

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 05/15/2015
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NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
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F 000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: May 11, 12, 13, 14 & 15, 2015</p> <p>Facility number: 003075 Provider number: 155695 AIM number: 200364160</p> <p>Census bed type: SNF/NF: 89 Total: 89</p> <p>Census payor type: Medicare: 10 Medicaid: 61 Other: 18 Total: 89</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<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 June 14, 2015.</p>	
F 356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours 			

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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	<p>worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to post the updated actual hours worked per shift on the Daily Nurse Staffing Form for 5 of 5 days the posting was observed. (5-11, 5-12, 5-13, 5-14, 5-15, 2015)</p> <p>Finding includes:</p> <p>The "Daily Nurse Staffing Form" was observed and reviewed during the 5 days of the survey (5-11, 5-12, 5-13, 5-14,</p>	F 356	<p>F- 356 – Posted NurseStaffing Information</p> <p>It is the practice of this facility to ensure that nurse staffing data is available to the public for review, to post the nurse staffing data on a daily basis and to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>What corrective action(s) will be accomplished for those</p>	06/14/2015

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	<p>5-15, 2015). On 5-11-2015 at 7:45 A.M., the "Report of Nursing Staff" indicated, "Date 5-8-2015." The posting included the total number of RN's (Registered Nurses), LPN's (License Practical Nurses), and CNA's (Certified Nursing Assistants). Under the column for "Actual Hours Worked," the posting was completely filled out for all shifts, current and future, for the day.</p> <p>On 5-15-2015 at 11:04 A.M., during an interview, Employee #5 indicated, "I do the schedule as well as the Daily Nurse Staff posting, I fill out the nurse staff posting and post it first thing in the morning Monday through Friday and the front desk person fills it out for Saturday and Sunday...they didn't get it done this weekend though...I usually write the actual hours worked on the schedules after I know if there were any call offs...I don't put the actual hours on the Daily Nurse Staff posting form...."</p>		<p>residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. The current nurse staffing information with the required information is being posted daily.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents have the potential to be affected by the finding. The updated actual hours worked per shift will be posted daily in accordance with the regulation on the daily nurse staffing form. The ED/DNS/designee is responsible for ensuring that this information is posted accurately and timely each day and that the data reflects the actual hours worked per shift.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>The ED/DNS/designee will be responsible to educate the staffing scheduler along with weekend managers on the requirement for posted Nurse Staffing Information inclusive of updating the daily staffing sheet to reflect the actual hours worked per shift. The</p>				

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F 371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to store and serve food under sanitary conditions in regards to the proper dating and storage of food and the storage of pans	F 371	re-education will be completed on or before 6.13.15. 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: To ensure ongoing compliance with this corrective action, the ED/DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Administration" daily for 3 weeks and weekly for 6 months. 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 systemic changes will be completed: Compliance Date: 6.14.15 F-371 – Food Procure, Store/Prepare/Serve – Sanitary It is the practice of this facility to store, prepare, distribute and serve food in a sanitary	06/14/2015	

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	<p>and bowls. This had the potential to effect 86 of 89 resident receiving meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 5/11/15 from 7:48 A.M. to 8::30 A.M., an initial tour of the kitchen was conducted with the DM (Dietary Manager). During the initial tour the following was observed:</p> <p>At 7:55 A.M. in the dry storage room: *An open to air, undated, box of Captain Crunch cereal. *A dented 4 pound can of sliced mushrooms. The DM indicated the can should be pulled off the rack and sent back.</p> <p>At 7:57 A.M., on a shelf over the three compartment sink: *4 steam table pans were observed stored upright with 3 of them nested together.</p> <p>At 7:58 A.M., under the prep table: *A storage bin with a broken lid containing a brown bag a of powdered milk with brown crusty substance in the bottom. The DM indicated the lid is broken that is why we still have the powdered milk in the bag.</p>		<p>manner.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>There were no specifically identified residents affected by this finding. Facility meals are being distributed and served to all residents under sanitary conditions. Food products are labeled and dated and the correct storage of food and kitchen equipment to include pans and bowls is ineffect. During the course of the survey the following areas were resolved. The items in the dry storage room to include open boxed cereal and dented can were removed. The steam table pans, pans on the clean pan rack and nested mixing bowls were washed and stored correctly. The powdered milk and pureed bread was stored in a clean airtight container. The milk and eggs with date opened issues were disposed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the finding. To ensure no other unlabeled, undated or incorrectly stored food</p>		

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	<p>At 7:59 A.M., on the prep table: *A box of pureed bread, open to air, with a scoop in it. The DM indicated the bread shouldn't have been open or have a scoop in it.</p> <p>At 8:05 A.M., in the reach in cooler: *A open gallon container of skim milk dated "Best if Used By 5/01/15," with a open date of 5/8/15. The DM indicated at this time the milk shouldn't be used after the best or used by date. *A dozen hard boiled eggs open with no date. The DM indicated at this time, no we shouldn't use these.</p> <p>At 8:09 A.M., on the clean pan rack: *2 pans and 2 nested mixing bowls were observed stored upright. The DM indicated the bowls and pans should be stored upside down.</p> <p>On 5/14/15 at 1:27 P.M., the current policy "Food Storage and Handling Clean Equipment and Utensils," revised 7/13 and 05/06, was provided by the DM. The policy indicated "4. Containers with tight fitting covers must be used for storing cereals, cereal products, flour, sugar... 5. Leaking or severely dated cans....should be disposed of... 14. Leftover prepared foods are to be stored in covered</p>		<p>or kitchen equipment items were present in the kitchen, the Dietary Manager did a comprehensive audit of all areas of the kitchen with appropriate corrections to identified areas of deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur:</p> <p>An in-service for the kitchen staff will be conducted to on or before 6.13.15 to include the policy on "Food Storage and Handling Clean Equipment and Utensils by the new Dietary Manager. Emphasis will be placed on labeling and dating of food product, storage of food product, protocol for storage of dented cans, monitoring for expiration dates and storage of clean equipment inclusive of pots, pans and bowls. In addition, the Dietary Manager or his designee will audit food storage areas daily to ensure appropriate labeling and dating as well as kitchen equipment and storage practices in accordance with policy.</p> <p>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:</p> <p>To ensure ongoing compliance</p>		

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F 456 SS=C Bldg. 00	<p>containers or wrapped securely... the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded... 17. All refrigerator units are kept clean and in good working condition... 2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them form contamination...."</p> <p>3.1-21(i)(2)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, interview and record review, the facility failed to maintain mechanical equipment in safe operating condition in regards to properly operating freezer. This had the potential to effect 86 of 89 resident receiving meals from 1 of 1 kitchen.</p> <p>Finding includes: On 5/11/15 from 7:48 A.M. to 8:30 A.M., an initial tour of the kitchen was conducted with the DM (Dietary Manager). During the initial tour the</p>	F 456	<p>with thiscorrective action, the Dietary Manager/designee will be responsible for completion of the Audit Tooltitled, "Kitchen Sanitation/Environmental Review" daily for 3 weeks and weeklyfor 6 months. If threshold of 90% is not met, an action planwill be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p>Bywhat date the systemic changes will be completed: Compliance Date: 6.14.15</p> <p>F-456 – Essential equipment, safe operating condition Itis the practice of this facility to maintain all essential mechanical,electrical, and patient care equipment in a safe operating condition. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: There were no specifically identified residents affected by thisfinding. Facility equipment ismaintained in a safe operating condition to include kitchen freezers. Duringthe course of the survey, the freezer</p>	06/14/2015	

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	<p>following was observed:</p> <p>At 8:07 A.M., the reach in freezer with a large amount of ice build up across inside ceiling of the freezer and condensation on the outside of the freezer around the doors. The DM indicated they were not sure what's wrong with this.</p> <p>On 5/14/15 at 1:27 P.M., the current policy "Food Storage," last revised 7/13, was provided by the DM. The policy indicated "17. All refrigerator units are kept clean and in good working condition...."</p> <p>3.1-19(bb)</p>		<p>identified was defrosted. In addition, a new seal has been placed on the freezer door.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the finding. Each of the freezers in the kitchen was evaluated for ice build-up and door seal replacement.</p> <p>De-Frosting and/or door seal replacement has occurred for each kitchen freezers in need.</p> <p>What measures will be put into place or what systemic changes will be made to practice does not recur: An in-service will be conducted by the ED/RD/Designee on or before 6.13.15 for the Dietary Manager and Director of Maintenance relative to freezer care to include identifying and resolving ice build-up and monitoring for seal integrity to promote maintaining this equipment in safe operating condition. As a portion of daily rounds, the Dietary Manager or his designee will monitor for ice build-up and the integrity of the seals to include identifying areas where condensation may be present on the outside. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>		

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F 465 SS=F Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure and sanitary, orderly and comfortable environment in regards to properly maintained flooring and walls. This had the potential to affect 89 of 89 residents.</p> <p>Findings Include:</p> <p>On 5/11/15 at 11:48 A.M., Room 310 was observed with peeling paint under the air conditioner unit and a chair rail, broken with splinters, beside bed A and B.</p>	F 465	<p>program will be put into place: To ensure ongoing compliance with this corrective action, the Dietary Manager/designee will be responsible for completion of the Audit Tool titled, "Kitchen Sanitation/Environmental Review" daily for 3 weeks and weekly for 6 months. 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.</p> <p>By what date the systemic changes will be completed: Compliance Date: 6.14.15</p> <p>F-465 – Safe/Functional/Sanitary/Comfortable Environment It is the intent of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were no specifically identified residents affected by this finding. However, the areas identified during the course of the survey have been addressed as follows: Painting has been completed for rooms 310, 112 and 113. The chair rail</p>	06/14/2015	

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	<p>On 5/11/15 at 11:52 A.M., Room 308 was observed with a hole on the wall from the handle of the bathroom door, scuffing of the paint on the inside bottom of the bathroom door and peeling pain at the bottom of the bathroom door frame.</p> <p>On 5/11/15 at 11:54 A.M., Room 112 was observed with peeling paint from walls across from bed B and dirt on the floor in the corners.</p> <p>On 5/11/15 at 11:55 A.M., Room 304 was observed with peeling paint on the bathroom door frame and a broken, splintered chair rail behind bed B.</p> <p>On 5/11/15 at 11:58 A.M., Room 301 was observed with a hole in wall behind the entrance door, broken tile in front of the bathroom door, peeling paint on the bathroom door frame and dirt on the floor in the corners</p> <p>On 5/11/15 at 12:20 P.M., Room 113 was observed with peeling paint from the walls and dirt on the floors in the corners.</p> <p>On 5/11/15 at 2:17 P.M., Room 110 was observed with dirt on the floor in the corners throughout the room.</p> <p>On 5/11/15 at 3:00 P.M., the flooring in the 100 hall and 400 hall in front of the</p>		<p>in rooms 310 and 304 has been replaced. The holes in the walls have been repaired and painted in rooms 310, 308,301 and 108. The door frame repairs and/or door painting have been completed for rooms308, 304 and 301. The floors have been thoroughly cleaned in rooms 112, 301, 113 and 110. The broken tile has been replaced in room 301. The electric boxes have been replaced and secured with lock and key. The tile flooring in the common areas to include 100 and 400 hallway hasbeen replaced. 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 have the potential to beaffected by the finding. A house-wide auditof resident care and common areas has been conducted by the Executive Director,Maintenance Director and Housekeeping Supervisor and a comprehensive list ofitems with needed repairs was established. In an effort to reach all areas that could benefit from enhancement, anoutside contractor was secured to address common area flooring needs, drywalland chair rail repairs in each resident room, painting of resident rooms andreplacement of floor tiles as needed. Refurbishmentof these areas will be initiated no later than</p>	

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	<p>nurses station was observed. The 100 hall floor had a 7-3/4 " by 6" wide area of laminate flooring, with loose peeling edges. The 400 hall floor had a 11" by 1-1/2" area of laminate flooring with loose peeling edges.</p> <p>On 5/14/15 at 10:00 A.M., Room 108 was observed with a hole in the wall of the bathroom wall underneath the toilet tank measuring 11" high by 8-3/4" wide, exposing pipes and a black substance on walls.</p> <p>On 5/15/15 between 1:35 PM and 2:15 P.M., an environmental tour was conducted with the Maintenance Director and the Housekeeping Supervisor. The following observations were made:</p> <p>At 1:35 P.M., the floor in front of the 100 hall nurses station indicated loose, peeling laminate flooring. The Maintenance Director indicated "...there is a floor drain underneath that part of the floor so it doesn't lay well there...."</p> <p>At 5/15/15 at 1:40 P.M., the electrical panels in 100 hall and 400 hall across from floor care room and in between the clean and soiled utility room, by Social Services office were observed unlocked. The Maintenance Director indicated at this time "...they are screwed shut</p>		<p>June 9th and will continue until all areas are completed over an estimated 12-16 week period. In addition, all resident room floors were evaluated for the need of deep clean and/or stripping and waxing has occurred to bring to standard. What measures will be put into place or what systemic changes will be made to practice does not recur: An in-service will be conducted by the ED/ Designee on or before 6.13.15 for the Maintenance Director and Housekeeping Supervisor, Housekeeping Staff and Customer Care Round Representatives relative to facility upkeep and identification of areas of environmental concern during grounds and service delivery. This will include communication to the Maintenance Director and the work order process for repairs and maintenance needs and the importance of maintaining a safe/functional/sanitary/comfortable environment. The facility will conduct environmental inspections weekly through the customer care program which will include observations of resident room cleanliness and identification of areas in need of repair. Areas identified as a portion of these rounds will be directed to the housekeeping or maintenance department for necessary resolve. The ED/designee will review areas</p>	

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	<p>normally but the screws must be stripped out...they have been this way since I have been here...."</p> <p>At 1:45 P.M., a hole on the bathroom wall underneath the toilet in Room 108, the Maintenance Director indicated at this time "...the pipes broke late February of this year we had a plumbing company in to cape it...it's on my rotation to fix it but but I'm a one man show...."</p> <p>At 2:00 P.M., Room 310 the wall under the air conditioning unit was observed with peeling paint, the chair rail behind bed A and B was broken, marred with jagged edges, holes in the wall behind the entrance door and the bathroom door frame scuffed. The maintenance director indicated "I put patches over the holes but it gets hit with the handle and it punches it back out...door stop just punch through the walls. I have a hard time figuring out what to do to fix the hole problem...chair rails shouldn't be like that...it's from being beat up by beds over the years...I try to paint a room when they deep clean, but if a bigger problem comes up it takes priority over painting...."</p> <p>On 5/15/15 at 2:05 P.M., the Housekeeping Supervisor indicated "...corners of the floor shouldn't be dirty that should be taken care of during the</p>		<p>identified to ensure that all necessary repairs and correctionshave been completed.</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance with thiscorrective action, the ED/Housekeeping Supervisor/Maintenance Director or/designee will be responsible for completion of the CQI Tool titled, "Environment of Care"daily for 3 weeks and weekly for 6 months. If threshold of 90% is not met, anaction plan will be developed. Findings will be submitted to the CQI Committeefor review and follow up. Bywhat date the systemic changes will be completed: Compliance Date: 6.14.15</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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 05/15/2015
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	
	daily cleaning...." 3.1-19(f)				