident was found in another resident's room with a plunger in his hand. A staff member attempted to assist the resident back in a chair but the resident became agitated. When other staff members came to assist, the resident			

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	became combative and hit a staff member with the plunger. The resident kept swinging the plunger in the air trying to hit everybody with it. The Progress Note, dated 10/30/24 at 1:04 a.m., indicated a staff member found the resident in the bathroom naked with the shower on. The resident was spraying himself outside the shower. The staff member assisted the resident to put new clothes on. The resident appeared very restless and was unable to sleep for more than a few minutes before he was back up. The resident was currently sitting on his roommate's bed, with the bed in the lowest position, and call light in reach. The Psychiatric Nurse Practitioner Note, dated 10/30/24 at 7:38 a.m., indicated the resident was previously started on Risperdal to assist with agitation and paranoia. A new order for Zoloft (antidepressant) 25 mg daily to improve agitation and mood. On 10/30/24 at 5:23 p.m., Resident D's roommate, Resident C, readmitted to the facility from the hospital. The Progress Note, dated 10/30/24 at 10:20 p.m., indicated the nurse heard Resident C yell for help. The nurse tried to enter the resident's room; however, the resident's room door was blocked by a wheelchair. The nurse gained access to the room from the room next door through the shared bathroom. When the nurse walked in the room, Resident D was standing over Resident C and stated, "where is my apology? You are trying to kill me!" Resident D had a wheelchair foot pedal in his hand hitting Resident C with it. The nurse intervened and immediately removed the wheelchair foot pedal from Resident D.			

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	The clinical record lacked documentation of increased safety measures or interventions to ensure Resident D's escalating behaviors were closely monitored upon his roommate's return. During an interview on 3/3/25 at 11:45 a.m., the Director of Nursing indicated on 10/29/24, a care plan was implemented for paranoia with interventions of snack, vital signs, psych to see and ensure room door when not providing care. They did not implement one on one- or 15-minute checks when Resident D's roommate readmitted due to Resident D's behaviors were towards staff. Resident D had not had any negative interaction with any resident. On 3/4/25 at 11:52 p.m., the Executive Director indicated the facility did not have a policy on dementia care, but provided a document titled "Behavior Management" dated 8/2022. It included, but was not limited to, "It is the policy...to provide behavior interventions for residents with problematic or distressing behaviors...Care plans should be initiated for any behavioral expression...Care plan interventions should include individualized and non-pharmacological interventions which address both proactive and responsive interventions...." 2. The clinical record for Resident C was reviewed on 3/3/25 at 11:37 a.m. The resident's diagnosis included, but was not limited to, dementia with mood disturbance. The Progress Note, dated 10/30/24 at 5:23 p.m., indicated Resident C had returned from the hospital. The Progress Note, dated 10/30/24 at 10:20 p.m., indicated the nurse heard Resident C yell for help.			

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	Resident D had a wheelchair foot pedal in his hand hitting Resident C. The nurse assessed Resident C and the resident was bleeding heavily from different spots on his head. The nurse called emergency medical services immediately and Resident C was sent to the emergency department for evaluation. The clinical record lacked documentation of increased safety measures or interventions to ensure the safety of Resident C upon readmission from his roommate's (Resident D) escalated behaviors. The Emergency Department Note, dated 10/31/24 at 12:56 a.m., included, but was not limited to, "the patient presented with a head injury. The patient was attached by another resident and hit repeatedly in the head with a wheelchair pedal...Diagnosis...Concussion without loss of consciousness...." The Past noncompliance began on 10/30/24 at 10:20 p.m. The deficient practice was corrected by 11/10/24 after the facility implemented a systemic plan that included the following actions: The interdisciplinary team was educated on identifying and responding to high risk behaviors (11/5/24); All residents were interviewed to assess for abuse and head to toe skin assessments were completed on non-interviewable residents (11/5/24); All staff were educated on "Recognizing and Responding to Behaviors" and "approaches and interventions to respond to behaviors" (11/10/24). 3.1-37			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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	Based on observation, interview and record review, the facility failed to ensure a resident's (Resident F) record accurately reflected the discontinuation of a wanderguard for 1 of 3 residents reviewed for documentation. Findings include: The clinical record for Resident F was reviewed on 3/4/25 at 10:30 a.m. The diagnoses included, but were not limited to, severe dementia with agitation and bipolar. The physician order, dated 12/27/24, indicated the resident had a security bracelet (wanderguard) to the left ankle and to check the placement and function every day shift and night shift. On 3/4/25 at 10:18 a.m., the resident was observed slightly reclined in a broda chair in the dining room. The resident did not have a wanderguard in place. The elopement risk assessment, dated 2/13/25 at 1:45 p.m., indicated the resident resided had a significant change, resided on a secure unit and was not assigned a security bracelet. The progress note, dated 2/14/25 at 10:45 a.m., indicated the interdisciplinary team determined the resident no longer required the use of a wanderguard due to the resident was in a wheelchair and unable to self-propel. Review of the February 2025 and March 2025 treatment administration record indicated between 2/15/25 and 3/4/25, the staff documented the resident had a wanderguard in place and the wanderguard was functioning properly.	F 0842	1 Resident F had an order written to discontinue use of wanderguard. 2 All residents requiring the use of a wanderguard have the potential to be affected. All resident requiring the use of a wanderguard have been reviewed by DNS/Designee to ensure MD orders and wanderguards are in place per order. 3 All changes in condition related to the use or discontinuation of use of a wanderguard will be reviewed in the morning meeting to ensure all orders are accurately documented in the medical record. (attachment # 1) All licensed nurses will be in-serviced on the process to discontinue wanderguard monitoring and accurately documenting in the medical record. (attachment # 2) 4 Elopement/Wanderguard QAPI tool (attachment # 3) 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	03/26/2025

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	During an interview on 3/4/25 at 11:21 a.m., the Executive Director indicated the staff were made aware of the discontinuation of the wanderguard and should have discontinued the order. During an interview on 3/4/25 at 11:59 a.m., the Director of Nursing indicated the only policy they had on wanderguards was in the elopement policy. 3.1-50(a)(2)		the ED. If a threshold of 100% is not achieved, an action plan will be developed.	