

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, 12, 15 &amp; 16, 2014</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Survey team: Sue Brooker RD TC Julie Call RN (September 8, 9, 10, 11, 12 &amp; 15, 2014) Martha Saull RN (September 8, 9, 10, 11, 12 &amp; 15, 2014) Virginia Terveer RN (September 8, 9, 10, 11, 12 &amp; 15, 2014)</p> <p>Census bed type: SNF/NF: 50 Total: 50</p> <p>Census payor type: Medicare: 3 Medicaid: 22 Other: 25 Total: 50</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		
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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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F000225 SS=D	<p>Quality review completed on September 19, 2014 by Randy Fry RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law</p>			

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	<p>(including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to initiate and complete a thorough investigation of 3 facility staff (Nurse #21, CNA (Certified Nursing Assistant) #7 and CNA #3, who were reported to have been rude, mean and grumpy to residents. The facility also failed to immediately report the elopement from the facility of 1 resident (Resident #43) to the state agency. This deficiency had the potential to affect the 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During a confidential resident interview on 9-8-2014 at 11:31 a.m., the resident reported Nurse #21 was "rude and was like that to everyone." The resident indicated the nurse had not been reported to the facility administrative staff.</p> <p>During a confidential resident interview on 9-8-2014 at 2:51 p.m., the resident reported CNA #7 spoke mean and CNA #3 was grumpy on more than one occasion. The resident indicated both the CNAs had not been reported to the facility administrative staff.</p>	F000225	<p>225</p> <p>1. Riverbend Health Care Center reported allegations of Nurse #21, CNA #3 and CNA #7 on September 16, 2014. Facility reported the elopement of Res #43 on September 13, 2014.</p> <p>2. All residents have the potential of being affected by this alleged deficient practice. Interviewable residents were interview regarding abuse on September 15 and 16 with no concerns voiced. An elopement risk assessment was completed on in-house residents by a licensed nurse. One resident was identified; the physician was notified and new orders were initiated by licensed staff.</p> <p>3. The Executive Director (ED)/Social Service Director (SSD) re-educated the staff on the Abuse policy on September 26, 2014. The staff will be re-educated on the missing resident policy by October 14, 2014. Elopement drills were completed prior to September 19, 2014.</p>	10/16/2014

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	<p>During an interview with the Regional Director of Clinical Services (DCS) and the Regional Vice President of Operations on 9-8-2014 at 4:45 p.m., both of the Directors were given a report of staff being rude (Nurse #21), mean (CNA #7) and grumpy (CNA #3) at residents based on confidential interviews with residents. The Regional DCS indicated the facility had self-reported about Nurse #21 and did an investigation on 7/17/14. The Regional DCS indicated the allegations could not be substantiated and the nurse was re-educated about customer service. The Regional DCS indicated she was not aware of any reports of rudeness or grumpiness by CNA #7 or CNA #3.</p> <p>An interview with the Regional DCS on 9-12-2014 at 1:50 p.m., indicated Social Services should have done some interviews with residents about staff being rude.</p> <p>An interview with Social Services on 9-12-2014 at 2:03 p.m., indicated there was not any documentation of the recent interviews conducted with residents after the report was made about rude staff on 9-8-2014. Social Services indicated several residents were asked about how things were going and there were no</p>		<p>4. The ED/SSD will conduct Quality Improvement (QI) monitoring of regulation F 225 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted 1x weekly for 8 weeks then 1x monthly for 4 months using a sample size of 5 interviewable residents and 5 staff members. Elopement drills will be conducted monthly times 6 months rotating shifts. The findings will be brought to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5. Completion date: 10.16.2014</p>				

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	<p>complaints.</p> <p>An interview with the Regional DCS and the Executive Director on 9-12-2014 at 2:15 p.m., indicated the 3 staff (Nurse #21, CNA #7 and CNA #3) reported to be rude, mean, grumpy were not investigated nor was there a report made to the ISDH (Indiana State Department of Health).</p> <p>A previous reportable to the ISDH was provided by the Regional DCS on 9-15-2014 at 11:00 a.m. The report was dated 7-17-2014 for Nurse #21 and indicated a "resident alleges nurse was rude and unprofessional." The investigation included witness statements, resident and staff interviews, and staff re-education. .</p> <p>A previous reportable to the ISDH was provided by the Regional DCS pn 9-15-2014 at 10:08 a.m. The report was dated 7-25-2014 for CNA #7, and indicated a resident accused the CNA of pulling her arm roughly causing red marks. The incident was reported to the Executive Director, an investigation was completed and witness statements did not substantiate the accusations.</p> <p>An interview with the Regional DCS on 9-15-2014 at 3:56 p.m., indicated 2 of the</p>				

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	<p>staff were being followed and no new concerns had been brought to the facility's attention. The Regional DCS indicated the concerns communicated on Monday, 9-8-2014 were not reported to the ISDH as the facility was not given the residents names as they were kept confidential.</p> <p>An interview with the Executive Director on 9-15-2014 at 5:25 p.m., indicated the concerns about the 3 staff being rude, mean and grumpy should have been followed through, with a report to the ISDH and a complete investigation should have been done.</p> <p>2. On 9/15/14 at 10:32 a.m., an Incident Report Form was received from the Indiana State Department of Health. A brief description of the incident indicated a resident left the facility on 9/12/14 at approximately 1:00 p.m. The description also indicated she was returned to the facility at 2:05 p.m.</p> <p>A timeline for Resident #43 for the date of 9/12/14, provided by the Administrator on 9/15/14 at 1:15 p.m., indicated she had left the building at 12:50 p.m., walked to a local high school (approximately 1 mile away), and was returned to the facility on 2:12 p.m. by 2 law enforcement officers.</p>						

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F000226 SS=D	<p>The Regional Director of Clinical Services was interviewed on 9/15/14 at 1:55 p.m. During the interview she indicated the elopement of Resident #43 was not reported to the state agency until 9/13/14 at 1:35 p.m.</p> <p>A current facility policy "Resident Abuse", revised on 1/1/2 and provided by the Receptionist on 9/12/14 at 11:35 a.m., indicated "...The abuse coordinator is responsible for reporting to appropriate official in accordance with Federal and State Regulations..."</p> <p>This deficiency was cited on the annual Recertification survey on 8-21-2013 and the Post Survey Revisit (PSR) on 10-29-2013 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-28(b)(2)(c) 3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review,</p>	F000226	226	10/16/2014

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	<p>the facility failed to implement and follow their policy on reporting to the appropriate state agencies, initiating and completing a thorough investigation of 3 facility staff (Nurse #21, CNA (Certified Nursing Assistant) #7 and CNA #3 who were reported to have been rude, mean and grumpy to residents. The facility also failed to ensure the policy and procedure for Resident Abuse included the directive to report any allegation and/or actual incident of abuse to the State Agency immediately or as soon as possible after the incident. This deficiency had the potential to affect the 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During a confidential resident interview on 9-8-2014 at 11:31 a.m., the resident reported Nurse #21 was rude and was like that to everyone. The resident indicated the nurse had not been reported to the facility administrative staff.</p> <p>During a confidential resident interview on 9-8-2014 at 2:51 p.m., the resident reported CNA #7 spoke mean and CNA #3 was grumpy on more than one occasion. The resident indicated both the CNAs had not been reported to the facility administrative staff.</p>		<p>1. Riverbend Health Care Center reported allegations of Nurse #21, CNA #3 and CNA #7 on September 16, 2014. Facility reported the elopement of Res #43 on September 13, 2014.</p> <p>2. All residents have the potential of being affected by this alleged deficient practice. Interviewable residents were interview regarding abuse on September 15 and 16 with no concerns voiced.</p> <p>3. The Executive Director (ED)/Social Service Director (SSD) will re-educate the staff on the Abuse policy emphasis will be placed on reporting to ISDH allegations and/or actual abuse to immediately or as soon as possible after the incident.</p> <p>4. The ED/SSD will conduct Quality Improvement (QI) monitoring of regulation F 225 by conducting interviews with interviewable residents and staff to determine if any instances of abuse and/or neglect have occurred and need to be reported to the Indiana State Department of Health (ISDH). QI monitoring will be conducted 1x weekly for 8 weeks then 1x monthly for 4 months using a sample size of 5 interviewable residents and 5 staff members. The findings will</p>		

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	<p>During an interview with the Regional Director of Clinical Services (DCS) and the Regional Vice President of Operations on 9-8-2014 at 4:45 p.m., both of the Directors were given a report of staff being rude (Nurse #21), mean (CNA #7) and grumpy (CNA #3) at residents based on confidential interviews with residents. The Regional DCS indicated the facility had self-reported about Nurse #21 and did an investigation on 7/17/14. The Regional DCS indicated the allegations could not be substantiated and the nurse was re-educated about customer service. The Regional DCS indicated she was not aware of any reports of rudeness or grumpiness by CNA #7 or CNA #3.</p> <p>An interview with the Regional DCS on 9-12-2014 at 1:50 p.m., indicated Social Services should have done some interviews with residents about staff being rude.</p> <p>An interview with Social Services on 9-12-2014 at 2:03 p.m., indicated there was not any documentation of the recent interviews conducted with residents after the report was made about rude staff on 9-8-2014. Social Services indicated several residents were asked about how things were going and there were no complaints.</p>		<p>be brought to two quarterly Quality Assurance Performance Improvement (QAPI) committee meetings. The QAPI committee consisting of the ED, DCS, Medical Director and 3 other staff members will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>	

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	<p>An interview with the Regional DCS and the Executive Director on 9-12-2014 at 2:15 p.m., indicated the 3 staff (Nurse #21, CNA #7 and CNA #3) reported to be rude, mean, grumpy were not investigated nor was there a report made to the ISDH (Indiana State Department of Health).</p> <p>A previous reportable to the ISDH was provided by the Regional DCS on 9-15-2014 at 11:00 a.m. The report was dated 7-17-2014 for Nurse #21 and indicated a "resident alleges nurse was rude and unprofessional." The investigation included witness statements, resident and staff interviews, and staff re-education.</p> <p>A previous reportable to the ISDH was provided by the Regional DCS on 9-15-2014 at 10:08 a.m. The report was dated 7-25-2014 for CNA #7, and indicated a resident accused the CNA of pulling her arm roughly causing red marks. The incident was reported to the Executive Director, an investigation was completed and witness statements did not substantiate the accusations.</p> <p>An interview with the Regional DCS on 9-15-2014 at 3:56 p.m., indicated 2 of the staff were being followed and no new</p>			

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	<p>concerns had been brought to the facility's attention. The Regional DCS indicated the concerns communicated on Monday, 9-8-2014 were not reported to the ISDH as the facility was not given the residents' names as they were kept confidential.</p> <p>An interview with the Executive Director on 9-15-2014 at 5:25 p.m. indicated the concerns about the 3 staff being rude, mean and grumpy should have been followed through, reported to the ISDH and a complete investigation should have been done.</p> <p>2. On 9/12/14 at 11:35 a.m. a copy of the facility policy and procedure for "Resident Abuse" was received from Receptionist #1. This policy was dated 1/1/2012. This policy included, but was not limited to, the following: "The Abuse coordinator is responsible for reporting to appropriate officials in accordance with Federal and State Regulations."</p> <p>On 9/12/14 at 12:05 p.m. the Executive Director was interviewed. She indicated she is the Abuse Coordinator and would notify the stated agency within 24 hours of the allegation and/or occurrence of incident. She indicated for some situations, like outages, she notifies the stated agency within 4 hours. She</p>						

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F000241 SS=D	<p>indicated she once she is made aware of an allegation and/or situation, she immediately begins her investigation. She indicated she starts the report the day she is notified of the allegation and/or situation.</p> <p>On 9/15/14 at 1:50 p.m. the Executive Director was made aware of the interpretation of the Federal Regulation which directs Executive Directors/Abuse Coordinators to notify the state agency as soon as possible and/or immediately after they are made aware of an allegation and/or actual situation.</p> <p>This deficiency was cited on the annual Recertification on 8-21-2013 and the Post Survey Revisit (PSR) on 10-29-2013 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review the facility failed to make personal items accessible to 1 resident (Resident #60) who had been in the</p>	F000241	<p>241</p> <p>1 Res #60's personal items were unpacked on 9/13/14 and Res # 42 was notified of air freshener that was</p>	10/16/2014

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	<p>facility for 1 week. The facility also failed to notify Resident # 42, he was not allowed to have an aerosol air freshener in his room and removed the air freshener from his room without the his knowledge.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #60 on 9/12/14 at 9:27 a.m., indicated the following: diagnoses included, but were not limited to, depressive disorder, senile dementia, and morbid obesity.</p> <p>Resident #60 was admitted to the facility on 9/5/14.</p> <p>Resident #60 was interviewed on 9/8/14 at 11:21 a.m. During the interview she indicated she did not have her remote control for her television and was not able to change the channels. All her personal belongings were observed to be sealed in boxes and clear plastic bags on the floor of her room.</p> <p>A Progress Note for Resident #60, dated 9/5/14, indicated she was admitted from another long term care facility and was considered to be a long term placement.</p> <p>During observations on 9/9/14, 9/10/14,</p>		<p>removed on 9/9/14.</p> <p>2 All residents have the potential to be affected by this alleged deficient practice. The Department Heads conducted rounds on current in-house residents to ensure personal items were accessible. No other residents were identified.</p> <p>3 The ED/SSD will re-educate the staff regarding dignity, personal passions, chemical in residents' rooms, and the Personal Items Inventory Policy by 10/16/2014.</p> <p>4. The SSD/ Medical Records (MR) will conduct QI monitoring of regulation F 241 to ensure personal items are made accessible and to ensure resident notification when items are not allowed. The resident's personal inventory sheet will be reviewed the next business days after admission and resident interviews will be completed using a sample size of 5 interviewable residents. QI monitoring will be conducted weekly for eight weeks then monthly for four months The ED/SSD will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>		

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>and 9/11/14, the sealed boxes and clear plastic bags of her personal belongings were observed on the floor of her room.</p> <p>Resident #60 was interviewed on 9/11/14 at 8:50 a.m. During the interview she indicated she still did not have the remote to her television. She also indicated she was bothered her personal belongings had not yet been unpacked.</p> <p>During observations on 9/12/14, the sealed boxes and clear plastic bags of her personal belongings were observed on the floor of her room.</p> <p>Resident #60 was interviewed on 9/12/14 at 10:30 a.m. During the interview she indicated she still did not have her television remote. She also indicated she would really like to have some of her clothes which were still in the sealed boxes and clear plastic bags on the floor of her room.</p> <p>The Director of Social Services was interviewed on 9/15/14 at 9:35 a.m. During the interview she indicated when a resident was admitted to the facility, their personal belongings were usually unpacked within several days of their admission. She also indicated it was the responsibility of nursing staff to un-pack the personal belongings of a resident.</p>		<p>5 Date of completion: October 16, 2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>She further indicated the personal belongings of Resident #60 still in boxes and plastic bags for 7 days was not acceptable.</p> <p>A current undated facility policy "Your Rights As A Nursing Home Resident", provided by the Social Service Director on 9/11/14 at 10:00 a.m., indicated "...You have the right to be treated with respect and dignity...A safe, clean, comfortable, home-like environment...."</p> <p>2. During an interview with Resident # 42 on 9/9/14 at 11:34 a.m., the resident indicated the facility staff did not treat him with respect or dignity. He indicated Nurse #12 had come into his room and took his air fresheners without asking him. He indicated he became angry and confronted Nurse #12 about taking the air fresheners out of his room. He indicated she should have asked him before taking them from his room.</p> <p>A review of the clinical record for Resident # 42 on 9/11/14 at 9:00 a.m., indicated the following diagnoses included, but were not limited to, diabetes mellitus, hypertension, peripheral vascular disease, below the knee amputation, and muscle weakness.</p> <p>An interview with the MDS Coordinator on 9/12/14 at 2:00 p.m., indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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>Resident #42's MDS (Minimum Data Set) Admission Assessment was completed on 8/2/14 and indicated Resident's BIMS (Brief Interview for Mental Status) score was 15. The MDS coordinator indicated 15 was the highest score and indicated Resident #42 was cognitively intact.</p> <p>A review of the clinical record for Resident #42 on 9/11/14 at 9:00 a.m., included a document titled, "...Inventory of Personal Effects..." It did not indicate the air fresheners were being stored by the nursing staff.</p> <p>A review of the SS (Social Services) Notes dated 9/9/14 (no time) indicated, "...Res was verbally aggressive toward staff this a.m. He was yelling saying, "They ... came in my room and took my things." When asking the nurse she said he was in the room while she was in there and nothing was taken w/out (without) his knowledge. Writer got him to calm down and stop yelling...."</p> <p>During an interview with the Social Services Director on 9/11/14 at 10:02 a.m., she indicated a Resident's personal items should not be removed from their room without their knowledge, especially if the Resident was alert and oriented.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>An interview with the Regional DCS (Director of Clinical Services) #18 on 9/11/14 at 10:25 a.m., indicated the facility does not have a policy on use or storage for Resident's personal use of air fresheners in their room. She indicated the air freshener was removed from the resident's room because it was an aerosol; it was flammable and indicated it should be kept out of the reach of children. She also indicated the facility did not have a MSDS (Material Safety Data Sheet) on the Resident's air fresheners.</p> <p>During an interview with Resident #42 on 9/11/14 at 3:20 p.m., he indicated he had the air fresheners in his room since the day after his admission to the facility and indicated the staff was aware he had them in his room. He indicated he discovered the air fresheners were missing from his room after he had been sleeping. He indicated, he confronted Nurse #12, the unit manager, about his missing air fresheners. He indicate Nurse #12 rolled her eyes and got an attitude and told him he was in the room when she had taken the air fresheners. He indicated he was a very sound sleeper. He further indicated the nurse did not give him a reason why he could not have the air fresheners in his room. The resident indicated the staff did not tell him he couldn't have the air freshener in</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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>his room until "State" (Indiana State Department of Health) came into the facility. He indicated he now has to call for housekeeping staff to come a spray air freshener in his room. During the interview, Resident #42 also indicated the facility did not have him verify by signing a document the facility was storing the air fresheners for the resident.</p> <p>During an interview with Nurse #12, unit manager, on 9/12/14 at 9:20 a.m., she indicated she was the nurse who had removed the air fresheners from Resident #42's room. She further indicated, Resident #42 was half asleep when she entered the room to tell Resident #42 the air fresheners needed to be removed from his room because there was not a MSDS in the facility for the air fresheners. She indicated she had not seen the facility policy and indicated she did not have the Resident sign any documents for the removal and storage of his air fresheners. She indicated the Resident's air freshener had been in his room since he was admitted.</p> <p>On 9/11/14 at 10:00 a.m., the SS Director provided the non-dated Facility's Resident Rights, titled, Your Rights as a Nursing Home Resident, indicated the following, "...You have the right to be treated with respect and dignity in</p>				

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>recognition of your individuality and preference...."</p> <p>On 9/12/14 at 9:46 a.m., the Executive Director (ED) provided the Facility's policy, titled, Personal Items Inventory, with review date of 4/23/14, which indicated the following, "...Nursing personnel will identify the resident's belongings on admission and record....An administrative representative will enclose valuables in an envelope with resident's name, date and signatures of administrative representative and resident (if resident is unable to sign and responsible party is unavailable, two employee signatures are required....Signature of resident or responsible party/date....Any property placed in the safe will be sealed in an envelope with resident's name, medical record number and contents listed on the outside. The envelope will be noted on the inventory of Personal Effects from under "items of specific value" indicated the items are in the safe...."</p> <p>This deficiency was cited on the annual Recertification on 8/21/13 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-3(t)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident with previously documented self injuring behaviors had interventions in place to monitor and/or prevent recurrence of self injuring behaviors for 1 of 1 resident's reviewed with self injuring behaviors. (Resident #7)</p> <p>Findings include:</p> <p>On 9/10/14 at 10 a.m. the clinical record of Resident #7 was reviewed. Diagnoses included, but were not limited to, the following: Parkinson 's, Schizophrenia, Chronic Airway Obstruction, Asthma, and borderline personality disorder. The Minimum Data Set (MDS) Assessment dated 7/14/14 included, but was not limited to, the following: independent cognition, diagnoses anxiety, schizophrenia and the resident was on antipsychotic and anti anxiety medication.</p> <p>When the clinical record was reviewed at this time, a copy of the following was</p>	F000250	<p>250</p> <p>1 Res #7 care plan and Kardex was updated on 9/24/2014 upon return from the hospital</p> <p>2 All residents have the potential to be affected by this alleged deficient practice. The care plans and Kardexes of in-house residents were reviewed to ensure monitoring and/or prevention interventions are in place for residents with documented self injuring behavior. Any issues identified were corrected immediately.</p> <p>3 The ED will re-educate the SSD on the regulation F250 as well as the facility's Social Service and Team Approach policies by October 10, 2014.</p> <p>4 The ED/ SSD will conduct QI monitoring of F 250 by reviewing residents' Nurses notes, Social Services notes and Behavior Monitoring along with residents' concern forms to ensure</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>observed: "(name of hospital) Behavioral Health Psychiatrist Discharge Summary." This document included, but was not limited to, the following: "Admit date 4/2/2014 and discharge date 4/7/2014. Reason for admission, included, but was not limited to, the following: "...history of paranoid schizophrenia...patient also reported cutting himself superficially in the past 2 days and that it was the first self injury in quite some time...nurse...reports the patient has been reporting the voices are telling him to hurt himself..." The top upper left hand corner of this document had a date of "Jul (July) 3, 2014, 10 a.m." printed on it.</p> <p>A Social Service Admission Evaluation, dated 7/7/14, included but was not limited to, the following: resident was admitted to facility on 7/3/14; diagnoses of schizophrenia; psychosocial evaluation: mental health diagnosis or behavioral/emotional concerns: "yes"; schizophrenia, borderline personality disorder, takes Abilify (antidepressant) daily; will be followed by psych (psychiatric) services in-house.</p> <p>A Psychological Diagnostic Evaluation, dated 7/10/14, found on the resident's clinical record, included, but was not limited to, the following: Past Psychiatric History: "Has had...self-harming</p>		<p>medically related social services needs are being care planned, types of conditions being responded to include but not limited to podiatry, dental, eye, hearing and need for adaptive equipment along with behavioral symptoms. QI monitoring will be conducted 1 x weekly for 8 weeks, then 1 and then 1 x monthly for 4 months using a sample size of 5 residents. The ED/SSD will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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>impulses...presently describes self harming thoughts as secondary to hallucinations..."</p> <p>A Social Service noted, dated 7/16/14, included the following: "Res (resident) has been getting more quiet and keeping to himself. When writer spoke to him he said, "I feel like I'm having an episode again." He couldn't expand on what he meant. Writer sat w/ (with) him w/ little verbal interactions."</p> <p>The next Social Service note, was dated 7/17/14 and the Social Service Director had contacted the psychiatric nurse regarding the resident's feelings. On 7/17/14, the resident's medication Buspar (anti anxiety medication) was increased to 20 mg three times a day.</p> <p>The Social Service note dated 7/21/14 indicated she had left a message for the psychiatric nurse due to nursing feeling like the resident continued to display a decline over the weekend.</p> <p>The resident was seen by the psychiatric nurse on 7/24/14 with no new recommendations given.</p> <p>The Social Service note, dated 8/1/14 indicated the resident was moved to a different room, so he could be closer to</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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 nurses ' station.</p> <p>A Social Service note, dated 8/8/14 included the following: "Staff reported to writer that they went in and res (resident) was rubbing a butter knife back and forth on his wrist. Writer went in and asked why he wanted to hurt himself and he said, "I've tried before and because I know how." Res. claims he will cont (continue) to try and writer said he would have to go out for treatment and he said, "I know..."</p> <p>Social Service notes dated 8/8/14 indicated the resident was admitted to the behavior unit and a note dated 8/14/14 indicated he returned to the facility on that date.</p> <p>On 9/12/15 at 10:05 a.m. the Social Service Director (SSD) was interviewed. She indicated the following: on admission, she does an assessment of the resident. She indicated she gathers information for the resident themselves if they are considered alert and oriented. She indicated this resident would be considered alert and oriented "if he wasn't having an episode." She indicated she reviews the history and physical, talks to the family about the residents. She indicated regarding the resident's psychiatric history that nursing and social</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>service review that information. The SSD indicated the resident did not mention ever self injuring himself during her admission assessment, for example, cutting himself. At the time, the SSD indicated she was not aware of the resident's documented incident from the psychiatric discharge summary dated 4/7/14. At the time, she indicated the date of 7/3/14 in the upper left hand corner indicated the document had been faxed to the facility, probably to the admissions office in the facility and she was unaware this document existed and/or had been put on the resident's clinical record. She indicated at the time, if she had been aware of this resident's history of self injury by cutting himself, the resident would have had a care plan to address this concern.</p> <p>On 9/12/14 at 10:20 a.m. a current copy of the resident's "Nurse Tech (technician) information Kardex" was received from the SSD. This form included, but was not limited to, the following: "Special considerations" and "Behavior Interventions" recommendation areas were blank as well as the back of the form. The section titled "safety" lacked documentation of reference to sharps and self injury of the resident.</p> <p>A policy and procedure for Behavior</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>Monitoring, provided by the Administrator (ADM) on 9/12/14 at 1:20 p.m. was dated 2/20/14. This policy included, but was not limited to, the following: "Residents demonstrating behaviors that place the resident at risk, or interfere with care or other residents will be monitored and interventions initiated as an individualized approach to minimize behavior." Procedure included, but was not limited to, the following: "Behavior monitoring: Residents who exhibit behaviors will have a "Behavior Symptom Monitoring" flow record completed. Documentation of behavior and interventions for those behaviors including non-pharmacological interventions will be completed with each behavior...Residents with active behaviors that place the resident at risk, interfere with care, or compromise the quality of care or quality of life will be reviewed by the interdisciplinary team on a regularly scheduled time. Residents with history of behaviors that are not active may be reviewed as determined by the interdisciplinary team. Interdisciplinary team will review behaviors, causative factors/triggers and or root cause to determine individualized interventions to minimize or eliminate the targeted behaviors. Resident's plans of care will be updated as needed..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>On 9/15/14 at 9:40 a.m. the Social Service Director was interviewed. She indicated the resident did not have a Behavior Flow record as was mentioned in the Behavior Monitoring Policy and Procedure. She indicated nursing would make her aware of a resident's behavior by noting the behavior on the 24 hour report. She also indicated the facility knows they can call her at any time day or night and the facility also has a member of management in the facility on the weekends. She indicated the facility was "monitoring everything on him." She indicated when the resident heard voices on 9/7/14, as was documented in the fall investigation on 9/7/14, she was not made aware of this situation until Monday, 9/8/14. She indicated it was not new for the resident to hear voices and it would depend on what "the voices were telling him" as to if she was notified or not.</p> <p>An observation on 9/15/14 at 9:40 a.m., included a bag with a safety razor which was now kept in the SSD office, and had been removed from the resident's room after the search conducted when they found the resident with "scratch" marks on his inner wrist on 9/8/14. The SSD indicated the resident had gone out of the facility with his sister on 9/6/14 but the facility was unaware how the safety razor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000281 SS=D	<p>got into the resident's room. The SSD indicated the facility did have a plan in place to keeps sharps out of the resident's room but she was unable to find documentation of this plan. The SSD indicated the resident was not to have sharps in his room due to his history of self injury. The plan of care was dated 7/9/14. She indicated the approach of "Maintain (resident's name) free of clutter and safety hazards" would indicate to not permit the resident to have sharps in his room.</p> <p>3.1-34(a)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview and record review, the facility failed to ensure Nurse #12 checked the placement of a jejunostomy tube (j-tube) prior to instilling medications through the j-tube for 1 of 1 resident reviewed for medication pass through a jejunostomy tube. (Resident #32)</p> <p>Findings include:</p> <p>During an observation of the medication pass on 9-10-2014 at 11:27 a.m., Nurse</p>	F000281	<p>281 1 Res #32 J tube placement is verified according to the Physician Order Sheet/MAR. 2 Residents utilizing a jejunostomy tube (J-tube) have the potential to be affected by this alleged deficient practice. No other residents utilize a J-tube. 3 The Director of Clinical Services/ Nurse Manager will re-educate the licensed nurses on J tube placement and verification by 10/14/2014. 4 The DCS/ Nurse Manager will conduct QI monitoring of regulation F281 by observing the nurse during medication administration via</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>#12 was observed to prepare medications for Resident #32 as follows:</p> <ul style="list-style-type: none"> <li>- miles magic suspension 10 ml (milliliters) poured into a 30 ml plastic cup</li> <li>- Diphenist (an antihistamine) 12.5 mg (milligrams)/5 ml, 10 ml was observed to be poured into a 30 ml plastic cup</li> <li>- acetaminophen (for pain) 160 mg/5 mg; 10 ml was observed to be poured into a 30 ml plastic cup</li> <li>-Hydromorphone (for pain) 2 mg tab-3 of the 1/2 tabs were crushed and placed in a 30 ml plastic cup</li> <li>- Ondansetron HCL (an anti-nausea and vomiting medication) 8 mg tab; 1 tab was crushed and placed in a 30 ml plastic cup</li> <li>- Tramadol (for pain) 50 mg tab; 2 tabs were crushed and placed in a 30 ml plastic cup</li> </ul> <p>Nurse #12 carried the six 30 ml cups into the resident's room. The contents of all 6 medication cups were administered through the J-tube (the crushed medications were each mixed with water). The J-tube was not observed to be checked for placement prior to administration of medications.</p> <p>An interview with the Regional Director of Clinical Services (DCS) on 9-12-2014 at 10:22 a.m., clarified the "Medications - Administration via Enteral Tube" policy indicated placement was to be checked</p>		<p>J-tube. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. 5 Date of Compliance: 10/16/2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>for either a G (gastrostomy) tube or a J (jejunostomy) tube prior to medication administration through either tube.</p> <p>An interview with Nurse #5 on 9-12-2014 at 10:34 a.m., indicated Resident #32's J-tube was not to be checked for placement. Further interview with Nurse #5 indicated the nurse was unaware of the facility policy for checking all enteral tubes for placement prior to administering anything through the tube.</p> <p>A J-tube care plan for Resident #32 provided by the Executive Director (ED) on 9-12-2014 at 10:40 a.m., indicated "...verify proper placement of tube prior to all fluids/meds...."</p> <p>An interview with Nurse #13 on 9-12-2014 at 10:51 a.m., indicated Resident #32 had little syringes in the resident's room. Nurse #13 indicated to check the J-tube for placement, a little bit of air from the syringe which was attached to the J-tube was pushed through the J-tube end and the nurse indicated she was able to listen to the swoosh with her stethoscope that was placed on the resident's abdomen.</p> <p>An interview with the Facility Director of Clinical Services #4 on 9-12-2014 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>12:15 p.m., indicated staff were unable to find the Lippincott Nursing Reference manual.</p> <p>An interview with the Regional DCS on 9-12-2014 at 1:30 p.m., indicated the facility had use of the Lippincott or Potter and Perry nursing reference books. Further interview with the Regional DCS indicated if the facility did not have the Lippincott or Potter and Perry nursing reference books available, the facility policy for checking enteral tubes should be followed.</p> <p>A policy "Medications-Administration via Enteral Tube" dated 8-8-2013 and provided by the Regional Director of Clinical Services on 9/11/14 at 4:00 p.m., indicated as follows: "13. if J-Tube (Jejunostomy Tube) a. turn stopcock to off position 1. c. pinch off the tube with your fingers or clamp and remove plug or open the cap, depending on the type of tube. Checking For Placement Of Enteral Tube To confirm proper placement 1. a. Attach syringe to end of tube and place stethoscope over left upper quadrant of the resident's abdomen. Instill approximately 20 cc (cubic centimeter) of air using the syringe while listening for a 'swooshing" sound in the stomach...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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F000282 SS=E	<p>3.1-35(g)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on interview and record review, the facility failed to ensure physician orders were followed for 1 resident (Resident #14) of 32 residents who were reviewed for physician orders.</p> <p>B. Based on observation, interview and record review, the facility failed ensure 3 of 6 nurses (Nurses #12, #15 and #14) followed physician orders for 3 of 9 residents (Residents #32, #30 and #5) observed during the medication pass.</p> <p>Findings include:</p> <p>A. 1. Review of the clinical record for Resident #14 on 9/10/14 at 8:40 a.m., indicated the diagnose's included but were not limited to, endocarditis, cardiac valve prosthesis, diabetes mellitus (DM), peripheral vascular disease, unilateral above the knee amputation (AKA), amputation of toe, debility, osteomyelitis, sepsis, open wound on buttock. The most recent MDS (minimum data set assessment) dated 8/15/14 indicated the</p>	F000282	<p>282 1 Res #14's physician's orders clarified. Res #32, #30, and #5 show no apparent adverse effects. 2 All residents have the potential to be affected by this alleged deficient practice. The DCS/ Nurse Manager reviewed the physician's orders and the Medication Administration Record (MAR) for in-house residents. Any discepenencies identified were corrected immediately. 3 The DCS/ Nurse Manager will re-educate the licensed nurses to follow physician's orders by 10/14/2014. 4 The DCS/ Nurse Manager will conduct QI monitoring of regulation F282 by observing the nurse during medication administration. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of 2 nurses. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken</p>	10/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>BIMS (Brief Interview Mental Status) score was 15 of 15 which indicated the resident was cognitively intact. The resident's clinical record also indicated the resident was admitted to Hospice Services on 8/22/14 with a diagnosis of endocarditis.</p> <p>The Physician's Orders included the following:</p> <ul style="list-style-type: none"> <li>-The admission orders from the hospital, dated 8/8/14 indicated, "...Hydrocodone-acetaminophen (Narco) 5-325 mg (milligrams) 1-2 tab (tablets) orally (po) every 6 hours as needed.</li> <li>-Dated 8/8/14 included, "...change Narco 5/325 mg mg 1-2 tab po q (every) 6 H (hours) as needed (PRN) to Norco 5/325 mg 1 tab po q 6 H as needed for pain moderate 1-5 and Narco 5/325 mg 2 tabs po q 6 H as needed for pain severe rate 6-10..."</li> <li>-Dated 8/15/14 indicated, "...Xanax 0.25 mg 1 (tab) po q 6 hrs PRN anxiety..."</li> <li>-Dated 8/18/14 indicated, "Oxybutynin 5 mg po TID for Bladder Spasms..."</li> <li>-The Physician's Orders recapulations dated 9/01/14 through 9/30/14, signed by the MD without a date indicated,</li> </ul>		and determine the continued time schedule for further monitoring. 5 Date of completion: 10/16/2014				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>"...Norco 5/325 mg 1 tab po q 6 hours PRN/moderate pain (original date 8/8/14). Narco 5/325 mg 2 tabs po BID (2 times a day) PRN/severe pain (original dated 8/8/14).</p> <p>-Dated 8/29/14 indicated, "...Norco 5/325 mg 1 po every 8 hours routine. Continue PRN dosing instructions...."</p> <p>The Physician Progress Note dated 8/15/14 at 10:00, indicated, "Acute visit. Pt asked to see writer. C/O (complaint of) SOB (shortness of breath). O2 sat(Oxygen level) 98%...BP (blood pressure) increased, HR (heart rate) increased, denies chest pain, afibrile, appetite is good, no cough...debility, DM II, morbid obesity, s/p (status post) AKA, Anxiety?? [sic]...Plan: Xanax 0.25 mg 1 po q 6 hrs prn anxiety...."</p> <p>The Palliative Medicine progress note on 8/18/14 at 11:00 a.m. indicated, "...groaning "the pain comes and goes, and it's bad." between bladder spasms rates pain 0 (zero), with spasms is 10....A/P (Assessment /Plan) Bladder spasms...Plan: 1) UA , C&amp;S (urinalysis and culture and sensitivity, lab test)...2) Irrigate Foley now and PRN...3)Oxybutynin 5 mg po TID (3 times a day)...4) Re-eval in 5-7 days...."</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>The non-dated MARS (Medication Administration Record Sheet) indicated the following:</p> <ul style="list-style-type: none"> <li>-Narco 5/325 mg 1 tab po q 8 hours routine at 7 am, 3 pm and 10 pm., indicated Narco was not given 8 hours routinely as ordered on the (September) 1st, 2nd or 3rd of the month.</li> <li>-Oxybutynin 5 mg po TID was not given until 9/19/14 at 8 a.m.</li> <li>-Xanax 0.25 mg 1 tab q 6 hours prn for anxiety was not listed on the August or September MARS.</li> </ul> <p>An interview on 9/11/14 at 4:35 p.m. with the Regional DCS indicated Resident #14 did not receive the ordered Oxybutynin for bladder spasms on 8/18/14 because the medication did not arrive at the facility until after the 10:00 p.m. pharmacy delivery. She indicated the nurse would have needed to call the physician to be able to give the Oxybutynin outside of the time parameters. She indicated the Oxybutynin was not available in the Facility's EDK (Emergency Drug Kit).</p> <p>An interview on 9/15/14 at 9:05 a.m. with the Facility DCS # 4 indicated she could not tell how the nurse would know</p>			
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>when the Narco could be given to the resident. She indicated she would have to review the Narco orders and MARS to determine the time between administration of the Narco. She further indicated the routine Narco was not documented as given as ordered on 9/1/14, 9/2/14, and 9/3/14.</p> <p>A review on 9/15/14 at 11:15 a.m. of Resident #14's Physician's Order dated 8/15/14 for Xanax 0.25 mg 1 tab po q 6 hr prn anxiety, indicated the order was not signed with the initials of the nurse as completed transcription of the order.</p> <p>An interview on 9/15/14 at 11:30 a.m. with the Facility DCS #4 indicated the MD order dated 8/15/14 for Xanax 0.25 mg q 6 hrs. PRN was not transcribed. She indicated the Xanax was not on the August or September 2014 MARS; the Xanax was not in the medication cart nor in the locked controlled substance box and there was not a Controlled Substance Record for the Xanax for Resident #14. She indicated the ordered must not have been received by the pharmacy and was not followed up by the facility's nurse and the resident had not received the Xanax as ordered.</p> <p>An interview on 9/15/14 at 12:33 p.m. with the Facility DCS #4 indicated she</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>reviewed the Resident #14's Narco orders and indicated the MD orders were not clear and not easy to follow. She indicated it was difficult to determine if the Resident should be given 1 or 2 tablets of the Narco for breakthrough pain. She indicated the Physician's Order for Narco needed to be clarified with Hospice.</p> <p>B.1. An observation of Nurse #12 included the following:                      - on 9-10-2014 at 11:27 a.m., 10 ml (millimeters) of Miles Magic Susp (Suspension) was poured into a medication cup. The medication was observed to be given per Resident #32's jejunostomy tube (j-tube).                      - on 9-10-2014 at 11:30 a.m., Hydromorphone was prepared for Resident #32 with three of the 1/2 tabs crushed and placed in a medication cup. The medication was observed to be given per Resident #32's j-tube.</p> <p>A review of Resident #32's orders for September 2014, indicated the following:                      - "Meds (medications) reviewed by...LPN...8-27-2014...."                      - the orders were signed by the physician and the signature was undated.                      - the order for Miles Magic Susp was dated 9-26-2013 and read "swish and spit 10 ml orally 4 times a day for mouth sores."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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 order for Hydromorphone 2 mg (milligram) tablet was dated 8-8-2014 and read "...give three 1/2 tabs (3 mg) orally every 4 hours around the clock."</p> <p>An interview with Nurse #12 on 9-10-2014 at 11:47 a.m., indicated the Miles Magic Suspension was administered through the j-tube and Nurse #12 indicated the Miles Magic Suspension should have been given by mouth for the resident to swish and spit.</p> <p>An interview with Nurse #12 on 9-12-2014 at 10:34 a.m., indicated the physician's order for the Hydromorphone on the September 2014 recapitulation for Resident #32 was to administer orally. Nurse #12 indicated the Hydromorphone order should have been written to administer via the j-tube.</p> <p>B.2. An observation of the medication pass by Nurse #15 on 9-11-2014 at 8:52 a.m., indicated the following: - Resident #30 was given the Advair diskus by Nurse #15 and the resident was observed to inhale 1 puff. The resident was not observed to be instructed by the nurse to rinse his mouth after the inhaler, nor was the resident observed to rinse his mouth on his own.</p> <p>A review of Resident #30's orders for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>September 2014 indicated the following:</p> <ul style="list-style-type: none"> <li>- the orders were signed by the physician and the signature was undated.</li> <li>- the order for the Advair 250-50 diskus was dated 6-11-2014 and read "inhale 1 puff orally once a day * rinse mouth after use * ...."</li> </ul> <p>A review of the package instructions provided by the Regional Director of Clinical Services (DCS) on 9-11-2014 at 11:20 a.m., indicated the prescription as follows, "Advair 250-50 diskus inhale 1 puff orally once a day * rinse mouth after use...." An additional sticker on the package indicated "after use: rinse mouth and spit...."</p> <p>An interview with Nurse #13 on 9-12-2014 at 10:10 a.m., indicated after Resident #30 inhaled the Advair diskus, the resident should have rinsed their mouth with water and spit.</p> <p>B.3. During an observation on 9/10/14 at 10:00 a.m., Resident #5 was observed resting in bed. A small plastic cup of thickened water was on a stand next to his bed. The small plastic cup contained a straw.</p> <p>During an observation on 9-11-2014 at 4:02 p.m., Nurse #14 was observed to administer a medication for Resident #5</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>with a nosy cup which contained thickened water and a straw.</p> <p>An interview with the facility Dietitian on 9-11-2014 at 4:30 p.m., indicated Resident #5 did not have an order for the use of a straw.</p> <p>A review of physician's order dated 8-4-2014 for Resident #5, indicated the following: "Recommend d/c (discontinue) straws to (arrow pointing up) increase liquid bolus control and (arrow pointing up) increase safety." The order was signed by the physician and dated 8-13-2014.</p> <p>An interview with Nurse #14 on 9-11-2014 at 4:38 p.m., indicated the September MAR (Medication Administration Record) had an order dated 6-3-2014 to use the straw. Further interview with Nurse #14 indicated the nurse was not aware of the 8-4-2014 order to discontinue the use of the straws.</p> <p>An interview with the Regional DCS on 9-11-2014 at 4:50 p.m., indicated the August and September 2014 MARs were not updated with the "no straw" order. The September 2014 recapitulation was signed by the physician on 8-13-2014 and reviewed by the nurse on 7-31-2014. The order on the MAR, "nosey cup for all</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>liquids w/ (with) straw was not updated to reflect the 8-4-2014 order for "no straws."</p> <p>A review of the nurse tech information kardex with the Regional DCS on 9-11-2014 at 4:51 p.m., indicated restrictions were nose cups; honey and thickened liquids were checked and the form lacked documentation of "no straws."</p> <p>An interview with the Regional DCS on 9-11-2014 at 4:52 p.m., indicated "no straws" should have been written on the nurse tech information kardex.</p> <p>A policy "Physician Orders" dated 5-9-2014 and provided by the Executive Director on 9-11-2014 at 4:00 p.m., indicated "a Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...4. The order must then be transcribed to all appropriate areas (MAR, Treatment Administration Record, ect)...5. The nurse shall sign off the orders upon completion...."</p> <p>This deficiency was cited on the annual Recertification survey on 8-21-2013, the Post Survey Revisit (PSR) #1 on 10-29-2013 and PSR #2 on 12-3-2013. The facility failed to implement a plan of correction to correct the deficiency.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000315 SS=D	<p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to provide services to maintain and/or prevent a decline in the resident's urinary status for 1 of 1 residents reviewed for urinary incontinence. (Resident #21)</p> <p>Findings include:</p> <p>On 9/11/14 at 3 p.m. the clinical record of Resident #21 was reviewed.</p> <p>Diagnoses included, but were not limited to, the following: Diabetes, cognitive deficit, chronic kidney disease and urinary incontinence. The MDS (minimum data set) assessment dated 4/18/14 included, but was not limited to, the following: a total cognition score of 10, which indicated moderately impaired cognition; extensive assist required for</p>	F000315	<p>315</p> <p>1. Res #21's urinary status reviewed and updated on 9.28.2014.</p> <p>2. Residents incontinent of bladder and residents with an indwelling catheter have the potential to be affected by this alleged deficient practice. The DCS/ Nurse Manager reviewed current in-house residents with incontinence of bladder or an indwelling catheter for a decline in status and no other residents were identified.</p> <p>3. The DCS/ Nurse Manager will re-educate licensed nurses on assessing the bladder and the facility's Bladder Independence/ Retraining policy by</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>toileting, occasionally incontinent (less than 7 episodes of incontinence in the review period) and not on a toileting program. The MDS dated 7/14/14 included, but was not limited to, the following: total cognition score of 12, which indicated a slight improvement in cognition but still moderately impaired; total dependence for toileting, frequently incontinent (7 or more episodes during the review period) and no toileting plan.</p> <p>The Admission Data collection form, dated 4/9/14, and included but was not limited to, the following: short term and long term memory ok; alert to person and place; moderately impaired cognition; occasionally incontinent of bladder, pads/briefs used and the skin assessment portion of the form indicated the resident's skin was "rarely moist."</p> <p>A plan of care, dated 4/10/14 addressed the problem of "(resident name) is at risk for urine retention due to BPH (benign prostatic hypertrophy) or obstructive uropathy. The goal is the resident will be able to empty his bladder. Approaches included but were not limited to the following: allow adequate time to urinate.</p> <p>A plan of care, dated 4/10/14, addressed the problem of "(resident name) is</p>		<p>October 14, 2016.</p> <p>4. The Minimum Data Set (MDS) Coordinator/Nurse Manager will conduct QI monitoring of regulation F315 by reviewing bladder assessments completed by licensed nurses. QI monitoring will be conducted once a week for eight weeks then monthly for four months using a sample size of 5 residents. The MDS Coordinator/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5. Date of Completion: 10/16/2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>occasionally incontinent of urine; approaches included but were not limited to, the following: provide verbal cueing; assist to bathroom or commode as needed.</p> <p>Care conference records dated 4/23/14 and 7/23/14 indicated quarterly assessment with no changes as well as no concerns.</p> <p>On 9/10/14 at 8:30 a.m. the resident was observed in his room in his wheelchair (wc). A urinal was observed on the resident's bedside table.</p> <p>On 9/11/14 at 9:26 a.m. the resident was interviewed. He indicated when he has to go to the bathroom, he "goes in the jug." He pointed to a urinal in his room, on the table. He indicated he is aware when he has to go to the bathroom, and calls the girls to help him "go in the jug. He then stated "I'm incontinent."</p> <p>On 9/11/14 at 9 55 a.m. CNA #30 was interviewed. She indicated she was caring for the resident today. She indicated the following: the resident will call for assistance when he has to go to the bathroom and use the urinal. She stated she takes him to the bathroom when he gets up in the morning and also after lunch. She indicated he doesn't</p>				

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>have to urinate before lunch.</p> <p>On 9/12/14 at 9 a.m. the FDSC (Facility Director of Clinical Services) and the RDSC (Regional Director of Clinical Services) were interviewed. They indicated that if an area of the Nurse Tech Information Kardex is left blank, the area does not have a concern. The RDSC indicated the information in the care tracker (computer system in which the CNAs (certified nursing assistants) input the resident's care information) is reflective of the care designated on the Kardex. They indicated the resident does let the staff know during the day when he needs to void. The RDSC indicated the resident is currently not on a formal toileting program and the bowel and bladder program at the facility is an area for improvement. She indicated the resident is able to verbalize his need to void and is not considered a "check and change." The RDSC did indicate at night the resident should be checked every 2 hours. The FDSC indicated the resident should have a plan for his bladder function on the Kardex.</p> <p>On 9/12/14 at 9:45 a.m. the MDS (minimum data set) assessment nurse was interviewed. She indicated she gets a report for the care tracker system and prints out a 7 day time frame. This</p>			

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	<p>indicated what the CNAs enter into the system is calculated by the computer regarding "frequently incontinent" is at least 1 episode of continence but mostly incontinent. She indicated "occasionally incontinent" is when the resident has under 7 incontinent episodes in a 7 day time period.</p> <p>On 9/12/14 at 10 a.m. the current "Nurse Tech (technician) information Kardex was reviewed. This form included, but was not limited to, the following: regarding elimination: incontinent of bladder, uses bathroom, uses urinal, assist of 1, scheduled toileting plan and incontinent; the entire section was blank.</p> <p>On 9/12/14 at 1:20 p.m. the Administrator provided a current copy of the facility policy for "Incontinence Data Collection - Urinary", which was dated 1/4/13. This policy included, but was not limited to, the following: "The Incontinence Data Collection tool will be completed on residents with incontinence on admission...quarterly...the information obtained by utilizing this tool will determine interventions to reduce incontinence...Obtain Incontinence Data Collection Tool, Interview residents...to complete Incontinence Data Collection Tool; complete incontinence data collection tool...determine type of</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000323 SS=E	<p>incontinence...characteristics...voiding pattern...implement interventions to assist in reducing incontinence."</p> <p>On 9/15/14 at 1:30 p.m. the RDSCS was interviewed. She indicated the facility does not determine the type of incontinence residents experience.</p> <p>On 9/15/14 at 2 p.m. the FDSCS was interviewed. She indicated she was aware the resident's Kardex was blank and did not reflect a plan of care to assist the resident in maintaining his bladder status.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to prevent and identify the elopement of 1 resident (Resident #43) who was missing from the facility for over 1 hour. Based on observation, interview and record review, the facility also failed to ensure a resident with a history of falls had adequate supervision and/or recommended interventions in place to</p>	F000323	<p>323</p> <p>1. Res #43 no longer reside in the facility. Res #7 and Res #15 interventions updated on 9/12/14, chemicals were removed from resident's access on 9/12/14.</p> <p>2. All residents have the potential to be affected by</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>prevent falls for 2 of 3 resident's reviewed for falls. (Resident #7, Resident #15) and to ensure resident medications, Epi-Clenz hand sanitizer, alcohol prep pads and bleach germicidal wipes were secured and out of reach of confused and mobile residents who resided in 3 of 3 halls (East, South and West) in the facility. This deficient practice had the potential to affect 11 confused and mobile residents of the 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #43 on 9/15/14 at 12:15 p.m., indicated the following: diagnoses included, but were not limited to, mood disorder, TBI (traumatic brain injury), depression, and anxiety.</p> <p>Resident #43 was admitted to the facility on 7/18/14.</p> <p>An Elopement Risk Evaluation for Resident #43, dated 7/21/14, indicated she was at high risk for elopement, due to having a history of elopement prior to admission.</p> <p>A physician's order for Resident #43, dated 7/21/14, indicated Wander Guard to ankle.</p>		<p>this alleged deficient practice.</p> <p>An elopement risk assessment was completed on current in-house residents by a licensed nurse. One resident was identified; the physician was notified and new orders were initiated by licensed staff.</p> <p>Current in-house residents were assessed for their risk for falls and care plans and Kardexes were reviewed for preventive interventions. Any discrepancies identified were corrected immediately.</p> <p>3 The DCS/ Nurse Manager will re-educate the nursing staff on the facility's falls risk and accident/incident polices by October 14, 2014. The staff will be re-educated by the ED/SSD on the missing resident policy by October 14, 2014. An elopement drill was conducted on September 18, 2014.</p> <p>4. The DCS/ Nurse Manager will conduct QI monitoring of regulation F323 to ensure resident medications, Epi-Clenz hand sanitizer, alcohol prep pad and bleach germicidal wipes are out of reach from confused and</p>		

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>Review of the Daily Skilled Nurse's Notes for Resident #43, dated 7/18/14 through 8/8/14, indicated she had not displayed any signs of exit seeking from the facility.</p> <p>An Elopement Risk Evaluation for Resident #43, dated 8/8/14, indicated she was no longer at high risk for elopement.</p> <p>A physician's order for Resident #43, dated 8/8/14, indicated to discontinue the Wander Guard.</p> <p>Review of the Daily Skilled Nurse's Notes for Resident #43, dated 8/8/14 through 9/11/14, indicated she had not displayed any signs of exit seeking from the facility.</p> <p>A timeline for Resident #43 for the date of 9/12/14, provided by the Administrator on 9/15/14 at 1:15 p.m., indicated the following:</p> <ul style="list-style-type: none"> <li>- At 12:50 p.m., a Certified Nursing Assistant (CNA) removed Resident #43's lunch tray from her room and she was visualized in her bathroom at that time.</li> <li>- At 12:55 p.m., a Dietary cook came up to the front lobby and observed Resident #43 in-between the lobby doors, although</li> </ul>		<p>mobile residents as well as to ensure residents are assessed for risk of fall and elopement, those found to be at risk have preventive measures in place by care plan review and observation of resident. QI monitoring will be conducted across all 3 shifts 5x a week times four weeks, 3x a week times four weeks, weekly times three months alternating shifts and using a sample size of 5 random residents. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5 Date of Completion: 10/16/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>she did not realize the woman she saw was a resident of the facility since she had never seen her before.</p> <p>- At 12:57 p.m., the Dietary cook observed Resident #43 outside of the facility and walking toward the parking lot.</p> <p>- At 1:45 p.m., the Receptionist answered a call from a local high school (approximately 1 mile from the facility). The school asked if the facility had a resident there by a different name. The Receptionist replied "no".</p> <p>- At 1:58 p.m., the Receptionist received a call from the Police Department asking if the facility had a resident there by the name of (resident's name) Resident #43. The Receptionist placed the police officer on hold, immediately checked the resident's room, and discovered she was not present in her room. The Receptionist then picked up the call at the nursing station and confirmed to the officer (resident's name) Resident #43 was a resident at the facility. The police officer informed the Receptionist Resident #43 was at the police department and they would be returning her to the facility. The Receptionist then asked the police officer to hold so he could speak with the Director of Clinical</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>Services.</p> <ul style="list-style-type: none"> <li>- At 2:02 p.m., the Director of Clinical Services informed the Administrator and the Regional Director of Clinical Services of the call from the police department and the imminent return of Resident #43.</li> <li>- At 2:12 p.m., Resident #43 was returned to the facility escorted by one officer from the police department and one officer from the sheriff department. The officers informed the Director of Clinical Services and the Regional Director of Clinical Services Resident #43 had entered the local high school and then wandered out toward the road. The police took her to the police station to assist and locate her place of living.</li> <li>- At 2:15 p.m., Resident #43 refused placement of a Wander Guard and physical assessment. The resident was placed on 1:1 supervision.</li> <li>- At 8:05 p.m., Resident #43 was transferred to a local hospital for further evaluation and treatment due to agitation and aggression evidenced by barricading herself in her room with furniture, refusing assessment, refusing 1:1 supervision (visual line of sight), refusing medication, care, and Wander Guard</li> </ul>			
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>placement.</p> <p>An Interdisciplinary Progress Notes for Resident #43, dated 9/12/14 at 2:00 p.m., indicated a call was received from the police department concerning a resident of the facility who was at the police department and had been there for approximately 10-15 minutes. The note also indicated the police officer stated they were bringing her back to the facility in a police car with police escort x (times) 2. The note further indicated the police arrived at the facility at approximately 2:20 p.m. Attempts were made to coax the resident into the facility. While the Regional Director of Clinical Services talked with police officer, Resident #43 started to wander away from the police car. The note indicated other staff arrived shortly thereafter and were able to coax the resident inside the facility. The note also indicated it was 2:30 p.m. before staff were able to get her to her hall and 2:45 p.m. before she went into her room.</p> <p>A Social Service Progress Note for Resident #43, dated 9/12/14, indicated she was returned to the facility at approximately 2:15 p.m. The note also indicated she was very agitated, refusing to walk away from the entry door, going into the dining room then returning to the</p>			
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>door. The note further indicated she made no attempt to try the code pad or push the door, but stood in front of the door mumbling, obviously angry due to her facial expression and tone of voice. The note indicated the writer was able to re-direct Resident #43 to her hall and then to her room. The writer and a CNA attempted to calm her down without any luck. The note also indicated the resident was put on 1:1 supervision, but staff had to sit outside her room due to resident not allowing anyone in the room and trying to barricade her door shut. The note further indicated Resident #43 refused any assessment, medications, and dinner. The note indicated this behavior was such a sudden onset the IDT (Interdisciplinary Team) made the decision to have her sent to a local hospital for an evaluation to determine if there was any medical issue.</p> <p>The Regional Director of Clinical Services was interviewed on 9/15/14 at 11:40 a.m. During the interview she indicated Resident #43 had not shown any signs of elopement until the incident on 9/12/14. She also indicated the facility was not able to determine how the resident was able to leave from the facility since all doors in the facility were locked with a code pad for exit. She further indicated Resident #43 was sent to the local hospital due to displaying</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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>unusual behaviors for her upon her return. Resident #43 was diagnosed with a urinary tract infection at the hospital.</p> <p>A current facility policy "Elopement Risk", revised on 9/1/12 and provided by the Administrator on 9/15/14 at 1:15 p.m., indicated "...It is the policy of The Company that on admission and quarterly, all residents will be assessed for elopement risk...If the resident is identified as an elopement risk based on the assessment, the care plan will reflect the interventions (i.e. Wander Guard or Code Alert)...Review and/or revise care plan following attempt to leave the facility...Resident identified as at risk for elopement will require nursing to check resident regularly...."</p> <p>2 a. On 9/10/14 at 10 a.m. the clinical record of Resident #7 was reviewed. Diagnoses included, but were not limited to, the following: Chronic Obstructive Pulmonary Disease, Asthma, Parkinson ' s, Schizophrenia with paranoia, Anxiety, Borderline personality disorder and Obesity. The MDS (minimum data set) assessment dated 7/14/14 included but was not limited to, the following: independent cognition; transfers, walking in room and corridor and toilet use required supervision; mobility with a wheelchair.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>On 9/8/14 at 11:59 a.m. the resident was observed in his room. This resident was lying in the bed beside the window. He was observed to get up out of the bed by himself and sat in his wheelchair, which was at the bedside. No alarm sounded when the resident got out of the bed, even though an alarm box was observed to be on the table beside the resident's bed. When the resident sat down in the wheelchair (wc), an alarm beeped three times. The resident then wheeled himself over to the bathroom, got up out of the wc, and again the pressure alarm in the wc beeped three times. The resident went into the bathroom and closed the door.</p> <p>At 12:01 p.m. the alarm again sounded 3 times. The alarm was able to be heard from the nurses ' station, just outside the resident's door. At the time, there were 2 nurses at the nursing station and a CNA (certified nursing assistant) in the hall where the resident's room was.</p> <p>At 12:25 p.m. the resident was observed getting out of his wheelchair and again the alarm sounded 3 times. The resident was observed to get back into his bed, again with no alarm sounding.</p> <p>On 9/10/14 at 12 p.m. the resident's room was observed. There were no non skid</p>			
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>strips observed in the resident's bathroom. The fall mat was observed on the floor at the resident's bedside but there were no non skid strips observed at the bedside accessible to the resident. There were Velcro type strips on the floor, which were covered by the fall matt.</p> <p>Nurses notes (NN) were reviewed on 9/9/14 at 9 a.m. and indicated the following: 7/5/14 at 2 a.m.: "...res (resident) stated "I slipped coming out of the bathroom...res given gripper socks as intervention..."</p> <p>7/5/14 at 1:30 p.m.: "Writer called down to res room by CNA (certified nursing assistant)...reported res told her "I did it again, I fell coming back from the bathroom."</p> <p>A physician order dated 7/11/14 indicated "non skid socks on when not wearing shoes, non skid strips BR (bathroom) and by bedside."</p> <p>NN dated 7/21/14 at 11 a.m. "Resident was found on floor next to bed...stated was trying to make his way to bathroom..."</p> <p>On 9/12/14 at 3 p.m. fall investigations were provided by the FDSC (Facility Director of Clinical Services). She</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>indicated she had provided all the fall investigations she could find for this resident and if any investigations were missing, she was unable to find them. She indicated she had been the FDCA for under a month. At the time, the fall investigations were lacking for the two falls on 7/5/14. The fall investigation for the fall on 7/21/14 included but was not limited to the following: the fall committee review indicated "non skid socks and UA (urinalysis) to be obtained."</p> <p>NN 7/22/14 at 6:30 p.m. indicated "Resident...found on floor on R (right) side next to bed and bedside table...stated he was trying to get away from the monsters and voices he was hearing in his head..."</p> <p>The fall investigation, dated 7/22/14, lacked documentation of "what intervention was implemented after fall," the supervisor report and the fall committee review/recommendations portion of the form were also blank.</p> <p>On 8/1/14 a "Consent to Room Transfer" was signed by the resident for the following reason "wanted (resident) closer to nurse's station d/t (due to) recent falls."</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>Documentation was lacking in the NN of a fall on 8/1/14 at 2:30 a.m.</p> <p>A fall investigation, dated 8/1/14 at 2:30 a.m. included, but was not limited to, the following: "Resident says he wanted to stand up at the bedside but doesn't remember why." The intervention implemented after the fall was "check in on frequently during the noc (night)." Documentation was lacking on this form of the Supervisor report and/or fall committee review/recommendations.</p> <p>NN dated 8/4/14 at 1:30 a.m. indicated the resident was found on the floor by the bedside.</p> <p>A fall Investigation dated 8/4/14 at 1:30 a.m. included the intervention implemented after the fall was "call light clipped to his pillow and placed in his hand, reminded to call for assistance." The supervisor report and fall committee review/recommendation portion of this form was blank.</p> <p>NN 8/5/14 at 7:30 a.m. indicated "Resident found on floor on knees...order received for low bed, bed and chair alarm et (and) mat on floor when in bed..."</p> <p>A physician order, dated 8/5/14, indicated the following: "May use bed</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>alarm, check placement et function q (every) shift. Mat on side of bed on floor, check placement when in bed every shift...May use wheelchair alarm, check placement et (and) function q shift."</p> <p>A physician order, dated 8/14/14, indicated the following: "May use bed alarm, check placement et function q (every) shift. Mat on side of bed on floor, check placement when in bed every shift...May use wheelchair alarm, check placement et (and) function q shift. Non skid socks when not wearing shoes."</p> <p>NN 8/18/14 at 7:15 p.m. "Resident found on floor...was...coming from bathroom..." Documentation was lacking in the NN and the "Post fall status" form of any additional intervention implemented to prevent further falls and/or if current interventions were being utilized and/or functional, ie: the bed and chair alarms.</p> <p>NN 9/7/14 at 7 a.m. "Resident alarm on wc sounding as staff entered the room... Resident stated he forgot to lock his wheels on the wheelchair before he got up..."</p> <p>A Fall Investigation, dated 9/7/14 at 6:48 a.m. included but was not limited to, the following: the answer to the question "Is</p>			
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>bed check/chair alarm used?", the answer was documented as "no." The question "Did staff verify it was working before resident placed in bed/chair?" was left blank; the questions "Did it function properly" and "how long did it take to respond?" were left blank. The intervention documented to be implemented after the fall was "Res (resident) educ (education) to lock brakes and use call light..."</p> <p>On 9/12/14 at 10:20 a.m. the current "Nurse Tech (technician) Information Kardex" was reviewed for the resident. This form included, but was not limited to, the following: Section titled "Safety" interventions listed were bed alarm; mat on floor and low bed; independent ambulation with a cane. "</p> <p>On 9/15/14 at 10:55 a.m. the FDSCS was interviewed. She indicated the resident required stand by assist to transfer to and from the bed and/or chair and indicated he was not always compliant with this. She was informed at the time, of the observations of the resident on 9/8/14 with the lack of function of the bed alarm and the lack of staff response to the chair alarm beeping 3 times. The FDSCS indicated at the time, the chair alarm beeping 3 times, indicated the battery was bad in the alarm.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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
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	<p>On 9/12/14 at 1:20 p.m. the ADM (Administrator) provided a copy of the current facility policy and procedure for "Accident and Incident Investigation", dated 9/8/2014. This policy included, but was not limited to, the following: "Certain accidents and incidents...will be investigated to determine root cause and provide for opportunity to decrease future occurrences of the event...Procedure...The following events warrant the completion of designated investigative forms: falls: using the fall root cause investigation..."</p> <p>2 b. On 9/10/14 at 2 p.m. the clinical record of Resident #15 was reviewed. Diagnoses included, but were not limited to, the following: Stroke and Alzheimer 's dementia. The MDS dated 5/30/14 indicated the following: severely impaired cognition, required limited assist for transfers and ambulation. The MDS dated 6/20/14 indicated the resident required extensive assistance for transfers.</p> <p>An Admission Data collection form dated 5/16/14 indicated the resident had a fall risk score of 5. The form indicated a score over 10 deemed the resident at risk for falls.</p>			
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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>NN 6/4/14 at 1:35 p.m. indicated "...1 assist with ...transfers..."</p> <p>NN 6/4/14 at 5 p.m. indicated "Res (resident) is up in wc with personal alarm in place. Activated x 1 d/t (due to) res transferring self without assistance from wc to bed..."</p> <p>NN 6/9/14 at 2:25 p.m. indicated "Resident found on floor in bathroom beside toilet and wall on back..."</p> <p>The Fall Investigation, dated 6/9/14, 2:25 p.m. included, but was not limited to, the following: "Is bed check/chair alarm used", "did staff verify it was working before resident placed in bed/chair" and "did it function properly?" were answered "yes." The question "how long did it take to respond?" and "What intervention was implemented after this fall?" was left blank. The supervisor report and the Fall committee review/recommendations portion of the report was also left blank.</p> <p>The IDT (interdisciplinary team) note dated 6/10/14 indicated non skid socks were given to the resident.</p> <p>A Fall investigation, dated 7/29/14 at 11 a.m. indicated the following: Resident was alert with confusion and prior to the fall was sitting in his wc; the chair alarm</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>was used and was verified to have been working properly and placed in the chair; and it took staff less than 3 minutes to respond to the alarm. The intervention implemented after the fall was documented as 15 minute checks.</p> <p>The Fall Investigation report dated 8/1/14 indicated the resident had fallen at 6:15 p.m. and the resident had seat/bed alarm, non skid strips by bed and in bathroom, toileting before and after meals and prn (as needed). This form indicated the resident had removed the alarm from shirt and it did not sound. The intervention implemented after the fall was "shower given, and to bed with safety measures on, call light in reach." The Supervisors report and the Fall committee review/recommendations portion of the form were left blank.</p> <p>An IDT note dated 8/13/14 indicated the resident had fallen on 8/12/14 at 5:30 p.m. This form indicated they would have the resident up around the nurses ' station when not in room or bed due to increased supervision.</p> <p>On 9/10/14 at 8:40 a.m. the resident was observed in the south dining room in his wheelchair with an alarm to the back of the wc. At 9:10 a.m. the resident remained in the south dining room, and</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
(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>no staff were consistently in the dining room. At 9:16 a.m. still no staff were consistently observed in the south dining room. A staff member was in and out of resident rooms at the end of the south hall, which is not in direct view of the dining room. At 9:30 a.m., staff were observed to randomly walk up and down the hall.</p> <p>On 9/10/14 at 9:37 a.m. the resident was observed to be in his bed in his room. At this time, there were no non skid strips observed to the bathroom floor and/or the side floor of the resident's bed.</p> <p>On 9/12/14 at 10 a.m. the "Nurse Tech Information Kardex" was provided. This form included but was not limited to, the following: "Safety: alarm: bed and chair, non skid socks and non skid strips by bed and bathroom; assist of 1 for transfers."</p> <p>A fall risk assessment was completed on 9/12/14 (no time) and indicated the resident now had a fall risk of 12. The form indicated a total score over 10 deems resident a high risk.</p> <p>The current September 2014 physician orders were reviewed on 9/12/14 at 1 p.m. and included, but were not limited to, the following: " 6/10/14: non skid</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>strips on R side of floor next to bed, check placement every shift and non skid strip in BR, non skid socks as resident will allow." The current physician orders also indicated the following dated for 6/13/14: tab alarm to chair and pressure alarm to bed."</p> <p>A plan of care, dated 5/16/14 addressed the problem of "...is at risk for falls...attempts to transfer self unassisted at times...approaches included but not limited to, the following: "6/11/14 tab alarm to wc; 8/12/14: increase visual supervision...8/13 when up to be at nurses station...non-skid strips on floor in bathroom and on floor by bed..."</p> <p>On 9/12/14 at 2 p.m. there were still no non skid strips on the floor beside the resident's bed and/or on the floor in the bathroom.</p> <p>On 9/12/14 at 3 p.m. the RDCS (Regional Director of Clinical Services) and the FDCS (Facility Director of Clinical Services) were interviewed. They indicated the resident should have a pressure alarm in his bed and wheelchair. At this time, they were made aware the resident did not have any anti skid strips on the floor bedside his bed and/or on the floor in the bathroom. No additional information was provided at this time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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>3. An observation in West hall on 9-8-2014 at 11:58 a.m., indicated the West hall unattended med (medication) cart had a resident's artificial tears and a 4 ounce bottle of Epi-Clenz antiseptic hand gel left out on top of the cart. The artificial tears had fluid which remained in the bottle.</p> <p>An observation of the West hall med cart on 9-8-2014 at 12:11 p.m., indicated the cart was parked outside the main dining room. The med cart was unattended with a resident's artificial tears left out on top of the cart.</p> <p>An observation of the West hall med cart on 9-8-2014 at 12:37 p.m. indicated the cart remained parked and unattended outside the main dining room with 1 alcohol prep pad out on top of the cart.</p> <p>An observation on 9-9-2014 at 8:31 a.m., indicated two 4 ounce containers of Epi-Clenz antiseptic hand gel were out on top of the recycling bin located in the area across from the nurse's station. There were no facility staff present near the hand gel.</p> <p>An observation 9-9-2014 at 11:51 a.m., indicated two 4 ounce containers of Epi-Clenz antiseptic hand gel were out on top of the recycling bin located in the area by</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

(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 nurse's station. One resident in a wheelchair was sitting near the hand sanitizer. There were 5 containers of bleach germicidal wipes observed at the nurse's station.</p> <p>An observation on 9-10-2014 at 11:06 a.m., indicated a 4 ounce bottle of Epi-Clenz antiseptic hand gel was left out on top of the unattended West hall med cart.</p> <p>An observation on 9-10-2014 at 11:25 a.m., indicated a resident identified by the facility as confused and mobile was wheeling through the unattended nurse station.</p> <p>An observation on 9-10-2014 at 12:13 p.m., indicated a 4 ounce bottle of Epi-Clenz antiseptic hand gel was observed on the West hall medication cart which was unattended and parked by the main dining room.</p> <p>An observation on 9-11-2014 at 8:55 a.m., indicated the unattended East/South hall med cart had a 4 ounce bottle of Epi-Clenz antiseptic hand gel and 2 alcohol pads left out on top of the cart.</p> <p>An observation on 9-11-2014 at 8:56 a.m., indicated 8 resident medication cards with the pills still intact were left</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>out, unattended and on top of the West hall med cart parked by the main dining room by Nurse #15. In addition, a plastic medication cup with 8 pills inside and a container with symbicort inhaler was left out on top of the unattended West hall med cart.</p> <p>An interview with the Regional Director of Clinical Services (DCS) on 9-11-2014 at 9:00 a.m., indicated medications, alcohol pads and hand gel should not be left out on unattended medication carts.</p> <p>An interview with Nurse #15 on 9-11-2014 at 9:04 a.m., indicated she was distracted and left the medications, hand gel and alcohol pads out on top of the unattended West hall med cart.</p> <p>An observation on 9-11-2014 at 9:06 a.m., indicated 2 large containers of bleach germicidal wipes were out on the nurses station counter.</p> <p>An interview with the Regional DCS on 9-11-2014 at 9:07 a.m., indicated the bleach germicidal wipes should not be out at the nurse's station.</p> <p>An observation on 9-11-2014 at 10:57 a.m., indicated a resident identified by the facility as being confused and mobile, wheeled self inside the unattended nurse's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>station.</p> <p>An observation on 9-11-2014 at 3:35 p.m. and on 9-15-2014 at 11:46 a.m., indicated a resident identified by the facility as being confused and mobile, wheeled self inside the nurses station.</p> <p>An observation on 9-11-2014 at 4:10 p.m., indicated Nurse #14 left a 4 ounce bottle of Epi-Clenz antiseptic hand gel out on top of the unattended East/South hall med cart.</p> <p>An review of the label on the bottle of Epi-Clenz antiseptic hand gel provided by the Regional DCS on 9-11-2014 at 10:30 a.m., indicated the following: "...Warnings for external use only...flammable, keep away from fire or flame...do not use in the eyes. In case of eye contact, immediately flush with water...Keep out of reach of children...if swallowed, get medical help or contact a Poison Control Center right away...."</p> <p>A review of the label for the medium prep pad alcohol antiseptic provided by the Regional DCS on 9-11-2014 at 11:00 a.m., indicated "...keep out of reach of children...."</p> <p>A review of the Material Safety Data Sheet (MSDS) dated 4/2002 for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>germicidal bleach and provided by the Regional DCS on 9-11-2014 at 10:00 a.m., indicated but was not limited to the following, "...Danger...corrosive...may cause severe irritation or damage to eyes and skin...harmful if swallowed...keep out of reach of children...."</p> <p>A policy "Hazardous Material Storage and Handling" dated 9-1-2011 and provided by the Executive Director on 9-12-2014 at 9:47 a.m., indicated "...hazardous materials shall be stored and handled in a manner that shall minimize the risk of injury or property damage...never leave containers of cleaning chemicals and other hazardous materials unattended...store in a locked cabinet and closets when not in use...."</p> <p>A policy "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 1-1-2013 and provided by the Regional DCS on 9-11-2014 at 11:20 a.m., indicated "...the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>				

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
(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	
F000327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the failed failed to ensure the resident's fluid intake was monitored to prevent the need for an Intravenous drip to provide hydration in response to critical high lab results and/or failed to ensure after the IV was discontinued a plan was in place to prevent additional episodes of dehydration for (Resident #7), and failed to ensure adequate fluid intake for a resident on thickened liquids and a history of dehydration and recurrent urinary tract infections (Resident #5). This deficient practice affected 2 of 3 residents reviewed for adequate hydration.</p> <p>Findings include:</p> <p>1. On 9/10/14 at 10 a.m., the clinical record of Resident #7 was reviewed. The resident was admitted to the facility on 7/3/14. Diagnoses included, but were not limited to, the following: Diabetes, Schizophrenia, Anxiety disorder, borderline personality disorder, obesity and hypertension. The Minimum Data</p>	F000327	<p>327 1 Res # 7 fluid needs will be reviewed and updated by a Dietician by 10/14/2014. Res #5's fluid need was reviewed and updated by the Dietician on 9/11/2014 dietary tray card has been updated with increased fluids offered during meals. 2 All residents have the potential to be affected by this alleged deficient practice. Current in-house residents were assessed for risk of dehydration and physician orders to monitor fluid intake, care plans and kardexes were reviewed by licensed nurses. Any discrepancies identified were corrected immediately 3 The DCS/ Nurse Manager will re-educate the nursing staff on the facility's Dehydration Prevention policy by October 14, 2014. Dietician was educated on 9/11/2014 on expectation of accuracy calculating and documenting resident fluid intake needs. 4 The DCS/ Nurse Manager will conduct QI monitoring of regulation F327 record review and observation of offering the resident fluids. QI monitoring will be conducted across all 3 shifts 5x a week times four weeks, 3x a week</p>	10/16/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>Set (MDS) Assessment, dated 7/14/14, included but was not limited to, the following: cognition was independent; eating required supervision, oversight, encouragement and cueing; weight was 299 pounds and height was 67 inches.</p> <p>The resident's medications on his admitting MAR (medication administration record), included, but were not limited to, the following: Lasix (diuretic) 40 mg daily at 8 a.m.</p> <p>A plan of care, dated 7/9/14, addressed the following problem: "Risk for dehydration, use of Lasix daily." The goal was documented to be free from signs and symptoms of dehydration thru next review, 10/23/14. Approaches included, but were not limited to, the following: administer medications as ordered; encourage to complete 100% of fluids provided; observe for signs and symptoms of dehydration ie (for example) dry mucous membranes, decreased or concentrated urine output, weight loss, fatigue, or thirst; labs as ordered, notify MD (medical doctor) as needed; monitor Lasix use and report s/s (signs and symptoms) of dehydration to MD.</p> <p>A plan of care, dated 7/10/14, addressed the following problem: "Nutritional Risk</p>		<p>times four weeks, weekly times four weeks then monthly times three months alternating shifts and using a sample size of 5 random residents. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring 5 Date of Completion:10/16/2014</p>	

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>related to: behavioral problems...Parkinson's Disease...Diabetes..." Approaches included, but were not limited to, the following: "monitor intake...monitor labs as ordered..."</p> <p>The Initial Nutritional Evaluation, dated 7/10/14, included, but was not limited to, the following: "lab test/BUN (blood urea nitrogen), dated 3/13/14" with a result of 30 (high); and Creatinine, dated 3/13/14, with a result of 1.3. Fluids needs were documented at "approximately 2040 - 2720" ccs, or 15-20 cc/kg. This was based on the residents weight of 299.2 pounds.</p> <p>A physician progress note, dated 7/30/14, included but was not limited to, the following: "RN called me, labs are critical. BUN 120, creatinine 3.7, K (potassium) was 5.9...He was not eating due to psych (psychiatric) issue, He is dehydrated...will start IV (intravenous) hydration...start NS (normal saline) IV 125/hr (sic) for 2 days. Recheck BMP (basic metabolic panel) on 8/1/14. Hold Lasix until lab reviewed on 8/1/14."</p> <p>A BMP report, dated 8/1/14 included, but was not limited to, the following: "BUN 89 mg/dl (normal range 9-21 mg/dl); creatinine 2.1 mg/dl (normal range 0.8 -</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>1.3 mg/dl).</p> <p>A physician order dated 8/2/14, included the following: "IV NS (normal saline) at 125 cc/hr x 24 hour, re check BMP on 8/3/14."</p> <p>A BMP dated 8/3/14 included but was not limited to, the following: "BUN 46 and creatinine 1.6..."</p> <p>A physician order, dated 8/3/14, included the following: "Stop IV..."</p> <p>A physician order, dated 8/4/14, included but was not limited to, the following: "Start Lasix 40 mg daily x 1 week, check BMP in 3 days."</p> <p>A BMP dated 8/7/14, included, but was not limited to, the following: "BUN 41, creatinine 1.6."</p> <p>A physician order, dated 8/7/14 included, the following: "Push fluids, recheck BMP on 8/20/14."</p> <p>A physician order dated 8/8/14 indicated the resident was transferred to the behavioral unit.</p> <p>A Nutrition Evaluation, dated 8/18/14, indicated the resident returned to the facility on 8/14/14. This form indicated</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>the resident's weight was 275 pounds and estimated fluid needs of 1875 cc daily, based on 15 cc/kg. This form indicated the resident was not currently on Lasix.</p> <p>A Urinalysis, dated 9/5/14, included, but was not limited to, the following result: "hazy yellow appearance...3+leukocytes (normal is negative); 10-20 WBC (white blood cells) (normal 0-5) , 3+ moderate bacteria (normal was to be none seen)...specimen sent to microbiology for culture..."</p> <p>A urine culture, dated 9/5/14, included the following result: over 100,000 orgs/ml Enterococcus species; over 100,000 orgs/ml growth of mixed skin flora.</p> <p>On 9/11/14 at 9:41 a.m. the MDS Coordinator, provided copies of the resident's "Meals and Fluids Detailed Entry Report." This form included, but was not limited to, the following: For the time period of 7/16/14 - 7/29/14, which was 14 days prior to the initiation of IV fluids, 12 days lacked documentation of the resident having received the evening meal; and documentation was lacking for meal intakes for all 3 meals on 7/25/14. For the time period of 8/15/14 - 8/31/14, the 17 days after the resident returned to</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>the facility from the hospital, 4 days lacked documentation of a dinner meal intake and/or on 8/27/14, documentation lacked regarding the breakfast and lunch meal intake.</p> <p>Nurse notes dated 7/25/14, did not indicate the resident had left the facility.</p> <p>On 9/11/14 at 10:12 a.m., the Regional Director of Clinical Services (RDCS) was interviewed. She indicated the facility does not monitor intake and output (I and O) unless the resident had a physician order to do so. The RDCS was interviewed regarding how the facility monitored the resident to know if the resident was receiving enough fluid to prevent dehydration and/or meet the recommended dietary fluid needs and the RDCS responded "we don't record the fluid intake." The RDCS indicated at the time "if it looks like the resident didn't get enough fluids, we increase the fluids." She also indicated if the resident showed signs and symptoms (s/s) of dehydration, they would increase the fluids provided to the resident.</p> <p>On 9/11/14 at 4:30 p.m. the Registered Dietician (RD) was interviewed. She indicated the following: the resident had not been eating due to psychiatric issues and had been sweating a lot. She</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>indicated the daily fluid requirements calculated on 15 cc/kg were adequate due to his mobility status and obesity, 275 lbs. She indicated due to the resident's diagnosis of hypertension, they would not want to overload him with fluids. She indicated his fluid status was "hard to balance" and "a fine line" due to his kidney function and fluid retention. She indicated at the time, it would be beneficial for the resident to at least monitor his fluid intakes. She indicated if the resident's daily fluid needs were calculated using 30 cc/kg, the resident's calculated fluids needs would be 4 1/2 liters of fluid daily and would be a fluid overload.</p> <p>On 9/12/14 at 10:20 a.m. the SSD (Social Service Director) provided a current copy of the resident's "Nurse Tech (technician) Information Kardex." This form was left blank in the area of "Fluids." The options which were left blank, included, but were not limited to, the following: "Intake, offer times..."</p> <p>2. Review of the clinical record for Resident #5 on 9/10/14 at 8:20 a.m., indicated the following: diagnoses included, but were not limited to, multiple sclerosis and catheter with recurrent UTI's (urinary tract infections).</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>Resident #5 was interviewed on 9/9/14 at 10:37 a.m. During the interview he indicated he only received fluids with meals and did not receive any fluid in-between meals.</p> <p>A Minimum Data Se (MDS) assessment for Resident #5, dated 6/1/14, indicated a score of 15 out of 15 on the Brief Interview for Mental Status, which indicated the resident was cognitively intact. The MDS also indicated he was totally dependent with the physical assistance of 1 staff for eating.</p> <p>A Nutrition Evaluation for Resident #5, dated 12/21/13, did not indicate his fluid needs.</p> <p>A physician's order for Resident #5, dated 5/20/14, indicated honey thick liquids due to dysphagia (problems with swallowing).</p> <p>A Nutrition Evaluation for Resident #5, dated 6/18/14, indicated he received honey thick liquids. The evaluation also indicated he required 20 cc's/kg (cubic centimeters per kilogram) based on a weight of 166.2 pounds. The evaluation further indicated his fluid needs were 1510 cc's per day.</p> <p>A physician's order for Resident #5, dated</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
--	---

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	<p>7/8/14, indicated liquids were to remain at honey thick consistency.</p> <p>Review of the physician orders and laboratory reports for Resident #5, indicated he was treated for urinary tract infections on 7/18/14, 7/31/14, 8/18/14, and 9/9/14.</p> <p>A Meals and Fluids Detailed Entry Report for Resident #5, provided by LPN #5 on 9/11/14 at 9:41 a.m., did not indicate the amount of fluids consumed during each meal.</p> <p>Review of the Medication Administration Records for Resident #5, did not indicate the amount of fluid consumed during medication pass.</p> <p>A family member of Resident #5 was interviewed on 9/10/14 at 1:10 p.m. During the interview she indicated the only time he received fluids was during mealtime or during medication pass. She also indicated he often expressed to her he was thirsty. She further indicated she had asked staff for thickened water for him when she visited, but none was provided.</p> <p>Resident #5 was interviewed on 9/10/14 at 3:47 p.m. During the interview he indicated he had not been offered any</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>fluids since lunch.</p> <p>The Registered Dietitian was interviewed on 9/11/14 at 4:21 p.m. During the interview she indicated the daily fluid need for Resident #5 should have been based on 30-35 cc's per kg of body weight, instead of 20 cc's per kg of body weight, due to his history of dehydration and the use of thickened liquids. She also indicated his nutrition assessment, dated 6/18/14, was completed by a dietetic intern. She further indicated his calculated daily fluid needs would be 2200 cc's to 2550 cc's, based on the range of 30-35 cc's per kg of body weight.</p> <p>Resident #5 was interviewed on 9/12/14 at 10:15 a.m. During the interview he indicated he had not been offered any fluids since breakfast.</p> <p>The Regional Director of Clinical Services was interviewed on 9/11/14 at 10:12 a.m. During the interview she indicated the facility did not track the amounts of fluids consumed by residents, even for those residents with a catheter unless there was a physician's order. She also indicated staff were to monitor residents for signs and symptoms of dehydration.</p> <p>A facility care plan for Resident #5, with</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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(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>a review date of 8/27/14, indicated the problem area of risk for dehydration related to depression, history of UTI, MS (multiple sclerosis), immobility/ROM (range of motion), dependent on staff for all food and fluids, needs fed per staff and thickened fluids. Approaches to the problem included, but were not limited to, offer thickened fluids per order during his meals, offer thickened fluids per his order between meals and upon his request, offer thickened fluids with medication administration, monitor for signs and symptoms of dehydration, resident requires total staff assist to eat and drink, discontinue straws to increase bolus control, and monitor urine output in catheter bag every shift.</p> <p>The 2011 edition of the Indiana Diet Manual indicated "...The goals of calculating fluid needs include ensure water and electrolyte balance, and tissue perfusion..." The manual also indicated the fluid requirements for oral feeding for adults was 25 to 30 milliliters per kilogram of body weight.</p> <p>A current facility policy "Hydration Policy", revised on 4/30/14 and provided by the Administrator on 9/15/14 at 1:44 p.m., indicated "...All resident will receive sufficient fluid intake to maintain proper hydration and health. Fluids will</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000332 SS=E	<p>be provided daily to all residents with meals, between meals, and at bedside, with the exception of those who are N.P.O. (nothing by mouth) or on a purposeful restriction of fluid status unless calculated in their fluid allowance...Each resident will be evaluated on admission utilizing the Admission Data Collection for Risk of Dehydration...Each resident will be given a water pitcher upon admission for their room unless contraindicated by the order/diagnosis, such as a fluid restriction, Thickened Liquids, or NPO status...Water will be served with all meals. The Dietary department will provide a minimum of 1500 cc per day on meal trays, unless fluid restriction or resident preference precludes...Dietary will provide hydration services with containers of beverages and ice water per facility schedule...."</p> <p>3.1-46(b)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate greater than 5%, with the facility having</p>	F000332	332 1 Res #32, #31, #23 and #59 were monitored and no adverse affects were identified. Nurses #11, #12 and #13 were re-educated by the DCS/ Nurse	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>4 medication errors out of 37 opportunities for error, resulting in a 10.81% error rate. This affected 4 of 9 residents observed for medication pass (Residents #32, #31, #23 and #59), and 3 of 6 nurses observed to pass medications. (Nurse #11, #12 and #13)</p> <p>Findings include:</p> <p>1. During the medication pass observation, Nurse #11 was observed to administer Resident #59's insulin (Humalog 6 units subcutaneously) for a blood sugar of 263 on 9-10-2014 at 11:11 a.m. in his room. Resident #59 indicated he would have his lunch meal in his room.</p> <p>An observation on 9-10-2014 at 12:45 p.m., indicated Resident #59 was served his lunch meal in his room.</p> <p>A review of the signed Physician's recapitulation (recap) for August 2014 indicated Resident #59's diagnoses included but were not limited to, diabetes, right below the knee amputation and hypertension.</p> <p>A review of the August 2014 recap indicated blood sugar 4 x (times) daily with Humalog coverage 4 x daily with the sliding scale updated on 9-9-2014.</p>		<p>Manager on correct medication administration practices 2 All residents have the potential to be affected by this alleged deficient practice. 3 The DCS/ Nurse Manager will re-educate the licensed nurses on medication administration by 10/14/2014. 4 The DCS/ Nurse Manager will conduct QI monitoring of regulation F332 by observing medication administrations. QI monitoring will be conducted across all three shifts 5x a week times four weeks, 3x a week times four weeks, weekly times four weeks then monthly times three months alternating shifts and using a sample size of 2 nurses. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring 5 Date of Compliance: 10/16/2014</p>				

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	<p>A review a physician's order dated 9-9-2014 indicated the following:</p> <ul style="list-style-type: none"> <li>- change sliding scale as follows: 150 - 200 = 2 u (units)</li> <li>201 - 250 = 4 u</li> <li>251 - 300 = 6 u</li> <li>301 - 350 = 8 u</li> <li>351 - 400 = 10 u</li> <li>&gt; 400 give 15 u and recheck in 2 hours.</li> </ul> <p>If still &gt; 400, notify MD.</p> <p>2. During the medication pass observation, Nurse #11 was observed to administer Resident #31's insulin (Humalog 2 units subcutaneously) for a blood sugar of 151 on 9-10-2014 at 11:11 a.m. in his room. Resident #31 indicated he would have his lunch meal in the main dining room.</p> <p>An observation in the main dining room on 9-10-2014 at 1:01 p.m., indicated the resident was the last resident to be served the lunch meal. The resident had not been provided a drink, snack or any food while waiting on the lunch to be served.</p> <p>A review of the physician's recap for September 2014, indicated Resident #31's diagnoses included but were not limited to, history of right hip fracture, diabetes, hypertension, depression, anxiety and right sided weakness.</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>A review of the September 2014 recap indicated accuchecks (blood sugar checks) before meals and at bedtime with Humalog coverage per sliding scale.</p> <p>A review of a physician order dated 9-8-2014 indicated an updated sliding scale as follows: 150 - 200 = 2 u 201 - 250 = 4 u 251 - 300 = 6 u 301 - 350 = 8 u 351 - 400 = 10 u &gt; 400 give 15 u and recheck in 2 hours and notify MD if still &gt; 400.</p> <p>An interview with Nurse #11 and Nurse #13 on 9-12-2014 at 9:10 a.m., indicated for residents who received Humalog insulin, a meal should have been served within a half hour of the insulin administration.</p> <p>An interview with the Facility Director of Clinical Services (DCS) on 9-12-2014 at 11:09 a.m., indicated residents given Humalog should have been given a meal or snack within 30 - 45 minutes after the insulin administration.</p> <p>An interview with the Regional DCS on 9-12-2014 at 11:25 a.m., indicated she would have to check the policy for giving</p>			

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	<p>food/snack after the injection of Humalog insulin. As of the exit date on 9-16-2014, no further information was received from the facility.</p> <p>The facility had a 2013 Nursing Drug Handbook at the nurse's station and a copy of pages 732 through 735 was provided by the Executive Director on 9-11-2014 at 2:36 p.m. The Humalog (insulin lispro) information indicated the following: "...lispro insulin...give within 15 minutes before a meal to prevent a hypoglycemic (low blood sugar) reaction...."</p> <p>3. During the medication pass on 9-10-2014 at 11:27 a.m., Nurse #12 was observed to prepare Miles Magic Susp (Suspension) 10 ml (milliliters) for Resident #32 in a 30 ml medication cup. In addition, the nurse prepared 2 more medication cups with liquid. The liquid in all 3 separate medication cups were shades of red. Three more medication cups were prepared with crushed pills and the contents of all six medication cups were observed to be administered on 9-10-2014 at 11:45 a.m., through Resident #32's jejunostomy tube (j-tube).</p> <p>An interview with Nurse #12 on 9-10-2014 at 11:47 a.m., indicated the Miles Magic Susp was administered</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>through the j-tube and Nurse#12 indicated the Miles Magic Susp should have been given by mouth for the resident to swish and spit.</p> <p>A review of the signed Physician's recapitulation (recap) for September 2014 indicated Resident's #32 diagnoses included but were not limited to, anorexia, celiac disease, depression, anemia, malabsorption syndrome and persistent nausea.</p> <p>A review of the September 2014 recap indicated an order for Miles Magic Susp swish and spit 10 ml orally 4 times a day for mouth sores.</p> <p>4. During the medication pass observation on 9-12-2014 at 9:59 a.m., Nurse #13 was observed to administer Resident #23's glimepiride 1 mg (milligram) tablet after the resident had finished his breakfast.</p> <p>A review of the physician's signed September 2014 recap for Resident #23, indicated diagnoses included but were not limited to, pneumonia, recurrent falls, iron deficiency anemia, diabetes, depression, hypertension, hyperlipidemia, glaucoma and dementia.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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F000353 SS=F	<p>A review of the September 2014 recap indicated an order for glimepiride 1 mg tablet, give 1 tablet orally 2 times a day before meals at 7 a.m. and 4 p.m. for diabetes mellitus.</p> <p>An interview with Nurse #13 on 9-12-2014 at 11:55 a.m., indicated she gave Resident #23 the glimepiride after breakfast.</p> <p>A review of the meal time schedule provided at entrance on 9-8-2014 by the Executive Director, indicated the breakfast hall carts were ready for South hall at 7:50 a.m. and the East/West hall cart was ready at 7:55 a.m. The lunch dining room serving time was 12:00 p.m. and the 1st cart (South hall) was ready at 11:50 a.m. and the 2nd cart for East/West hall was ready at 11:55 a.m.</p> <p>The 2014 Nursing Drug Handbook indicated for glimepiride administration to "...give drug with first meal of the day...."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to</p>				

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient staffing to meet the needs of the residents per 11 of 19 confidential resident interviews and Residents #5 and #19, 1 of 3 confidential family interviews, interviews with staff (Certified Nursing Assistants #1, #6, #7, #8, #9, #10, and Dietary #20) and observations of Resident #5, potentially affecting 50 of 50 residents who resided in the facility.</p> <p>Findings include:</p> <p>1. During the resident interviews conducted on 9/8/14 and 9/9/14, 11</p>	F000353	<p>353</p> <p>1 Res #5's shows no apparent adverse affect and appointment was rescheduled. On 9/9/14 res #19 received ice water. Resident # 19 shows no apparent adverse affect.</p> <p>2 All residents have the potential to be affected by this alleged deficient practice.</p> <p>3 The ED/ DCS will re-educate the staff to answer the call lights timely, pass ice water each shift for those residents who may receive ice water, and assist residents with</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
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	<p>residents interviewed indicated there were not enough staff in the facility to meet their needs. Their confidential comments included the following:</p> <p>- On 9/8/14 at 11:46 a.m., an anonymous resident interview indicated the facility was short of staff during certain times of the day, especially around meal time. The resident also indicated a wait of 20 minutes with staff answering the call light and stating they had to assist another resident. The resident further indicated some staff don't do anything if they don't have to.</p> <p>- On 9/8/14 at 3:28 p.m., an anonymous resident interview indicated the facility was short of staff on nights during the weekend. The resident also indicated a long wait in the bathroom with the O2 (oxygen) cannula falling off. The resident further indicated panic set in and the nurse heard the resident yelling for help.</p> <p>- On 9/8/14 at 3:05 p.m., an anonymous resident interview indicated the facility did not employ enough staff, especially aides. The resident also indicated the call light was unanswered the other day when the resident wanted to go to an activity. There was not enough help on 2nd shift.</p>		<p>transportation needs by October 14, 2014.</p> <p>4. The DCS/ Nurse Manager will conduct QI monitoring of regulation F353 to ensure sufficient staffing to meet the needs of the resident by observing call light response times, ice water distribution and resident assistance with transportation. QI monitoring will be conducted across all 3 shifts 5x a week times four weeks, 3x a week times four weeks, weekly times four weeks then monthly times three months alternating shifts and using a sample size of 5 random residents. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring</p> <p>5 Date of Completion: 10/16/2014</p>				

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>- On 9/9/14 at 10:38 a.m., an anonymous resident interview indicated the facility did not have enough staff.</p> <p>- On 9/9/14 at 11:45 a.m., an anonymous resident interview indicated the facility was short of staff during the afternoons and evenings.</p> <p>- On 9/9/14 at 11:37 a.m., an anonymous resident interview indicated the facility needed to hire more staff since there were more residents. The resident also indicated they sometimes have to wait on a second person for the transfer lift.</p> <p>- On 9/8/14 at 2:55 p.m., an anonymous resident interview indicated they had to wait for over 1 hour for staff to come. The resident also indicated they were not sure if the call light was working.</p> <p>- On 9/9/14 at 8:58 a.m., an anonymous resident interview indicated the facility was short of staff and the resident has had to wait 45 minutes for the call light to be answered.</p> <p>- On 9/9/14 on 10:07 a.m., an anonymous resident interview indicated the facility only had 2 people working in the building during the weekends at times.</p>			

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	<p>- On 9/8/14 at 11:53 a.m., an anonymous resident interview indicated the facility works very short on the weekend. The resident also indicated breakfast was to be served at 8:00 a.m., but was usually served late on the weekends at 9:00 a.m. due to staff shortage.</p> <p>- On 9/9/14 at 11:10 a.m., an anonymous resident indicated the facility was short of staff. The resident also indicated the meal cart stayed in the hall for almost an hour, especially in the evening.</p> <p>2. On 9/9/14 at 11:22 a.m., an anonymous family member interviewed indicated the facility did not have enough staff in the facility especially on the weekends.</p> <p>3. Confidential interviews with the facility staff indicated the following:</p> <p>- Certified Nursing Assistant (CNA) #7 indicated the facility had staff calling off on the 3rd shift and other facility staff would have to cover their hours.</p> <p>- CNA #8 indicated there were not enough staff working in the facility and there were frequent call-ins, especially on 3rd shift.</p>			
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	<p>- CNA #9 indicated there were lots of call-ins on the 3rd shift, at least 2-3 times a week, and 2nd shift staff had to stay over.</p> <p>- CNA #1 indicated there were not enough staff working in the facility. The CNA also indicated when the facility was short of staff, restorative aides were pulled to work the floor.</p> <p>- CNA #10 indicated if all staff worked as scheduled, staffing in the facility would be okay.</p> <p>- Dietary #20 indicated the 2nd shift worked short staffed and at times the staff were not able to get the meal trays served timely.</p> <p>4. Resident #5 was interviewed on 9/10/14 at 10:00 a.m. During the interview he indicated he needed staff to bring the Hoyer lift to his room and requested the surveyor notify staff. When queried he indicated he wanted to go to Bingo. The posted Activity calendar indicated Bingo started in the main dining room at 10:15 a.m. At 10:45 a.m., Resident #5 was brought into the dining room for Bingo by staff.</p> <p>5. During an observation on 9/11/14 at 10:45 a.m., Resident #5 was seated in his</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>specialized wheelchair in the hallway near the nursing station. When interviewed he indicated staff did not get him up in time to go to his neurology appointment. CNA #6, who accompanied Resident #5, was interviewed on 9/11/14 at 2:00 p.m. During the interview she indicated staff did not get him up in time to make his 10:00 a.m. appointment. She also indicated when they arrived at the physician's office the driver of the facility vehicle entered the office to determine if he could still be seen. She further indicated the physician did not see Resident #5 since they had missed the scheduled time for his appointment. Inspection of the facility appointment book indicated Resident #5 had a neurology appointment scheduled for 9/11/14 at 10:00 a.m.</p> <p>6. Resident #19 was interviewed on 9/9/14 at 8:58 a.m. During the interview he indicated facility staff did not pass ice water every shift due to being short staffed.</p> <p>The Resident Acuity Report for the facility, provided by the Director of Nursing Services on 9/15/14 at 11:53 a.m., indicated the following:</p> <p>- 13 residents required total assistance</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000364 SS=E	<p>with a mechanical lift for bed mobility, transfer, eating and toilet use.</p> <p>- 17 residents required the physical assistance of 2 staff for bed mobility, transfer, and toilet use.</p> <p>The Director of Nursing Services was interviewed on 9/15/14 at 11:30 a.m. During the interview she indicated the staffing level in the facility as follows:</p> <p>- 1st shift - 2 nurses and 1/2 time of the Assistant Director of Nursing Services, 4 CNAs, plus 1 CNA for 1:1 supervision</p> <p>- 2nd shift - 2 nurses, 4 CNAs, plus 1 CNA for 1:1 supervision</p> <p>- 3rd shift - 2 nurses and 2 CNAs.</p> <p>This deficiency was cited on the annual Recertification on 8/21/13 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-17(a)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p>			
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	<p>Based on observation, interview and record review, the facility failed to ensure food temperatures were adequate for 11 of 19 residents interviewed. This deficiency had the potential to affect the 50 residents who resided in the facility. The interviewed residents ate at least 1 meal from the hall carts per day.</p> <p>Findings include:</p> <p>1. Confidential resident interviews were completed as follows: On 9-8-2014 at 11:08 a.m., the resident indicated the food was always cold; The resident indicated he eats in his room and the food cart would sit for an hour at times before the meal trays were served. The resident had asked for staff to re-heat the food, but the staff had indicated they do not have time.</p> <p>On 9-8-2014 at 11:43 a.m., the resident indicated he eats in his room, and by the time the meal tray was delivered, the food was cold and the milk was warm. The resident indicated he was concerned about the safety of the food.</p> <p>On 9-8-2014 at 3:28 p.m., the resident indicated the food was served at the proper temperature "sometimes." The resident indicated he had not asked to have the food re-heated.</p>	F000364	<p>364</p> <p>1 No resident identifiers were offered.</p> <p>2 All residents served from the kitchen have the potential to be affected by this alleged deficient practice. To ensure food temperatures are adequate for residents receiving hall trays the facility purchased insulated dome base and covers to maintain temperatures on 9/12/2014. The facility purchased butter knives on 9/11/14.</p> <p>3 The Dietary Manager/ DCS will re-educate the dietary and nursing staff regarding food temps and expectations of serving meals at the appropriate temperature by 10/14/2014.</p> <p>4 The ED/ Food Service Director (FSD) will conduct QI monitoring of regulation F364 to ensure food temperatures are adequate by serving and testing the temperature of a test tray. QI monitoring will be conducted 5x a week times four weeks, 3x a week times four weeks, weekly times four weeks then monthly times three months rotating</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>On 9-8-2014 at 2:25 p.m., the resident indicated she had her meals in her room and the temperature of the food was not good.</p> <p>On 9-8-2014 at 3:01 p.m., the resident indicated the hot foods were not hot enough as the eggs and ham were served only at a medium temperature.</p> <p>On 9-9-2014 at 10:10 a.m., the resident indicated her breakfast meal was served in her room and was usually cold. The resident further indicated the eggs were always cold and the french toast was served cold and turned rubbery.</p> <p>On 9-8-2014 at 11:38 a.m., the resident indicated she was served her meals in her room and the food was cold.</p> <p>On 9-9-2014 at 1:33 p.m., the resident indicated she ate her meals in the dining room and the food was not served hot.</p> <p>On 9-8-2014 at 12:31 p.m., the resident indicated the food was sometimes served cold.</p> <p>2. An observation and interview on 9-11-2014 at 8:37 a.m., indicated a resident was served his meal tray in his room and the plate was served without</p>		<p>meals. The ED/FSD will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring</p> <p>5 Date of Completion: 10/16/2014</p>	

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	<p>the plastic insulated base. The resident indicated there had never been an insulated base for his plate.</p> <p>An observation on 9-11-2014 at 8:40 a.m., indicated the south hall tray cart had 8 returned meal trays and none had the insulated base for the plates.</p> <p>An interview with Dietary Aide #16 on 9-11-2014 at 11:57 a.m., indicated there were 8 East hall lunch trays in the cart without insulated bases for the plates.</p> <p>An observation of the West/South hall trays on 9-11-2014 at 11:59 a.m., indicated there were 15 trays delivered without the insulated bases for the plates.</p> <p>An interview with Cook #17 on 9-11-2014 at 12:00 p.m., indicated she prepared the hall trays and did not use insulated bases for the plates. The cook indicated there were not enough insulated bases for the plates and she had to use some of the insulated bases as insulated covers for the plates, as there were not enough insulated covers.</p> <p>An interview with the Executive Director (ED) on 9-11-2014 at 12:01 p.m., indicated she was not aware there were not enough insulated covers and bases for the plates served to residents. Further</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>interview with the ED indicated she was aware the test tray from 9-10-2014 was served with an insulated base.</p> <p>3. An observation on 9-11-2014 at 12:20 p.m., indicated a lunch hall tray was served to a resident without an insulated base for the hot food. The resident uncovered the insulated cover and there was no steam observed to come from the meatloaf, mashed potatoes, or the cooked zucchini &amp; tomato.</p> <p>The meal time schedule was provided at entrance on 9-8-2014 by the ED and indicated breakfast was served in the dining room at 8:00 a.m. The 1st hall cart (South hall) was ready 7:50 a.m. and the 2nd hall cart (East/West) was ready at 7:55 a.m. The lunch dining room serving time was 12:00 p.m. and the 1st hall cart (South hall) was ready at 11:50 a.m. and the 2nd hall cart for East and West hall was ready at 11:55 a.m.</p> <p>The lunch menu for 9-10-2014 was provided by the ED on 9-10-2014 at 9:35 a.m. and indicated the following: -Meatsauce -Spaghetti Noodles -Tossed Salad with Dressing -Dinner Roll/Bread -Ice Cream -Milk</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>-Coffee or Hot Tea</p> <p>A copy of the lunch food temperature log for 9-10-2014 was provided by the ED on 9-11-2014 at 2:36 p.m. and indicated the following temperatures for the lunch meal:</p> <ul style="list-style-type: none"> <li>-regular and ground entree temperatures was 183 degrees Fahrenheit</li> <li>- puree 155 degrees Fahrenheit</li> <li>- starch 179.3 degrees Fahrenheit</li> <li>- vegetable 175 degrees Fahrenheit</li> <li>- pureed vegetable was 164.5 degrees Fahrenheit</li> <li>- salad 32 degrees Fahrenheit</li> <li>- milk 0 (sic)</li> <li>- beverage 32 degrees Fahrenheit</li> </ul> <p>An interview with the Food Service Director (FSD) and the Regional Registered Dietitian on 9-15-2014 at 9:08 a.m., indicated there were approximately 24 hall trays served at each meal in the 2 carts. Further interview with the FSD indicated there were not enough insulated covers and bases for the plates and sometimes the insulated bases would serve as the insulated covers.</p> <p>An interview with the ED on 9-12-2014 at 9:16 a.m., indicated there was not a policy for the serving of meal hall trays.</p> <p>4. During Stage 1 Resident interviews on 9/8/14 and 9/9/14 the Residents indicated</p>				

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	<p>the following:</p> <p>-On 9/8/14 at 2:51 p.m., a Resident indicated the food was mostly cold and the ice cream was melted and runny.</p> <p>-On 9/8/14 at 3:25 p.m., a Resident indicated the food was not served at the proper temperature and also indicated the food was not hot when the staff has to help someone during meal pass.</p> <p>-On 9/9/14 at 10:47 a.m., a Resident indicated meals were eaten in the south dining room and also indicated the food sits too long on the cart in the hallway before it was served to the residents and indicated all of the meals were cold.</p> <p>5. On 9/10/14 at 1:01 p.m., a noon meal test tray was served and the temperature of the foods were tested. The meal tray arrived with the plate of food placed on top of an insulated plate base and it was covered with domed plate cover. The Salad was covered with plastic wrap. The noon meal included the following food:</p> <p>-Spaghetti with meat sauce, the temperature measured 142.3 degrees F. (Fahrenheit, measurement of temperature).</p> <p>-Garlic bread stick with mozzarella cheese in the center, the temperature</p>						

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F000371 SS=E	<p>measured 122 degrees F. -Lettuce salad, measured 58.2 degrees F. -Ice Cream Cup, measured 30 degrees F and was still frozen.</p> <p>6. An observation on 9/10/14 at 1:15 p.m. in the South dining room, there were 5 Residents eating in the South dining room and none of the resident's plates were placed on insulated bases. The plates were only covered with domed plated covers.</p> <p>7. An observation on 9/11/14 at 12:30 p.m., indicated 5 Residents were eating in the South dining room. 1 of the 5 Resident meal plates were placed on an insulated base and the other 4 meal plates were were only covered with a domed plate lid.</p> <p>A policy "Food Temperatures" dated 1-1-2012 and provided by the ED on 9-11-2014 at 12:45 p.m., indicated "food temperatures are monitored at all critical control points to ensure safety and acceptability...the Director of Dining Services is responsible for monitoring temperatures to ensure foods...served at the correct temperature...."</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE,</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p><b>STORE/PREPARE/SERVE - SANITARY</b> 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 ensure staff washed their hands appropriately for the recommended amount of time and at the appropriate time potentially affecting 26 of 26 residents who ate their meals in the main dining room. The facility also failed to have an adequate supply of butter knives in the facility for resident use.</p> <p>Findings include:</p> <p>1. During an observation of the lunch meal on 9/8/14 the following was observed:</p> <p>- At 12:08 p.m., Certified Nursing Assistant (CNA) #1 was observed to lather her hands for 11 seconds prior to rinsing. She then started beverage service to residents seated in the dining room.</p> <p>- At 12:12 p.m., CNA #2 was observed to place her hands on the front of her uniform slacks. She then was observed to pass beverages to residents in the</p>	F000371	<p>371 1 The DCS/ Nurse Manager will re-educate CNA # 1, 2, 3 and Nurse # 4 on the facility's Hand washing technique policy by October 14, 2014. The facility purchased butter knives on 9/11/14.2 All residents served from the kitchen have the potential to be affected by this alleged deficient practice. 3 The DCS/ Dietary Manager will re-educate the dietary and nursing staff on hand washing and meal service by October 14, 2014. 4 The DCS/ Dietary Manager will conduct QI monitoring of regulation F371 by observations of hand washing and of the dietary tray line. QI monitoring will be conducted 5x a week times four weeks, 3x a week times four weeks, weekly times four weeks then monthly times three months using a sample size of 3 employees serving meals and rotating meals for tray line observations. A par level of forks, knives and spoons equal to two of each utensil per resident has been developed and will be maintained. The dietary manager will be responsible for taking a physical count of said utensils 3 times per week fo 4 weeks, weekly for 4 weeks,</p>	10/16/2014	

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819		
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	<p>dining room without washing her hands.</p> <p>- At 12:24 p.m., CNA #3 was observed to lather her hands for 14 seconds prior to rinsing. She then was observed to continue with meal service.</p> <p>2. During an observation of the breakfast meal on 9/9/14 the following was observed:</p> <p>- At 8:32 a.m., CNA #3 was observed to put liquid soap on her hands and immediately placed her hands under the running water rubbing them together under the running water for 11 seconds. She then was observed to resume meal service in the dining room.</p> <p>- At 8:34 a.m., CNA #1 was observed to lather her hands for 7 seconds before rinsing. She then assisted a resident by pushing his wheelchair, picked up a glass of water and gave it to the resident. She was not observed to wash her hands after touching the wheelchair.</p> <p>- At 8:36 a.m., CNA #1 was then observed to deliver a meal tray to a resident and picked up his eating utensils to help prepare his plate. She was not observed to wash her hands.</p> <p>3. During an observation of the lunch</p>		<p>monthly for 4 months. The DCS/ Dietary Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring 5 Date of Compliance: 10/16/2014</p>		

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	<p>meal on 9/11/14 the following was observed:</p> <ul style="list-style-type: none"> <li>- At 11:59 a.m., CNA #1 was observed to lather her hands for 15 seconds prior to rinsing. She then removed a gait belt from around a resident's waist and left the dining room. She returned to the dining room at 12:03 p.m. and was observed to lather her hands for 9 seconds before rinsing. She then started beverage service to residents.</li> <li>- At 12:07 p.m., CNA #3 was observed to lather her hands for 12 seconds before rinsing. She then was observed to continue with meal service.</li> <li>- At 12:21 p.m., CNA #2 was observed to lather her hands for 7 seconds before rinsing. She then was observed to pull a dining chair up to a table with residents and began to feed a resident his lunch meal.</li> <li>- At 12:26 p.m., Nurse #4 was observed to lather her hands for 5 seconds. She then assisted a resident with his meal.</li> <li>- At 12:28 p.m., Nurse #4 was observed to put liquid soap on her hands and immediately placed her hands under the running water rubbing them together under the running water for 6 seconds.</li> </ul>			
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	<p>She then was observed to continue with meal service.</p> <p>- At 12:29 p.m., CNA #1 was observed to lather her hands for 9 seconds before rinsing. She then was observed to continue with meal service.</p> <p>The Administrator was interviewed on 9/12/14 at 12:33 p.m. During the interview she indicated staff were to wash their hands for at least 20 seconds during meals service.</p> <p>The Certified Dietary Manager (CDM) was interviewed on 9/12/14 at 3:22 p.m. During the interview she indicated staff were to wash their hands for 20 seconds. She also indicated staff were to wash their hands in-between residents and after touching anything soiled.</p> <p>4. During an observation of the lunch meal on 9/11/14 at 12:12 p.m., the family member of a resident who was seated at a dining table with her, was observed to walk up to the pass-through window into the kitchen and asked for a butter knife to spread the butter on his mashed potatoes. He was informed by the dietary staff the facility only had a few butter knives, not enough for each resident to have one. He was provided with a plastic butter knife only after requesting one. During</p>						

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	<p>the observation only 2 of the 16 residents who did not receive a texture modified diet in the dining room received a butter knife, 2 of 4 residents who did not receive a texture modified diet in the South dining room received a butter knife, and 1 of 4 residents who did not receive a texture modified diet in the East Hall did not receive a butter knife.</p> <p>The CDM was interviewed on 9/11/14 at 12:33 p.m. During the interview she indicated staff notified her of the missing butter knives the previous week. She also indicated she had planned to order butter knives the following week.</p> <p>A current facility policy "Hand Washing Technique", revised on 9/1/11 and provided by the Administrator on 9/11/14 at 2:04 p.m., indicated "...All personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infections...Hands must be washed:...In between resident contacts...After contact with contaminated items or surfaces...Wet hands thoroughly. Take approximately 3-5 ml of soap from the dispenser. Thoroughly distribute soap over the entire area of hands and wrists...Work suds between fingers and high up on wrists, Keep rubbing and working the lather over every part of the hands...Rub</p>						

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F000431 SS=E	<p>hands together vigorously for 10-15 seconds, generating friction on all surfaces of the hands and fingers...Dry hands with paper towels and turn faucets off with the paper towel...."</p> <p>This deficiency was cited on the annual Recertification on 8/21/13 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-21(i)(1) 3.1-21(i)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			

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	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure open dates were recorded on the eye drops for 7 of 14 residents who were prescribed eye drops (#16, #6, #13, #45, #32, #60 and #3). The facility also failed to ensure insulin vials were not used after the expiration date and failed to remove the expired insulins from the medication cart for 7 of 16 residents who used insulin (#55, #22, #6, #4, #14 and #21). This affected 2 of 2 medication carts in the facility.</p> <p>Findings include:</p> <p>1. An observation with Nurse #13 on 9-15-2014 from 10:46 a.m. to 11:15 a.m. of the East/South hall medication (med) cart indicated the following:</p> <p>Eye drop containers were not labeled with an opened date -Resident #45 - Artificial Tears with a prescription date on the label of 6-7-2014</p>	F000431	<p>1 Res #16,#6, #45, #32, #60, #55, #22, #4, #14 and #21 did not have any adverse affects from administered medications. Eyedrops and insulins were removed from medication carts.2 No other residents were identified3 Nursing inservice regarding dating medications upon opening and identifying and removing expired medications from med carts to be completed by October 16,2014. Med cart audits will be completed 3x/week for 3 months then 1 time weekly for 3 months by DCS/Designee4 Audit results will be submitted to QA monthly for review to ensure compliance5 Date of Completion: 10/16/2014</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/16/2014	
NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>-Resident #32 - Artificial Tears with a prescription date on the label of 8-22-2014</p> <p>-Resident #60 - Artificial Tears with a prescription date on the label of 9-5-2014</p> <p>-Resident #3 - Artificial Tears with a prescription date on the label of 8-14-2014</p> <p>-Resident #3 - Prednisolone with a prescription date of 9-12-2014</p> <p>Insulin for the following residents were expired and remained in the East/South med cart:</p> <p>-Resident #4 had a Humalog vial with an open date of 8-16-2014 written on the label.</p> <p>-Resident #14 had a Humalog vial with an open date of 8-15-2014 written on the label and a Lantus vial with an open date of 8-15-2014 written on the label.</p> <p>-Resident #21 had a Levemir vial with an open date of 7-28-2014 and an expiration date of 9-8-2014 written on the label.</p> <p>-Resident #21 had a Novolog vial open date of 7-30-2014 and an expiration date of 8-27-2014 written on the label.</p> <p>A review of Resident #4's September 2014 MAR provided by the Regional DCS indicated Humalog insulin was given on the following dates: 9-14-2014 4 units at 11 a.m. 9-14-2014 4 units at 8 p.m.</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>The vial of Humalog insulin for Resident #4 would have expired on 9-13-2014, 28 days after the 8-16-2014 opened date.</p> <p>A review of Resident #14's physician orders dated 8-22-2014 indicated the Humalog and Lantus insulin were discontinued on 8-22-2014 and the expired vials remained in the East/South hall medication cart.</p> <p>A review of Resident #21's September 2014 MAR provided by the Regional DCS on 9-15-2014 at 3:05 p.m., indicated the Novolog insulin was given on the following dates after the expired date of 9-8-2014:</p> <p>9-9-2014 5 units in the evening 9-10-2014 5 units in the evening 9-11-2014 5 units in the evening 9-12-2014 5 units in the evening 9-13-2014 5 units in the evening 9-14-2014 5 units in the evening</p> <p>A review of Resident #21's September 2014 MAR provided by the Regional DCS indicated Humalog insulin (open date 7-30-2014) was given on the following dates after the expired date of 8-27-2014:</p> <p>8-28-2014 4 units given at 7 a.m. 8-29-2014 4 units given at 7 a.m. and 6 units given at 4 p.m. 8-30-2014 4 units given at 7 a.m.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>8-31-2014 4 units given a 7 a.m. and 2 units given at 4 p.m.</p> <p>9-1-2014 4 units given at 7 a.m. and 2 units given at 4 p.m.</p> <p>9-2-2014 2 units given at 7 a.m. and 4 p.m.</p> <p>9-3-2014 4 units given at 7 a.m. and 4 p.m.</p> <p>9-4-2014 4 units given at 7 a.m. and 2 units at 4 p.m.</p> <p>9-5-2014 4 units given at 7 a.m. and 4 p.m.</p> <p>9-6-2014 4 units given at 7 a.m. and 4 p.m.</p> <p>9-7-2014 4 units given at 7 a.m. and 2 units at 4 p.m.</p> <p>9-8-2014 4 units given at 7 a.m. and 2 units at 4 p.m.</p> <p>9-9-2014 2 units given at 7 a.m.</p> <p>9-10-2014 2 units given at 7 a.m. and 6 units given at 4 p.m.</p> <p>9-11-2014 2 units given at 7 a.m. and 4 units given at 4 p.m.</p> <p>9-12-2014 2 units given at 7 a.m. and p.m.</p> <p>9-13-2014 2 units given at 7 a.m.</p> <p>9-14-2014 2 units given at 7 a.m.</p> <p>9-15-2014 2 units given at 7 a.m.</p> <p>An interview with Nurse #13 on 9-15-2014 at 11:05 a.m., indicated all insulins and eye drops should be dated when opened. Further interview with Nurse #13 indicated the Novolog,</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>Humalog and Lantus insulins had expiration dates of 28 days after opening.</p> <p>2. An observation of the West Hall cart with the Regional Director of Clinical Services (DCS) on 9-15-2014 from 11:40 a.m. - 11:55 a.m., indicated the following:</p> <p>Eye drop containers were not labeled with an opened date</p> <ul style="list-style-type: none"> <li>-Resident #16 - Artificial tears with an expiration date of 2/17</li> <li>-Resident #6 - Genteal Severe 0.3% eye gel with a prescription date of 8-28-2014</li> <li>-Resident #13 - Artificial Tears vial and without a prescription bottle</li> </ul> <p>Insulin for the following residents were expired and remained in the West hall med cart:</p> <ul style="list-style-type: none"> <li>-Resident #55 had a vial of Novolog opened on 8-15-2014.</li> <li>-Resident #22 had a vial of Lantus with a prescription date of 7-2-2014 and no open date was recorded on the vial or container.</li> <li>-Resident #6 had a vial of Novolog 70/30 with a prescription date of 8-9-2014 and no open date was recorded on the vial or the container.</li> </ul> <p>A review of Resident #55's September 2014 Medication Administration Record</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>(MAR) provided by the Regional DCS indicated Novolog insulin was given on the following dates:            9-13-2014 4 units at 11 a.m.            9-13-2014 6 units at 4 p.m.            9-14-2014 2 units a 6 a.m.            9-14-2014 8 units at 4 p.m.            9-14-2014 2 units at 8 p.m.            9-15-2014 2 units at 6 a.m.            The vial of Novolog insulin for Resident #55 would have expired on 9-12-2014, 28 days after the 8-15-2014 opened date.</p> <p>A review of Resident #22's September 2014 MAR provided by Nurse #12 indicated Lantus insulin was given on the following dates:            9-1-2014 70 units in the morning and evening            9-2-2014 70 units in the morning and evening            9-3-2014 70 units in the morning (70 unit dose was discontinued on 9-3-2014)            9-3-2014 75 units in the evening            9-4-2014 75 units in the morning and evening            9-5-2014 75 units in the morning and evening            9-6-2014 75 units in the morning and evening            9-7-2014 75 units in the morning and evening            9-8-2014 75 units in the morning and evening</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>9-9-2014 75 units in the morning and evening</p> <p>9-10-2014 75 units in the morning and the Lantus was discontinued.</p> <p>The vial of Lantus insulin for Resident #22 would have expired on 7-30-2014, 28 days after the 7-2-2014 opened date.</p> <p>A review of Resident #6's September 2014 Medication Administration Record (MAR) provided by the Regional DCS indicated Novolog 70-30 insulin was given on the following dates:</p> <p>9-6-2014 55 units in the morning and 50 units in the evening</p> <p>9-7-2014 55 units in the morning and 50 units in the evening</p> <p>9-8-2014 55 units in the morning and 50 units in the evening</p> <p>9-9-2014 55 units in the morning and 50 units in the evening</p> <p>9-10-2014 55 units in the morning and 50 units in the evening</p> <p>9-11-2014 55 units in the morning and 50 units in the evening</p> <p>9-12-2014 55 units in the morning</p> <p>9-14-2014 55 units in the morning and 50 units in the evening</p> <p>9-15-2014 55 units in the morning</p> <p>The vial of Novolog 70-30 insulin for Resident #6 would have expired on 9-5-2014, 28 days after the prescription date of 8-9-2014 (since there was not an opened date).</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>A copy of the Insulin Storage recommendations last revised on 3-31-2014 was obtained from the Regional DCS on 9-15-2014 at 11:30 a.m., and indicated the vials of Humalog, Lantus and Novolog expired 28 days after the date opened. The Levemir vial expired 42 days after the opened date.</p> <p>An interview with the Facility DCS on 9-15-2014 at 11:31 a.m., indicated the days to expiration were counted from the date opened for the insulin.</p> <p>A policy "Storage and Expiration of Medications, Biologicals, Syringes and Needles" dated 1-1-2013 and provided by the Regional DCS on 9-15-2014 at 2:28 p.m., indicated "...facility should ensure that medications...have not been retained longer than recommended by manufacturer or supplier guidelines...once any medication opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications...staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...facility should ensure that the medications ...for each resident are stored in the containers in which they were originally received...facility should</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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F000441 SS=E	<p>destroy or return all discontinued, outdated/expired...medications...facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis...."</p> <p>This deficiency was cited on the annual Recertification on 8-21-2013 and the Post Survey Revisit (PSR) on 10-29-2013 and the facility failed to implement a plan of correction to correct the deficiency.</p> <p>3.1-25(j)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>						

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review the facility failed to ensure a glucometer, with the potential to be used by multiple residents was cleaned in a manner to prevent potential cross contamination of blood borne pathogens in 1 of 2 observations of cleansing of used glucometers.</p> <p>Findings include:</p> <p>On 9/11/14 at 11:45 a.m. LPN #11 was observed to pull the glucometer out of the medication cart. She indicated residents do have glucometers in their rooms but the facility does keep glucometers on the cart for when a resident is not in their room and needs their blood sugar checked. She applied gloves, cleaned the</p>	F000441	<p>441</p> <p>1 No resident identifiers were given. The DCS/ Nurse Manager will re-educate LPN #11 on the facility's policy for cleaning glucometers by October 14, 2014.</p> <p>2 Diabetic residents have the potential to be affected by this alleged deficient practice.</p> <p>3 The DCS/ Nurse Manager will re-educate the licensed nurses on the facility's cleaning procedures of glucometers by October 14, 2014.</p> <p>4 The DCS/ Nurse Manager will conduct QI monitoring</p>	10/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>resident's finger, performed the fingerstick, obtained the blood from the resident to the glucometer test and received the result.</p> <p>She opened an alcohol wipes and cleaned the exterior portion of the glucometer unit. At the time, she was interviewed. She indicated she used the alcohol wipes to clean the glucometer. She opened the bottom drawer of the medication cart and was aware of the location of the bleach wipes. She was unsure of the facility policy and procedure regarding which product was to be used to clean the multi use glucometer.</p> <p>On 9/11/14 at 2 p.m. the Executive Director provided a current facility policy and procedure for "Blood Glucose Monitoring." This policy was dated 3/5/14 and included but was not limited to, the following information: "cleanse glucometer after each resident use with a dilute bleach solution of 1:10 (one part bleach to 9 parts water) (or) utilize approved disinfectant wipes per manufacturer's instructions.</p> <p>This deficiency was cited on the annual Recertification survey on 8/21/13 and the facility failed to implement a plan of correction to correct the deficiency.</p>		<p>of regulation F441 to ensure glucometers are cleaned in a manner to prevent potential cross contamination. QI monitoring will be conducted 5x a week times four weeks, 3x a week times four weeks, weekly times four weeks then monthly times three months via observation using a sample size of 2 nurses. The DCS/ Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring</p> <p>5 Date of Compliance: 10/16/2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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F000465 SS=D	<p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure the facility was maintained in a clean, sanitary and homelike environment for 1 of 3 halls of the facility. (West Hall and Room 112)</p> <p>Findings include:</p> <p>On initial tour of the facility on 9/8/14 at 10:15 a.m. the West hall shower room was observed. When the door was opened, the wall directly across the room was observed to have splotches of a white spackling type material, ranging from a foot in diameter to two feet in diameter. The white spackling type material was in contrast to the pale pink wall color.</p> <p>The shower area was observed to have a shower chair placed directly over the drain. The strap to the shower chair had a dark black, moldy like residue observed throughout the surface of the strap. The drain beneath the shower chair was observed to have two green leafy plant</p>	F000465	<p>465</p> <p>1 West Hall shower room drain and chair was cleaned appropriately on 9/15/2014. Paint, baseboard repair and tile to shower room and Room 112 paint, dry wall repair, and kick plate materials for repair will be ordered and repairs will be made immediately upon arrival.</p> <p>2 All residents have the potential to be affected by this alleged deficient practice. The ED/ Maintenance Director conducted environmental rounds of the resident rooms and common areas of the facility. Any areas identified will be corrected.</p> <p>3 The ED will re-educate the Maintenance Director on the facility's Maintenance and Maintenance Checklist Policies by October 14, 2014. The Maintenance Director/ Nurse Manager will re-educate the staff</p>	10/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>like sprouts growing upright. One sprout was at least 1 inch in height and the other was at least 1/2 in height. The drain was observed to have what appeared to be a large quantity of hair strands overlaying on the grids of the drain plate, in some areas of the drain, the metal plate beneath was not visible due to the coverage of hair type material.</p> <p>The tiled shower was observed to have jagged caulking along the edges of the shower where the wall tiles intersect the floor tile. The caulking was observed to have large amount of accumulation of black matter throughout. All but one of the tile along the back side of the shower were cracked and/or laden with black type matter. The end of the divider wall, which faces the door to the shower room, was missing the baseboard cover at the bottom, which exposed the bare drywall beneath. The baseboard cover along the outer side of the divider wall, was laying on the floor, beside the wall, also exposing the bare drywall beneath.</p> <p>At the time, a current shower schedule was observed to be posted in the west hall shower room.</p> <p>On 9/15/14 at 11:30 a.m. the Housekeeping Supervisor (HS) was interviewed. He indicated the showers</p>		<p>on the facility's Maintenance Request Form by October 14, 2014 emphasis will be placed on location and indication for use.</p> <p>4 The Maintenance Director/ ED will conduct QI monitoring of regulation F 465 to ensure the facility is maintained in a clean, sanitary and homelike environment QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random resident rooms and one other area (i.e. dining room, shower room or common sitting area). The ED/ Maintenance Director will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>5 Date of Completion: 10/16/2014</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>are cleaned daily and they use a germicidal for the cleaning. At the time, he provided a copy of the "Housekeeping inservice" dated 1/1/2000. This Housekeeping Supervisor indicated the "Housekeeping Inservice" form directed the staff daily to clean the shower using a solution of the properly diluted germicide and sanitize all horizontal surfaces. This form also directed the walls, especially by trash cans will need special attention. The form also directed the importance "the most important area of a patient's room is the floor. This is where most airborne bacteria will settle and so it needs to be sanitized daily."</p> <p>At the time, the HS provided documentation of the "Deep cleaning schedule" form the West Hall. He indicated the documentation indicated the shower on the west hall had last been deep cleaned on 8/14/14 and was due to be deep cleaned again on 9/24/14. He provided documentation the west hall shower room had last been cleaned on 9/7/14.</p> <p>On 9/15/14 at 2 p.m. Room #112 was observed. This room was observed to have a line of exposed dry wall at least a foot and a half in length at the level of the top of the trash can, which was in front of the exposed dry wall. The trash can was</p>			
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	<p>just to the right of the resident's door on entry into the room. Along the wall, next to the resident's bed, was observed a radiator type wall vent which extended along the wall beneath the resident's window. This radiator type wall vent was at least 4 feet long and was sparsely covered in a white paint, with the metal material beneath the pain visible. This wall vent was easily visible without moving any furniture and was also visible from the door to the resident's room. The door to the bathroom was observed to have mars on the inside and outside of the door. The vinyl kick plate which covered at least 1/3 of the bottom of the door (height wise) was ripped, and exposed the gashed door beneath.</p> <p>On 9/15/14 at 2:45 p.m. the RDCS toured Room 112. She indicated the facility does mock survey rounds and had identified several rooms that were in need of repairs. She indicated she was unable to provide the mock survey results at this time. The RDCS indicated she was in agreement the above identified repairs needed to be made.</p> <p>This deficiency was cited on the annual Recertification survey on 8/21/13 and the facility failed to implement a plan of correction to correct the deficiency.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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F000514 SS=D	<p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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 maintain complete documentation of pain medications for 1 of 1 resident (Resident #14) reviewed for pain medications.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #14 on 9/10/14 at 8:40 a.m., indicated the following diagnoses, included but were not limited to,</p>	F000514	<p>514</p> <p>1 Res #14's pain medication was clarified on 9/16/2014</p> <p>2 All residents have the potential to be affected by this alleged deficient practice.</p> <p>Current in-house residents receiving pain medication will have their physician orders and MAR reviewed by the DCS/ Nurse Manager. Any issues identified will be corrected immediately.</p>	10/16/2014			

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	<p>endocarditis, cardiac valve prosthesis, diabetes mellitus (DM), peripheral vascular disease, unilateral above the knee amputation (AKA), amputation of toe, debility, osteomyelitis, sepsis, open wound on buttock. The most recent MDS (minimum data set assessment) dated 8/15/14 indicated the BIMS (Brief Interview Mental Status) score was 15 of 15 which indicated the resident was cognitively intact. The Resident's clinical record also indicated the Resident was admitted to Hospice Services on 8/22/14 with diagnosis of endocarditis.</p> <p>The Physician's Orders indicated the following:</p> <p>-The admission orders from the hospital, dated 8/8/14 indicated, "...Hydrocodone-acetaminophen (Narco) 5-325 mg (milligrams) 1-2 tab (tablets) orally (po) every 6 hours as needed.</p> <p>-Dated 8/8/14 indicated, "...change Narco 5/325 mg mg 1-2 tab po q (every) 6 H (hours) as needed (PRN) to Norco 5/325 mg 1 tab po q 6 H as needed for pain moderate rate 1-5 and Narco 5/325 mg 2 tabs po q 6 H as needed for pain severe rate 6-10...."</p> <p>-The Physician's Orders recapitulation dated 9/01/14 through 9/30/14, signed by</p>		<p>3 The DCS/ Nurse Manager will re-educate the licensed nurses on the Pain management protocol and documentation by 10/14/2014.</p> <p>4 The DCS/ Nurse Manager will conduct QI monitoring of regulation 514 to ensure complete documentation of pain medication. Five residents will have their physician's orders, MAR and TAR reviewed for discrepancies by the DCS/ Nurse Manager weekly times four weeks then monthly for five months. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated.</p> <p>5 Date of completion: 10/16/2014</p>	

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	<p>the MD without a date indicated, "...Norco 5/325 mg 1 tab po q 6 hours PRN/moderate pain (original date 8/8/14). Narco 5/325 mg 2 tabs po BID (2 times a day) PRN/severe pain (original dated 8/8/14).</p> <p>-Dated 8/29/14 indicated, "...Norco 5/325 mg 1 po every 8 hours routine. Continue PRN dosing instructions...."</p> <p>Review of the Controlled Substances Record, the MARS (Medication Administration Record Sheet), and the Pain Flow Sheet for Resident #14, for the dates of 8/10/14 through 9/12/14 indicated the following discrepancies:</p> <p>-The MARS were not dated with the month or year.</p> <p>- On 8/10/14, the MARS indicated Narco 5-325 mg 2 tabs were given. The Controlled Substances Record for the same date indicated Hydrocodone-APAP 5-325 mg, 2 tablets were signed out by staff at 5:15 a.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/10/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 4:45 p.m., there was no documentation present on the MARS for</p>			

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	<p>the same time period.</p> <p>-On 8/11/14, the MARS and Controlled Substances Record indicated Narco 2 tabs were given at 2:30 p.m.; there was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/11/14, the MARS and Controlled Substances Record indicated Narco 2 tabs were given at 9:00 p.m.; there was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/12/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 4:00 a.m.; there was no documentation on the MARS for the same date and time.</p> <p>-On 8/15/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 7:40 a.m.; there was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/15/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 3:00 p.m.; there was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/17/14, the MARS and Controlled Substances Record indicated Narco 2</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>tabs was signed out and given at 8:00 a.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/17/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 8:45 p.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/18/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 3:00 a.m. and 9:00 a.m. There was only 1 set of nurse's initials on the MARS for the date. There was no documentation on the Pain Flow Sheet for the same date and times.</p> <p>-On 8/19/14, the Controlled Substances Record and the Pain Flow Sheet indicated Narco 1 tab was signed out and given at 1:00 a.m. There was no documentation on the MARS for the same date and time.</p> <p>-On 8/20/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 8:00 a.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/25/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 4:00 a.m. There was no</p>						

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	<p>documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/25/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 8:00 a.m. There was no documentation on the MARS.</p> <p>-On 8/26/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 11:30 p.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/27/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 9:30 a.m. The documentation on the MARS and the Pain Flow Sheet for the same date and time indicated Narco 1 tab was given to the Resident.</p> <p>-On 8/28/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 2:30 p.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 8/29/14, the Controlled Substances Record and the MARS indicated Narco 2 tabs were signed out and given at 10:40 a.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>-On 8/29/14, the MARS and Controlled Substances Record indicated Narco 2 tabs were signed out and given at 7:30 p.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/30/14, the MARS and Controlled Substances Record indicated Narco 1 tab was signed out and given at 11:30 (did not indicated a.m. or p.m.). There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/30/14, the MARS and Controlled Substances Record indicated Narco 2 tabs were signed out and given at 7:30 p.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 8/31/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 7:30 p.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 9/1/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 8:30 p.m. The documentation on the MARS indicated Narco 1 tab was given and the Pain Flow Sheet indicated Narco was given but did</p>			

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	<p>not indicate if 1 or 2 tabs were given on that date and time.</p> <p>-On 9/1/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 8:30 p.m. There was no documentation on the MARS for the same time and date.</p> <p>-On 9/2/14, the Pain Flow Sheet indicated Narco 2 tabs were given at 8:30 p.m., the MARS was initialed by the nurse Narco 2 tabs were given on 9/2/14. There was no documentation on the Controlled Substances Sheet the Narco was signed on 9/2/14.</p> <p>-On 9/4/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 12:00 a.m. There was no documentation on the MARS or the Pain Flow Sheet for the same time and date.</p> <p>-On 9/4/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 8:00 p.m. There was no documentation on the MARS for the same time and date.</p> <p>-On 9/5/14, the Controlled Substances Record and the MARS indicated Narco 1 tab was signed out and given at 12:00 a.m. There was no documentation on the Pain Flow Sheet for the same time and</p>			

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	<p>date.</p> <p>-On 9/5/14, the Controlled Substances Record and the Pain Flow Sheet indicated Narco 1 tab was given at 1:45 a.m. There was no documentation on the MARS for the same time and date.</p> <p>-On 9/6/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 1:00 a.m. The documentation on the MARS and Pain Flow Sheet indicated Narco 1 tab was given on the same time and date.</p> <p>-On 9/6/14, the Controlled Substances Record indicated Narco 2 tabs were signed out at 9:00 p.m. There was no documentation on the MARS or the Pain Flow Sheet for the same time and date.</p> <p>-On 9/7/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 12:30 a.m. There was no documentation on the MARS or the Pain Flow Sheet for the same time and date.</p> <p>-On 9/8/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 2:00 a.m. There was no documentation on the MARS or the Pain Flow Sheet for the same time and date.</p> <p>-On 9/8/14, the Controlled Substances</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819
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	<p>Record indicated Narco 2 tabs were signed out at 8:00 p.m. The documentation on the Pain Flow Sheet indicated Narco 2 tabs were given at 7:30 p.m.</p> <p>-On 9/9/14, the Controlled Substances Record and MARS indicated Narco 1 tab was signed out at 12:00 a.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 9/9/14 the Controlled Substances Record and the MARS indicated Narco 2 tabs were signed out at 3:00 p.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 9/10/14, the Controlled Substances Record indicated Narco 1 tab was signed out at 12:00 a.m. There was no documentation on the MARS or the Pain Flow Sheet for the same date and time.</p> <p>-On 9/10/14, the Controlled Substances Record and the MARS indicated Narco 2 tabs were signed out and given at 4:00 a.m. The documentation on the Pain Flow Sheet indicated Narco 2 tabs were given at 3:00 a.m.</p> <p>-On 9/11/14, the Controlled Substances Record and the MARS indicated Narco 1 tab was given at 12:00 a.m. There was</p>			

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	<p>no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 9/11/14, the Controlled Substances Record and Pain Flow Sheet indicated Narco was signed out and given at 3:00 a.m. There was no documentation on the MARS for the same date.</p> <p>-On 9/11/14, the Controlled Substances Record and the MARS indicated Narco 2 tabs were signed out and given at 8:00 p.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 9/12/14, the Controlled Substances Record and the MARS indicated Narco 1 tab was given at 12:00 a.m. There was no documentation on the Pain Flow Sheet for the same date and time.</p> <p>-On 9/13/14, the Controlled Substances Record and the Pain Flow Sheet indicated Narco 1 tab was given at 3:00 a.m. There was no documentation on the MARS for the same date.</p> <p>During review of the MARS on 9/15/14 at 11:30 a.m. indicated, "...Pain Assessment -Document pain Scale 1-10 every shift..." The documented pain scale did not always match the pain scale documented on the Pain Flow Sheet.</p>			

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NAME OF PROVIDER OR SUPPLIER  RIVERBEND HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819			
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	<p>During an interview on 9/11/14 at 3:00 p.m. with the Facility's DCS (Director of Clinical Services) indicated the MARS should be dated with the month and date. She indicated it was not easy to determine which MARS was for August 2014 and September 2014. She further indicated the Nurse should have documented the administration time on the MARS, and the nurses entries were difficult to read. She indicated the pain assessment scale should have been documented each shift and included the highest pain level rated for the shift. She indicated when the Narco 1 or 2 tablets were given PRN (as needed) for pain, the nurse should have documented the administration on the MARS, the Pain Flow Sheet and the Controlled Substances Record. She indicated the facility was cited for the same thing on last year's survey.</p> <p>On 9/11/14 at 2:05 p.m., the Administrator provided the Facility's Policy, with revision Date of 08-29-2014, titled, Pain Management indicated the following, "...Review the resident's current pain medication regimen to determine the following: 1. Name of drug, dose, and frequency ordered. 2. How long the resident ha [sic] been on this medication. 3. Degree of relief</p>						

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F000520 SS=F	<p>experienced for this medication....Use pain scale when the resident describes his or her pain and amount of pain relief...Documentation in the Clinical notes is done...."</p> <p>On 9/11/14 at 2:05 p.m., the Administrator provided the Facility's Policy, with the revision date of 02-18-2014, titled, Pain Assessment indicated the following, "...A Pain Flow Record will be maintained with the resident's Medication Administration Record. This is to be completed when the resident has identified they have pain. Record the following: 1. Date and time 2. Site/location 3. Type of pain 4. Intensity 5. Precipitating/aggravating 6. Interventions - non-med / medications 7. Intensity of pain after intervention 8. Side effects 9 Initials...."</p> <p>This deficiency was cited on the annual Recertification survey on 8/21/13 and on the post survey revisits on 10/29/13 and 12/3/13 and the facility failed to implement a plan of correction to correct the deficiency. 3.1-50(a)(1)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155359	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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	<p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility QAA (Quality Assessment and Assurance Committee) failed to implement an adequate action plan for the identified concerns which included the following: not investigating a reported allegation and not reporting the allegation to the Indiana State Department of Health, not treating residents with dignity and respect, not implementing and updating Resident's care plans, not following Physician's orders, not maintaining a Resident current urinary status, not ensuring the safety of residents, not maintaining</p>	F000520	<p>520</p> <p>1 Facility holds QA meetings monthly tracking identified concerns</p> <p>2 All residents have the potential of being affected by this alleged deficient practice.</p> <p>3 The ED will re-educate the Department Heads on the facility's QAPI process by October 14, 2014.</p> <p>4 The Regional Vice-President of Operations (RVPO)/Regional Director of Clinical Services will monitor the QAPI monthly times</p>	10/16/2014

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	<p>hydration, not maintaining a medication error rate of less than 5%, not providing adequate staff to meet the residents needs, not serving foods at the proper temperature, not labeling multi use medications with open dates, not discarding expired medication, inadequate handwashing during meal service, not providing butter knives to residents during meal services, inadequate cleaning of the glucometers, inadequate cleaning of the facility's shower rooms and disrepair of furnishings, and inaccurate and incomplete documentation. These deficiencies had the potential to affect 50 of 50 residents who resided at the facility.</p> <p>Findings include:</p> <p>An interview with the Executive Director (ED) on 9/15/14 at 3:20 p.m., indicated she became the ED on 9/8/14, had reviewed the prior QAA Committee minutes, and indicated the QAA Committee met monthly. She indicated the QAA Committee was aware of many of the identified concerns and indicated the QAA Committee had done audits on the following areas: call lights, incidents and accidents, Resident's Trust, falls, catheters, antibiotics, safety, the medical charts, documentation compliance, hydration, range of motion, sanitation in</p>		<p>six months to ensure substantial compliance. A member of the regional team will attend two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated.</p> <p>5 Date of Completion: 10/16/2014</p>		

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	<p>the kitchen, meal service, staffing, and residents on thickened liquids. The ED indicated some of the identified concerns were cited on last year's surveys and indicated the concerns will need to be addressed by the QAA Committee.</p> <p>The QAA committee consisted of the Executive Director, the DCS (Director of Clinical Services), the ADCS (Assistant Director of Clinical Services/Unit Manager, the Medical Director the Pharmacist Consultant and the Managers of each of the Facility's Departments. The committee met monthly and failed to develop and implement an adequate action plan to correct to correct the identified concerns which included the following: not investigating reported allegations and not reporting the allegation to the Indiana State Department of Health, not treating residents with dignity and respect, not implementing and update resident's care plans, not following Physician's orders, not maintaining a Resident current urinary status, not ensuring the safety of residents, not maintaining hydration, not maintaining a medication error rate of less than 5%, not providing adequate staff to meet the residents needs, not serving foods at the proper temperature, not labeling multi use medications with open dates, not discarding expired</p>						

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	<p>medication, inadequate handwashing during meal service, not providing butter knives to residents during meal services, inadequate cleaning of the glucometers, inadequate cleaning of the facility's shower rooms and disrepair of furnishings, and inaccurate and incomplete documentation.</p> <p>On 9/15/14 at 5:10 p.m., the Facility's DCS(Director of Clinical Services) provided the facility's policy, with the revision date of 03-07-2014, titled, Performance Improvement (Quality Assurance), which indicated, "...The facility and organization will have an ongoing Performance Improvement Program with a design and scope that is ongoing and comprehensive dealing with a full range of services offered by the facility including the full range of departments that addresses all aspects of care...pursue opportunities to improve resident care, resolve identified problems and identify opportunities for improvement...examines both outcomes and processes relevant to these outcomes with the objective of improving the organization's performance..."</p> <p>This deficiency was cited on the annual Recertification on 8/21/13 and on the post survey revisit on 10/29/13 the facility failed to implement a plan of</p>			

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

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	correction to correct the deficiency.  3.1-52(a)(2)				