| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155621 | A. BUILDING 00<br>B. WING | 11/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RIVER BEND NURSING AND REHABILITATION | 3400 STOCKER DR<br>EVANSVILLE, IN 47720 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 9/11/23.<br>This visit was in conjunction with the Investigation of Complaints IN00420446, IN00417400 and Covid -19 Focused Infection Control Survey.<br><br>Survey dates: October 30, 31, November 1, 2, 2023<br><br>Facility number: 000442<br>Provider number: 155621<br>AIM number: 100266510<br><br>Census Bed Type:<br>SNF/NF: 59<br>SNF: 5<br>Total: 64<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 42<br>Other: 14<br>Total: 64<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on November 8, 2023. | F 0000 | This plan of correction is prepared and executed because the provisions of state and federal law require it and not because River Bend Nursing and Rehabilitation Center agrees with the allegations and citations listed. River Bend Nursing and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review for this plan of correction. | |
| F 0732<br>SS=C<br>Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: | | | |

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

Christina Malvern | Administrator | 11/17/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | (i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets contained the correct information and were posted at all entrances daily for 4 of 4 days during the survey. | F 0732 | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>No resident was identified | 12/07/2023 |

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| | Findings include:<br><br>On 10/30/23 at 8:45 A.M., a posted nurse staffing sheet was observed posted on the wall between the door and the receptionist's desk at the main entrance. The posted nurse staffing sheet was dated 10/28/23 and the length of shift and actual hours worked were not included on the posting.<br><br>On 11/2/23 at 10:35 A.M., posted nurse staffing sheets were provided for the following dates:<br>10/30/23<br>10/31/23<br>11/1/23<br>11/2/23<br>Each posted nurse staffing sheet lacked the length of shift and actual hours worked were not included on the posting.<br><br>During an interview on 11/2/23 at 12:34 P.M., the Administrator and Scheduler were unaware their posting was incorrect, lacked the length of shift and actual hours worked, and that it should be posted upstairs as well since it has a separate entrance.<br><br>On 11/2/23 at 12:30 P.M., a current Posted Nurse Staffing policy was provided by the Administrator and indicated " 1. The Daily Staffing Sheet will be posted on a daily basis and will contain the following information: ... c. the current date d. the total number and actual hours worked ... 2. The facility will post the Daily Staffing Sheet at the beginning of each shift ... 3. The information posted will be: ... b. In a prominent place readily accessible to residents and visitors ... "<br><br>This deficiency was cited on 9/11/23. The facility failed to implement a systemic plan of correction to prevent recurrence. | | as being affected in this statement of deficiency.<br>The ED created a new form during the survey process that specified the exact shift and numbers of nursing associates in the facility. This form was immediately implemented and provided to the surveyors on 11/2/2023.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>All residents have the potential to be affected by not specifying the number and specific shift on the posted daily staffing hours form.<br>The ED created a new form that includes all requirements and was immediately put into place on 11/2/2023.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>The ED/designee will provide education to the management team including facility staffing scheduler on the required information to be listed on posted nurse staffing form at all entrances.<br>The ED/designee has assigned the responsibility to the | |

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| | | | facility scheduler. Scheduler to ensure the daily staffing hour form includes the required information and is posted in a common area at all entrances that is easily accessible to residents and visitors.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The ED/designee will audit the posted staffing hours daily x's 4 weeks, then weekly x's 5 months for a total of 6 months of monitoring. Form to include the date, facility name, current census, number and actual hours worked licensed and unlicensed nursing associates. Form to be posted in a clear & readable format and in a common area readily accessible to residents and families at all entrances. Any findings will be addressed.<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring.<br>Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist. | |

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| | | | Compliance Date: December 7, 2023. The Administrator at Riverbend Nursing and Rehabilitation Center is responsible for ensuring compliance of this plan of correction. | |
| F 0880 SS=D Bldg. 00 | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to | | | |

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| | identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which 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; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as | | | |

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| | necessary.<br>Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 2 residents observed for tracheostomy (trach) care. Sterile gloves were not worn, staff failed to wash or sanitize hands between glove changes, and the facility's Trach Care Policy did not follow the latest CDC (Centers for Disease Control) guidelines. (Resident 416, Resident 56)<br><br>Findings include:<br><br>1. On 10/31/23 at 9:45 A.M., trach care was observed on Resident 416. RN (Registered Nurse) 16 and CNA (Certified Nurse Aide) 17 both washed their hands and put on clean gloves. RN 16 laid out supplies for the trach care and then washed his hands again. RN 16 opened the suction kit and prepped a sterile field. He tried to put on sterile gloves from the suction kit, but they were too small and when he pulled them on, the left glove tore so he discarded them. RN 16 opened the trach kit, put those sterile gloves on, and then he loosened the trach collar. He used his left hand to pull out the split gauze dressing and held the trach with his right hand. Then CNA 17 held Resident 416's trach in place while RN 16 went to wash his hands. RN 16 put on clean gloves. He dipped 4x4 gauze into the peroxide and wiped around the trach site. He took another 4x4 gauze and dipped it into the sterile water to rinse the site. He took gloves off, washed his hands, and put on clean gloves. He removed the disposable trach as CNA 17 held the base in place from the left side of the bed. He disposed of the dirty trach and replaced with a clean trach. He attached the trach collar and gave Resident 416 time to recover. He then loosened his trach collar again, placed the split gauze dressing in place | F 0880 | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>Resident 416 did not experience a negative outcome. Resident 56 did not experience a negative outcome.<br>The ED/designee ordered sterile gloves in a variety of sizes on 11/2/2023.<br>RN 16 was provided with education on trach care via sterile technique by the DON/designee. LPN 42 was provided with hand hygiene and appropriate use of gloves by DON/designee.<br><br>**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be** taken?<br>There are no other residents with a tracheostomy currently residing in the facility. No other trachs existed during the survey process.<br>The Indiana Q-Source nurse will provide education to licensed nursing staff on trach care, and This plan of correction is prepared and executed because the provisions of state and federal law require it and not because River Bend Nursing and Rehabilitation Center agrees with the allegations and citations listed. River Bend | 12/07/2023 |

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| | around the trach, and refastened the collar.<br><br>During an interview on 10/31/23 at 10:15 A.M., RN 16 indicated there were no sterile gloves available that fit his hands.<br><br>During an interview on 11/2/23 at 9:41 A.M., the DON (Director of Nursing) indicated she would expect staff to follow the facility policy about sterile glove use. She further indicated that she had ordered larger sterile gloves to keep on hand.<br><br>2. On 10/31/23 at 10:27 A.M., trach care was observed on Resident 56. LPN (Licensed Practical Nurse) 42<br>washed hands. She then raised the resident's bed, put feeding on hold, laid an ambu (artificial manual breathing unit)bag onto the bed, adjusted the HOB (head of bed), changed the radio station, opened the sterile water, pulled sterile gloves out from the box on the window sill, pulled out head cushion from behind resident, and laid out trach and suction supplies on the resident's bed. LPN 42 put on sterile gloves, took off the oxygen mask covering Resident 56's trach, moved the pillow from under the resident's head, and put a cushion under her head. Then she pulled out split gauze dressing, laid it on her sterile field, and put new trach collar around the resident's neck, pulled out the old trach collar, discarded it into the trash, and then pulled the new trach collar through. LPN 42 took off gloves and opened the suction kit, opened box, and put on sterile gloves. She poured sterile water into the box and used her right hand to hold suction tube and left to plug tube into the suction machine. She suctioned the resident twice and then undid the tube and discarded in trash and turned off suction machine. She removed her gloves. LPN 42 opened another set of sterile gloves, opened the trach kit, and dropped the | | Nursing and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review for this plan of correction.<br><br>W**hat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>Directed in-service training to be completed by Indiana Q-Source nurse on infection control measures during trach care, including maintaining sterile process. Post tests must be successfully passed with a score of 100% before being assigned residents requiring trach care.<br>DON/designee to provide education on handwashing technique and appropriate use of gloves.<br>The DON/designee will complete random observations of licensed nursing staff performing trach care as noted below. Any | |

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| | contents onto the sterile field. She put on the sterile gloves, pulled out the disposable trach cannula with her left hand and snapped the new trach cannula in with her right hand glove. She placed new gauze around the trach site. LPN readjusted the resident's oxygen mask over her trach site, adjusted the resident's pillow and cushion behind her head, took off her gloves, and discarded all trash. She lowered the resident's bed and used ABHR (alcohol based hand rub) when leaving the room.<br><br>During an interview on 11/2/23 at 9:41 A.M., the DON indicated she would expect staff to follow the facility policy regarding hand sanitation between glove use.<br><br>During an interview on 11/2/23 at 9:53 A.M., the DON referenced the Trach Care Policy and indicated there was a trach checklist that was used for educational purposes to teach staff, but the policy was what the nursing staff should follow. She further indicated the policy did not specify staff was to sanitize their hands between changing gloves.<br><br>A current Trach Care Policy was provided on 11/2/23 at 9:46 A.M., by the DON and indicated " ... Sterile gloves must be used for anything other than stoma care ... "<br><br>A current Infection Control Guidelines for All Nursing Procedures Policy was provided on 11/2/23 at 1:09 P.M., by the DON and indicated " ... 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: ... b. Before donning sterile gloves ... h. | | findings will be addressed.<br>Facility current policy meets the latest CDC guidelines.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>The DON/designee will complete 4 random trach care observations to ensure sterile process is maintained. Observations to include 1 nurse providing trach care daily Mon-Fri x's 4 weeks, 4 nurses performing trach care weekly x's 4 weeks, then 4 nurses performing trach care monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed.<br>The DON/designee will complete handwashing and glove use observations. 30 observations per month per CDC recommendations x's 6 months of monitoring. Any findings will be addressed.<br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of | |

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| | After handling used dressings, contaminated equipment, etc i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, and j. after removing gloves ... "<br><br>"Hand Hygiene Guidance" (January 30, 2020) was retrieved 11/3/23 from the Centers of Disease Control (CDC) website. The guidance included " The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: ... Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, after touching a patient or the patient's immediate environment, immediately after glove removal ... Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations ... "<br><br>This deficiency was cited on 9/11/23. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-18(b)<br>3.1-18(l) | | noncompliance exist.<br><br>Compliance Date: December 7, 2023. The Administrator at Riverbend Nursing and Rehabilitation Center is responsible for ensuring compliance of this plan of correction. | |