STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E185	A. BUILDING _____ B. WING _____	09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-SALUDA	PO BOX 303 US 17 SALUDA, VA 23149

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F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted on 9/5-9/7/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents 1-12) and 2 closed record reviews (Residents 13 and 14)	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		9/29/17

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

Electronically Signed | 09/22/2017

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 225	Continued From page 1 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 2 Based on staff interview and facility documentation review the facility staff failed to ensure Certified Nursing Assistant (CNA) certification was verified with the Department of Health Professions (DHP) for 1 (Employee 4) of 5 certified/ licensed staff. Employee #4's CNA certification expired on 8/31/17. The certification was not verified with DHP by the facility staff until 9/5/17. Employee #4 worked at the facility during this time period. The finding included: During a review of the employee records, it was identified that Employee #4's CNA certification expired on 8/31/17. The facility staff rechecked the certification with DHP on 9/5/17. A review of Employee #4's time card documented that Employee #4 worked at the facility on 9/1/17, 9/2/17, 9/3/17, and 9/4/17. The time card was reviewed with the Corporate Nurse on 9/7/17 at 11:30 a.m.. She stated that Employee #4 was sent home after approximately 3 hours of work on Friday, 9/1/17 because the facility had identified that the certification was expired. She stated that Employee #4 came back to work over the weekend (9/2/17-9/4/17). It was reviewed with the Corporate Nurse that Employee #4 worked at the facility without the facility staff knowing if Employee #4 had a valid certification status to work. The issue was also reviewed with the Corporate Nurse and Administrator at the end of day meeting on 9/7/17.	F 225	F-225 Investigate/Report Allegations/Individuals 1. Employee #4 license was verified on Sep. 5, 2017 with DHP to be active by Human Resources 2. Director of Nursing/designee will validate all certified nursing assistants' licenses for current status through the Virginia Department of Health Professions by September 20, 2017. 3. A new process for tracking expiration of applicant work status and date of licensure renewal will be initiated and tracked by the business office liaison (BOL) by Sep. 20, 2017. Final verification will be through the Virginia Department of Health Professions. Staff with expired certification/license will be removed from the schedule until verification of renewal is obtained by the facility. Education will be provided to Administrator, DON, Nurse Leadership and BOL for new process and the Board of Nursing Licensing regulations will be completed by the Director of Clinical Education by September 29, 2017. 4. Director of Nursing/designee will audit report for pending licensure expirations twice monthly. All audits for licensing requirements will be reported at the QA meeting by the Administrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. Corrective actions will be completed by September 29, 2017.	

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F 226	Continued From page 3	F 226		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to	F 226	F-226 Develop/Implement Abuse/Neglect Etc. Policies	9/29/17

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F 226	Continued From page 4 implement the abuse prohibition policy. The facility staff failed to ensure Certified Nursing Assistant (CNA) certification was verified with the Department of Health Professions (DHP). The findings included: During a review of the employee records, it was identified that Employee #4's CNA certification expired on 8/31/17. The facility staff rechecked the certification with DHP on 9/5/17. A review of Employee #4's time card documented that Employee #4 worked at the facility on 9/1/17, 9/2/17, 9/3/17, and 9/4/17. The time card was reviewed with the Corporate Nurse on 9/7/17 at 11:30 a.m.. She stated that Employee #4 was sent home after approximately 3 hours of work on Friday, 9/1/17 because the facility had identified that the certification was expired. She stated that Employee #4 came back to work over the weekend (9/2/17-9/4/17). It was reviewed with the Corporate Nurse that Employee #4 worked at the facility without the facility staff knowing if Employee #4 had a valid certification status to work. The facility policy titled "Abuse Prevention and Management" was reviewed. The section titled "Prevention" read "The facility will not employ or otherwise engage individuals who: i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment of individuals by a court of law; ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of	F 226	1. Employee #4 license was verified on 9/5/2017 with DHP to be active by Human Resources 2. Director of Nursing/designee will validate all certified nursing assistants' licenses for current status through the Virginia Department of Health Professions by September 20, 2017. 3. A new process for tracking expiration of applicant work status and date of licensure renewal will be initiated and tracked by the business office liaison by Sep. 20, 2017. Final verification will be through the Virginia Department of Health Professions. Staff with expired certification/license will be removed from the schedule until verification of renewal is obtained by the facility. Education will be provided to Administrator, DON, Nurse leadership and BOL for new process, Abuse Policy and the Board of Nursing Licensing regulations will be completed by the Director of Clinical Education by September 29, 2017. 4. Director of Nursing/designee will audit report for pending licensure expirations twice monthly. All audits for licensing requirements will be reported at the QA meeting by the Administrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. Corrective actions will be completed by September 29, 2017.	

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F 226	Continued From page 5 their property; or iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property." The issue was reviewed with the Corporate Nurse and Administrator at the end of day meeting on 9/7/17.	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		9/29/17

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F 309	Continued From page 6 the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for 1 resident (Resident #8) of 14 residents to ensure the bowel management protocol was initiated. According to the February 2017 bowel elimination record, Resident #8 had five bowel movements. Facility staff did not intervene to implement the bowel management protocol. The findings included: Resident #8, an 86 year old, was admitted to the facility on 12/26/14. Diagnoses included hypertension, diabetes, Alzheimer's disease, dementia, depression, and irritable bowel syndrome. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 8/22/17. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with her activities of daily living. Resident #8 was observed in the dining room eating breakfast on 9/7/17 at 8:25 a.m.	F 309	F-309 Provide Care/Services for Highest Well Being 1. The Provider and Resident Representative were informed on Sep. 7, 2017 by nursing supervisor that the bowel management protocol for Resident #8 was not initiated according to the February 2017 medication administration record (MAR) by Sep. 7, 2017. The resident has been monitored and has had bowel movements with no intervention necessary. 2. All residents have been audited using the 72 hour Bowel Movement (BM) report for need to initiate bowel protocol on Sep. 12, 2017 by Director of Nursing. No residents needed the bowel protocol initiated. 3. The licensed nurses and certified nursing assistants will receive re-education regarding the necessity to adhere to the facility protocol regarding bowel management, with focus on documentation of bowel movement and implementation of bowel protocol by Director of Nursing/designee. Starting Sep. 12, 2017 daily checks of 72-hr BM	

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F 309	Continued From page 7 A significant change MDS with an ARD of 2/21/17 was reviewed. Section "H0400: Bowel Continence" was coded with a 9 indicating "not rated" as explained by the instructions "if during the 7 day look back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation)." Resident #8 did not have an ostomy. Resident #8's February 2017 bowel elimination record was provided by facility staff. For the month of February 2017, it was documented that Resident #8 had a bowel movement on the following dates: 2/1/17 2/7/17 2/8/17 2/12/17 2/13/17 On 7/6/17 at 4:00 p.m., the Corporate Nurse was notified that Resident #8's MDS had coded her as not having a bowel movement for 7 days. Resident #8's bowel elimination record was also reviewed. The Corporate Nurse was asked if the facility had a bowel protocol. She stated yes, but it was not a written document. She stated that the staff were to call the physician and start the oral bowel protocol. It was reviewed with the Corporate Nurse that no medications for the treatment of constipation were administered for Resident #8. It was reviewed that there were no nursing notes regarding constipation or the monitoring of the issue and that the physician had not been contacted. The Corporate Nurse agreed that no	F 309	report will be completed by nursing staff with appropriate treatment initiated. 4. The DON/designee will complete weekly audits to ensure that residents identified on the 72-hour BM report have had the bowel protocol implemented. Audit results will be monitored for trends and patterns by the DON/designee and reported to the QA committee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. Corrective actions will be completed by September 29, 2017.	

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interventions were initiated. She stated that the resident had not complained.

On 9/7/17 at 10:30 a.m., Licensed Practical Nurse A (LPN A), a floor nurse, was asked if the facility had a bowel management protocol. LPN A stated yes. LPN A explained that a bowel movement report was generated on a daily basis. The report was supposed to be reviewed daily by the nursing supervisor or the floor nurse. The report flagged residents who were on their third day of not having a bowel movement. LPN A stated that the protocol included:
7-3 shift: give prune juice
3-11 shift: give milk of magnesia
11-7 shift: give suppository

When asked if the nurses were to notify the doctor, LPN A stated that the doctor would not automatically be notified. She stated that it depended on the effectiveness of the interventions.

Resident #8 had the following medications for the management of constipation:
1. Polyethylene glycol 17 grams every two days (Administered as ordered according to the February 2017 Medication Administration Record)
2. Polyethylene glycol 17 grams as needed every 24 hours (Never administered according to the February 2017 Medication Administration Record)
3. Bisacodyl 10 milligram rectal suppository (Never administered according to the February 2017 Medication Administration Record)
4. Milk of Magnesia 30 milliliter as needed every 24 hours (Never administered according to the February 2017 Medication Administration Record)
5. Senna 8.6 milligram as needed two times per day (Never administered according to the

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F 309	Continued From page 9 February 2017 Medication Administration Record) According to the February 2017 Medication Administration Record, the bowel management protocol was not initiated for Resident #8. Constipation was included on Resident #8's care plan. The care plan indicated that Resident #8 was at risk for constipation due to orders for medications known to contribute to constipation, reduced physical mobility, history of constipation, and history of irritable bowel syndrome, loose stools and hemorrhoids. The goal read "Resident will maintain a pattern of bowel elimination of no less than every 3-4 days." Interventions included monitor and document bowel elimination pattern, administer medications per bowel protocol. The issue was reviewed with the Administrator and Corporate Nurse at the end of day meeting on 9/7/17. No adverse outcome was identified in the clinical record as a result of the bowel management protocol not being implemented.	F 309		