

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/02/2016
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NAME OF PROVIDER OR SUPPLIER RIVERBEND	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure survey.</p> <p>Survey dates: August 1 and 2, 2016</p> <p>Facility Number: 010885 Provider Number: 010885 AIM Number: N/A</p> <p>Residential Census: 110</p> <p>Sample: 22</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 34233 on August 7, 2016.</p>	R 0000	<p>This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on August 31, 2016 does not constitute an admission of fault of liability to the government entity of any third party, on the part of Riverbend Assisted Living, as to the accuracy of the surveyors' findings or the conclusions drawn there from. Submission of this plan of correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the communities policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 47 of the Federal Rules of Evidence and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to the admission of this statement of deficiency or the plan of correction under any other theory of law. The</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R 0152 Bldg. 00	<p>410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure clean and soiled linens were handled and stored in a safe and sanitary manner in 3 of 6 laundry/clean linen rooms. (Laundry Rooms B, D, & C)</p> <p>During the environmental tour on 8/2/16 from 8:45 a.m. to 9:35 a.m., with the Maintenance Supervisor, the following was observed:</p> <p>1. In the Cottage D Hall Laundry Room were two full bio hazard waste trash cans. The cans were surrounded by clean towels, wash clothes, and blankets. One of the bio hazard waste trash can was directly touching a resident's clean shirt.</p> <p>During an interview on 8/2/16 at 9:03</p>	R 0152	<p>community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.</p> <p>It is the practice of this facility to ensure clean and soiled linens are handled in a safe and sanitary manner. What corrective action will be accomplished or those residents found to have been affected by the deficient practice: 1. The biohazard trash cans were immediately removed from the Cottage D Hall laundry room and placed in a separate record/biohazard room. 2. The dirty clothes were removed immediately from the Cottage C Hall mop-sink utility tub and placed in the washer. 3. The dirty clothes located in the Cottage B Hall laundry room were removed immediately from the mop sink utility tub and placed in the washer. 4. The blanket was removed immediately from the Cottage B Hall Laundry room and placed in the washer. How the residents having the potential</p>	08/31/2016			

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	<p>a.m., the Housekeeping Supervisor #1 indicated the towels, wash clothes, blankets and the shirt touching the bio-hazard waste trash cans in the Cottage D Hall Laundry Room were clean.</p> <p>2. In the Cottage C Hall Laundry Room dirty clothes were in the mop-sink/utility-tub. The tub was located in between the washer and dryer. The dirty clothes were un-bagged and touching both the washer and the dryer.</p> <p>3. In the Cottage B Hall Laundry Room dirty clothes were in the mop-sink/utility-tub. The tub was located in between the washer and dryer. The dirty clothes were un-bagged and touching both the washer and the dryer.</p> <p>During an interview on 8/2/16 at 9:43 a.m., the Administrator indicated the bio-hazard waste trash cans should not be touching the clean clothes and should not be in with the clean laundry. The Administrator further indicated the cans should be kept in the record room away from the clean clothes.</p> <p>4. During a second observation of the Cottage B Hall Laundry Room with Certified Nursing Aide (CNA) #2 on 8/2/16 at 10:25 a.m., a dirty un-bagged</p>		<p>to be affected by the same deficient practice and what corrective action will be taken. All laundry rooms were audited on 8-3-16 to ensure the facility is handling clean and soiled linens in a safe and sanitary manner. No further issues were found.</p> <p>The record room/biohazard room was audited to ensure the red biohazard barrels were present and stored properly. No further issues noted. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>All nursing staff will be inserviced on 8-12-16 to ensure they handle clean and soiled linens in a safe and sanitary manner. How the corrective action will be monitored to ensure the deficient practice will not recur. The Clinical Director will audit the laundry rooms on a weekly basis for a period of 6 months to ensure the facility continues to handle clean and soiled linen in a safe and sanitary manner. The date the systematic change will be completed by is August 31, 2016</p>	

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R 0273 Bldg. 00	<p>blanket was in the mop-sink/utility-tub in between the washer and dryer. The blanket was touching the dryer and laying on the washer's water hose.</p> <p>During an interview on 8/2/16 at 10:16 a.m., CNA #2 indicated the bio-hazard waste trash cans should not be touching the clean clothes and should not be in with the clean laundry. CNA #2 further indicated the dirty laundry was supposed to be stored in a separate container or bin.</p> <p>The current undated policy and procedure, "Infection Control Procedures" was received from the Administrator on 8/2/16 at 9:44 a.m. The policy included, but was not limited to, "... store soiled laundry in a separate covered container..."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling</p>			

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	<p>standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure gloves were changed during dining, after staff was observed touching his/her uniform, table edges, resident chairs, and picked up dropped food off the floor during 1 of 2 lunch meal observations. This deficient practice had the potential to affect all 110 of the 110 residents currently being served.</p> <p>Findings include:</p> <p>During the initial lunch observation, on 8/1/16 between 11:05 a.m. and 11:35 a.m., Dietary Aide (DA) #1 was observed passing grilled cheese sandwiches and bowls of chili to the residents in the dining room. DA #1 used the same gloves throughout the dining observation. The DA #1 was observed to straightened her shirt sleeves, hold her hands on her hips, touch the table edges and backs of the resident's chairs, and pick up a grilled cheese sandwiches that fell onto the floor. The DA #1 did not change her gloves or use hand gel through out the dining meal.</p> <p>During an interview on 8/1/16 at 11:35 a.m., DA #1 was unable to indicate what she should have done after picking up the sandwich off the floor.</p>	R 0273	<p>It is the practice of this facility to ensure gloves are changed timely during resident meal times and food is served in a safe and sanitary manner. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Dietary aide #1 was in serviced after meal service to ensure she understood to change her gloves timely during meal times and serve food in a safe and sanitary manner. How the residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On August 3, 2016 the Dietary Manager supervised and audited the meal service times at both the House and the Cottage to ensure the dietary servers were changing gloves timely and was serving food in a safe and sanitary manner. No further issues were noted. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. All dietary staff will be in serviced on 8-12-16 to ensure they understand to change gloves timely during meal service and serve food in a safe and sanitary manner at all times. How the corrective action will be monitored to ensure the deficient practice will not recur. The Dietary Manager will audit meal service in both buildings on a</p>	08/31/2016			

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R 0304 Bldg. 00	<p>In an interview with the Dietary Manager (DM) on 8/2/16 at 10:20 a.m., the DM indicated after touching tables and resident chairs staff should have removed their gloves, washed or sanitized their hands, and donned new gloves. The DM further indicated gloves should be changed especially after picking up something from the floor. DM indicated staff were only to handle the food with their gloved hands and not the residents or the furniture.</p> <p>On 8/2/16 at 9:50 a.m., the DM presented a copy of the facility's current policy titled: "Meal Preparation". The policy included, but was not limited to, "...8. To prevent food-borne illness, dietary Employee Partners must use good personal hygiene and adhere to work habits, which maintain a sanitary environment..."</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, interview and record review, the facility failed to</p>	R 0304	<p>weekly basis, for a period of 6 months, to ensure the dietary servers continue to change gloves timely during meal service and serve food in a safe and sanitary manner. The date the systematic change will be completed by is August 31, 2016</p> <p>It is the practice of this facility to ensure the nursing staff does not prepare more than one scheduled</p>	08/31/2016			

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	<p>prepare no more than one scheduled administration medication pass, and properly label prepared medication dose cups. This deficient practice affected 1 of 4 medication carts. (Residents #5, #6, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, and #20)</p> <p>Findings include:</p> <p>During the medication observation of the medication house cart on 8/2/16 at 11:11 a.m., with Licensed Practical Nurse (LPN) #1 the following was observed. Sitting in the top drawer of the medication cart were several medication cups with only room numbers written on the side of the medication cups. The cups contained the residents medications for the 12:00 p.m. and 2:00 p.m. medication pass. The medications in the cups were stacked and mixed together. The 12:00 p.m. medications being stored in the top drawer were for Residents #7, #9, #10, #11, #14, #15, #17, and #19. The 2:00 p.m. medications being stored in the top drawer were for Residents #5, #6, #8, #10, #12, #13, #16, #18, #19, and #20.</p> <p>During an interview on 8/2/16 at 11:15 a.m., LPN #1 indicated all the medications in the top drawer during the observation were for the 12:00 p.m. and</p>		<p>administration medication pass and to properly label prepared medication dose cups. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Clinical Director immediately addressed LPN #1 and instructed her to destroy the extra pulled medication pass. She also instructed LPN #1 on properly labeling medication dosage cups How the residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On August 2nd, the Clinical Director audited four medication passes and audited 4 medication carts to ensure the nursing staff did not pull more than one scheduled administration medication pass at a time and to ensure they labeled the medication cups correctly. No further issues were noted. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur. On August 12th, 2016 the Clinical Director will in service all nurses to ensure compliance and understanding nurses are not to pull more than one scheduled administration pass at a time and all medication cups are to be labeled correctly. How the corrective action will be monitored to ensure the deficient practice will not recur. The Clinical</p>	

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	<p>2:00 p.m. medication pass. LPN #1 further indicated she should have only pulled the next medication pass which was the 12:00 p.m. doses. LPN #1 indicated she should have not pulled the 2:00 p.m. medications and she knew that she could not pull two scheduled medication doses but she got ahead of herself.</p> <p>An interview was conducted on 8/2/16 at 11:30 a.m. with the Director of Nursing (DON). The DON indicated medications that are pulled prior to medication administration can only be prepared for the next scheduled dose.</p> <p>An interview was conducted on 8/2/16 at 12:30 p.m., with the Administrator. The Administrator indicated medications that are pulled prior to medication administration can only be prepared for the next scheduled dose. The Administrator further indicated the facility did not have a policy and procedure on prior preparations of medications for the next scheduled dose.</p>		<p>Director will audit two med passes a week, for a period of 6 months, to ensure the nursing staff does not pull more than one administration medication pass at a time and all medication cups are to be labeled correctly. The date the systematic change will be completed by is August 31, 2016</p>				