

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00156211.</p> <p>Complaint IN00156211 - Substantiated. Federal/State deficiencies related to the allegations are cited at F514.</p> <p>Survey Dates: September 26 & 29, 2014</p> <p>Facility number: 003075 Provider number: 155695 AIM number: 200364160</p> <p>Survey team: Diana McDonald, RN-TC</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 10 Medicaid: 60 Other: 18 Total: 88</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The 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 of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after October 29, 2014.</p>	
---------	--	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000514 SS=D	<p>Quality Review completed on October 7, 2014, by Brenda Meredith, R.N.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to have a system in place to maintain accurate documentation related to the clinical information about each resident. This affected 1 of 1 residents, Resident A.</p> <p>Findings include:</p> <p>Resident A's clinical record review on 9/26/2014 at 2:15 p.m. Resident A's Diagnoses include, but were not limited to, dementia, senile, history of urinary track infection, muscle weakness,</p>	F000514	<p>F514– Resident Records – Complete/Accurate/Accessible It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized and that contain sufficient information to identify the resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident “A” has been</p>	10/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>osteoporosis, and hearing loss. Resident A's Brief Interview for Mental Status (BIMS) dated 8/29/2014, indicated a score of 3, severe cognitive impairment.</p> <p>On 9/29/2014 at 8:45 a.m., the Nursing Note's and Shower records for Resident A were reviewed. The following was indicated:</p> <p>1. 6/25/2014 Nursing Notes, 10:37 a.m., "...bruising continues R. [right] arm...." 6/25/2014 Nursing Note at 9:44 p.m., "...Bruising remains on right arm and is slowly resolving...."</p> <p>The 6/25/2014 Shower Report indicated no bruising or any skin problems for Resident A.</p> <p>2. 6/28/2014 Nursing Notes at 2:34 a.m., "...Bruising to right arm resolving, +2 edema to right ankle...." 6/28/2014 Nursing Notes at 10:40 a.m., "...Bruising to r [right] arm remain...." 6/28/2014 Nursing Notes at 8:04 p.m., "...Bruises to arm remain...."</p> <p>The 6/28/2014 Shower Report indicated no bruising or any skin problems for Resident A.</p> <p>3. 8/9/2014 Nursing Notes at 3:19 a.m.,</p>		<p>discharged from the facility. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken: All residents are at risk to be affected by thisfinding. A skin inspection was completedon each resident by the Nurse Management Team. Any skin issues noted during this inspection was addressed and followedup with per the facility Skin Management Program. Weekly Skin Assessments are completed on allresidents as well as skin inspections during routine bathing and showercare. Shower sheets will be completed bythe nurse aide during bathing and shower care. Any skin alterations will be noted on the shower sheet and immediatelyreported to the Charge Nurse for investigation and follow up. Shower sheets will be reviewed during weekdayclinical meetings by the Nurse Management Team and Charge Nurse on the weekendto ensure all shower sheets are accurately reflecting any resident skinalterations. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur: A nursing in-service will be conducted by theDNS/designee on or before 10/29/14. Thein-service will include review of the facility Skin Management</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>"...skin tear to right knee, a bump to right forehead, red mark on her upper and lower lips..." 8/9/2014 Nursing Notes at 6:33 a.m., "...skin tear to right night [thigh] measuring 1.5 centimeters x 3 centimeters..." 8/9/2014 Nursing Notes at 1:00 p.m., "...Res [Resident] air cast present to RLE [Right Lower Extremity], light blue bruise on forehead..." 8/9/2014 Nursing Notes at 11:38 p.m., "...Dressings on bilateral feet changed...Res[Resident] air cast present to RLE [Right Lower Extremity], light blue bruise on forehead present. Edema +2 present on right foot..."</p> <p>The 8/9/2014 Shower Report indicated no bruising or any skin problems for Resident A.</p> <p>4. 8/13/2014 Nursing Notes at 3:29 a.m., "Dressing changed to skin tears..." 8/13/2014 Nursing Notes at 10:21 a.m., "...dressings in place both legs..."</p> <p>The 8/13/2014 Shower Report indicated no dressings or skin problems for Resident A.</p> <p>5. 8/20/2014 Nursing Notes at 3:43 a.m., "...changed dressings to BLE [Bilateral Lower Extremities]..."</p>		<p>Program and the importance of accurately reporting and documenting any skin alterations noted during routine bathing and shower care. Weekly Skin Assessments are completed on all residents as well as skin inspections during routine bathing and shower care. Shower sheets will be completed by the nurse aide during bathing and shower care. Any skin alterations will be noted on the shower sheet and immediately reported to the Charge Nurse for investigation and follow up. Shower sheets will be reviewed during weekday clinical meetings by the Nurse Management Team and Charge Nurse on the weekend to ensure all shower sheets are accurately reflecting any resident skin alterations. DNS/designee will discuss and address and discrepancies in documentation with the nurse aide. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Skin Management Program" daily for 3 weeks and weekly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014	
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>The 8/20/2014 Shower Report indicated no dressing or skin problems for Resident A.</p> <p>6. 8/23/2014 Nursing Notes at 5:46 a.m., "...changed dressings to BLE [Bilateral Lower Extremities]..."</p> <p>The 8/23/2014 Shower Report indicated no dressing or skin problems for Resident A.</p> <p>During an interview with the DON (Director of Nursing) on 9/29/14 at 2:02 p.m., the DON, indicated the CNA when giving a shower or bath will notify the nurse with any skin issues and whether a dressing is clean, dry, and intact on a resident. This information should be documented on the residents shower report. Either the nurse or the CNA may document on the shower report.</p> <p>During an interview with CNA #1 on 9/29/2014 at 2:24 p.m., CNA #1 indicated she would report any skin problems or dressing problems to the nurse and document the skin problem on the drawings of the body on the shower sheet. "I just circle the body area and document it in the comment section."</p> <p>This Federal tag relates to Complaint</p>		<p>systemic changes will be completed: Compliance Date: 10/29/14.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	IN00156211. 3.1-50(a)(2)			