

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 09/02/2015	
NAME OF PROVIDER OR SUPPLIER RIVERBEND				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130			
(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
R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure survey. This visit included the Investigation of Complaint IN00179477.</p> <p>Complaint IN00179477 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 1 and 2, 2015</p> <p>Facility number: 010885 Provider number: 010885 AIM number: N/A</p> <p>Census bed type: Residential: 104 Total: 104</p> <p>Sample: 14</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>			R 0000	<p>This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Riverbend Assisted Living as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. 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 Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be 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</p>		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/02/2015	
NAME OF PROVIDER OR SUPPLIER RIVERBEND				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130			
(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			
R 0273 Bldg. 00	<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 standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure food storage and preparation areas were kept sanitary, food was stored properly, employee food was separated from resident food, and open food was dated with the opened date, for 2 of 2 observations of facility kitchens. (House Kitchen and Cottage Kitchen)</p> <p>Findings include:</p> <p>During the kitchen sanitation tour in the House Kitchen, with Cook #1, on 9/1/15 at 9:25 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. In the freezer was a bag of opened, undated, chicken pieces. 2. In the freezer was a bag of opened, undated, cookies. 3. In the dry storage room was an onion sitting directly on the ground under the shelf. 4. The dry storage room light cover had a 	R 0273	<p>or affiliated companies.</p> <p>It is the practice of this facility to ensure food storage and preparation areas are kept sanitary, food is stored properly, employee food is separated from resident food and open food is sealed and dated. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. The bag of chicken pieces was sealed and dated upon discovery. 2. The cookies were sealed and dated upon discovery. 3. The onion was disposed of immediately. 4. The light in the dry storage room was cleaned on 9-2-15. 5. The vent in the dry storage room was cleaned on 9-2-15. 6. The chips and crackers were disposed of immediately. 7. The employees eggs were removed immediately. 8. The two intake vents were cleaned on 9-2-15. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Both food storage rooms were audited by the Food Service Director on 9-3-15 to ensure correct food storage, all</p>	10/01/2015			

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 09/02/2015	
NAME OF PROVIDER OR SUPPLIER RIVERBEND				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130			
(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>large amount of dead bugs, too numerous to count.</p> <p>5. In the dry storage room was a dust covered vent and a two inch diameter of dust covering the ceiling surrounding the vent.</p> <p>6. In the dry storage room was a bag of crackers and a bag of chips, both were opened and undated.</p> <p>During the kitchen sanitation tour in the Cottage Kitchen, with the Food Service Director, on 9/1/15 at 11:00 a.m., the following was observed:</p> <p>7. In the resident's refrigerator on the top shelf was an opened, undated box of eggs that belonged to an employee of the facility.</p> <p>8. One of the two intake vents was observed with dust covering the intake vent.</p> <p>During an interview on 9/1/15 at 11:25 a.m., Cook #1 indicated the eggs located on the top shelf in the resident's refrigerator belonged to an employee.</p> <p>During an interview on 9/2/15 at 11:00 a.m., the Food Service Director confirmed all the above issues. The Food</p>		<p>food was sealed and dated and facilities were sanitary. Neither food storage facility was found to have any further issues. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All dietary staff will be inserviced by 9-15-15 on sanitation, storing food properly, ensuring all food is sealed and dated at all times and ensuring employee food is separated from resident food. How the corrective action will be monitored to ensure the deficient practice will not recur: The Food Service Supervisor will audit the dry food storage facilities, weekly, to ensure it is sanitary, food is stored properly, food is sealed and dated and there is no employee food mixed with resident food.</p>				

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 09/02/2015
--------------------------------------------------	---------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER RIVERBEND	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130
-----------------------------------------------	--------------------------------------------------------------------------------------------

(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>Service Director indicated the employee's eggs should not have been stored in residents refrigerator. She indicated if food is opened it should be dated. She indicated if stock is brought in the back door, bugs tend to end up in the dry storage room. She indicated she concentrates on cleaning the vents that are by or over the food in the kitchen, not in the dry storage room. She also indicated she was unaware of an issue with food being kept in the refrigerator or dry storage room that was opened and undated.</p> <p>An undated policy titled, "Storage of Products", was provided by the Food Service Director on 9/2/15 at 11:00 a.m. and was identified as current. The policy indicated, "...potentially hazardous foods, such as eggs, must be stored on the bottom shelf of the refrigerator... ..no foods should be on the floor of the dry storage room... ..leftover foods that are not frozen should be discarded after three days if not used... ..frozen foods that are stored and opened should be labeled with a description of the product and the date it was placed in freezer".</p>			

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 09/02/2015
--------------------------------------------------	---------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------

NAME OF PROVIDER OR SUPPLIER RIVERBEND	STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130
-----------------------------------------------	--------------------------------------------------------------------------------------------

(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
R 0414 Bldg. 00	<p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) 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>Based on observation, interview and record review, the facility failed to ensure proper use of hand sanitizer and/or handwashing by staff during medication administration for 3 of 5 residents observed during medication administration. (Resident #9, #10 and #11)</p> <p>Findings include:</p> <p>During an observation of medication administration on 09/01/15 between 11:40 a.m. and 11:50 a.m., Licensed Practical Nurse (LPN) # 1 administered medication to Resident # 9 in the main dining room, retrieved the used medication cup from the resident and placed it in the medication carrier. She then walked over to Resident # 10,</p>	R 0414	<p>It is the practice of this provider to ensure the facility uses proper handwashing techniques by staff during medication administration. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: LPN#1 and QMA#1 were inserviced immediately and asked to perform proper hand hygiene. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice. LPN#1 and QMA#1 were inserviced immediately on proper hand hygiene during medication administration. What meassuers will be put into place or what systemic changes the facility will make to ensure that the deficient</p>	10/01/2015

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 09/02/2015	
NAME OF PROVIDER OR SUPPLIER RIVERBEND				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130			
(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>administered medication, retrieved the used medication cup, and placed it into the medication carrier. The LPN entered Resident # 12's room, retrieved keys and handed them to the resident. The LPN then entered Resident # 11's room and administered medication. During the entire observation, handwashing was not performed and hand sanitizer was not used.</p> <p>On 09/01/15 at 2:34 p.m., during an interview with LPN # 1, she indicated she would wash her hands at the beginning of her shift. She indicated she would then prepare medications for the residents, using hand sanitizer between each resident. She also indicated she would use hand sanitizer between each resident's medication administration.</p> <p>During an interview on 09/02/15 at 10:46 a.m., Qualified Medication Aide (QMA) # 1 indicated she would use hand sanitizer after each medication pass. She also indicated she would use soap and water after passing medications to two residents.</p> <p>During an interview on 09/02/15 at 10:52 a.m., the Director of Nursing (DON) indicated the staff should sanitize their hands with hand sanitizer after every medication pass. She indicated the staff</p>		<p>practice does not recur: All nursing staff will be inserviced by 9-30-15 on ensuring proper hand hygiene is maintained between each resident contact during medication administration. How the corrective action will be monitored to ensure the deficient practice will not recur: The Clinical Director will audit 3 medication passes a month, for a period of 6 months, to ensure proper hand hygiene is maintained between each resident contact during medication administration.</p>				

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 09/02/2015	
NAME OF PROVIDER OR SUPPLIER RIVERBEND				STREET ADDRESS, CITY, STATE, ZIP CODE 2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130			
(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>should wash their hands with soap and water after every second medication pass. She also indicated every medication cart contained hand sanitizer.</p> <p>The Administrator provided a copy of the facility's current policy for "Infection Control during Medication Pass" on 09/02/15 at 9:26 a.m. The policy indicated, but was not limited to, "Wash hands at the start of every medication pass....Use hand sanitizer between every resident if no direct patient contact... Wash hands after direct patient contact... Wash hands after using hand sanitizer three times".</p>						