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	08/27/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 Complaint IN00440394. Complaint IN00440394 - Federal/State deficiency related to the allegations is cited at F760. Survey date: August 27, 2024 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 10 Medicaid: 55 Other: 36 Total: 101 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024.	F 0000	Please accept this plan as the facilities credible allegation of compliance. Please note facility respectfully requests paper review for this survey.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to prevent a significant medication error related to insulin administration for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include:	F 0760	1 1) Resident B did not have any ill effects related to the deficient practice. 2 2) All residents who receive insulin have the potential to be affected by the alleged deficient practice. 100% audit has been	09/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Martin		09/16/2024

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	The clinical record for Resident B was reviewed on 8/27/24 at 10:08 a.m. The resident's diagnosis included, but was not limited to, diabetes with hyperglycemia. The care plan, dated 7/24/24, indicated the resident was at risk for hyperglycemia and to administer medication as ordered. The physician's order, dated 7/23/24, indicated the resident was to receive insulin degludec (ultralong-acting insulin) 50 units, subcutaneously every morning at 6:30 a.m. The physician was to be notified of a blood sugar less than 60 or greater than 400. The July 2024 medication administration record indicated on 7/24/24 at 6:30 a.m., Resident B's blood sugar was 390. The July 2024 medication administration lacked documentation that the insulin was administered as ordered by the physician. A notation was documented by RN (Registered Nurse) 4 that the drug item was not available, the resident was new and the medication dose was unavailable. Review of the pharmacy shipment delivery indicated Resident B's insulin arrived at the facility on 7/24/24 at 7:19 a.m. During an interview on 8/27/24 at 10:38 a.m., RN 4 indicated on 7/24/24, the resident's insulin had not arrived at that time and the dosage needed was not in the omnicell (emergency drug kit). She reported to the oncoming nurse, RN 3, the residents blood sugar and RN 3 was going to give the insulin upon arrival.		completed on all diabetics to ensure timely insulin administration was completed and ensure no other residents were affected. No other residents have been identified. 3 3) Insulin administration will be reviewed daily by DNS/Designee to ensure that all insulin is given timely per physician orders. Education to be completed with all Licensed staff on administration of insulin. 4 4) Diabetic Monitoring/Insulin Administration QAPI will be completed weekly by the DNS/Designee weekly x 4 weeks, bi-monthly x 2 months, Monthly x 4 months 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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	During an interview on 8/27/24 at 10:45 a.m., RN 3 indicated she did not give the insulin because she was not aware that Resident B did not receive his insulin since the blood sugar checks were completed on night shift. During an interview on 8/27/24 at 3:16 a.m., the DON (Director of Nursing) indicated the insulin should have been administered upon arrival to the facility at 7:19 a.m. On 8/27/24 at 2:20 p.m., the DON provided a current copy of the document titled "Medication Errors" dated 11/02. It included, but was not limited to, "Policy...It is the policy of this provider to ensure residents residing in the facility are free of mediation errors..." This Citation relates to Complaint IN00440394 3.1-48(c)(1)			