STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING ______ B. WING ______	C 08/04/2017

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RIVERSIDE REHABILITATION CENTER AT HAMPTON	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/1/17 through 8/4/17. Three complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 101 at the time of the survey. The survey sample consisted of 22 resident reviews; 18 current residents (Residents #1 through #18) and 4 closed record reviews (Residents #19 through #22).	F 000		
F 206 SS=D	POLICY TO PERMIT READMISSION BEYOND BED-HOLD CFR(s): 483.15(e)(1)(2) (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and	F 206		9/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/26/2017

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 206	Continued From page 1 (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. (e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on a closed clinical record review, staff and Resident Representative interview and facility documentation review, the facility staff failed to allow 1 of 22 residents (Resident #19) to return to the facility once medically cleared after hospitalization to their previous room if available or immediately upon the first availability of a bed. The findings include: Resident #19 was admitted to the nursing facility on 2/23/17 at 5:20 p.m. from an acute care facility with diagnoses that included but not limited to urinary tract infection (UTI) with sepsis, indwelling urinary catheter (Foley brand), chronic kidney disease, ongoing colon bladder fistula as a consequence of diverticular abscess which had	F 206	1. The facility has established a written policy on readmissions in accordance to regulations. The resident no longer resides at the facility. 2. An audit of all current resident admission agreements starting on 8/24/2017 by Business Manager/Designee to ensure all residents have received the current policy on readmission. The center providers, leadership team and admissions coordinators have been educated on the readmission policy by the Clinical Educator or designee 8/23/17. 3. The Admissions Coordinator or designee will audit resident records of those who were hospitalized with an	

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F 206	Continued From page 2 been drained while in the hospital, prior to admission to the facility. She was admitted with a PICC line (peripherally inserted central catheter for intravenous treatments) on IV (intravenous) antibiotics and subcutaneous heparin. Resident #19's Admission Minimum Data Set (MDS) assessment dated 2/24/17 indicated they had not yet completed the cognitive section. The resident was coded with an indwelling urinary catheter and incontinent of bowel. Diagnoses included but were not limited to septicemia, UTI, IV medications and isolation for an infectious disease. The care plan dated 2/24/17 identified the resident had a UTI, a PICC line for IV antibiotics and an indwelling urinary catheter. The nurse's notes on 2/24/17 at 8:30 a.m., entered by Licensed Practical Nurse (LPN) # 3, indicated the resident complained she was urinating on herself and the nurse noted that the pad under the resident was wet with a small amount of urine. It was documented that the indwelling urinary catheter (Foley brand) was without kinks with urine observed in the Foley drainage bag. The resident's abdomen was not distended and the resident did not complain of pain. A family member was concerned about the lack of urine draining into the bag and it was documented the family member attempted to reposition the Foley herself with no urine drainage. It was recorded that the Registered Nurse (RN) Unit Manager #2 came and deflated the Foley and repositioned the Foley with observed urine draining and no further concerns, "resolved at this time."	F 206	expectation to return to center. 4. The Business Office Liaison or designee will validate compliance with policy of all readmitting residents for 12 weeks. Results of the audits will be presented by the Admissions Director at the centers monthly QA meeting for 3 months for evaluation of compliance and ongoing monitoring for continuous improvement analysis after implementation	

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The nurse's notes on 2/24/17 at 1:15 p.m., indicated the physician gave an order to send the resident to the Emergency Room (ER) with complaints of a new severe abdominal pain and Foley complications (no specific complications were recorded in the nurse's notes). EMS (911) was called and the nurse's noted indicated a time of 12:45 p.m.

On 8/2/17 at approximately 1:30 p.m., when asked of the Director of Nurses (DON) why Resident #19 did not return to the nursing facility after her hospitalization, she began to say "No matter what we did, it was never good enough for the granddaughter. She was obsessed with something being wrong with the Foley catheter. The granddaughter and the resident's mother (Power of Attorney) were nurses." She said the RN Unit Manager #2 told her the resident's granddaughter constantly manipulated the Foley catheter, but neither the DON or the Unit Manager wrote nurse's notes or filed any incident reports about the granddaughter's practice. The care plan did not identify this was a problem and that the family required education.

On 8/2/17 at 3:30 p.m., an interview was conducted the RN Unit Manager #2, Admissions Director and Director of Rehabilitation. When asked of the RN Unit Manager #2 specifically what the resident's family did to the Foley catheter, she stated; "The granddaughter kept pushing the catheter tubing in and out a lot and I told her I knew she had nursing experience, but the nurses here will take care of it. I did not document what the granddaughter was doing with the Foley and I should have. I did not file an incident report either, but looking back I should have. I think we changed it, flushed and

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F 206	Continued From page 4 repositioned the Foley and it was draining fine. On the same day around noon, the resident complained of a new abdominal pain and the doctor gave an order to send out to the ER to be evaluated. The resident was discharged on 2/24/17 and I don't know anything else as to why she did not come back." During the above interview, the Director of Rehabilitation stated she screened the resident on 2/24/17 and set up a Physical Therapy (PT) plan of care. She stated the resident was receptive to the plan of care, was not in any discomfort and "I told her I would see her next time and the last thing I knew they said the paramedics came and sent her out with abdominal pain." The Admissions Director stated she documented in "E-Discharge" that the resident was officially discharged from the facility on 2/24/17 because "we were not able to meet her needs" and that the Administrator told her to "put that note in." She said the Administrator had the final say on Resident #19's readmission. She also presented referrals and communication from the local hospital sent to the Administrator with updates on the resident's condition, 2/25/17, 2/27/17 and 3/7/17. She said the hospital sends referral information at different times waiting on a response. A notation of decline readmission was entered by the Administrator on 2/27/17. When asked why, she stated "It was his decision she not come back." On 8/2/17 at 2:45 p.m., another interview was conducted with the DON and she said the physician wanted the resident to be evaluated in the ED and be seen by a urologist to make sure there were no additional problems based on the resident's new pain before she came back, but	F 206		

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that because she had the fistula they probably could not care for her. The DON could not explain how having the fistula and the Foley, both conditions present on the resident's admission had a bearing on the resident's readmission if she was medically stable. In addition, the DON stated she did not have a record of any conversations with the family and if she did she could not recall any details. She stated she did not generate an incident report regarding what she was told from the nurse about the granddaughter pushing the Foley catheter "in and out", nor did she have documentation that she spoke to the POA about the matter or that there was a need for family education.

On 8/2/17 at 3:02 p.m., a telephone interview was conducted with the resident's physician. The physician stated she saw the resident only cursorily and that the resident arrived the evening of 2/23/17 and was gone early the next day. She stated she never saw the granddaughter or daughter, who were both RNs, ever manipulate the Foley catheter, but was told that by the RN Unit Manager #2 and she entered what the Unit Manager said in her progress note. She said the resident presented with a new pain on 2/24/17 and thought it was best to have her sent out to be evaluated and shared the same information with the POA who was the resident's daughter. She stated she was in the building when the ED called and stated the resident's pain was under control and there were no other complications, but she wanted the nephrologist to evaluate the resident to know her status completely. The physician further said, "I never heard anything else. I knew that the daughter was okay with the resident coming back; in fact, she did not want her to go out and thought we could do what we needed to

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do without her going to the ER. I did not know why she could not have come back here once they ruled out any complications. I never stated the resident could not return." The physician did not document in any progress note that the resident was not able to return to the nursing facility.

On 8/3/17 at 1:34 p.m., an interview was conducted with Resident #19's POA (daughter of resident). She stated the resident was admitted to the hospital on 2/24/17 with a Urinary Tract Infection and mucous was blocking some of the flow of urine into the tubing and drainage bag. She said the hospital called her with a report on 2/24/17 and was told they had plans to send the resident back to the nursing facility on 2/27/17, but that the facility told her the resident had been discharged from the nursing facility on 2/24/17 and not allowed back into the facility with no reason. She said she came to the nursing facility on Monday 2/27/17 to discuss the reason for the discharge and spoke to the Administrator first and was told that the physician informed him the resident could not come back. The POA stated she asked the Administrator where she could find the Ombudsman's phone number and was told, "it's out there on the wall." She said she was able to speak to the physician on 2/27/17, as well and was told by her that she was not the one who made the decision the resident could not come back, but that it had been the decision of the DON.

During the interview with the POA she stated she proceeded to speak to the DON on the same day and was told by her that the resident could not come back because her care took too much nursing time. The POA stated she asked if staff

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F 206	Continued From page 7 did rounds to check when and if Foley was leaking or whether it was kinked or pulled out, the DON stated she did not have the staff to provide that kind of care. When asked if she had been told it was a concern from the nursing staff that the granddaughter may have been manipulating the Foley, she stated, "The DON never told my daughter or me that was a concern voiced by the nurses, but emphatically said she could not take my Mom back without any sound reason." She stated on the day they sent the resident out she and the granddaughter both being nurses looked at the Foley, but never pushed the catheter in and out, but asked if the Foley had been changed and thought the resident may have bladder spasms. When asked if she knew the physician wanted the resident to be evaluated by a nephrologist before she came back, she stated she was not told by anyone in the facility to include the physician and if she had been, she would have make sure it was done, if it had not already been done. The POA said during her discussion with the DON, she told the DON she had nowhere to send the resident, but was told again they were not going to take her back. The POA stated the resident had to stay in the hospital until they could find a place that had an available female bed and while in the hospital not moving around like she would have in the nursing facility, she developed a non-occlusive Deep Vein Thrombosis (DVT). She stated they finally found a place that provided skilled services and ultimately the resident was discharged back home with her, doing well. She stated the resident's fistula and a Foley catheter were going to be chronic issues because she would not be a surgical candidate to repair the fistula due to advanced age and comorbidity. The	F 206		

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POA stated, "It's probably a good idea now that she did not come back because I would not want her there if they did not want her, but it was not right and not fair to my mother at the time. I really think it was because they did not like that we were intuitive nurses and they did not like us asking questions about the Foley leaking. We did not do anything out of the ordinary. My mother spent too many extra days in the hospital while we were looking for another skilled facility. I took care of my Mom at home and thought we could work with the facility, as we worked with the skilled facility she was ultimately sent to on 3/7/17. "

The hospital records indicated the resident was evaluated in the local hospital's ER on 2/24/17 at 1:40 p.m. with a urinary catheter problem and bladder spasms. The ER physician's notes indicated "The resident had new abdominal pain upon her transfer from the nursing home with pain medication and no relief. In the hospital, the Foley catheter was checked, working well, seemed to have a small mucous/sediment plug which dislodged, urine analysis was loaded with white blood cells, but patient was already being treated with antibiotics. Abdomen was soft and non-distended, suprapubic tenderness." The CT scan showed no acute change. Morphine (narcotic) IM given for pain and on recheck, she was pain free. The case was forwarded to urology where the CT scan was reviewed with no increase in size of pelvic collection, urology advised to start Detrol (antispasmodic) with prescription written and also recommended B&O suppository if having current pain, but was not needed at the time. It was decided the resident would be admitted as an inpatient. The resident was diagnosed with a recurrent UTI due to Foley

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F 206	Continued From page 9 catheter (antibiotic treatment) and existing colon/bladder (colovesical) fistula. The plan was to discharge resident back to the rehabilitation center on Monday 2/27/17. Continued review of the hospital medical records indicated the resident was followed by hospitalist, as well as multiple specialists: nephrology, surgery, vascular and cardiology. The resident's admission bilateral lower extremity edema was evaluated through a PVL study on 3/3/17 where it was diagnosed she had non-occlusive peroneal DVT, not into the popliteal veins. It was also noted not sure if the DVT was present upon hospital admission. She was not started on anticoagulation and the plan was to elevate extremities, repeat PVL studies in 2 weeks to make sure did not progress into the popliteal veins and this would be deferred to attending physician and/or rehab attending. Follow up with cardiology in 2 weeks, Infectious Disease (ID) specialist in 2 weeks and nephrology in 2 weeks. The hospital Medical Social Worker (MSW) progress note dated 2/26/17 and 2/27/17 indicated the resident was at (name of current skilled facility), but not allowed to return, declined readmission specifically on 2/27/17. The resident was still in need of skilled nursing facility services and skilled facility choices were presented to the patient/POA. On 2/28/17 a facility was identified and a plan to discharge the patient on 3/1/17 when bed available and her needs included IV antibiotic therapy, PT/OT due to debilitation/deconditioning with Activities of Daily Living (ADL) impairment. Urology further notes on 3/3/17 that the resident remained stable and was around her baseline at best. The MSW progress note dated 3/6/17 indicated there were issues	F 206		

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with transfer to skilled facility based on unavailability of female beds until 3/7/17. The resident was discharged to a skilled nursing facility on 3/7/17.

On 8/3/17 at 4:15 p.m., a debriefing was conducted with the Administrator, DON, Assistant Director of Nursing (ADON) and four corporate nurses. Five surveyors were present during this interview. They stated the physician made the decision not to accept the resident back into the facility because they could not meet her needs. All of the aforementioned issues were reviewed again to include the interview with the physician who stated she wanted the resident to be evaluated by the nephrologist for any complications before returning to the facility. It was shared with the group that the physician stated the following: "... I did not know why she could not have come back here once they ruled out any complications. I never stated the resident could not return." There were no physician progress notes or referral notes back and forth to the hospital that indicated she would not accept the resident's re-admission to the nursing facility. There was no documentation provided to the survey team that directly stated the physician indicated the resident could not return to the facility. The interview the surveyor had with the POA was also shared with the group that indicated the DON was emphatic she could not accept the resident back without giving a clear reason, as well as the interview she had with the Administrator where she was told the same information.

During the debriefing, the group could not provide an explanation as to why referrals and updates were not reviewed to ascertain if the resident had

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been evaluated by the nephrologist to determine any complications existed that would bar the resident from returning as a skilled resident. In addition, there was no explanation as to why the nursing staff or Administration did not document or file an incident report if they observed the family was interfering with care by manipulating the Foley catheter or that they provided family education. The resident was admitted to another skilled facility and ultimately discharged back home with the POA.

The facility's policy and procedures titled "Resident Admission" dated 1/2009 indicated; "The following categories of resident may be accepted for admission: Ambulatory, bedridden, postoperative, diabetic, cancer/oncology, incontinence care (indwelling urinary catheter), tube feeding, pressure areas, IV fluids and medications, neuromuscular disorders, dementia, mild mental retardation, status-post cerebrovascular accident (stroke), HIV/AIDS, cardiac and pulmonary, renal failure, trauma related injuries, orthopedics and PT/OT/ST. Other categories shall be reviewed by the admission team for approval based on the care needs of the resident. The acceptance of residents not listed in the above categories are made with the authorization and approval of the Medical Director or resident's physician, DON, and the Administrator..."

The Admission agreement document presented to residents and POA indicated the following (Resident #19's agreement was signed by her POA and Admissions Director on 2/24/17): "...If the resident does not hold the bed, the resident is eligible for readmission to the Center provided the center can provide the level of care required by

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F 206	Continued From page 12 the resident; and the resident requires the services of the Center and is eligible for medicare skilled nursing facility services or Medicaid nursing services. In this event, the resident shall be readmitted to the Center to his/her previous room if available or immediately upon the first availability of a bed in a semiprivate room when you are ready to leave the hospital..."	F 206		
F 253 SS=E	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and in the course of a complaint investigation, the facility staff failed to ensure housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for Residents of the Facility. The Findings Included: During the task of General Observations, multiple Resident Rooms and Rooms frequented by Residents were observed as followed: The following were observed on 8/3/17 at approximately 12:30 p.m. with the surveyor and the Maintenance Director. Room 1: Peeling wallpaper at bathroom door and on walls Room 2: Peeling wallpaper at bathroom door, sink was loose from the wall, wallpaper starting to	F 253	1. The facility is providing housekeeping services necessary to maintain a sanitary interior in accordance to regulations. The centers maintenance department has established a plan for needed repairs and a schedule has been developed. All repairs listed were completed by facility maintenance or housekeeping. The sink in room 2, 43 and 227 were repaired on 8/3/17, the rails around the toilet in the north wing shower room was replaced on 8/3/17, the sink in room 45 were repaired on 8/2/17, the over bed tables in room 53 and 54 were replaced on 8/3/17, the sink in room 20 was repaired on 8/4/17, the heater vent cover in 214 was replaced on 8/4/17, the toilet in shower room # 3 was repaired 8/2/17, the electrical outlet in room 234 was replaced on 8/2/17, the over bed table in 208 was replaced on 8/2/17 and the air vent in room 46 was opened on 8/3/17. The bed control for	9/5/17

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buckle at the air conditioning unit
Room 3: Peeling wallpaper behind Bed A, Bed unable to be adjusted by the Resident, Staff must be called to make adjustments at the foot of the bed
Room 4: Peeling wallpaper at bathroom and stained ceiling tile in the bathroom
Room 5: A red/pink color on the wall to the left of the air conditioning unit. The Resident stated, "I tried to wipe it off, but it won't come off."
Room 6: Peeling wallpaper at the sink and in the bathroom
Room 7: Peeling wallpaper at door
Room 8: B Bed area has strong urine odor, Both residents were out of the room. B Bed was made. Peeling wallpaper border toward the ceiling, in the bathroom and around the sink. The Director of Maintenance stated that he could smell the strong urine odor.
Room 9: Stain observed on the wall near the air conditioning unit
Room 10: Peeling wallpaper border, Peeling wallpaper near the bathroom door and stains observed on the walls
Room 11: Peeling wallpaper near the sink and bathroom
Room 12: Peeling Paint throughout the room
Room 13: Rusty ceiling tile surrounds
Room 14: Peeling Paint
Room 15: Rusting Ceiling tile surrounds, and ceiling tile stains
Room 16: Observed blanket and Bed Pad covering the entire bathroom floor.
Room 17: Marred wood strip at door, peeling wallpaper around sink
Room 18: Marred wood strip at door

The following rooms were observed on 8/2/17 at approximately 1:00 p.m. by the surveyor and the

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room 3 was replaced on 8/3/17. The disabled heating strip in bathroom in room 48 was removed 8/23/17. The lightbulb in 211 was replaced on 8/3/17. The rough areas to bathroom door in 212 were repaired on 8/4/17. The headboard in room 54A was repaired on 8/2/17. On 8/3/17, room # 8 and 52 were deep cleaned by housekeeping, and odors corrected. On 8/1/17 shower room # 4 was deep cleaned and hair removed from drain. The odor was corrected. On 8/2/17, the dust on the fan blades in the dining room was removed. On 8/4/17, the supply room on the second floor was dusted and stored items removed from room. On 8/3/17, the blanket and bed pad that resident residing in room 16 spread across floor in bath room, was removed off floor. On 8/3/17, the stained area by air conditioner in room 9 and stained area on wall of room 10, were cleaned by housekeeping. On 8/2/17, the nonskid surface in the North wing shower room was cleaned. The stained shower chair in shower room 4 was discarded on 8/2/17. Housekeeping removed the scuff marks from floor in 206, 205 and 204 on 8/2/17. The scuff marks on the walls in room 203, 202 and 201 were cleaned on 8/3/17, as well as the stained area in the corner in room 211. Work orders were completed for remaining items. A log has been developed with repair goal dates assigned by priority. For areas cited where more extensive work is indicated, a construction management plan will be developed by 9/5/17.
2. The facility administrator and

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F 253	Continued From page 14 Maintenance Director with the following problems. In addition Room temps were taken as the air conditioner had been broken and being repaired on 8/3/17. Room Temps were within range. North Shower Room: Rails around the toilet are loose. Tub non slip surface is brownish in color. Missing tiles in Bathroom. Room 43: Sink loose from the wall Room 44: Multiple stained ceiling tile stains Room 45: Loose sink from wall Room 46: Ceiling tile stains, Air Conditioner vent closed off, no air getting into the room Room 47: Ceiling tile stains, peeling wallpaper Room 48: Ceiling tile stain, peeling wallpaper, rusty disable heater strip in bathroom Room 49: Cracking observed in wall at sink The following rooms were observed by the surveyor and the Maintenance Director on 8/3/17 at approximately 1:55 p.m. Room 50: Ceiling tile stains, wall board holes above bed Room 51: Peeling wallpaper Room 52: Strong odor in bathroom, the toilet had been flushed and no trash or soiled linens were left behind. The Maintenance Director stated he smelled the odors as well. Room 53: Overbed table at B Bed showing the inner compressed board, peeling wallpaper issues at the sink area and on walls Room 54: Broken bed headboard at A Bed, B Bed's over bed table showing the inner compressed board, bathroom ceiling tile issues Room 55: Ceiling tile stains, wallpaper peeling at the sink and in the room	F 253	maintenance team have performed a house wide sweep starting on 8/24/2017 to identify areas in need of repair and work orders were entered for any additional maintenance and housekeeping services needed. 3. Housekeeping staff have been educated on general cleaning practices of resident rooms, shower rooms and other interior locations by housekeeping director on 8/21/17, 8/23/17 and 8/24/17. We have updated the housekeeping log process to include all areas and storage areas of the facility, frequency of cleaning, and details of cleaning each area. Housekeepers will be required to document cleaning tasks daily. Education was provided to staff on responsibilities of cleaning up hair from shower drain after each shower on 8/23/17 by DON or designee. A log will be implemented for each work order to be logged when opened and completed. 4. The housekeeping director will audit 5 rooms daily/ 5 days per week utilizing the centers housekeeping cleaning checklist to validate compliance with maintaining a sanitary interior for 12 weeks. Any areas of concern will be immediately addressed. The center administrator or designee will review the maintenance repair log and the work order log weekly for 12 weeks, then monthly for 3 months, to validate repairs are on schedule until all repairs completed. Results of the audits will be presented by the Administrator or designee at the centers monthly QA meeting for 3 months for evaluation of compliance and ongoing monitoring for continuous improvement analysis after	

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F 253	Continued From page 15 Room 24: Peeling baseboard under the sink, Ceiling tile stains in the Bathroom Room 25: Peeling wallpaper at the bathroom door Room 26: Peeling wallpaper at the sink and at B Bed Room 27: Peeling wallpaper at door Room 20: sink loose from the wall, peeling wallpaper loose near the ceiling, ceiling tile stains Room 19: Peeling wallpaper at sink and bathroom Room 28: Peeling wallpaper at sink, in bathroom and on room walls The following rooms were observed on 8/2/17 at approximately 2:30 p.m. with the surveyor and the Maintenance Director. The following items were observed: Room 213: Ceiling tile stains, peeling wallpaper at bathroom door and sink and around B Bed Room 214: heater vent covers missing, peeling wallpaper throughout Room 215: Ceiling tile cracked and stained, Peeling floor baseboard Room 216: Cracked wall near heater Room 217: Peeling wallpaper seams and cracking at sink and at bed Room 218: Wallpaper seam cracking under the sink Shower Room 3 Toilet not secure to the floor Room 219: Peeling wallpaper near bathroom door, and walls of room Room 220: Peeling wallpaper above the sink, at bathroom door and at AC unit Room 222: Loose Velcro strip at door, Peeling	F 253	implementation.	

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F 253	Continued From page 16 wallpaper at bathroom door Room 224: Peeling wallpaper at head of bed and near the AC and sink Room 225: Peeling wallpaper at sink and on walls Room 226: Peeling wallpaper at bathroom door Room 227: sink loose from wall, peeling wallpaper at sink and bathroom door Room 229: peeling wallpaper at B bed, sink and bathroom door Shower room 4 Stained shower chair. On 8/1/17 at approximately 10:45 a.m. a large amount of hair was observed in the shower room drain. This shower room had an odor of cleanser over top of a foul odor that came from the area in back of the room where multiple chairs were stored. Dust was observed on top of the fan blades in the dining room. Supply Room Second Floor: This room had shelving units in addition to plastic bin drawers. The plastic bin drawers outer surfaces were observed to have a thick layer of dust. In front of these plastic bins that held dressings, were multiple plastic bags on floor in front of the drawers, a suitcase awaiting pick-up from family or resident. This room also had staff lockers. Shower Room 6: Stripping at the bathroom door was loose and wallpaper has been shredded at the bathroom door and around the sink. Room 206: scuffed floor from wheel chair, Peeling at bathroom door and behind bed	F 253		

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F 253	Continued From page 17 Room 205: scuffed floor from wheel chair, Peeling at bathroom door and behind bed Room 204: scuffed floor from wheel chair, Peeling at bathroom door and behind bed Room 203: scuffed wall Room 202: Scuffed wall Room 201: scuffed wall Room 234: electrical socket cracked, peeling wallpaper at bathroom and a B bed Room 233: Peeling wallpaper at B bed and bathroom door Room 232: Peeling wallpaper at bathroom door and at beds Room 231: Peeling wallpaper at bathroom door Second Floor Soiled Utility Room: hole at baseboard Room 207: peeling wallpaper, stained ceiling tile Room 208: Peeling wallpaper by bed, sink and bathroom door and the over bed table has worn area Room 209: Peeling wallpaper at AC and at bathroom door, scratched area on bathroom door, Stained ceiling tiles, peeling baseboard Room 211: Light bulb out over the sink, Peeling wallpaper at bed and corner, stained areas in corner, Rust spot on floor under sink, no leaking observed Room 212: rough area of bathroom door, wallpaper peeling behind door and in bathroom A Facility document titled, "Preventive Maintenance Safety Schedule" documented the following: Shower chairs and Merry Walkers: Check PVC integrity, seats, and overall condition, repair as needed: Frequency: Weekly	F 253		

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F 253	Continued From page 18 Electrical appliances in resident rooms: Check wiring, examine for wear and breakage: Frequency: Monthly Furnishings in resident rooms: Check chairs and furniture for stability, breakage and repair needs: Frequency: Monthly A Facility document titled, "Bathing Room Checklist" documented the following: Floors Clean Walls Clean Lights Working Equipment Working Dust Free Work Needed List Below Items to be corrected No frequency of this guideline was documented. A Facility document titled, "Shower Room Checklist" documented the following: Commode Sink Tub Floor Walls Lights No frequency of this guideline was documented A Facility Policy and Procedure titled, "Standard Cleaning Procedures" documented the following: Purpose: To assure a safe, clean living space for residents, families and staff. Specific Procedure/Requirements: High Dusting Cleaning and sanitizing surfaces Cleaning Bathroom The facility administration was informed of the	F 253		

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F 253	Continued From page 19 findings during a briefing on 8/3/17 at approximately 6:30 p.m.. The Administrator produced a two page document of Resident rooms that had some marked with a yellow highlighter. The Administrator stated that the yellow marked rooms indicated rooms that repairs had been completed in. When the Administrator was asked when the repairs were begun he stated about a year ago. The Administrator stated that the Maintenance Director had been sick and his assistant had retired several months ago. The facility did not present any further information about the findings.	F 253		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain	F 323		8/26/17

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F 323	Continued From page 20 informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, a complaint investigation and resident and staff interviews the facility staff failed to provide a two person assist during transfer for one resident (Resident #2) in the survey sample of 22 residents which resulted in a fall with a fracture. The findings included: 1. Resident #2 was admitted to the facility on 4/15/16 with diagnoses which included anemia, cardio vascular accident, vascular dementia depression, diabetes, muscle weakness, and hypertension. An annual Minimum Data Set (MDS) dated 2/21/17 assessed Resident #2 in the area of Cognitive Patterns (Brief Interview for Mental Status) BIMS with a score of 13 out of 15 indicating no cognitive impairment. In the area of Activities of Daily Living (ADL) this resident was coded in the area of Transfer Limited assist of Self - Performance, Provide two person physical assist. In the area of balance during Transitions and walking this resident was coded as a (2) Not steady, only able to stabilize with staff assistance when moving from seated to standing position and surface to surface transfers (transfer between bed and chair or wheelchair). This resident was not coded for walking, turning around or moving on and off toilet (8). A Falls Risk Evaluation dated 2/21/17 indicated: Resident #2 was assessed as being a high risk	F 323	Past noncompliance: no plan of correction required.	

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for falls with a score of 10. The range indicated a score of 10 or above represents high risk for falls.

A Care Plan dated 9/20/16 through 3/28/17 indicated: "Problem- Resident has been assessed as having no or limited potential for change in ADL performance and requires extensive to total assistance with ADL's. Goal- Resident will not experience adverse outcomes from requiring extensive assistance with or being dependent in ADL's. Interventions- Transfer resident with mechanical lift and assist of 2 staff; as needed if resident is unable to use slide board. Resident has risk for falls and/or history of falls related to unsteady gait, Loss of balance, poor sitting balance/poor trunk control, Requires staff assistance for transfers. Goals- Resident will not experience fall- Interventions - keep bed in lowest position for safe transfer, keep bed wheels locked, Provide assistive mobility devices as recommended by therapy; report unsafe use to therapy."

A Physical Therapy Care Plan dated 2/20/17 indicated: "Problems- 1. Fall risk 2. Generalized weakness 3. Dependent for transfers. Goals- 1. Complete transfers using sit to stand lift for all functional transfers. Completed stand pivot transfers with CGA (contact guard assist)/minimal assist bed to w/c (wheelchair). 3. Pt (patient) will ambulate 3-5 feet with FWW (front wheeled walker) and CGA.

Transfer training: sit to stand x 3 with maximal assist of 2 with verbal cues for hand placement, forward flexed posture, technique throughout. On first 2 attempts pt (patient) was very resistive and felt as though she was unable to stand and would push back in order to try and sit down. On third

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attempt, pt was able to stand fully upright for 20 seconds with increased encouragement and minimal assist to maintain balance throughout. Pt has not made progress towards goals to this point as pt still requires maximal assist from 2 people for transfers."

An event report dated 3/9/17 indicated: "The time to be 11:15 A.M., Fall during transfer, Fall Event Details- Assisted resident to ground/floor by employee, witness by staff, Assistive device - wheelchair, transferring to or from bed, chair etc. Person affected- Resident #2. Brief Factual Description of Events- Resident being transferred from bed to w/c legs buckled and she went down on her knees. Impact from fall- Injury related to fall - (NO INJURY is documented). Resident Interview: Resident did not know she was going to fall. Notification- Director of Nursing (DON) and family."

A clinical note dated 3/9/17 at 4:21 PM indicated: "(name of Resident #2) fell during transfer from bed to wheelchair, put back in bed VIA lift. Resident complained right leg/knee pain. Resident grimacing saying my leg hurts. right leg noted to have toes pointing out and shorter appearance compared to left leg. Resident assessed NP (Nurse Practitioner) in building with the order to send to ED (Emergency Department) for eval. 911 called and resident transported VIA stretcher to hospital. X-ray from the ED (emergency department) shows right femur spiral fracture."

The DON provided the following Plan of Correction:
The Incident Report indicated: "Incident:- On 3/9/17 resident was being assisted from bed to

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F 323	Continued From page 23 shower chair via sit to stand lift. Aide reports that right leg "buckled" and patient went to her knees. Resident received a right femoral fracture. Resident History: Resident is a 86 year old female with a diagnosis of osteoporosis, Vit (vitamin) D deficiency, DJD (degenerative joint disease), stenosis of the spine osteoarthritis of the knees, osteopenia and has been on long term prednisone. She has a history of prior ankle fracture and osteoporosis compression fractures. Resident is alert, oriented to self and place. Pleasantly confused at times. On resident's last MDS dated 2/21/17, it notes that residents BIMS was 13. That resident requires extensive assist with bed mobility and dressing /grooming. Resident required limited assist with transfers and mobility and was independent with eating. Resident has been receiving Vit D for some time now for Vit D deficiency. Investigation: Investigation conducted utilizing staff and resident interviews, and medical records review. The aide transferring resident reports she utilized the sit to stand mechanical lift during transfer. She reports prior to lifting the resident that she validated pt was secure on sling. She reports she validated feet properly placed on foot support and that hands were holding hand grip. She reports sling was in place around upper back. Aide reports as she started to raise lift, she saw resident's right leg buckle and the resident lost balance and went to her knees on the lift stand foot support. Aide reports an attempt to physically support resident during this time to prevent a traumatic fall. The aide called for help and pt was assisted back into the bed in a Hoyer like lift. Resident was sent to hospital for medical work up due to suspected fracture. RN (Registered Nurse) Unit Manager	F 323		

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assessed pt. Resident was also assessed in center by an NP (Nurse Practitioner) that was in the center at time of event. Resident could not recall or express what had occurred.
Findings:
The sit to stand lift has been utilized at PACE and Nursing Home for transfers. Per the manufactures guidelines, resident must be able to bear weight on lower extremities and be able to hold onto the hand supports. The resident profile indicated resident was a mechanical lift for transfers. The maintenance director indicates lift in proper working condition.
Actions and On-Going Interventions:
1. residents who utilize the sit to stand mechanical lift are at risk to be affected.
2. Residents who utilize the sit to stand mechanical lift were re-evaluated to determine if they meet the patient guidelines the manufactures suggest use for. The plan of care was adjusted as needed as well as resident profiles.
3. Staff were re-educated on transfers status. mechanical lifts (both sit to stand and Hoyer type), and resident profiles. Maintenance Director inspected lifts. Noted to be in proper working condition. Transfer observations initiated X 6 weeks."
AOC date 3/22/17
No other falls with injuries have occurred.

A manufactory guideline for the use of the sit to stand indicated: "in Section C- fig-13 (3). patients who have suffered a "stroke" who can only hold with one hand, or patients who cannot hold on at all, may still be lifted by the SARA but it will be necessary for the operator or a second nurse to support the patient's arm/arms down in front of the body during the lift."

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	495308	A. BUILDING ______ B. WING ______	C 08/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE REHABILITATION CENTER AT HAMPTON	**414 ALGONQUIN RD HAMPTON, VA 23661**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A facility policy for "Transfer Using the Mechanical Lift" indicated: "Policy- mechanical lifts will be utilized by nursing staff to transfer residents who cannot help themselves, resident who fall, and residents who need repositioning that requires a mechanical lift. The number of staff assisting with transfer using the mechanical lift is dependent on: manufacturer guidelines- facility must review guidelines prior to use. Conditions that may require more than one person to assist during transfer and will be addressed in the resident care Plan (i.e. bariatric need, uncontrollable body movements, etc.)."

A written statement from the Unit Manager (Undated) indicated: "On 3/9/17 about 11:25 A.M., staff nurse reports to me that resident had fallen during a transfer. Nurse had assessed the resident and requested I go in and assess the resident. On entering the room, the resident was lying on her back in her bed. resident was moaning occasionally and saying her leg hurts. Asked resident if she could tell me what happened she replied she could not. I asked her if she had fallen she stated she didn't know. I asked her where her pain was and she said her leg. I asked her if she was hurting anywhere else and she denied any other pain. Visual assessment done, nurses note in vision."

A Nurses Note from the Unit Manager dated 3/9/17 at (2:06 P.M.) indicated: "Resident fall during transfer from bed to wheel chair put back in bed VIA lift. Resident c/o (complained) right leg/knee pain. Resident grimacing saying my leg hurts. Right leg noted to have toes pointing out and shorter appearance compared to left leg. Resident assess by NP in building with the order

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to send to ED for eval. 911 called and resident transported VIA stretcher to hospital for eval. Out of building at 12:15, daughter aware of above and will meet at the ED. Provider was notified of fall prior to being seen by facility provider and an x-ray was ordered for the right leg D/T (due to) the appearance of the leg and the residents pain this writer requested the in facility provider assess d/t this writer's concern for time frame for portable x-ray. NP assessed and gave order to send to ED for eval."

During an interview on 8/3/17 at (9:00 A.M.) with the Unit Manager she stated, "I was not in the room when Resident #2 fell. I did not witness the type of lift used to transfer her. I was called to Resident #2's room to assess her for a fall. This was five minutes after her fall. When I first saw her she was already in bed. I assessed her and called for the Nurse Practitioner to come and assess her also."

During an interview on 8/3/17 at 11:07 A.M. with Certified Nursing Assistant (CNA) #1, she stated, "This was not my first time using the sit to stand lift. I all ways used it by self. I was only taught to use one to for the sit to stand lift. I had her positioned in the right way. I was getting her up to take a shower. Her leg slipped as I was lifting her up, her leg buckled. I assisted down to the floor. I called for help. Another CNA came and we used a total lift and placed her back in bed."

A written statement from CNA #1 dated 3/9/17 indicated: "It was (name of Resident #2's) shower day. I was preparing her for the bathroom. I put her on the sit to stand that she always use and I

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make sure that she was secure on the the sit to stand. Her hands, legs and body was secure rightly (sic) before I started lifting her up. I have (sic) not lifted her up far before she slid on her knee and I immediately called for help to get her up back in her bed. She complain of her legs and she was taken to the hospital."

During an interview on 8/4/17 with the DON she stated, "the facility followed the sit to stand manufactory guideline in their care plan to assist with the number of staff needed for transferring a resident." When shown the Care Plan for Resident #2, the DON stated the facility did not have manufactory guidelines included in the care plan.

A Nurse Practitioner note dated 3/9/17 at 12:54 P.M. indicated: "Asked by Nurse Manager to see Resident #2 after what sounds like a fall.
Resident #2 is not one of my usual patients so my familiarity with her is limited.
She is seen resting in bed on her back. She is awake, alert and interactive with me. her speech is clear. She does seem to have some memory/cognitive impairment-she cannot tell me what happened.
Limited ROS (review of systems) was completed. She is positive for pain both hips, she denies chest pain, shortness of breath and difficulty breathing.
Physical exam reveals that her right lower extremity is externally rotated and is shorter than her left. She has significant pain to palpation in that right hip. She exhibits facial grimaces with passive range of motion to both lower extremities; right greater than left.
Vital signs at the time of my visit: 96.7 - 79-22-183/79

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She was sent to the emergency room status post fall with the above -noted assessment reasons. Visit Diagnoses: fall, initial encounter."

A Fall Prevention and Management Policy:
Purpose- To promote safety by identifying residents at risk of falls by use of falls risk predictors, including resident history, diagnosis. ambulatory status. gait/balance, mental status, medication regimen, elimination status. vision status, and systolic B/P (blood pressure). Using an interdisciplinary approach to fall management and prevention.
Procedure: (C) The initial fall risk care plan is established at time of admission based on the resident's risk factors. A score of 10 or above on the Falls risk Assessment indicated "high risk for falls."
II. -B Care of Resident following a Fall
4. Do not move the patient until potential injures are identified and safety assured."

The facility staff failed to provide Resident #2 with a two person assist to prevent a fall with injury and assess resident prior to moving.

Complaint Deficiency