

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  09/25/2015
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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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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182857.</p> <p>This visit was done in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00182857 - Substantiated. Federal/State deficiency related to the allegations is cited at F-353.</p> <p>Survey dates: September 17, 18, 21, 22, 23, 24 &amp; 25, 2015.</p> <p>Facility number: 000250 Provider number: 155359 AIM number: 100289980</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicaid: 27 Other: 1 Total: 28</p> <p>Sample: 3</p> <p>This deficiency reflects state findings</p>	F 0000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider with the statement of deficiencies. This Plan of Correction is prepared and/or executed because it is required by provision of Federal and State regulations.	

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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F 0353 SS=F Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on September 29, 2015 by 17934.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to 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 nursing staff provided the necessary care and services to meet the needs of the</p>	F 0353	1.Resident C was assisted by nursing staff at9:25pm on 9/21/2015, who were completing resident care in another room on SouthHall. The other licensed nurse and CNA on duty were	10/25/2015

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	<p>residents who resided in the building. This had the potential to affect 28 of 28 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation on 9-21-2015 at 9:15 p.m., Resident C was observed walking down the East hall in a hospital gown (with the back open), an incontinence brief and bare feet towards the nurses station. The bed alarm was heard sounding in the hallway. Resident C grabbed a surveyor's arm with a tight grip and another surveyor's hand. The bed alarm continued to sound and no staff were visible or able to be located in any of the hallways. After 10 minutes, 2 staff appeared from South hall and assisted Resident C. The two staff from the West hall were not able to be located during the entire time the alarm was sounding.</p> <p>An observation of the nurse staff posting on 9-21-2015 at 9:30 p.m., indicated 2 LPNs (Licensed Practical Nurse) and 2 CNAs (Certified Nursing Assistants) were on duty for the 2nd shift (3:00 p.m. to 11:00 p.m.)</p> <p>An observation on 9-21-2015 at 9:58 p.m., indicated the West hall nurse left the building. The 3rd shift nurse was not</p>		<p>providing care to other residents on West Hall.</p> <p>2. All residents will be reviewed for care needs and nursing assignments will be adjusted to ensure at least one staff member is present at nurses' station, in hallways, or within distance to hear and respond to resident alarms, call lights, etc. to meet the needs of residents.</p> <p>3. Nursing staff will be in-serviced to ensure staff is present at nurses' station, in hallways, or within distance to hear and respond to resident alarms, call lights. Etc. Interdisciplinary team members, including the Administrator, DCS, and department directors, will provide staff support daily, from 12p to 8p to assist with call lights, meal service, and resident requests. IDT members will notify nursing staff of direct patient care needs.</p> <p>4. Administrator or designee will conduct 5 resident and staff interviews per week for 4 weeks, then 2 times per month x 2, then 3 monthly x 3; to determine if residents and staff are meeting the needs of residents. IDT will conduct rounds M-F to ensure residents care needs are addressed. Facility will continue recruitment and retention of nursing staff through use of human resource programs, community advertisements, etc. Results of interviews, rounds, and</p>		

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	<p>observed to have arrived, leaving only one nurse in the building.</p> <p>During the annual survey from 9-17-2015 through 9-25-2015, confidential interviews with residents deemed interviewable by the facility indicated the following concerns from individual residents:</p> <p>"Staff short on weekends" and resident indicated not getting showers per schedule.</p> <p>"Not enough staff after lunch until supper" and the resident indicated having incontinence accidents because it took staff 30 to 45 minutes to answer the call light. The resident also indicated "not getting showers because there was not enough help." The resident indicated this past weekend there was not enough staff and dinner was late on Sunday evening as it was not served until 6:30 p.m. The resident indicated there was not enough staff to assist for toileting during mealtimes.</p> <p>This resident indicated "short staffed all the time. Staff will answer call light, turn if off and say they will come back, but don't come back. Had to wait an hour and a half for staff to change brief." The resident indicated this past weekend,</p>		Human Resource efforts will be reviewed monthly in QA. QA will determine corrective action and the need for continue monitoring.		

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	<p>management staff had to come in to provide care for residents.</p> <p>This resident indicated "short staffed on 2nd and 3rd shift and has had to wait several hours" for staff to put resident to bed. The resident indicated this past Sunday, they did not get dinner until 7:30 p.m. and evening medications were not passed until 11:00 p.m.</p> <p>This resident indicated "has had to wait for call light to be answered, short staffed on night shift and shorter on weekends." The Resident indicated when the Administrator and RNs leave, the staff were more "lax."</p> <p>This resident indicated in regards to staffing, "it depends if staff comes in."</p> <p>This resident indicated after a fall it took 10 minutes for staff to respond.</p> <p>This resident indicated over the weekend something was going on Saturday with staffing as morning medications were not passed until evening.</p> <p>A family member of a resident indicated when looking for staff for another resident, no staff members were found at the nurses station or in the hallways. The family member indicated staff do not</p>			

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	<p>answer call lights.</p> <p>Confidential interviews with staff who provided care for residents indicated the following:</p> <p>"The facility works short. They try to replace staff who call in but can't always find replacements. Several residents require 2 person assists for lifts and transfers."</p> <p>Another staff member who provides care for residents indicated 2nd shift has been short staffed frequently.</p> <p>A staff member who provides care for residents indicated the sounding of an alarm would mean the resident got up and staff was to try to get to the resident as soon as possible. The staff member indicated there had been times when care was being provided for another resident and the staff member was unable to get to the resident whose alarm was sounding.</p> <p>Another staff member indicated the facility was "very short of staff on Sunday the 20th. No one was available to pass the meal trays. The Director of Clinical Services (DCS) was supposed to work, but called in."</p> <p>On 9-22-2015 at 9:35 a.m., Social</p>			

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	<p>Services provided a list of 10 residents which were deemed interviewable.</p> <p>On 9-22-2015 at 11:40 a.m., the MDS (Minimum Data Set) nurse provided a list of 8 residents who required 2 staff for transfers.</p> <p>An interview with the ADCS (Assistant Director of Clinical Services) on 9-23-2015 at 9:25 a.m., indicated it was determined that the evening shift needed a manager in the building to ensure things were getting done and to monitor the activity and attitude of the staff. The ADCS indicated she usually worked from 5:00 p.m. to 1:30 a.m., but since the DCS had been off with her vision problems, she had been covering days.</p> <p>The ADCS indicated all positions were scheduled for Saturday, 9-19-2015 and Sunday 9-20-2015 until a Certified Nursing Assistant (CNA) called off for a double shift (days and evenings). The ADCS indicated the night CNA called off. The ADCS indicated the DCS came in to cover from 7:30 a.m. to 2 p.m. (the paper schedule indicated until 1:30 p.m.)</p> <p>Actual punch times for facility staff who worked on 9-20-2015 and 9-21-2015 were provided by Human Resources on 9-22-2015 at 9:30 a.m. The punch times were reviewed and did not indicate the</p>				

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	<p>DCS had punched in for her shift.</p> <p>An interview with Human Resources on 9-22-2015 at 10:15 a.m., indicated the Managers did not use the time clock. She indicated the Managers included the Administrator, DCS, ADCS, and Social Services. Human Resources also provided 2 time clock adjustment forms for a staff member for worked times on 9-19-2015 and 9-21-2015. Human Resources indicated the staff member did not clock in or out on her shifts and the times would have to be entered manually. There was a discrepancy in the paper form dated 9-21-2015 and the actual end time observed on 9-21-2015.</p> <p>An updated, clearly written staffing schedule was provided by the ADCS on 9-22-2015 at 11:25 a.m. A review of the updated staff schedule with the actual time punches were reviewed with discrepancies noted. The Saturday schedule indicated the DCS worked until midnight. The Saturday schedule indicated the Administrator worked from 12 a.m. to 6 a.m. on Saturday morning.</p> <p>An observation of the Medical Records LPN on 9-23-2015 at 10:10 a.m., indicated she was passing ice water in the West hall. She indicated she was helping out the aides.</p>			

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	<p>An observation of the Medical Records LPN on 9-24-2015 at 8:48 a.m., indicated she was passing medications to residents in the East hall. The Medical Records LPN indicated she was filling in for someone who did not show up. An observation on 9-24-2015 at noon indicated the Medical Records LPN was passing the noon medications to residents in the East hall.</p> <p>During an interview with the Administrator, the Regional Director of Clinical Services and the ADCS on 9-24-2015 at 9:30 a.m., they indicated the DCS was in the building as the aide until midnight on both Saturday 9-19-2015 and Sunday 9-20-2015. The Administrator and ADCS indicated the DCS was working as the only aide after 6:30 p.m. on Sunday evening until midnight.</p> <p>Further interview with the Administrator indicated she came in Sunday night and assisted with getting residents to bed. The staffing information previously provided by the ADCS did not indicate the Administrator was in the building on Sunday evening. The Administrator indicated she did not know what time she was here and she indicated she did not enter any documentation on the care she provided.</p>			

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	<p>A current policy, "Staffing" dated 11-30-2014 was provided by the Administrator on 9-25-2015 at 12:45 p.m. and indicated "...Staffing will be maintained by the facility in accordance with State and Federal Requirements. The facility will have appropriate staff to provide for the needs of the residents at all times...."</p> <p>3.1-17(a)</p> <p>This federal tag relates to Complaint IN00182857.</p>			

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

PRINTED: 10/13/2015

FORM APPROVED

OMB NO. 0938-0391

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