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 _____	09/01/2016

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 8-30-16 through 9-1-16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey will follow. There were no complaints investigated during the survey. 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 through #8, and #10 through #13). Also included were 2 closed record reviews (Residents #9 and #14).	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to complete a SCSA (significant change in	F 274	F- 274 Comprehensive Assess After Significant Change	10/7/16

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

Electronically Signed | 09/16/2016

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F 274	Continued From page 1 status assessment) within 14 days after determination of a change in status for 1 Residents (Residents #8) of 14 residents in the survey sample. For Resident #8, the facility staff failed to assess the Resident for a significant change in condition after the Resident had significant weight loss, and became extensively dependent in the ambulation, eating, behaviors, and bladder incontinence areas of their Activities of Daily Living (ADL's). The findings included: Resident #8, was admitted to the facility on 3-18-16. Diagnoses included; Blindness, congestive heart failure, hematuria, macular degeneration, cardiac artery disease, high cholesterol, diabetes, dementia, anxiety, depression, and psychotic disorder. The current MDS (Minimum Data Set) was a quarterly assessment with an ARD (assessment reference date) of 6-21-16. Staff assessment of mental status coded Resident #8 with moderately impaired cognition, scoring 9 of a possible 15 points on a brief interview for mental status (BIMS) assessment. The Resident was coded as behaviors directed at others for 1-3 days, and needing extensive assistance of one staff member for ambulation, eating, and frequently incontinent of bladder activities of daily living. The Resident was coded as having no significant weight loss of 5% or more during the "last month", which was May 2016, or 10% or more in the "last 6 months". The Resident had not resided in the facility for 6 months. The Most recent Full MDS assessment was used for comparison. This assessment was an Admission Assessment with an Assessment	F 274	1. A significant change and status assessment with ARD of August 31, 2016 was completed and submitted on resident # 8 on September 13, 2016. The care plan has been revised by the Interdisciplinary Team with RP involvement. 2. All residents within the facility are at risk for not having a significant change and status assessment completed. A review of all residents will be completed September 28, 2016 and any resident identified meeting the criteria will have a significant change MDS completed within 14 days. 3. The DON/designee will re-educate the MDS Coordinator by September 21, 2016 on the criteria needed to schedule a significant change to ensure that the MDS□s are completed within 14 days of identification. Residents will be evaluated at the weekly At Risk meeting by the IDT for significant change with ARD□s set as needed. 4. The DON/designee will review 2 residents MDS□s weekly for one month; 3 monthly for 3 months. The results of the review will be reported at the QA meeting by DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed by October 7, 2016.	

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Reference Date (ARD) of 3-25-16, and was completed immediately before the most recent assessment, as the Resident had only been in the facility for 3 months prior to the most recent quarterly assessment. The changes experienced by Resident #8 between these two assessments follow below:

The Admit Assessment dated 3-25-16 coded Resident #8 with a BIMS score of 11 of 15 points (mild cognitive impairment), no behaviors, and as requiring only supervision in walking in his room, and limited assistance off of the nursing unit for ambulation, with supervision for eating, and occasionally incontinent of bladder.

The quarterly assessment dated 6-21-16 coded Resident #8 with a BIMS score of 9 of 15 points (moderate cognitive impairment), behaviors directed at others 1-3 of the seven day look back, and as requiring extensive assistance of one staff member for walking in his room, and for off of the nursing unit, extensive assistance of one staff member for eating, and frequently incontinent of bladder. The Resident was also coded with no weight loss of 5%, from the last month, which did occur from May 2016 to June 2016.

Review of the 2 MDS assessments completed and compared above, reveals that the decline in ADL's, cognition, and weight loss, continued through the 6-21-16 assessment. A Significant Change assessment is required within 14 days of recognition of the change and when the change does not improve, or is self limiting. Staff had the opportunity for a significant change assessment to be completed in July 2016, and did not complete one.

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F 274	Continued From page 3 On 8-31-16 the RN MDS coordinator was interviewed, and stated that a significant change assessment should have been completed, and that a correction would be made. On 8-31-16 at 5:00 p.m., at the end of the day debrief, the Administrator and DON (director of nursing) were notified of the findings. No further documentation was available to be presented.	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 2 residents (Residents #3 and # 12) in the survey sample of 14 residents, to follow the professional standards of nursing for documentation of medication administration. 1. The facility staff failed to document the administration of medications on the Medication Administration Record on four dates in August 2016 and also on 7/14/2016 for Resident #3. 2. For Resident #12, the facility staff failed to document that a diabetes medication was held due to blood sugar parameters. The Findings included: 1. The facility staff failed to document the administration of medications on the Medication	F 281	F- 281 Services Provided Meet Professional Standards 1. Licensed nurses who did not follow the professional standards of nursing for documentation of medication administration. On residents #3 and #12 have been re-educated on the importance of appropriate documentation of medications per provider order, by the DON or designee on August 31, 2016. The Provider was notified of missing documentation on August 31, 2016 by administrator. No adverse effect has been identified for the residents. 2. All residents within the facility are at risk for omission of proper documentation of medication administration and adherence to the facility policy and procedure. 3. The licensed nurses received	10/7/16

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F 281	Continued From page 4 Administration Record on four dates in August 2016 and also on 7/14/2016 for Resident #3. Resident #3 was an 86 year old who was admitted to the facility on 2/5/14. Resident #3's diagnoses included but were not limited to Pressure Ulcer of Left Buttock, Stage 4, Dysphagia, Seizure Disorder, Polyneuropathy, Depression, Stroke, Hypertension and Chronic Pain Syndrome. The most recent MDS (Minimum Data Set) was a Significant Change Assessment with an Assessment Reference Date of 8/2/16. The MDS coded Resident #3 as requiring total assistance of one staff person for Activities of Daily Living except requiring total assistance of two staff persons for transfers. On 8/31/2016 at 11 AM, a review of the clinical record was conducted. Review of the August 2016 MAR (Medical Administration Record) revealed missing documentation of medication administration on four dates: 8/9/16, 8/10/16, 8/23/16 and 8/25/16. Divalproex Sprinkle 125 MG (milligrams) 2 capsules by mouth three times a day. 8/9/16 at 9 PM, 8/10/16 at 9 PM, 8/23/16 at 3 PM, 8/23/16 at 9 PM, 8/25/16 at 9 PM, 8/27/16 at 3 PM Artificial Tears Ophthalmic Solution administer 2 drops in each eye three times a day on 8/9/16 at 9 PM, 8/10/16 at 9 PM, 8/23/16 at 3 PM, 8/23/16 at 9 PM, 8/25/16 at 9 PM, 8/27/16 at 3 PM. Review of the July 2016 MAR revealed missing	F 281	re-education relating to facility policy and procedure regarding appropriate documentation of medication administration on August 31, 2016 and the 6 rights of medication administration by DON/designee. The licensed nurses will be re-educated starting on September 13, 2016. The nurses were reeducated September 13, 2016 to complete MAR to MAR check with oncoming and off going nurses for compliance in documentation. 4. DON/designee will complete 5 MAR Audits to assure complete documentation weekly for one month; 4 monthly for 3 months. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed by October 7, 2016.	

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documentation of administration of the same two medications on 7/14/2016 at 3 PM. The medications not administered were:
Divalproex Sprinkle 125 MG (milligrams) 2 capsules by mouth.
Artificial Tears Ophthalmic Solution administer 2 drops in each eye.

No nurse's initials were evident in the spaces on the days listed above. There was no documentation on the back of the MARs or in the nurses notes explaining a reason for omission of the medications on those dates.

Valid Physicians Orders were evident for the medications not documented as having been administered on the above dates.

On 8/31/2016 at 5 P.M. an interview was conducted with the Director of Nursing (Employee B). When asked why the medication had not been administered, the DON stated, "I cannot be 100% sure the medications were given. Nurses are expected to administer all medications as ordered by the physicians and document at the time of administration."

On 8/31/2016, during the end of day debriefing, the Administrator, Director of Nursing and Corporate Consultants were informed of the missing documentation of administration of medications as ordered by the physician.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, page : Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing

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Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

On 9/1/2016 at 10 AM, the Director of Nursing asked to talk with the surveyor about the missing documentation of medications for Resident # 3. The Director of Nursing stated she believed the medications were administered by the nurses but thought there was a problem with the documentation. She stated "the Pharmacy delivers medications in plastic bags and those bags would have been left in the medication cart if they had not been administered and the next shift would have seen the medications." The Director of Nursing stated there had been no reports of medications being left in the medication carts. She also stated the nurses were expected to document at the time of the administration.

On 9/1/16 at 11 AM, a review was conducted of facility documentation, revealing a Medication Administration Policy. It read, "2/2010. Medication Error Reporting and Monitoring - Medication must be given accurately and appropriately for the resident to receive the intended therapeutic effect. Incorrect administration of certain drugs can result in harmful side effects. This may be due to the preparation or administration of drugs

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F 281	Continued From page 7 that are not in accordance with physician orders, manufacturers specifications or accepted professional standards of practice." The facility cited " Mosby ' s " as their guidance for nursing professional standards. Potter and Perry are the authors and Mosby ' s is the publisher. During the end of day debriefing on 9/1/2016 at 1 PM, the Administrator, Director of Nursing and Corporate Consultants again were informed of the failure of the staff to ensure medications were administered as ordered for Resident # 3 in July 2016 and August 2016. No further information was provided. 2. Resident #12 was a 76 year old who was admitted to the facility on 4/2/16. Resident #12's diagnoses included Diabetes, Dementia, and Anxiety Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/19/16, coded Resident #12 as being able to	F 281		

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understand and be understood by others. In addition, he was coded as having received insulin injections.

On 9/1/16, a review was conducted of Resident #12's clinical record, revealing the following signed physician's order dated 8/1/16, "Humalog 100 u/ml (units/milliter) before meals and HS (Hour of Sleep) for coverage:

70-250	0 units
251-350	2 units
351-400	4 units
401-450	5 units
451-500	6 units
greater than 500	call MD
less than 60	call MD"

Resident #12's Care Plan dated 4/21/16 read, "Resident has diabetes. Requires insulin coverage. Obtain blood sugars as ordered; administer sliding scale insulin coverage as ordered by MD (Medical Doctor). Report findings outside of sliding scale coverage to MD. See Medication Administration Record. Administer insulin and/or oral agent as ordered."

Resident #12's Medication Administration Record (MAR) for August, 2016 was reviewed. On 8/31/16 at 6:00 A.M. his blood sugar was documented as being 145 milligrams/deciliter. The medication was not documented as having been held, either on the front or the back of the MAR.

In addition, the Nurse's Notes were reviewed. There was no documentation regarding the medication being held.

On 9/1/16, at 1:00 P.M. an interview was

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F 281	Continued From page 9 conducted with the Director of Nursing (Administration B-DON) in the conference room. She stated that the medication was not given, because of the blood sugar reading of 145. She said that the nurse forgot to document the MAR correctly. The DON further stated, "They need to document on the MAR or in the Nurse's Note why it wasn't given. It's important for continuity of care." On 9/1/16 at 4:00 P.M. the facility Administrator was informed of the findings. No further information was received.	F 281		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to meet the nutritional needs of one resident (Resident #8) of 14 residents in the survey sample. For Resident #8, the facility staff failed to provide physician ordered nutritional supplements, for a	F 325	F- 325 Maintain Nutrition Status Unless Unavoidable 1. Licensed nurses responsible for missing documentation of nutritional supplement on resident #8 have been re-educated on the importance of	10/7/16

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F 325	Continued From page 10 Resident who had experienced a significant weight loss. Findings included: Resident #8 was admitted to the facility on 3-18-16. Diagnoses included; Blindness, congestive heart failure, hematuria, macular degeneration, cardiac artery disease, high cholesterol, diabetes, dementia, anxiety, depression, and psychotic disorder. The current MDS (Minimum Data Set) was a quarterly assessment with an ARD (assessment reference date) of 6-21-16. Staff assessment of mental status coded Resident #8 with moderately impaired cognition. The Resident is coded as needing extensive to total assistance of one staff member for activities of daily living. Resident #8 was also coded as being frequently incontinent of bladder, and always incontinent of bowel. The Resident was coded as having no significant weight loss of 5% or more during the "last month", which was May 2016, or 10% or more in the "last 6 months". The Resident had not resided in the facility for 6 months. The MDS also coded the Resident as not on a physician prescribed weight loss program. On 8-31-16 a review of Resident #8's clinical record was conducted including " Monthly Weights and Vital Signs Record ", and "Nutrition Review" completed by the Registered Dietician (RD). These documents showed an admission weight on 3-21-16 of 133 lbs (pounds). The document denoted that from 5-4-16 a weight was obtained that was 139 lbs, and on 6-14-16 a weight of 127 lbs, which indicated a 12 lb weight loss in the month preceding the MDS assessment, which was not coded. A 5% weight loss would equal 6.5 lb, and the Resident lost almost twice that. At the time of the RD assessment a recommendation was made for	F 325	documenting the administration of the nutritional supplements per provider order, by DON or designee on August 31, 2016. The Provider has been notified of all missing documentation. The resident□s weight has stabilized since with no further weight loss since September 1, 2016. 2. All residents within the facility are at risk for omission of proper documentation of nutritional supplements and adherence to the facility policy and procedure. 100 % chart audit of supplements has been completed as of September 30, 2016. All residents with missing documentation of nutritional supplements will be evaluated for weight loss by the IDT by October 7, 2016. 3. The licensed nurses received re-education relating to the facility policy and procedure regarding appropriate administration and documentation of nutritional supplements on August 31, 2016. The nurses were reeducated on September 13, 2016 to complete MAR to MAR check with ongoing and off going nurses in compliance of documentation. 4. Audits will be performed by the DON/designee for 5 of the provider ordered nutritional supplements of the MAR□s for accurate documentation weekly for 1 month; 4 monthly for 3 months. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective action will be completed	

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nutritional supplements.
Weight gains were experienced by the Resident, as a physician's order was present dated 6-7-16 for "Glucerna 120 ml (milliliters) four times per day, for weight maintenance." The gains were documented on the weight and RD records, and are as follows;
7-2-16 - (128) lbs
8-2-16 - (130) lbs
The Resident gains had not returned him to the admission weight.
On 8-31-16 at 9:00 AM, an observation of Resident #8's breakfast meal consumption was observed. Resident #8 was in his room, sitting in bed at a bedside table. Breakfast was completed. Resident #8 was not eating, and staring straight ahead. The tray was observed, and no staff was observed trying to cue or assist the Resident in eating. The tray was 25% consumed.
Review of the "Tray card" which denoted to the kitchen staff what diet to prepare for the Resident revealed, "Regular" diet, even though the Resident had no teeth.
On 8-31-16 the Medication and Treatment Administration Records (MAR/TAR) for August 2016 were reviewed. The MAR documentation revealed that Resident #8 had not been documented as receiving the Glucerna Supplement 13 times during August. Those dates and times were as follows:
8-1-16 at 9:00 p.m., 8-8-16 at 9:00 p.m., 8-16-16 at 2:00 p.m., 8-18-16 at 9:00 p.m., 8-19-16 at 10:00 a.m., 8-19-16 at 2:00 p.m., 8-19-16 at 9:00 p.m., 8-26-16 at 6:00 a.m., 8-27-16 at 6:00 a.m., 8-27-16 at 10:00 a.m., 8-27-16 at 2:00 p.m., 8-29-16 at 9:00 p.m., and on 8-30-16 at 10:00 a.m.
On 8-31-16 at 11:00 a.m. the Director of Nursing

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(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 325	Continued From page 12 (DON) was interviewed and asked why the supplement was not documented as administered. The DON admitted that there was no documentation by staff in the nursing notes, or on the MAR to disclose why the staff had not administered the supplement for a Resident who had a history of weight loss. She went on to say that the Resident was combative and would refuse things at times, however, that had not been documented as the reason why the Resident did not receive the supplement on these occasions. It is notable to mention that nurses had documented medications as being administered at the same times that the supplement would have been administered. The Administrator and Director of Nursing were made aware of the staff failure to institute available interventions to arrest or reverse the avoidable weight loss for Resident #8, on 8-31-16, and 9-1-16 at the end of day debriefs. No further information was available to be provided.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		10/7/16

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 _____	09/01/2016

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F 371	Continued From page 13 Based on observation, staff interview, and facility documentation review, the facility staff failed to prepare, store and serve food in a sanitary manner. On 8/30/16 at 6:30 P.M., an observation was conducted of the kitchen. A Dietary Aide (Employee A) was not wearing a beard restraint. His beard was approximately 1 inch long. He was storing clean dishes after they were washed. In addition, he prepared a large tray of approximately 20 glasses of water. After filling the glasses with water, he placed the tray in the refrigerator. When asked who the water was for, Employee A said that the water would be served to residents. When asked about the importance of wearing hair restraints, he stated, "You don't want the resident to choke on hair. It could also cause an allergic reaction. I forgot to put a beard restraint on. I was informed that there is a policy that we wear hair restraints. I'm not the only one. If you come in here tomorrow, there's another guy who never wears one." On 8/31/16 at 12 Noon, another observation was made of the kitchen during lunch tray preparation. There was one male Dietary Aide preparing food for residents. He was bald, in addition he did not have any facial hair. All of the other Dietary Aides were wearing hair restraints. On 9/1/16 a review was conducted of facility documentation, revealing the Employee Personal Hygiene Policy dated 3/21/16. It read, "Along with the policy on gloves and handwashing, the purpose of this policy is to protect the food supply from sources of infection that could be introduced	F 371	F- 371 Food Procure, Store/Prepare/Serve - Sanitary 1. The Dietary Aide responsible for not wearing a beard restraint was re-educated on the proper donning of beard restraint protocol use by the Dietary Director on September 1, 2016. 2. All residents are at risk for the dietary staff not wearing beard restraints in the kitchen and adherence to the facility policy and procedure. 3. The Dietary staff received re-education relating to the facility policy and procedure regarding hair and beard restraints on September 1, 2016 by the Dietary Director and Dietician. 4. Audits will be performed by the Dietary Director/designee of 3 dietary staff members at random times of the day 3x□s/week for one month; 4x□s/ month for 3 months. The results of the audits will be reported at the QA meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective actions will be completed by October 7, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 14 by an employee. Hair restraints are to be worn in the kitchen and other food preparation areas at all times, by all employees who enter the area." On 9/1/16 at 4:00 P.M. the facility Administrator (Administration A) was informed of the findings. No further information was received.	F 371		