

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 08/29/2013
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMONS	STREET ADDRESS, CITY, STATE, ZIP CODE 7235 RIVERWALK WAY N NOBLESVILLE, IN 46062
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 27, 28, and 29, 2013.</p> <p>Facility number : 004417 Provider number : 004417 AIM number : N/A</p> <p>Survey team : Michelle Hosteter RN-TC Gloria Bond, RN</p> <p>Census bed type : Residential : 92 Total : 92</p> <p>Census payor type : Other : 92 Total : 92</p> <p>Sample : 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on September 4, 2013.</p>	R000000	<p>This creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and request Desk Review in lieu of a Post Survey Review on or after August 29, 2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review the facility failed to conduct a fire and disaster drill in conjunction with the fire department at least every six (6) months. This had the potential to affect 92 of the 92 residents residing in the facility.</p> <p>Findings include:</p> <p>On 8/29/2013 at 9 A.M., the Maintenance Manager provided a</p>	R000092	The Maintenance Manger had a scheduled and completed a fire drill with the fire department on September 25,2013. He will schedule 2 a year. (6 month intervals) This task was also added to our TELLs system, which will monitors for completed task with our maintenance department. If it not completed notification from the tracking system will be sent to maintenance director, executive director, and the regional director of	09/25/2013			

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	<p>logbook documentation with the date and time of the past year's fire and disaster drills. The record indicated a disaster drill was conducted on 12/26/2012 in conjunction with the fire department. The next disaster drill was conducted on 7/27/2013 but it was not in conjunction with the fire department.</p> <p>During an interview on 8/29/2013 at 9 A.M., the Maintenance Manager indicated he thought they were just suppose to have one fire and disaster drill with the fire department once per year and not every six months.</p>		<p>maintenance.</p>				

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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, interview and record review the facility failed to keep the oven and stove top in the Bridge to Rediscovery memory care area clean and a door to a bottom cupboard in the same kitchen area in good repair. This had the potential to affect 22 of 22 residents residing in the Bridge to Rediscovery memory care area.</p> <p>Findings include:</p> <p>During an environmental tour on 8/28/2013 at 8:50 A.M., with the Maintenance Manager, the stove in the Bridge to Rediscovery memory care area was found to have dark baked on debris on the bottom of the oven and the drip pans under each burner were also observed with food debris on the bottom of each. The Maintenance Manager indicated that he would have to put that stove and oven on a cleaning schedule.</p> <p>The corner cupboard door near the oven was observed to have a loose hinge and the Maintenance Manager</p>	R000154	The Maintenance Manger cleaning of the stove on the daily cleaning list for both the housekeeping department and care givers in Memory Care. The housekeeping staff and care staff will be in-service on the new up-dated list. Ongoing the Maintenance Manger and Memory Care Director will monitor weekly. Audit will be done by Executive Director for compliance.	09/02/2013			

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	indicated he needed to put that on his list of repairs to get done.			

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to update a service plan for 1 of 5 residents reviewed for service plans in a sample of 7. (Resident #1034)</p> <p>Findings include:</p>	R000217	The resident's service plan was updated to include "hospice" services immediately. It was a transcription error and the ADON and DON will be auditing orders weekly. The ADON and DON will audit new orders using the triplicate copies on the MD orders. The audits will take place weekly. Quality Assurance Audits	10/01/2013			

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	<p>The record review for Resident # 1034 was completed on 8/28/13 at 2 P.M. Diagnoses included, but were not limited to, diabetes, dementia, abdominal aortic aneurysm, and high cholesterol. The resident's record indicated she weighed 145.2 lbs (pounds) on 4/30/13 and 134.4 lbs. (pounds) on 7/15/13. A loss of 7.4% of her total body weight in 2 ½ months. This resident was placed on Hospice on 5/23/13 due to an abdominal aortic aneurysm. A Physician order dated 8/15/13, indicated to give the supplement Ensure if the resident had a poor appetite.</p> <p>The most recent service plan for Resident #1034 was dated 4/30/13. There was no documentation of the resident having lost weight, receiving supplements as needed, or her receiving Hospice services.</p> <p>During an interview with the Director of Nursing on 8/28/13 at 12:25 P.M., she indicated the weight loss, the supplement, and the Hospice services should have been added to the Service plan.</p>		<p>for each resident record will take place with the Service plan reviews with the residents and families semi- annually and with changes in condition. The orders will be compared with the Service Plan as another check. The auditing is already in place and all charts will be reviewed by November 15, 2013. The Director of Nursing and the Assistant Director of Nursing will in-service the licensed nurses on receiving orders and making sure that they are placed on the service plans. The In-services will be complete within 30 days.</p>				

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R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review the facility failed to follow safe sanitation of food temperature thermometers used in checking food temperatures in the kitchen. This had the potential to affect 92 out of 92 residents residing in the facility that were served food from the kitchen.</p> <p>Findings include:</p> <p>On 8/27/2013 at 11:20 A.M., during a food temperature check, Cook #1 was observed rinsing the food temperature thermometer in the hand washing sink and then taking a clean paper towel and drying it off between food temperature testing.</p> <p>On 8/28/2013 at 10:30 A.M., during a food temperature check, Cook # 2 was observed on his way to check the temperature of soup after checking the temperature of asparagus without sanitizing the food temperature thermometer. He turned around and decided to put the food temperature thermometer in the sanitizing bucket</p>	R000273	<p>The Dietary department will utilize the alcohol pad procedure for cleaning the food thermometers. They were in-serviced immediately on the procedure. It went into effect immediately. The Kitchen staff will be in-serviced on the cleaning of the thermometers. The Food Service Director will monitor the cooks to ensure compliance several times weekly. This will affect all of the residents. Ongoing tempature log will be used to monitor and will be checked by Dining Service Manager and Designee. Compliance will be audited by the Executive Director.</p>	10/01/2013			

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	<p>water solution before proceeding to check the temperature of the vegetable soup. He indicated he just lets it air dry on the way to check the temperature.</p> <p>Immediately after checking the temperature of the food, Cook #2 was observed attempting to check the concentration of the sanitizing solution he had used to sanitize the thermometer. The test strip did not get a reading. At that time the Dietary Director indicated the testing tape Cook #2 had must not be working. The Dietary Director obtained a new testing strip but a new bucket of sanitizing solution was tested. The reading was in the 200 ppm (parts per million) range.</p> <p>Record review of the guidelines for checking food temperatures, the Dietary Director indicated he used, was reviewed on 8/28/2013 at 2:50 P.M.,indicated the following: "Make certain the thermometer is clean and has been sanitized with an appropriate sanitizer (100 ppm [parts per million] bleach solution or 25 ppm iodine solution). The use of individual foil wrapped alcohol pads also is acceptable for sanitizing probes; however, allow time for the alcohol to evaporate before inserting the probe</p>						

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	<p>into the food."</p> <p>During an interview on 8/28/2013 at 3 P.M., with the Dietary Director, he indicated he needed to review the proper procedure for sanitizing the food temperature thermometers with the kitchen staff.</p>			
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R000301	<p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the medication labels were current for 2 of 5 residents observed during the medication pass. (Resident # 1245 and Resident #1030)</p> <p>Findings include:</p> <p>1. The medication pass was completed on 8/29/13 at 9:15 A.M. Resident # 1030 was given Tramadol 37.5/325 milligrams one tablet. The label indicated Tramadol 37.5/325 milligrams 1 tablet every 6 hours as needed for pain.</p> <p>The physician's orders indicated the order was changed on 7/15/13 from Tramadol 37.5/325 milligrams 1 tablet</p>	R000301	The labels were requested and received from CVS the very same day. They were corrected at that time. The licensed nurses were all in-serviced on the medication ordering process completed on 9/24/2013. All residents with a medication order change will have an "order change" sticker placed on the package, the nurse will request a new label and will write it on the order that the request was placed. It will be audited with the order audits by the DON and ADON. Audits will be completed weekly for four weeks and monthly thereafter. The DON and ADON will keep a log. The labels were requested and received from CVS the very same day. It was corrected that that time.	10/01/2013			

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	<p>by mouth every 6 hours as needed for pain to Tramadol 37.5 milligrams 1 tablet by mouth twice daily.</p> <p>2. Resident # 1245 was given her medication at 10:15 A.M. The resident received the medication Norvasc 10 milligrams one tablet by mouth. The medication label indicated Norvasc 10 milligrams give one half tablet by mouth daily. The physician's orders indicated on 6/22/13 the order was changed to Norvasc 10 milligrams one tablet by mouth daily.</p> <p>Resident #1245 was also given Norco 5/325 milligrams one tablet every 4 hours for pain. The label indicated Norco 5/325 milligrams every 4 hours as needed for pain. The physician's orders indicated the order for Norco 5/325 milligrams every 4 hours as needed for pain was discontinued on 7/23/13 and a new order to give Norco 5/325 milligrams every four hour for pain.</p> <p>Resident #1245 was given Gas-X 80 milligrams two tablets by mouth. The label indicated Gas-X 80 milligrams 1 tablet by mouth every 6 hours as needed for gas. The physician's orders indicated on 8/7/13 the Gas-X 80 milligrams 1 tablet by mouth every</p>						

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	<p>6 hours as needed for gas was discontinued and the order was changed to Gas-X 80 milligrams 2 tablets every day at 9 A.M.</p> <p>3. In an interview with the Director of Nursing on 8/28/13 at 2:30 P.M., she indicated the labels on the medications should have a sticker placed on it when the medication orders were changed by the physician.</p> <p>A policy titled, "Medication Management Program Guidelines": dated 11/14/05 indicated, "...Changes in medication orders will require a label change to reflect the current prescription. The Community is responsible for obtaining an updated label from the pharmacy. Until the new label is provided, a colored sticker may be placed on the outdated label (alert staff to an order change)...."</p>						