STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 30 - February 2, 2012 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Survey team: Honey Kuhn, RN, TC Carol Miller, RN Shelly Vice, RN Census bed type: SNF/NF: 83 Total: 83 Census payor type: Medicare: 8 Medicaid: 61 Other: 14 Total: 83 Sample: 17 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 2/10/12 by Jennie Bartelt, RN.	F0000	Enclosed please find our plan of correction for the deficiencies cited in our recent annual survey. This plan of correction is to be considered as our credible allegation of compliance. Our certificate of compliance date is March 3, 2012. We respectively request a desk review of this plan of correction. **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.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 03/03/2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F0431 SS=E	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. 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. 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. 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. Based on observations, record reviews and interviews, the facility failed to ensure refrigerated medications were stored within acceptable temperature ranges indicated on temperature logs for 2 of 3 medication refrigerators observed.	F0431	**F 431**It is the practice of this provider to ensure all drugs are in locked compartments under proper temperature controls. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/03/2012

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	The deficient practice potentially affected 60 of 77 residents whose medications would be stored in the refrigerators. Findings include: During interview on the Environmental Tour on 1/31/12 between 9:30 a.m. and 10:45 a.m., the Maintenance Manager and Housekeeping/Laundry Supervisor indicated they had not been notified of any problems with temperatures in the medication room refrigerators being out of acceptable range. On 1/31/12 at 9:35 a.m., the refrigerator in the medication room on Heritage Hall was observed with LPN # 1. A thermometer hanging on the outer rim of the shelf beneath the freezer compartment indicated 30 degrees Fahrenheit. Three trays containing residents' medications and vials of purified protein derivative (PPD) for tuberculosis skin tests were observed. The medications included antibiotics and insulin. The liquid in the tuberculin skin tests vials were observed to be liquid without ice crystals. During interview at this time, LPN # 1 indicated the medications should not be stored at a temperature below freezing. LPN # 1 indicated the temperature in the refrigerator was checked daily and recorded. During interview on 1/31/12 at		**practice?** There was no negative outcome as a result of this finding. New refrigerators were purchased and placed inside the Medication rooms on Liberty and Heritage nurse's stations and provided with new thermometers for each refrigerator. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. New refrigerators have been placed in the medication rooms of Heritage and Liberty units. The temperatures will be documented and reviewed by the Charge Nurse daily during day shift. The Nurse Management Team will review the temperature logs weekly to ensure compliance. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A mandatory nursing in-service will be held 2/28/2012. This in-service will include review of the facility policy titled, "Food Storage" that includes procedures for nursing unit refrigerators. This in-service will include the procedure for recording refrigerator temperatures and the proper guidelines for medication storage. The temperatures will be documented and reviewed by the	

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	9:38 a.m., LPN# 1 indicated the temperature logs of the medication room refrigerators could not be located. On 1/31/2012 at 2:00 p.m. the refrigerator temperature records for December 2011 and January 2012 for Heritage Hall and Liberty Hall were provided by LPN #1. Review of the logs indicated instructions at the bottom of each temperature log for, "Normal Ranges: Refrigerator 34 - 41 Degrees F [Fahrenheit]; Freezer 0 - 10 Degrees F; Notify Supervisor if Equipment is not within Normal Ranges." "Heritage. Equipment Temperature Record. Month/Year: Dec 2011. Location: Med. [Medication]" log indicated temperatures below 34 degrees Fahrenheit on the following dates: 12/9/11, 12/10/11, 12/12/11, 12/13/11, 12/15/11 (tested twice), 12/18/11, 12/26/11, and 12/27/11. "Heritage. Equipment Temperature Record. Month/ Year: Jan 2012. Location: Med." log indicated temperatures below 34 degrees Fahrenheit on the following dates: Dates: 1/14/12 and 1/20/12. "Liberty. Equipment Temperature Record. Month/ Year: Jan. 2012. Location: Med. Room. Insulin Fridge" log indicated on 1/19/12, the temperature was 30 degrees		Charge Nurse daily during day shift.**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit Tool titled, “Medication Storage Review”, 3 times a week for 4 weeks, 1 time a week for 4 weeks and 1 month times 3 months and then monthly thereafter. 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.Compliance Date: 03/03/2012	

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	Fahrenheit. On 2/1/2012 at 9:32 a.m., an observation was made of the refrigerator/freezer unit of Heritage Hall. When the refrigerator door was opened, the same medications were observed to remain as they had been the day prior, 1/31/2012, and the temperature reading was noted at 32 degrees F. On 2/2/2012 at 9:00 a.m., the Administrator and Director of Nursing (DON) provided policy and procedure for "Food Storage," which included the equipment procedure for refrigerators. The policy indicated the following: "16. Refrigeration: a) Temperatures for refrigerators should be between 35- 40 (degree) Fahrenheit." No mention of medication storage was indicated within the policy and procedure provided. On 2/2/2012 at 9:02 a.m., an interview with the Administrator and DON indicated the policy provided for review was followed for the medication room refrigerators for Heritage Hall and Liberty Hall. The DON indicated this policy and procedure was stored in "...the dietary department." 3.1-25(m)			

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F0441 SS=E	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. (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. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record reviews and interviews, the facility failed to follow the facility policy and procedure in regards to screening for tuberculosis. This finding is	F0441	**F 441** It is the practice of this provider to maintain an Infection Control program that is designed to provide a safe, sanitary,	03/03/2012

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	evidenced by failing to ensure a pre-admission chest x-ray was completed for 1 of 17 sampled residents (Resident #87), annual tuberculin screening was completed for 1 of 1 resident with a positive tuberculin test in a sample of 17 (Resident #48), and tuberculin testing was completed following admission for 2 of 17 sampled residents (Resident #37 and Resident #86) reviewed related to tuberculosis screening. Finding includes: 1. The closed record of Resident #87 was reviewed on 02/02/12 at 9:00 a.m. Resident #87 was admitted to the facility on 12/10/10 with diagnoses including, but not limited to, atrial fibrillation, COPD (chronic obstructive pulmonary disease), emphysema, and anxiety. Resident #87 expired on 12/07/11. Review of the record indicated no chest x-ray was completed prior to admission. Interview with the DNS (Director Nursing Services), DOH (date of hire) 01/13/12, on 02/02/12 at 1:00 p.m., indicated the facility could not determine a pre-admission chest x-ray was completed. 2. The record of Resident #48 was reviewed on 01/31/12 at 8:00 a.m. Resident #48 was admitted to the facility		comfortable environment and prevent the development of and transmission of disease and infection. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 87 has been discharged from the facility. Resident # 48 annual TB screen and questionnaire has been completed. Resident # 37 has had a competed first and second step TB test. Resident # 86 has been discharged from the facility. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents are at risk to be affected by this finding. A facility audit of all records will be completed by the Nurse Management Team. This audit will ensure all residents have a pre-admission chest x-ray, first and second step TB skin tests and annual TB skin testing and/or screening as indicated in their medical record. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A mandatory nursing in-service held on 02/28/2012. This	

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	on 11/19/10 with diagnoses including, but not limited to, CAD (coronary artery disease), atrial fibrillation, diabetes, and Alzheimer disease. Review of the record indicated a PPD (skin test for TB: tuberculosis) administered on 11/19/10 was positive in reaction with the site measuring 17 mm (millimeters). The admission chest x-ray was negative. The facility did not complete an annual TB screening in 2011. Interview with the DNS, on 02/02/12 at 2:00 p.m. indicated the screening was "missed." 3. The record of Resident #37 was reviewed on 01/20/12 at 2:30 p.m. Resident #37 was admitted to the facility on 12/15/11 with diagnoses including, but not limited to, diabetes, dementia, anxiety and HTN (hypertension). Review of the record indicated PPD skin testing for TB (tuberculosis) had not been done. Interview with the DNS, on 02/02/12 at 1:00 p.m., indicated the facility had not followed the facility's policy and procedure in regards to TB testing. 4. The closed clinical record of Resident		in-service will include review of the facility policy titled, "Tuberculosis Control Program". The in-service will include review of the facility process for obtaining, reporting, recording and filling tuberculin test results in the clinical record. The nurse managers or other designee will ensure all tuberculin results are filed in the clinical record after physician and family notification. The Infection Control nurse will monitor the Tuberculosis Control Program on a weekly basis ensuring all resident's are up to date with TB testing and/or screening and document and report findings to DNS or designee. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this corrective action, the DNS and/or Designee will be responsible for completion of the CQI tool titled, "Resident Mantoux". This tool will be completed once a week times 8 weeks, then once a month times 3 months and then monthly thereafter. 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. Compliance Date: 03/03/2012	

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	#86 was reviewed on 2/2/12 at 11:00 a.m., and indicated the resident had diagnoses included but not limited to, hyperlipidemia and hypertension. The resident was admitted to the facility on 9/12/11. Resident # 86 received a tuberculosis test on 9/14/12 and was read on 9/17/12 and was negative. Review of the chart by the Director Nursing Services (DNS) at this time indicated a second step tuberculin test was not documented as done. On 2/12/12 at 2:15 p.m. the DNS was interviewed in regard to the resident's second step tuberculin, and the DNS indicated the second step tuberculin test had not been given. The DNS indicated the resident had been at the facility since 1/13/12. The DNS provided the undated policy and procedure, titled, TUBERCULOSIS (TB) CONTROL PROGRAM, on 02/01/2012 at 1:00 p.m. The policy indicated: "POLICY: All residents, prior to or upon admission, will be screened for TB in accordance with state and federal regulations...			

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	A. TUBERCULIN SKIN TESTING (TST): ...2. Screening for TB will consist of a TST (Mantoux-PPD)... 3. TST is considered positive with a 10 mm or more reaction, ... 4. TST procedures consist of two-step procedure-initial injection followed by a second injection 1-3 weeks later.... 6. All TST are documented in the medical record. 7. Annual TB screening is required for all residents. This includes: a. TST... b. TB Questionnaire B. CHEST X-RAY: 1. ALL residents are required on admission or within tree (3) months prior to admission to have a chest x-ray. 2. In addition, all residents must be screened for TB.... 4. If a resident is unable to receive TST, annual questionnaire should be completed. 5. Follow up chest x-ray would only be necessary for symptoms/concerns." 3.1-18(c) 3.1-18(e) 3.1-18(f) 3.1-18(i)			

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F0456 SS=C	The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observations, record reviews and interviews, the facility failed to ensure the hopper sinks in the soiled utility rooms on the three nursing units flushed properly. The deficient practice potentially affected 77 of 77 residents residing at the facility. Findings include: On 1/31/2012 from 9:30 a.m. to 10:45 a.m., an Environmental Tour was conducted with the Housekeeping/Laundry Supervisor, and included the following observations: 1. The dirty utility hopper sink disposal equipment in the dirty utility area on Heritage Hall did not complete a full dumping flush. Water was not completely removed from the basin during a flush. On 1/31/2012 at 9:50 a.m., an interview with the Housekeeping/Laundry Supervisor indicated the dirty utility hopper sink disposal equipment was not properly flushing in the Heritage Hall nurses station dirty utility room. 2. On Auguste Cottage Dementia Hall the hopper did not flush with each	F0456	**F456** It is the practice of this provider to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The identified dirty utility hopper sinks were serviced by an outside vendor immediately following the environmental tour. **How will you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this finding. The identified dirty utility hopper sinks were serviced by an outside vendor immediately following the environmental tour. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A mandatory all staff in-service will be held 02/28/2012. The in-service will include review proper use of the dirty utility hopper sinks. The in-service will review the process for staff to inform maintenance of issues with the hoppers as well as	03/03/2012

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	depression of the handle for flushing. Water from the basin would back up into the basin instead of flushing downward. On 1/31/2012 at 10:15 a.m., an interview with the Housekeeping/Laundry Supervisor indicated the dirty utility hopper sink disposal equipment was not properly flushing in the Auguste Cottage Dementia Unit dirty utility room. 3. On the Liberty Hall, the hopper would not flush with the depression of the handle for flushing. After several attempts to flush the hopper, water would fill back up into the hopper instead of a flush. During the Environmental Tour on 1/31/2012 at 10:37 a.m., an interview with the Housekeeping/Laundry Supervisor indicated the dirty utility hopper sink disposal equipment was not properly flushing in the Liberty Hall nurses station dirty utility room. During interview at the time of the Environmental Tour, the Housekeeping/Laundry Supervisor indicated the hoppers were used to aid in removing waste from non-disposable linens before they are sent on to the laundry for washing. The Housekeeping/Laundry Supervisor indicated the dirty utility rooms were cleaned once a day.		documentation and follow up of proper equipment function. Housekeeping will check Hoppers on a weekly basis to ensure proper function. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** To ensure ongoing compliance with this correction action, the Executive Director and/or designee will be responsible for completion of the CQI tool titled, "Facility Environment Review". The CQI tool will be completed twice a week times 4 weeks, then once a week times 4 weeks, once a month times 3 months, and then monthly thereafter. 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. Completion Date: 03/03/2012	

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	During the Environmental Tour on 1/31/2012 at 10:35 a.m., an interview with LPN #2, working the Liberty Hall unit, indicated the dirty utility hopper sink disposal equipment had been brought to the attention of the past administration and had remained unfixed. She indicated she had worked for Riverside for years and indicated it had not worked properly for a very long time. She indicated the hopper would routinely hold human waste removed into the hopper from dirty laundry from resident care. On 1/31/2012 at 1:30 p.m., three separate records related to prior plumbing services at Riverside Village in 2011 were provided by the Housekeeping/Laundry Supervisor. Review of the records for plumbing services indicated dates of 6/2011, 10/2011 and 11/2011, and did not specifically address the sluggish flushing of the dirty utility hopper sink disposal equipment. On 1/31/2012 at 2:15 p.m., the Housekeeper/Laundry Supervisor provided a copy of a receipt from a plumbing service provider for service, provided on 1/31/2012, indicating recent work performed at Riverside Village. The receipts indicated, "Cabled mop sink @ (at) trap. Had to cable dual sink in same room @ 1 1/2 line access. under			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	02/02/2012

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	sink. lots of junk & (and) trash in line. All work was done @ crt (center) of Main Hall." On 1/31/2012 at 2:45 p.m., the Housekeeper/Laundry Supervisor provided a copy of a faxed letter addressed to "ATTN [attention]: [name of Housekeeping Laundry Supervisor]. Riverside Village." It was dated January 31, 2012, from a plumbing service provider. The letter clarified prior services provided to Riverside. These services were indicated previously by the Housekeeper/Laundry Supervisor during the Environmental Tour. The Housekeeper/Laundry Supervisor indicated the actual date of service corresponded to one of the three previously provided records for review noted above in 2011. The letter indicated a drain to the hopper sink was cleaned in the Liberty (Hall) solid (soiled) utility closet by the nurses station. This letter indicated a "wash rag and a pair of rubber gloves" were removed at this visit. 3.1-19(bb)			

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