This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00268074.

Complaint IN00268074 - Substantiated. Federal/State deficiencies related to the allegations are cited at F690.


Facility number: 003075
Provider number: 155695
AIM number: 200364160

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality Review was completed on August 3, 2018.

**483.21(b)(1)**
Develop/Implement Comprehensive Care Plan
§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable

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 August 26, 2018.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.
objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c) (6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

Based on interview and record review, the facility failed to ensure a hospice care plan was in place with the required information for 1 of 20 residents.
whose care plans were reviewed. (Resident 64)

Finding Includes:

A clinical record review was conducted on 07/25/18, at 11:14 AM, for Resident 64 and indicated her diagnoses included, but were not limited to: congestive heart failure, schizophrenia, depression, glaucoma, cardiac arrhythmia, anxiety, hypertension, diabetes, and dementia.

The MDS (Minimum Data Set) assessment, dated 06/18/18, indicated a BIMS (Brief Interview for Mental Status) score of 3, severe cognitive impairment. Hospice care was indicated.

The care plans did not indicate an appropriate plan in place related to hospice care. No provider, diagnosis, contact information, code status, or individualized approaches were indicated.

Hospice services were indicated, with a physician's order in place. A section in the chart was utilized as a hospice communication binder.

During an interview, on 07/25/18 at 3:07 PM, the Corporate SSD (Social Services Director) indicated the care plan was not comprehensive and should be corrected.

A policy was provided by the DON (Director of Nursing) on 07/27/18 at 8:15 AM, titled "IDT Comprehensive Care Plan Review", dated 11/2017, and indicated this was the policy currently used by the facility. The policy indicated "...The care plan will include measurable goals and resident specific interventions based on resident needs...."

3.1-35(a)

develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #64 care plans have been reviewed and updated to reflect Hospice care including the provider, diagnosis and hospice contact information as well as her code status and individualized approaches.

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:

All residents who are receiving Hospice services have the potential to be affected by this finding. A facility audit will be conducted by the Care Plan Team. This audit will include review of care plans for any resident receiving Hospice Services. This audit will ensure that all needed and required information related to Hospice care and services including provider, diagnosis and hospice
### REQUIREMENTS

**Summary Statement of Deficiency**

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

The Interdisciplinary Care Plan team and nursing staff in-service will be conducted on or before 08/26/18 by the DNS/designee. This in-service will include review of the facility policy related to development and implementation of person-centered care plans for each resident including those residents receiving Hospice Services. All nursing staff will be re-educated on the process of reviewing, updating and following all resident care plans as outlined in the comprehensive assessment.

**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**

Ongoing compliance with this corrective action will be monitored.
## Statement of Deficiencies and Plan of Correction

**Identification Number**: MULTIPLE CONSTRUCTION 08/20/2018

### Name of Provider or Supplier
**RIVERSIDE VILLAGE**

### Street Address, City, State, Zip Code
1400 W FRANKLIN ST
ELKHART, IN 46516

### Summary Statement of Deficiency

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Regulatory or LSC Identifying Information</th>
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<tbody>
<tr>
<td>483.21(b)(2)(i)-(iii)</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>Care Plan Timing and Revision</td>
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</table>

Care Plan Timing and Revision

§483.21(b) Comprehensive Care Plans

§483.21(b)(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in

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through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to Care Plan Review weekly for 4 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.
Based on record review, observation and interview, the facility failed to ensure a urinary incontinence care plan was revised to be resident specific based on the residents voiding schedule for 1 of 3 residents reviewed for urinary incontinence. (Resident B)

Findings include:

On 7/25/18 at 3:39 P.M., a clinical record review was completed, indicating Resident B's current diagnosis included, but were not limited to: hypertension, diabetes, hypothyroidism and cataracts.

A MDS (Minimum Data Set) assessment, dated 6/27/18, indicated the Resident B had a BIMS score of 7, severe cognitive impairment. She required extensive assist of 2 staff for bed mobility, transfers, dressing, toilet use and limited assist of 1 staff for eating. She was frequently incontinent of bladder and bowel and was not on a toileting program.

A current, 3/29/18, care plan problem indicated Resident B required staff assist with ADL's (activities of daily living) including bed mobility, transfers, and toileting related to decreased mobility, advanced age, incontinence and unsteadiness on feet. Interventions included, but were not limited to: offer to toilet every 2 hours while awake and as needed throughout the night.

A 3 day voiding diary, dated 3/29, 3/30, and

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</table>

F657 – Care Plan Timing and Revision

It is the practice of this provider that each resident's individualized care plan be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident B has been discharged from the facility.

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:

All residents at risk for urinary incontinence have the potential to be affected by this finding. An audit will be completed by the IDT/Care Plan Team to identify those residents at risk for urinary incontinence. These identified residents will have their toileting care plans reviewed and/or re-assessed with a new Three-Day Voiding pattern if appropriate. Once the specific toileting needs of each resident has been determined, the care plan will be revised to be resident-specific.
3/31/18, indicated Resident B was found wet 6 times on the 29th, 6 times on the 30th, and 5 times on the 31st. Incontinence times documented were: 1 am x 2 days, 7 am x 2 days, 10 am all 3 days, 1 pm x 2 days, 6pm x 2 days and 9pm x 2 days.

A 3 day voiding dairy, dated 4/2, 4/3, and 4/4/18, indicated Resident B was still documented as being incontinent at 1 am, 10 am, 1 pm and at 9pm.

The Bladder Continence Review, dated 4/5/18, indicated Resident B was frequently incontinent (incontinent daily but at least one episode of urinary incontinence). Under the Toileting Program section was marked for "Resident will be considered for Habit Training/Scheduled Toileting (such as upon rising, before and after meals and at bed time) in an attempt to develop or maintain a voiding pattern. Care plan and resident profile updated- yes."

During an interview, on 7/27/18 at 9:05 A.M., the Director of Nursing indicated the resident should have been put on a resident specific toileting schedule per her 3 day voiding dairies and updated the care plan.

On 7/27/18 at 8:15 A.M., the Director of Nursing provided the policy titled," IDT Comprehensive Care Plan Review", and indicated the policy was the one currently used by the facility. The policy indicated "...The care plan will include measurable goals and resident specific interventions based on resident needs. Care plan problems, goals and interventions will be update based on changes in resident assessment/condition, resident preferences or family input...."

identified, the care plan will be reviewed/revised and updated to reflect the identified resident specific toileting need. Resident toileting needs are assessed and determined by the IDT with any change in continence, discontinuation of an indwelling catheter, at admission and/or re-admission to the facility using the Three-Day Voiding Tool. Results of the Three-Day Voiding Tool will be used to determine each resident’s specifically identified toileting needs.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:
All nursing staff will be in-serviced on or before 8/26/18. This in-service will be conducted by DNS/designee and will include review of the facility policy related to bladder programs and individualized toileting needs. This in-service will emphasize the importance of reviewing and following the resident plan of care related to specific individualized toileting needs.

How the corrective action(s) will 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
On 7/27/18 at 12:15 P.M., the Director of Nursing provided the policy titled, "Bowel and Bladder Program", and indicated the policy was the new policy currently used by the facility. The policy indicated "...The care plan must be resident specific based on the resident's voiding schedule. The care plan and resident profile must represent the appropriate program and resident specific interventions...."

3.1-35(d)(2)(B)

483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices
§483.25(d) Accidents. The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, interview and observation, the facility failed to implement appropriate fall interventions following 2 falls and failed to follow the care plan to prevent further falls for 1 of 3 residents reviewed for accidents. (Resident 77).

Findings include:

A clinical record review was completed on 7/26/18 at 9:12 A.M., indicating Resident 77's current diagnosis included, but were not limited to: fracture right femur, dysphagia, vascular dementia, glaucoma, diabetes and Alzheimer's.

F 0689 – Free of Accident Hazards/Supervision/Devices
It is the practice of this facility that the resident environment remains as free from accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
Resident #77 fall care plan has...
A MDS (Minimum Data Set) assessment, dated 6/15/18, indicated Resident 77’s BIMS (Brief Interview for Mental Status) score was 2, severe cognitive impairment. She required extensive assist of 2 staff for bed mobility, toilet use, transfers, dressing, and limited assist for eating. She is always incontinent of bowel and bladder, and was not on a toileting program.

A nurses' note, dated 6/3/18 at 4:00 P.M., indicated Resident 77 fell and sustained a fractured right hip.

A Fall Event dated, 6/15/18 at 7:52 P.M., indicated Resident 77 had an unwitnessed fall and was found in her room sitting on the floor up against her bed. Resident 77 stated, "I was trying to get in bed but slid." Intervention put into place to prevent another fall was the resident was placed on 15 minute safety checks.

An IDT (Interdisciplinary team) progress note dated, 6/19/18 at 10:32 A.M., indicated immediate intervention included bringing her to the nurses station for observation and 15 minute checks for 24 hours.

A Fall Event dated, 7/5/18 at 2:30 P.M., indicated Resident 77 had an unwitnessed fall. She was sitting at the table in the lounge area working with a busy box and was found sitting on the floor in front of her wheel chair. Intervention put into place to prevent another fall was resident was placed on 15 minute safety checks for 24 hours.

An IDT (Interdisciplinary team) progress note dated, 7/6/18 at 1:54 P.M., indicated every 15 minute safety checks started for 24 hours.

A nurses note dated, 7/19/18 at 2:48 P.M., been reviewed and updated to reflect her current needs and resident specific fall prevention interventions. Changes and updates to her fall care plan have been communicated to all caregivers. Physician and family have been updated regarding this resident's overall status.

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:

Any resident identified as being at risk for falls has the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team to identify all residents at risk for falls. Each identified resident’s Fall Risk Assessment as well physician’s orders and/or therapy recommendations regarding fall prevention will be reviewed and then compared to each resident’s fall care plan. Each intervention on the fall care plan will be reviewed for accuracy and appropriateness. A root cause analysis will be determined with any resident fall and/or accident. Immediate resident specific interventions will be implemented, added to the fall care plan and communicated to direct care staff to prevent further falls based on this identified root cause.

What measures will be put into place or what systemic
indicated Resident 77 had a witnessed fall. Resident 77 was by the nurse's station and was reaching for something and slid out of her wheelchair. Therapy was notified for an evaluation. A new order was received to have a high back wheelchair and place dycem (non skid pad) on top of the wheelchair cushion.

A current, 6/8/18, care plan problem indicated the resident has impaired mobility related to: Right hip fracture. Interventions included, but were not limited to: assess and document skin condition weekly and as needed, encourage resident to participate in transfer and bed mobility activities, praise for their efforts, hip precautions, pillow abductor between legs while in bed, notify therapy of declines in mobility or improvement in mobility, observe for pain, therapy to screen quarterly and as needed, turn and reposition every 2 hours and as needed, and WBAT (weight bearing as tolerated) to RLE (right lower extremity).

A current, 7/20/18, care plan problem indicated Resident 77 was at risk for falls due to: unsteadiness on feet, history of falls, advanced age, requires assist with mobility, ambulation and transfers, impaired balance, high fall risk medication use, visual and auditory impairment and impaired mobility related to right hip fracture. Interventions included, but were not limited to: dycem to top of wheelchair cushion, offer to toilet every 2 hours before lunch and as needed throughout the night, bed in lowest position while in bed, therapy screen quarterly and as needed and non skid foot ware.

During an interview, on 7/27/18 at 8:15 A.M., the Director of Nursing indicated they did not implement new/appropriate interventions related changes will be made to ensure that the deficient practice does not recur: A nursing staff in-service will be conducted on or before 8/26/18 by the DNS/designee. This in-service will include review of the policy related to fall and accident prevention. This in-service will also include review of the importance of strict adherence to established care plans, physician's orders and therapy recommendations regarding resident specific fall and accident prevention interventions. Staff will be re-educated on determining root cause analysis at the time of any fall and/or accident immediately implementing interventions to prevent further falls based on this identified root cause.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/Designee will be responsible for completing the QAPI Audit tool related to Fall Management daily for 4 weeks and weekly for at least 6 months. If threshold of 90% is not met, an action plan will be
### Summary of Deficiencies and Plan of Correction

#### Identification Number
- Name of Provider or Supplier: RIVERSIDE VILLAGE
- Address: 1400 W FRANKLIN ST, ELKHART, IN 46516
- ID: 155695
- Prefix: 07/27/18

#### Statement of Deficiency

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulatory or LSC Identifying Information</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 0690</td>
<td>SS=D</td>
<td>Bldg. 00</td>
<td>developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.</td>
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</table>

#### Provider's Plan of Correction

1. During an observation, on 7/27/18 at 11:26 A.M., Resident 77's wheelchair was observed with no dycem on the cushion.

2. During an interview, on 7/27/18 at 11:27 A.M., LPN 4 indicated there should be dycem on top of the wheelchair cushion.

3. On 7/27/18 at 8:15 A.M., the Director of Nursing provided the policy titled, "Fall Management Program", dated 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated...” It is the policy "...to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls. Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls...."

4. 3.1-45(a)(2)

5. 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI

   §483.25(e) Incontinence.

   §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.
§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that:

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

Based on record review, observation and interview, the facility failed to implement an individualized toileting program to prevent incontinence for 1 of 3 residents reviewed for incontinence. (Resident B)

Findings include:

On 7/25/18 at 3:39 P.M., a clinical record review was completed, indicating Resident B's current diagnosis included, but were not limited to: hypertension, diabetes, hypothyroidism and

<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 0690 | F690 - Bowel/Bladder Incontinence, Catheter, UTI | 08/26/2018 | It is the practice of this facility that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 07/27/2018

#### Name of Provider or Supplier

**RIVERSIDE VILLAGE**

**Address:** 1400 W FRANKLIN ST ELKHART, IN 46516

#### Summary Statement of Deficiency

**Prefix: (Each Deficiency Must Be Preceded By Full Regulatory or LSC Identifying Information)**

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>ID</th>
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<tbody>
<tr>
<td>Cataracts.</td>
<td>155695</td>
<td>A. BUILDING</td>
<td>00</td>
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<tr>
<td>A MDS (Minimum Data Set) assessment, dated 6/27/18, indicated the Resident B had a BIMS score of 7, severe cognitive impairment. She required extensive assist of 2 staff for bed mobility, transfers, dressing, toilet use and limited assist of 1 for eating. She was frequently incontinent of bladder and bowel and was not on a toileting program.</td>
<td>155695</td>
<td>B. WING</td>
<td></td>
</tr>
<tr>
<td>A current, 3/29/18, care plan problem indicated Resident B required staff assist with ADL’s (activities of daily living) including bed mobility, transfers, and toileting related to decreased mobility, advanced age, incontinence and unsteadiness on feet. Interventions included, but were not limited to: offer to toilet every 2 hours while awake and as needed throughout the night.</td>
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<tr>
<td>During an interview, on 7/26/18 at 7:30 A.M., certified nursing assistant 6 indicated she tries to toilet the resident every 2 hours. She indicated the resident does not refuse to be toileted and the resident has never told her no she didn't want to go.</td>
<td>155695</td>
<td></td>
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<tr>
<td>On 7/26/18 at 9:07 A.M., Resident B was brought back to her room by certified nursing assistant 6. Resident B was not toileted at that time.</td>
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<td>On 7/26/18 at 9:18 A.M., certified nursing assistant 9 entered the residents room and asked if there was anything they needed. Resident B was not offered to toilet at that time.</td>
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<td>During an interview, on 7/26/18 at 10:30 A.M., certified nursing assistant 2 indicated she will toilet the resident every 2 hours and as needed.</td>
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#### Provider's Plan of Correction

**(Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)**

<table>
<thead>
<tr>
<th>Correction</th>
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<tr>
<td>Resident B has been discharged from the facility. <strong>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:</strong> All residents at risk for urinary incontinence have the potential to be affected by this finding. An audit will be completed by the IDT/Care Plan Team to identify those residents at risk for urinary incontinence. These identified residents will have their toileting care plans reviewed and/or re-assessed with a new Three-Day Voiding pattern if appropriate. Once the specific toileting needs of each resident has been identified, the care plan will be reviewed/revised and updated to reflect the identified resident specific toileting need. Resident toileting needs are assessed and determined by the IDT with any change in continence, discontinuation of an indwelling catheter, at admission and/or re-admission to the facility using the Three-Day Voiding Tool. Results of the Three-Day Voiding Tool will be used to determine each resident's specifically identified toileting needs. <strong>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice:</strong></td>
<td>155695</td>
<td></td>
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</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
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<tr>
<td>F 0693 SS=D Bldg. 00</td>
<td>483.25(g)(4)(5)</td>
<td>Tube Feeding Mgmt/Restore Eating Skills</td>
<td>§483.25(g)(4)-(5)</td>
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</tbody>
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Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

Based on record review, interview and observation, the facility failed to correctly administer medications via enteral tube for 1 of 2 residents reviewed for tube feedings. (Resident 75)

Findings include:

During a medication observation, on 7/25/18 at 9:20 A.M., LPN (Licensed Practical Nurse) 6 entered Resident 75's room, applied gloves and with the assistance of the Director Of Nursing, lifted the resident up in bed. LPN 6 sanitized her hands and reapplied gloves. She then lifted up the residents' gown exposing the resident's gastrostomy tube. LPN 6 placed the syringe in the gastrostomy tube and flushed with 60ml's (milliliter) of water. LPN 6 then administered 3 medications, separately, with flushes of 10 ml's of tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #75 is receiving
### Summary of Deficiencies

#### Water in between Each Medication

Following the last medication administered, LPN 6 flushed the tube and restarted tube feeding.

During an interview, on 7/25/18 at 9:27 A.M., LPN 6 indicated she did not check for patency, placement and for residual (gastric content) prior to administering the medications.

On 2/27/18 at 12:15 P.M., the Director of Nursing provided the policy titled, "Enteral Therapy", 1/2015, and indicated the policy was the one currently used by the facility. The policy indicated "...Placement of the enteral therapy tube (Gastric tube, PEG tube, Nasogastric tube, etc.) is to be assessed by the licensed nurse no less than once every shift and before any substance is administered through the tube...."

#### Appropriate Treatment and Services

Physician and family are aware of this resident's enteral feedings and medication administration. This resident experienced no negative outcome related to this finding.

### 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:

All residents with orders for enteral tubes and enteral tube medication administration have the potential to be affected by this finding. An audit will be completed by the DNS/designee to identify all residents with orders for enteral tube care and enteral tube medication administration.

Physician orders will be reviewed and verified to ensure all enteral care and medication administrations via enteral tube are being followed per physician’s order and facility policy. In addition, the DNS/CEC and/or designee will be responsible for completing skills validations and return demonstrations related to enteral tube care and medication administration via enteral tube with all licensed nurses. These skills validations will include observations related to checking for patency, placement and residual prior to administrating the tube.
**NAME OF PROVIDER OR SUPPLIER**  
RIVERSIDE VILLAGE

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
1400 W FRANKLIN ST  
ELKHART, IN 46516

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<thead>
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<th>ID</th>
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**ENTERAL TUBE MEDICATIONS.**

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

A Nursing In-service will be conducted on or before 8/26/18 by the DNS/designee. This in-service will include review of the policy related to enteral tube care and enteral tube medication administration. Each licensed nurse will be validated and required to complete return demonstrations related to enteral tube care and medication administration via enteral tube including checking for patency, placement and residual prior to administration of medications via enteral tube. Skills validations are completed on all licensed staff and upon hire, when specific needs are identified and at least annually.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:

Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DNS/designee will be responsible for completing the QAPI Audit tool related to Enteral Tube Care and Medication Administration weekly.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155695

NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN 46516

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<td>F 0791</td>
<td>SS=D</td>
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<td>483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs</td>
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<td>§483.55 Dental Services</td>
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<td>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</td>
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<td>§483.55(b) Nursing Facilities.</td>
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<td>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:</td>
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<td>(i) Routine dental services (to the extent covered under the State plan); and</td>
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<td>(ii) Emergency dental services;</td>
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<td>§483.55(b)(2) Must, if necessary or if requested, assist the resident-</td>
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<td>(i) In making appointments; and</td>
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<td>(ii) By arranging for transportation to and from the dental services locations;</td>
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<td>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the</td>
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for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.

483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs

§483.55 Dental Services

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

§483.55(b) Nursing Facilities.

The facility-

§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
(i) Routine dental services (to the extent covered under the State plan); and
(ii) Emergency dental services;

§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the
§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.

Based on record review and interview, the facility failed to ensure a resident receiving Medicaid Benefits received dental services for a missing lower denture in one of 1 residents reviewed for dental services. (Resident 44)

Finding includes:

During an interview, on 7/24/18 at 10:01 A.M., Resident 44's daughter indicated that the lower dentures were missing since the beginning of the year and the resident did have some trouble with eating.

The clinical record for Resident 44 was reviewed on 7/25/18 at 11:28 A.M. The diagnoses included, but were not limited to, dementia and repeated falls.

The significant change MDS (Minimum Data Set) assessment, dated 5/30/18, indicated Resident 44 had a BIMS (Brief Interview of Mental Status) score of 3, severe cognitive impairment and required extensive assist with ADLs (activities of daily living).

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #44 received dental services on 7/27/18 and the process for denture replacement was initiated. The family and physician are aware of this resident's oral health status.

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:

All residents have the potential to be affected by this finding and will be identified through a facility...
A care plan, dated 12/20/17, indicated Resident 44 was edentulous and utilized upper dentures and had an intervention to follow up with consult for lower dentures.

During an interview, on 7/25/18 at 2:27 P.M., the SSD (Social Service Director) indicated the facility was waiting for medicaid approval for lower dentures.

During an interview, on 7/25/18 at 2:44 P.M., the SSD indicated Medicaid has been approved since 3/1/2018.

During an interview, on 7/26/18 at 3:33 P.M., the SSD indicated Resident was not seen by a dentist for lower dentures as indicated in care plan and that she was unaware that resident needed lower dentures.

On 7/27/18 at 8:15 A.M., the DON (Director of Nursing) provided the Dental Service policy, dated 9/2017, and indicated the this was the policy currently being used by the facility. The policy indicated the facility would obtain needed dental services, including routine and emergency dental services: assists in providing these services and makes prompt referrals for dental services as needed.

3.1-24(a)(3)

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

An all staff in-service will be conducted by the DNS/designee on or before 8/26/18. This in-service will include review of the facility policy related to oral care and dental services. Staff will be re-educated regarding the process for addressing any oral or dental issues identified during routine care. Any signs of oral health concerns or changes in a resident’s oral/dental status will be identified through daily ADL care by direct care staff and/or during Weekly Nursing Assessments.

audit. This audit will be completed by the DNS/SSD/designee and will review any resident with missing dentures, ill-fitting dentures and/or residents in need of dental services. Necessary dental arrangements will be offered for any resident identified to be in need of dental services. Any signs of oral health concerns or changes in a resident’s oral/dental status will be identified through daily ADL care by direct care staff and/or during Weekly Nursing Assessments and reported timely through daily clinical meetings. Social Services will be responsible for scheduling, monitoring and following up with routine dental needs for all residents.

What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

An all staff in-service will be conducted by the DNS/designee on or before 8/26/18. This in-service will include review of the facility policy related to oral care and dental services. Staff will be re-educated regarding the process for addressing any oral or dental issues identified during routine care. Any signs of oral health concerns or changes in a resident’s oral/dental status will be identified through daily ADL care by direct care staff and/or during Weekly Nursing Assessments.
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### SUMMARY STATEMENT OF DEFICIENCY

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<th>Each deficiency must be preceded by full regulatory or LSC identifying information</th>
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- **Food Procurement, Store/Prepare/Serve-Sanitary**
  - §483.60(i) Food safety requirements.
  - The facility must -
    - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**
  - The DNS/SSD/designee will be responsible for completion of the QAPI Audit Tool related to Dental Services weekly for 4 weeks and monthly for 6 months to ensure ongoing compliance with corrective action. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance Performance Improvement Committee for review and follow up.
### SUMMARY STATEMENT OF DEFICIENCY

1. **ID**
   - Prefix
   - Tag

2. **PROVIDER'S PLAN OF CORRECTION**
   - Each corrective action should be cross-referenced to the appropriate deficiency.

3. **COMPLETION DATE**

#### Findings Include:

- During an observation of the main dining room, on 07/23/18 at 12:40 PM, CNA (Certified Nurse Aide) 12 was observed placing her thumb on the eating surface of 3 plates served to residents. AA (Activities Assistant) 13 was observed placing her thumb on the eating surface of 1 plate. CNA 10 was observed to placing her right hand on top of a resident's sandwich while cutting it. She then moved a puzzle and placed her hand on the back of the chair, then served drinks. No handwashing was observed.

#### F0812 – Food Procurement, Store/Prepare/Serve – Sanitary

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

All resident meals are being served utilizing proper technique and facility protocol related to staff hands and fingers not coming into contact with eating surfaces of plates, not touching prepared food with bare hands and proper hand washing procedure and infection control practices during meal service. Ready to serve food is

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**Note:**

- (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
- (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
- (iii) This provision does not preclude residents from consuming foods not procured by the facility.

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**§483.60(i)(2)** - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

Based on observation and interview the facility failed to ensure thumbs did not come into contact with the eating surface of plates, failed to ensure staff did not touch prepared food with bare hands, failed to properly perform hand washing, and failed to ensure ready to serve food was covered during transportation for 2 of 3 dining rooms observed. (Main and Assist dining rooms)

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**Findings Include:**

- During an observation of the main dining room, on 07/23/18 at 12:40 PM, CNA (Certified Nurse Aide) 12 was observed placing her thumb on the eating surface of 3 plates served to residents. AA (Activities Assistant) 13 was observed placing her thumb on the eating surface of 1 plate.

---

**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**

All resident meals are being served utilizing proper technique and facility protocol related to staff hands and fingers not coming into contact with eating surfaces of plates, not touching prepared food with bare hands and proper hand washing procedure and infection control practices during meal service. Ready to serve food is

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**Event ID:** WHN511  **Facility ID:** 003075  **Page 22 of 27**
During an observation of the assist dining room, on 07/24/18 at 12:12 PM, RN (Registered Nurse) 8 was observed placing her thumb on the eating surface of 5 plates. She touched her nose and adjusted her glasses and hair, then completed a 5 second hand wash before returning to serve. Staff was observed to carry 9 trays across the hall without covering. CNA 9 was observed touching a chair and holding hands with a resident. No hand washing was observed before she began to assist another resident.

During a second main dining observation, on 07/24/18 at 12:20 PM, RN 11 was observed placing her thumb on the eating surface of 1 plate.

A policy was provided by the DON (Director of Nursing) on 07/27/18 at 12:25 PM, titled "Hand Hygiene Policy", dated 03/2018, and indicated this was the policy currently used by the facility. The policy indicated "...Indication for Handwashing...Prior to the start of passing meal trays...Indication for Hand-rubbing...After contact with a patient's intact skin...After contact with inanimate objects...in the immediate vicinity of the resident...After touching self or clothing during meal service...."

A policy was provided by the DON (Director of Nursing) on 07/27/18 at 12:30 PM, titled "General Food Preparation and Handling", dated 11/2017, and indicated this was the policy currently used by the facility. The policy indicated "...Prepared food will be transported to other areas either covered or in covered containers/enclosed carts...."

3.1-21(i)(3)
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<td>Facility policy. They will also be re-educated and in-serviced on the policy related to covering ready to serve food during transportation from the kitchen to the assisted dining room.</td>
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<td>This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. To ensure ongoing compliance with this corrective action, the ED/DM/designee will be responsible for completion of the Food and Nutrition/Meal Observations at a minimum of one meal daily for 4 weeks and weekly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up.</td>
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<tr>
<td>F9999</td>
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<td>3.1-14 PERSONNEL</td>
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<td>It is the practice of this provider that at the time of employment, or within one month prior to employment, and at least annually thereafter, employees and</td>
<td>08/26/2018</td>
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method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting date. The facility must assure the following:

(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and non-paid personnel of facilities shall be screened for tuberculosis. For health care workers who have had a documented negative tuberculin skin test result during the proceeding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one to three weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.

This state rule as not met as evidenced by:

Based in record review and interview, the facility failed to ensure that a second step Mantoux skin test was completed in 1-3 weeks after the first step and that health care workers were screened annually for 5 of 10 employee records reviewed. (Activity Assistant 14, CNA 15, LPN 16, QMA 17 and CNA 18)

Findings include:

1. The Employee Records form indicated AA (Activity Assistant) 14's start date in the facility non-paid personnel of facilities be screened for tuberculosis. If the first step tuberculin skin testing is negative, a second test should be performed one to three weeks after the first step.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Activity Aide #14 - personnel file has been reviewed and updated and includes all necessary documents related to their employment including an updated Employee Immunization Record. Nurse Aide #15 - personnel file has been reviewed and updated and includes all necessary documents related to their employment including documentation related to Mantoux Tuberculin Skin testing. Licensed Nurse #16 – personnel file has been reviewed and updated and includes all necessary documents related to their employment including an updated Employee Immunization Record. QMA #17 - personnel file has been reviewed and updated and includes all necessary documents related to their employment including an updated Employee Immunization Record. Nurse Aide #18 - personnel file has been reviewed and updated and includes all necessary documents related to their employment including an updated Employee Immunization Record.
1. The Employee Records Form indicated CNA (Certified Nurse Aide) 15's hire date was 4/9/18. There was no documentation available for the second test Mantoux Tuberculin Skin testing. 

2. The Employee Records Form indicated CNA (Certified Nurse Aide) 15's hire date was 4/9/18. There was no documentation available for the second test Mantoux Tuberculin Skin testing. 

3. The Employee Records form indicated LPN (Licensed Practical Nurse) 16's hire date was 12/22/15. There was no Employee Immunization Record for annual Tuberculin Skin Test. 

4. The Employee Records form indicated QMA (Qualified Medication Aide) 17's hire date was 3/17/16. There was no Employee Immunization Record for annual Tuberculin Skin Test. 

5. The Employee Records form indicated CNA 18's hire date was 6/25/14. There was no Employee Immunization Record for annual Tuberculin Skin Test. 

During an interview, on 7/27/18 at 2:00 P.M., the ADM (Administrator) indicated the facility did not administer the annual tuberculin or the second-step screening to the employees reviewed in the employee records.

On 7/27/18 at 12:46 P.M., the HR (Human Resource) personnel provided the Tuberculosis (TB) Screening for Employees, dated 6/2016, and indicated this was the policy currently being used by the facility. The Policy indicated Pre-employment screening was required for all hires and must include one of the following TB screening tests no more than one month prior to employment: (a) Tuberculin Skin Test (TST). A two-step screening was required unless the

### 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:

All employees have the potential to be affected by this finding. An audit will be completed by ED/designee of all employee personnel files. This audit will ensure that all employee personnel files contain all necessary documents related to their employment including an updated Employee Immunization Record and documentation related to required Mantoux Tuberculin Skin Testing. Any identified concerns related to missing items/documentation will be corrected at that time.

### What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:

The ED/designee will be responsible for in-servicing and re-educating each Department Head regarding the paperwork and documents required for each employee personnel record. This in-service will be conducted on or before 8/26/18. The ED/designee will be responsible for ensuring that all required personnel documents are obtained and filed.
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<th>B. WING</th>
<th>X3) DATE SURVEY</th>
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<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
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<td>ELKHART, IN 46516</td>
<td>1400 W FRANKLIN ST</td>
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**Summary Statement of Deficiency**: Applicant has a TST in the past 12 months and can provide a date given and read, results in millimeters and interpretation (positive or negative), then one single (one step) follow up TST is needed. Employee annual/yearly screening was required of all employees.

**Provider's Plan of Correction**: In the personnel record per facility policy by using the Employee File Checklist.

**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**: This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The ED/Designeee will be responsible for completing the QAPI Audit tool related to Personnel and Confidential Employee File Checklist weekly for 4 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.