

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/08/2015
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NAME OF PROVIDER OR SUPPLIER  RIVERSIDE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516
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F000000	<p>This visit was for the Investigation of Complaint IN00161727.</p> <p>Complaint IN00161727 - Substantiated. Federal/State deficiencies related to the allegations are cited at F246 and F309.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: January 5, 6, 7 &amp; 8, 2015</p> <p>Facility number: 003075 Provider number: 155695 AIM number: 200364160</p> <p>Survey team: Diana McDonald, RN-TC</p> <p>Census bed type: SNF/NF: 83 Total: 83</p> <p>Census payor type: Medicare: 16 Medicaid: 55 Other: 12 Total: 83</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings</p>	F000000	<p><b>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after February 7, 2015.</b></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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F000246 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on January 19, 2014, by Brenda Meredith, R.N.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to accommodate the safety needs of Resident D, Resident G, and Resident E. The residents did not have their call lights in reach. This affected 3 out of 3 residents reviewed for care plans, Resident D, Resident G and Resident E.</p> <p>Findings include:</p> <p>A. Resident D's clinical record was reviewed on 1/08/2015 at 10:25 a.m. Resident D's diagnoses included, but were not limited to osteoarthritis,</p>	F000246	<p><b>F246– Reasonable Accommodation of Needs/Preferences</b> It is the practice of this facility that each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual of other residents would be endangered. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident D &amp; E's fall care plan have been reviewed and updated to reflect their current status and</p>	02/07/2015	

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	<p>dementia, hypertension, anemia and chronic obstructive pulmonary disease. Resident D's Brief Interview for Mental Status (BIMS), dated 11/19/2014, indicated a score of 7, moderately impaired.</p> <p>A care plan, dated 4/05/2011, indicated to encourage and remind resident to use call light. The care plan also indicated, fall risk related to generalized weakness, gait unsteady at times, history of dizziness, receives daily antidepressant medication, occasional incontinent, ambulates with walker and history of falls.</p> <p>During an observation, on 1/08/2015 at 12:55 p.m., while Resident D was resting in her bed, the call light was not in reach. The social services director (SSD) entered the room and indicated Resident D should have her call light in reach and found the call light wrapped around the call light box attached to the wall on the roommates side of the privacy curtain. The SSD gave the call light to Resident D and indicated the call light cord needed a clip so it could be secured to the bed.</p> <p>During an interview with the SSD, on 1/08/2015 at 12:58 p.m., she indicated that Resident D should have her call light in reach.</p>		<p>abilities. Call lights are within reach for both residents. Resident G – has been discharged from the facility.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents who are at risk for falls have the potential to be affected by this finding. An audit was completed by the Nurse Management Team. This audit included review of the fall care plan for all residents identified as being at risk for falls. This audit was conducted to ensure fall prevention interventions are accurate and appropriate for each resident specifically identified need and ability including proper call light placement for residents in their rooms. Determination of resident's ability to use the call light was also assessed and care plans were updated based on the results of this assessment. Charge nurses on all shifts will ensure call lights are properly within resident reach during nursing rounds every shift. Proper and appropriate placement of call lights will also be observed during daily Customer Care Rounds by members of the Customer Care Program.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>		

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	<p>During an interview with Resident D, on 1/08/2015 at 1:00 p.m., she indicated "I don't have a call light, I use to have one, I don't know why they moved it."</p> <p>B. Resident G's clinical record was reviewed on 1/07/2015 at 3:07 p.m. Resident G's diagnoses included, but were not limited to stress fracture to femoral neck, osteoporosis, peripheral vascular disease, dementia and diabetes. Resident G's Brief Interview for Mental Status (BIMS), dated 12/6/2014, indicated a score of 3, severe impairment.</p> <p>The care plan for Resident G indicated an approach started on 12/06/2013, to include, "...call light in reach...."</p> <p>Resident G was at risk for falls due to unsteady balance and gait, poor safety awareness and impaired cognition related to (r/t) dementia. A history of falls with left hip fracture and right hip fracture.</p> <p>During an observation, on 1/08/2015 at 12:59 p.m., the call light and cord was curled up at the foot of the bed next to Resident G's feet while Resident G was sleeping on her side.</p> <p>During an interview with the SSD, on 1/08/2015 at 12: 59 p.m., she indicated Resident G can not use a call light so that is why it was not in reach. The SSD</p>		<p><b>practice does not recur:</b> A mandatory in-service will be conducted by theDNS/designee on or before 2/7/15. Thisin-service will include review of the facility policy related to safety, fallprevention and following established care plans. Proper placement of call lights for residentsin their rooms will also be reviewed and discussed. Charge nurses on all shifts will ensure calllights are properly within resident reach during nursing rounds everyshift. Proper and appropriate placementof call lights within resident reach will be observed during daily Customer CareRounds by members of the Customer Care Program. <b>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</b> To ensure ongoing compliance with this correctiveaction, the DNS/designee will be responsible for completion of the CQI AuditTool titled, "Call Lights" daily for 3 weeks and weekly for 6 month. If threshold of 90% is not met, an actionplan will be developed. Findings will besubmitted to the CQI Committee for review and follow up. <b>Bywhat date the systemic changes will be completed:</b> Compliance Date: 2/7/15.</p>				

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	<p>stepped toward Residents G's bed but then stepped back. The call light was not put in reach.</p> <p>C. Resident E's clinical record was reviewed on 1/08/2015 at 11:00 a.m. Resident D's diagnoses included, but were not limited to organic brain syndrome, history of intercranial hemorrhage and dysphagia. Resident E's Brief Interview for Mental Status (BIMS), dated 11/25/2014, indicated a score of 3, severe impairment.</p> <p>A care plan for Resident E indicated an approach was started on 3/10/2014, to include, "...call light in reach..." Resident E was at risk for falls because he required extensive staff assist for ADL's, generalized weakness, unsteady gate and balance and impaired cognition.</p> <p>During an observation, on 1/08/2015 at 1:05 p.m., Resident E's call light cord was wrapped around the bed crank handle and on the floor. Resident E was sitting at the head of bed eating his lunch. The Director of Nursing (DON) entered Resident E room and un tangled the call light cord from the bed crank handle and placed it on the bed next to Resident E.</p> <p>During an interview with the DON, on 1/08/2015 at 1:07 p.m., the DON</p>				

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F000309 SS=D	<p>indicated the call light was not in reach and it must have fallen on the floor.</p> <p>This Federal tag relates to Complaint IN00161727.</p> <p>3.1-3(v)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to provide an accurate skin assessment for Resident C. The skin assessment failed to identify a yeast infection of the skin under both breasts and groin area. This affected 1 out of 1 resident review for assessments, Resident C.</p>	F000309	<p><b>F309– Provide Care/Services for Highest Well-Being</b> It is the practice of this facility to provide thenecessary care and services to attain or maintain the highest practicablephysical, mental, and psychosocial well-being, in accordance with thecomprehensive assessment and plan of care. <b>Whatcorrective action(s) will be accomplished for those</b></p>	02/07/2015	

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	<p>Finding includes:</p> <p>Resident C's clinical record was reviewed on 1/07/2015 at 10:30 a.m. Resident C's diagnoses included, but were not limited to: candidiasis - site not otherwise specified (NOS) -monilial dermatitis breasts and obesity. Resident C's Brief Interview for Mental Status (BIMS), dated 1/06/2015, indicated a score of 8, moderately impaired.</p> <p>Resident C was observed, on 1/8/2015 at 11:15 a.m., while CNA #1 was providing care. The CNA lifted resident sweatshirt and exposed right and left breasts, under each breast was a red rash with blisters under left breast. CNA #1 indicated a strong odor of yeast, coming from under breasts. CNA #1 exposed the groin area, the groin area had a red rash under skin fold, CNA #1 indicated an odor of yeast from groin area.</p> <p>During an interview with LPN #1 on 1/08/2015 at 11:20 a.m., LPN #1 indicated Resident C has a yeast infection under both breasts and groin area. LPN indicated Resident C has had the yeast infection under both breasts and groin area for months.</p> <p>During an interview with Resident C's daughter, on 1/06/2015 at 11:31 a.m., the</p>		<p><b>residents found to have been affected by the deficient practice:</b> Resident "C" had a new Skin Assessment completed 1/26/15. The physician and family are aware of her current skin condition. Treatment orders are in place and her care plan has been updated to reflect her current status.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents are at risk to be affected by this finding. A skin inspection was completed on each resident by the Nurse Management Team. Any skin issues noted during this inspection were addressed and followed up with per the facility Skin Management Program. Weekly Skin Assessments are completed on all residents as well as skin inspections during routine bathing and shower care. Shower sheets will be completed by the nurse aide during bathing and shower care. Any skin alterations will be noted on the shower sheet and immediately reported to the Charge Nurse for investigation and follow up. Shower sheets will be reviewed during weekday clinical meetings by the Nurse Management Team and Charge Nurse on the weekend to ensure all shower sheets are accurately reflecting any resident</p>				

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	<p>daughter indicated Resident C has a bad yeast infection under her breasts and in her groin area. The facility does not seem to be applying the cream. Mom had a visit to the family physician in early December and he was very upset by the yeast infections.</p> <p>Review of "Weekly Nursing Summary and Skin Assessment," dated 11/20/2014, indicated the following:</p> <p>"...Resident skin is Check all that apply..." response indicated "...Warm and dry, Pink..."</p> <p>"Indicate any areas of skin integrity alteration the resident currently has Check all that apply..." the skin condition list "...Skin tears, Open areas, Marks, Bruises, Discoloration/Rashes, Dry/cracked lips, Dry mucous membranes, None of the above..." response indicated "...Marks - left forearm, Bruises - arms..."</p> <p>Review of "Weekly Nursing Summary and Skin Assessment," dated 12/04/2014, indicated the following:</p> <p>"...Resident skin is Check all that apply..." response indicated "...Warm and dry...."</p>		<p>skinalterations.</p> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <p>A nursing in-service will be conducted by the DNS/designeeon or before 2/7/15. The in-service willinclude review of the facility Skin Management Program and the importance ofaccurately reporting and documenting any skin alterations noted during routinebathing and shower care. Weekly SkinAssessments are completed on all residents as well as skin inspections duringroutine bathing and shower care. Showersheets will be completed by the nurse aide during bathing and shower care. Any skin alterations will be noted on theshower sheet and immediately reported to the Charge Nurse for investigation andfollow up. Shower sheets will bereviewed during weekday clinical meetings by the Nurse Management Team andCharge Nurse on the weekend to ensure all shower sheets are accuratelyreflecting any resident skin alterations. DNS/designee will discuss and address any discrepancies in documentationwith the nurse aide.</p> <p><b>How the corrective action(s) will bemonitored to ensure the deficient practice will not recur,</b></p>		

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	<p>"Indicate any areas of skin integrity alteration the resident currently has Check all that apply..." the skin condition list "...Skin tears, Open areas, Marks, Bruises, Discoloration/Rashes, Dry/cracked lips, Dry mucous membranes, None of the above..." response indicated "...Marks - left hand old area..."</p> <p>Review of "Weekly Nursing Summary and Skin Assessment," dated 12/06/2014, indicated the following: "...Resident skin is Check all that apply..." response indicated "...Warm and dry..."</p> <p>"Indicate any areas of skin integrity alteration the resident currently has Check all that apply..." the skin condition list "...Skin tears, Open areas, Marks, Bruises, Discoloration/Rashes, Dry/cracked lips, Dry mucous membranes, None of the above..." response indicated "...Marks left arm..."</p> <p>Review of "Weekly Nursing Summary and Skin Assessment," dated 1/06/2015, indicated the following: "...Resident skin is Check all that apply ..." response indicated "...Warm and dry, Pink..."</p> <p>"Indicate any areas of skin integrity</p>		<p><b>i.e., what quality assurance program will be put into place:</b> The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Skin Management Program" daily for 3 weeks and weekly for 6 month to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance Date: 2/7/15.</p>				

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F000371 SS=E	<p>alteration the resident currently has Check all that apply..." the skin condition list "...Skin tears, Open areas, Marks, Bruises, Discoloration/Rashes, Dry/cracked lips, Dry mucous membranes, None of the above..." response indicated "...None of the above...."</p> <p>This Federal tag related to Complaint IN 00161727.</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure the hamburgers served to resident were thoroughly cooked prior to serving to the residents.</p>	F000371	<p><b>F371– Food Procure, Store/Prepare/Serve – Sanitary</b> It is the practice of this provider to store,prepare, distribute and serve food in a sanitary manner. <b>Whatcorrective action(s) will be</b></p>	02/07/2015

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	<p>This practice resulted in 11 raw hamburgers served in the main dinning room and 6 raw hamburgers served in the assisted dinning room. This practice affected 17 out of 83 residents in the facility.</p> <p>Finding includes:</p> <p>During an interview on 1/05/2015 at 1:20 p.m., with the President of the Resident Council, Resident A, indicated the food at lunch today was "not fit for dogs." He indicated the hamburger was raw in the middle and requested a second hamburger, which was also raw in the middle. Resident A indicated his table mates all received raw in the middle hamburgers and no one at his table of four residents ate the hamburger once they saw the raw meat in the middle.</p> <p>During an observation on 1/05/2015 at 1:25 p.m., of the dinning room, Resident A's table had four plates with one third of the hamburger eaten on each plate. The hamburger was bright red in the middle, the hamburger patties on each plate was about three inches in diameter with a bun and only the outer half inch of the hamburger was cooked. Resident A's had requested a second hamburger and received a second raw in the middle</p>		<p><b>accomplished for those residents found to have been affected by the deficient practice:</b> Facility meals are being distributed and served to all residents using sanitary conditions and proper and acceptable cooking temperatures for all foods including ground beef/hamburger. All pans of food will be checked at each meal prior to serving to ensure the food is fully cooked and is served at the appropriate temperature. None of the residents were negatively affected by this finding.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. Dietary staff responsible for cooking and food preparation is utilizing proper technique concerning food production standards and acceptable cooking temperatures for all foods. All pans of food will be tested for quality /temperature prior to meal service to ensure food is prepared to acceptable cooking standards. A Dietary staff in-service will be conducted on or before 2/7/15 by the ED/DM/designee. This in-service will include review of the policy related to General Food Prep and Handling and proper cooking temperature of all foods. Dietary staff will be educated regarding</p>				

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	<p>hamburger. There were eleven plates remaining in the main dinning room and each plate had a partially eaten hamburger which was raw in the middle. In the assisted dinning room six plates had partially eaten raw in the middle hamburgers remaining on the plates.</p> <p>During an interview on 1/05/2015 at 1:30 p.m., the chef indicated the middle of the hamburgers looked rare. The chef indicated the hamburger should be cooked to 165 degrees.</p> <p>3.1-21(i)(2)</p>		<p>the importance of serving food in a sanitary manner and acceptable food temperatures prior to meal service.</p> <p><b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:</b></p> <p>A Dietary staff in-service will be conducted on orbefore 2/7/15 by the ED/DM/designee. This in-service will include review of the policy related to GeneralFood Prep and Handling and proper cooking temperature of all foods. Dietary staff will be re-educated regardingthe importance of serving food in a sanitary manner and acceptable foodtemperatures prior to meal service. All pans of cooked food will be tested for quality/ temperature prior toeach meal service by the dietary manager/designee to ensure food is fully cookedand prepared to acceptable cooking standards and appropriate temperatures.</p> <p><b>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place:</b></p> <p>To ensure ongoing compliance with this correctiveaction, the ED/DM/designee will be responsible for completion of the CQI Audittool titled, "Food Temperature" for every meal for 30 days and weeklythereafter for at least 6 months. Ifthreshold of 100% is not met, an action plan</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155695	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/08/2015
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date: 2/7/15.		