STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING _____ B. WING _____	C 11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVALESCENT CNTR WE	2960 CHELSEA ROAD WEST POINT, VA 23181

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/30/2018 through 11/1/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/30/2018 through 11/1/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this Medicare/Medicaid certified bed facility was 53 at the time of the survey. The survey sample consisted of 27 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		12/7/18

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

Electronically Signed | 11/24/2018

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview and staff interview and clinical record review, the facility staff failed to maintain a dignified existence for one resident (Resident # 33) in a survey sample of 27 residents. For Resident # 33, the facility staff failed to toilet her timely resulting in an incontinent episode. Findings included: Resident # 33 was a 77 year old female, was	F 550	1. Resident #33 was toileted on 10/31/18. Staff # A & B were provided education by the DON on 11/1/2018 regarding the importance of responding timely to resident needs and to offer the residents a choice on available and appropriate lifts for transfers to maintain dignity for the resident. 2. On 10/31/18 the Director of Nursing interviewed all residents requiring assistance for toileting to ensure their toileting needs are being met to avoid an	

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F 550	Continued From page 2 admitted to the facility on 1/29/2016. Her diagnoses included but were not limited to: Pneumonia, Diabetes Mellitus, Edema, Hypertension, Rheumatoid Arthritis, Arnold -Chiari Syndrome without Spina Bifida, Spondylosis with Myelopathy, Cervical Region, Difficulty Walking, Spinal Stenosis, Abnormality of Gait, Degenerative Joint Disease and Unspecified Ptosis of Bilateral Eyelids. Resident 33's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/19/2018 was coded as a Quarterly assessment. She was coded as having a BIMS (Brief Interview for Memory Status) code of 15 indicating no cognitive impairment. She was also coded as needing extensive to total assistance of one to two staff persons to perform all of her activities of daily living except for eating. For eating, she was coded as needing supervision. She was coded as occasionally incontinent of bowel and always continent of bladder. On 10/30/2018 at 3:30 PM, a Group interview was conducted with 14 cognitively intact residents. One of the concerns expressed by the group was that they often had to wait to be toileted by the staff because of no access to the particular Hoyer lift they preferred to use. The consensus of the group was that they felt safer using a particular hoyer lift. They stated they sometimes were incontinent as a result of waiting to use a particular lift. On 10/31/2018 at 1:30 PM, Surveyor A and Surveyor B were standing in the hallway on the Mattaponi Hall where Resident # 33 resided. Both surveyors observed the call light on for 18 minutes in Resident # 33's room. Surveyor A	F 550	incontinent episode. There were no concerns noted. 3. The Clinical Educator/designee will provide education to the nursing staff on offering use of alternate lifts to avoid delays in toileting and ensure the dignity for the residents are maintained by 12/7/18. 4. The Director of Nursing or designee will interview 2 residents per week for 4 weeks and then 1 resident per week for 8 weeks to ensure their needs for assistance with toileting are being met timely and their dignity is maintained. The results of the interviews will be reported at the QA Committee by the Director of Nursing or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 550	Continued From page 3	F 550		

observed Resident # 33 sitting in her wheelchair not in her room. At 1:31 PM, both surveyors heard Resident # 33 yell "Somebody please help me. I have to go to the bathroom." There were staff members observed in the hallway.

At 1:48 PM, Surveyor A observed Certified Nursing Assistant (CNA) A and Certified Nursing Assistant B going into Resident # 33's room and asking if Resident # 33 needed help. Resident # 33 replied, "Yes, I need to go to the bathroom." CNA A stated "Oh, I thought that was what you needed. The lift you like to use is already being used on someone else." Resident # 33 replied that she really needed to go to the bathroom.

Surveyor A was standing in the hallway next to Resident # 33's room. Surveyor A asked what was going on. CNA A stated Resident # 33 needed to use the bathroom but only liked a certain Hoyer lift that was already in use. Surveyor A asked CNA A what else she could do for Resident # 33. CNA A stated Resident # 33 had to wait because the Hoyer lift she preferred was in use. Resident # 33 stated she could not wait because she had to go to the bathroom "really bad" and that she was going to go in her clothes if she didn't get to the bathroom. Resident # 33 was shifting side to side in her wheelchair and looking up at the staff stating she really had to go to the bathroom. CNA A again stated that Resident # 33 had to wait.

CNA B stated he came to the room to help CNA A get Resident # 33 on the Hoyer lift per CNA A's request. Surveyor A left the room, went to the Director of Nursing's office and asked the Director of Nursing to come to Resident # 33's room. Another CNA (CNA C) was in the Director

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F 550	Continued From page 4	F 550		

of Nursing's office when the surveyor entered. CNA C stated she often worked with Resident # 33. CNA C stated Resident # 33 really did like to use only one particular Hoyer Lift but that the residents should be toileted as needed with whatever lifts were available. The Director of Nursing went with the surveyor to Resident # 33's room. The Director of Nursing asked Resident # 33 if she would use another Hoyer Lift to which she replied "yes", then she stated "I think it is too late. I am already going."

CNA A explained to the Director of Nursing that she thought the Hoyer lift Resident # 33 liked to use was already in use but it was not. The Director of Nursing asked the nursing staff to help Resident # 33 into to the shower room to get her cleaned up immediately due to the incontinent episode. CNA C stated she showed CNA A that two of the Hoyer lifts look similar but one was actually taller. CNA C stated the taller one was the one Resident # 33 preferred to use.

On 10/31/2018 at 2:50 PM, an interview was conducted with Resident # 33 stated she preferred the taller lift because she felt safer on that one. Resident # 33 stated she was embarrassed because of being incontinent and stated she held it as long as she could.

On 10/31/2018 at 2:58 PM, an interview was conducted with CNA A with the DON present. CNA A stated she was sorry but thought the Hoyer Lift that Resident # 33 preferred was already in use. CNA A stated she could have toileted Resident # 33 sooner but made a mistake. CNA A stated that she tried to use the type of lifts the residents preferred because she was afraid the resident could fall if a Hoyer Lift

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F 550	Continued From page 5 was used that was not preferred by the resident. CNA A was apologetic and stated that in the future she would offer another lift for toileting and notify her charge nurse of any problems. During the end of day debriefing on 10/31/2018 at approximately 4:50 PM, the DON, Assistant Director of Nursing and Corporate Consultants were informed of the findings. The Director of Nursing and Consultants stated residents should be toileted as soon as possible with any available lift to avoid increase in incontinent episodes. No further information was provided.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		12/7/18

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F 582	Continued From page 6 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to provide notice to Resident #38's responsible party of a change in Medicare or Medicaid coverage in a survey sample of 27 residents. Findings:	F 582	1. The Director of Clinical Reimbursement provided 1:1 education on proper process for issuing the NOMNC to Resident #38 to the Director of Therapy on 10/31/18. 2. On 11/9/18 the Administrator audited all skilled discharges since 11/1/18 to ensure that the NOMNC was issued	

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F 582	Continued From page 7 Resident #38 was admitted on 6/26/2018. A partial list of her diagnoses included: difficulty walking and Alzheimer's disease. Resident #38 received Medicare Part A skilled services to include physical and occupational therapy. She was discharged on 7/21/208, and readmitted on 7/31/2018. Her most recent comprehensive assessment was dated 8/7/2018, and showed that Resident #38 needed extensive staff assist with all self-care. The resident was listed as having significant cognitive impairment in the Brief Interview for Mental Status (BIMS) portion of the assessment. Due to the resident's cognitive impairment, her daughter executed a healthcare Power of Attorney, and was listed as the responsible party. The facility determined that Resident #38's Medicare Part A coverage would end on 8/9/2018. The facility completed a Notice of Medicare Non-Coverage (NOMNC), but did not provide this document in writing to the resident's responsible party. Facility staff reviewed the form by phone. The responsible party did not sign the form to show that she received this notice and understood the rights of the resident to appeal the determination. On 10/31/2018, an interview was conducted with Employee F, the corporate Quality Assurance nurse. When shown the NOMNC and asked if she saw any problems with the form, she replied "Yes, the resident or responsible party need to sign this. We should have mailed a copy for them to sign." No other information was provided prior to exit.	F 582	appropriately. No other concerns were identified. 3. The Administrator or designee will review all upcoming level of care changes at the weekday morning meeting and verify that the NOMNC is being appropriately provided. Beneficiary Notice Education was provided to Social Worker, Administrator, DON, ADON and Director of Rehab by the Director of Clinical Reimbursement on 11/8/18 and 11/13/18. 4. The Administrator or designee will audit 2 residents per week for 4 weeks and then 1 resident per week for 8 weeks who have discharged from skilled service with Medicare skilled days remaining, to ensure the NOMNC was issued properly. The results of the audits will be reported at the QA Committee by the Administrator or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		12/7/18

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F 622	Continued From page 9	F 622		

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 10 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review the facility failed to notify a receiving provider of the resident's comprehensive care plan goals for one of 27 sampled residents (Resident #20). Findings: Resident #20 was admitted to the facility on 6/14/2018. Partial listing of her diagnoses include: impaired gait, stroke, psychotic disorder with delusions, and dementia. On 10/7/2018 at 4:25 AM, Resident #20 was sent emergently to the hospital after a fall resulting in hip pain. The provider sent transfer paperwork with the resident which included an INTERACT (Interventions to reduce acute care transfers) tool. While this tool has a space to record care plan goals, none was listed. On 11/1/2018, at 10:10 AM, an interview was held with Employee F, the corporate Quality Control nurse. When asked if the resident's care plan goals were sent to the hospital, she replied "No." No other information was provided prior to exit.	F 622	1. Resident #20 was readmitted to the facility on 10/13/18. 2. On 11/1/18, the Director of Nursing audited all discharges since 10/1/18 to ensure that the care plan goals were included on the Interact form for discharges as appropriate. All findings will be reported to the QA Committee. 3. The Director of Nursing or designee will review discharges at the weekday morning meeting to ensure completion of the Interact form to include comprehensive care plan goals and communication to the receiving provider. DON/Designee will provide immediate education for all discrepancies found. Education on Communicating Comprehensive Care Plan goals to receiving provider will be completed by the clinical educator to the nursing staff by 12/7/18. 4. The Director of Nursing or designee will audit 2 residents per week for 4 weeks and then 1 resident per week for 8 weeks who have discharged from facility to the ED to ensure the Interact form including CP goals have been completed and communicated to the receiving provider. The results of the audits will be reported at the QA Committee by the Director of	

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F 622	Continued From page 11	F 622	Nursing or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review the facility staff failed to provide an environment free from accident hazards for 2 residents (Resident #49 and #55) of 27 residents in the survey sample. 1. Resident #49 was not observed wearing a wander guard or gripper socks per physician order. 2. Resident #55's wheel chair breaks were not applied when transferred by the Certified Nursing Assistant (CNA) resulting in a fall. The findings included: 1. Resident #49 was not observed wearing a wander guard per physician order or gripper socks per the comprehensive care plan. Resident #49, an 82 year old, was admitted to the	F 689	1. Resident #49 was reassessed by the ADON 10/31/18 and the wander guard was discontinued per physician order. Resident #49□s gripper socks were reapplied by her CNA on 10/31/18. Clinical staff were educated on 11/1/2018 by DON regarding need to secure brakes in locked position prior to transferring all residents, including resident #55. 2. All residents are at risk of staff failing to provide an environment that is free of accident hazards. On 10-31-18 the Director of Nursing audited that all residents fall prevention interventions and wanderguards were appropriately ordered/care planned and in place. All identified concerns were immediately corrected. 3. The Director of Nursing or designee will review new orders for fall and elopement interventions at the morning meeting and verify implementation. Care	12/7/18

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	495303	A. BUILDING _____ B. WING _____	C 11/01/2018

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F 689	Continued From page 12 facility on 5/25/18. Diagnoses included hypertension, chronic obstructive pulmonary disease, depression, anxiety, and vascular dementia. The most recent Minimum Data Set assessment was a 14 day assessment with an assessment reference date of 9/20/18. Resident #49 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #49 had a physician order dated 9/10/18 for a wander guard to be worn continuously. The resident had a history of exit seeking behaviors. The wander guard was also included on the comprehensive care plan as an intervention to address wandering. The intervention dated 9/10/18 read, "Wander guard placed for elopement prevention." Resident #49 had a history of falls. She had a comprehensive care plan that included fall interventions. Include was the intervention dated 6/7/18, "Footwear will fit properly and have non-skid soles." On 10/31/18 at 1:25 p.m., Resident #49 was observed sitting on her bed. She was wearing one white sock and one yellow gripper sock. CNA C was in the room with this surveyor. CNA C was asked to observe Resident #49's and locate the wander guard. CNA C checked the resident's arms, legs and wheel chair. She did not locate a wander guard. CNA C was not sure if Resident #49 was supposed to have a wander guard.	F 689	plans will be monitored at At Risk Meeting by DON/designee for appropriate fall and elopement interventions. Education will be provided to nursing staff by Clinical Educator or designee on ensuring that preventative interventions for safety and safe transfer techniques are in place by 12/7/18. 4. The Director of Nursing or designee will audit 2 residents per week x 4 weeks and then 1 resident per week for 8 weeks to ensure that all fall preventative orders/interventions and wanderguards are current and in place. The Director of Nursing or designee will observe 2 transfers per week for 4 weeks and then 1 transfer per week x 8 weeks to ensure safe transfer techniques are utilized. The results of the audits will be reported at the QA Committee by the Director of Nursing or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 689	Continued From page 13	F 689		

On 10/31/18 at 1:55 p.m., the corporate nurse (Admin C) observed Resident #49 in the presence of this surveyor to identify whether the resident was wearing Ted hose. During the observation, Resident #49 was standing at her closet. She was wearing one white sock and one yellow gripper sock.

On 11/1/18 at the end of day meeting, the Director of Nursing (DON) stated that Resident #49 was not wearing the wander guard because it had been discontinued. It was reviewed that the wander guard was an active physician order at the time the resident was observed without it applied. The facility obtained a physician order to discontinue the wander guard on 10/31/18, after the observation with CNA K. The facility also discontinued the "Wandering or Elopement" problem from the comprehensive care plan on 10/31/18 after the observation with CNA C. The DON was asked why the wander guard was discontinued. She stated the resident had an improved status change. Admin C was asked if she noticed that Resident #49 was wearing two different socks when she had observed the resident for Ted hose, one of which did not have a non-skid sole. Admin C stated that she did not notice.

2. Resident #55's wheel chair breaks were not applied when transferred by the Certified Nursing Assistant (CNA) resulting in a fall.

Resident #55, a 96 year old, was admitted to the facility on 2/17/10. Diagnoses included chronic obstructive pulmonary disease,emphysema, reflux, epilepsy, and osteoarthritis.

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F 689	Continued From page 14	F 689		

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/10/18. Resident #55 was coded with a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment and required extensive assistance with activities of daily living. Resident #55 was coded to need extensive assistance from one staff when transferring.

Resident #55's clinical record included the following nursing note dated 10/8/18, 6:47 a.m., "resident had a witnessed fall/ per aide's statement resident was transferring from wheelchair to bed and slid in floor upon aide's inspection resident did not lock wheels of chair and slid to floor/ resident was able to get up with minimal assistance on to bed/resident was assessed and no apparent injury was noticed/r care was done, vital signs and family notified/will pass on to next shift/will continue to monitor/resident tolerated night medication/resident slept quietly through the night".

The fall investigation was provided by the facility. The section titled "Initial Investigation Notes" read, "witness fall resident transferring from chair to bed did not properly lock wheelchair and slid in floor".

On 11/1/18 at 2:35 p.m., CNA D was asked if the nurse or CNA should check to see if wheel chair breaks are locked prior to transferring a resident. CNA D stated yes, staff should check to see if the breaks are locked before transferring.

At the end of day meeting on 11/1/18, it was reviewed with the DON, Administrator and

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F 689	Continued From page 15 corporate staff that Resident #55's fall was a result of staff not locking the resident's wheel chair prior to a transfer.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		12/7/18

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F 690	Continued From page 16 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, group interview and staff interview and clinical record review, the facility staff failed to provide continence services for one resident (Resident # 33) in a survey sample of 27 residents. For Resident # 33, the facility staff failed to toilet her timely resulting in an incontinent episode. Findings included: Resident # 33 was a 77 year old female, was admitted to the facility on 1/29/2016. Her diagnoses included but were not limited to: Pneumonia, Diabetes Mellitus, Edema, Hypertension, Rheumatoid Arthritis, Arnold -Chiari Syndrome without Spina Bifida, Spondylosis with Myelopathy, Cervical Region, Difficulty Walking, Spinal Stenosis, Abnormality of Gait, Degenerative Joint Disease and Unspecified Ptosis of Bilateral Eyelids. Resident 33's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/19/2018 was coded as a Quarterly assessment. She was coded as having a BIMS (Brief Interview for Memory Status) code of 15 indicating no cognitive impairment. She was also coded as needing extensive to total assistance of one to two staff persons to perform all of her activities of daily living except for eating. For eating, she was coded as needing supervision. She was coded as occasionally incontinent of bowel and always continent of bladder.	F 690	1. Resident #33 was toileted on 10/31/18. Staff # A & B were provided education by the DON on 11/1/2018 regarding the importance of responding timely to resident needs and to offer the residents a choice on available or appropriate lifts for transfers 2. On 10/31/18 the Director of Nursing interviewed all residents requiring assistance for toileting and ensure their toileting needs are being met to avoid an incontinent episode. There were no concerns noted. 3. Education will be provided to nursing staff on the importance of responding timely to resident needs and offering use of alternate lifts to avoid delays by the Clinical Educator by 12/7/18. 4. The Director of Nursing or designee will interview 2 residents per week for 4 weeks and then 1 resident per week for 8 weeks that need assistance with toileting to ensure their toileting needs are being met timely. The results of the interviews will be reported at the QA Committee by the Director of Nursing or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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On 10/30/2018 at 3:30 PM, a Group interview was conducted with 14 cognitively intact residents. One of the concerns expressed by the group was that they often had to wait to be toileted by the staff because of no access to the particular Hoyer lift they preferred to use. The consensus of the group was that they felt safer using a particular hoyer lift. They stated they sometimes were incontinent as a result of waiting to use a particular lift.

On 10/31/2018 at 1:30 PM, Surveyor A and Surveyor B were standing in the hallway on the Mattaponi Hall where Resident # 33 resided. Both surveyors observed the call light on for 18 minutes in Resident # 33's room. Surveyor A observed Resident # 33 sitting in her wheelchair not in her room. At 1:31 PM, both surveyors heard Resident # 33 yell "Somebody please help me. I have to go to the bathroom." There were staff members observed in the hallway. At 1:48 PM, Surveyor
A observed Certified Nursing Assistant (CNA) A and Certified Nursing Assistant B going into Resident # 33's room and asking if Resident # 33 needed help. Resident # 33 replied, "Yes, I need to go to the bathroom." CNA A stated "Oh, I thought that was what you needed. The lift you like to use is already being used on someone else." Resident # 33 replied that she really needed to go to the bathroom.
Surveyor A was standing in the hallway next to Resident # 33's room. Surveyor A asked what was going on. CNA A stated Resident # 33 needed to use the bathroom but only like a certain Hoyer lift that was already in use.
Surveyor A asked CNA A what else she could do for Resident # 33. CNA A stated Resident # 33 had to wait because the Hoyer lift she preferred

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F 690	Continued From page 18	F 690		

was in use. Resident # 33 stated she could not wait because she had to go to the bathroom "really bad" and that she was going to go in her clothes if she didn't get to the bathroom. Resident # 33 was shifting side to side in her wheelchair and looking up at the staff stating she really had to go to the bathroom. CNA A again stated that Resident # 33 had to wait. CNA B stated he came to the room to help CNA A get Resident # 33 on the Hoyer lift per CNA A's request. Surveyor A left the room, went to the Director of Nursing's office and asked the Director of Nursing to come to Resident # 33's room. Another CNA (CNA C) was in the Director of Nursing's office when the surveyor entered. CNA C stated she often worked with Resident # 33. CNA C stated Resident # 33 really did like to use only one particular Hoyer Lift but that the residents should be toileted as needed with whatever lifts were available. The Director of Nursing went with the surveyor to Resident # 33's room. The Director of Nursing asked Resident # 33 if she would use another Hoyer Lift to which she replied "yes", then she stated "I think it is too late. I am already going."

CNA A explained to the Director of Nursing that she thought the Hoyer lift Resident # 33 liked to use was already in use but it was not. The Director of Nursing asked the nursing staff to help Resident # 33 into to the shower room to get her cleaned up immediately since the incontinent episode. CNA C stated she showed CNA A that two of the Hoyer lifts look similar but one was actually taller. CNA C stated the taller one was the one Resident # 33 preferred to use.

On 10/31/2018 at 2:50 PM, an interview was conducted with Resident # 33 stated she

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F 690	Continued From page 19 preferred the taller lift because she felt safer on that one. Resident # 33 stated she was embarrassed because of being incontinent and stated she held it as long as she could. On 10/31/2018 at 2:58 PM, an interview was conducted with CNA A with the DON present. CNA A stated she was sorry but thought the Hoyer Lift that Resident # 33 preferred was already in use. CNA A stated she could have toileted Resident # 33 sooner but made a mistake. CNA A stated that she tried to use the type of lifts the residents preferred because she was afraid the resident could fall if a Hoyer Lift was used that was not preferred by the resident. CNA A was apologetic and stated that in the future she would offer another lift for toileting and notify her charge nurse of any problems. During the end of day debriefing on 10/31/2018 at approximately 4:50 PM, the DON, Assistant Director of Nursing and Corporate Consultants were informed of the findings. The Director of Nursing and Consultants stated residents should be toileted as soon as possible with any available lift to avoid increase in incontinent episodes. No further information was provided.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		12/7/18

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F 695	Continued From page 20 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure oxygen was available for 1 residents (Resident #55) of 27 residents in the survey sample. Resident #55 was observed seated in her wheelchair in the hallway wearing a nasal cannula for oxygen. The tubing was connected to a portable oxygen tank that was empty. The findings included: Resident #55, a 96 year old, was admitted to the facility on 2/17/10. Diagnoses included chronic obstructive pulmonary disease, emphysema, reflux, epilepsy, and osteoarthritis. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 10/10/18. Resident #55 was coded with a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment and required extensive assistance with activities of daily living. Resident #55 had a physician order dated 8/7/18 for oxygen 2 liters per minute via nasal cannula as needed. On 10/31/18 at 2:55 p.m., Resident #55 was observed sleeping in her wheelchair in the hallway outside of her room wearing the nasal cannula for oxygen. There were no staff present in the hallway. The nasal cannula tubing was connected to a portable oxygen tank that was	F 695	1. Resident # 55 portable oxygen was replaced on 10/31/18 by LPN A. 1:1 education was provided on 10/31/2018 by DON to the responsible nurse. 2. On 10-31-18 Director of Nursing audited that all residents receiving oxygen to ensure oxygen was in place as ordered by the physician. There were no other issues with empty O2 tanks identified. 3. Education on monitoring O2 tanks for needed cylinder change will be provided to nursing staff by the Clinical Educator by 12-7-18. 4. The Director of nursing or designee will audit 2 residents per week for 4 weeks and then 1 resident per week for 8 weeks who have oxygen cylinders to ensure cylinders are not in need of changing and that they are receiving oxygen as ordered by the physician. The results of the audits will be reported at the QA Committee by the Director of Nursing or designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 695	Continued From page 21 empty, as the needle on the tank gauge was in the red area. Licensed Practical Nurse A (LPN A) exited a resident room. She was asked to observe Resident #55's oxygen tank. When asked if the tank was empty, LPN A stated yes. She stated she would get a new tank. On 11/1/18 at the end of day meeting, the Administrator, Director of Nursing and corporate staff were notified of the oxygen issue.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		12/7/18

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F 755	Continued From page 22 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to ensure medication was available for administration for 1 residents (Resident #107) of 27 residents in the survey sample. For Resident #107, a Vitamin B-12 injection was unavailable during the medication pour and pass observation. The findings included: Resident #107, a 65 year old, was admitted to the facility on 10/17/18. Diagnoses included peripheral vascular disease, amputation, depression, vascular dementia, insomnia, epilepsy, stroke and hypertension. As Resident #107 was new to the facility, a Minimum Data Set assessment had not been completed. On 10/31/18 at 10:50 a.m., a medication pour and pass observation was conducted with Licensed Practical Nurse A (LPN A). While preparing medications for Resident #107, LPN A stated that the Vitamin B-12 was a new order and it was not available so she would hold the medication. Resident #107 took all of his other medications	F 755	1. Resident #107 medication was obtained by the staff nurse and administered per physician order on 11/1/2018. 2. The DON/Designee completed an audit to ensure all residents were receiving all medications as ordered by the physician on 11/1/2018. 3. The Clinical Educator or Designee will provide education to the licensed nurses on the process of Medications Unavailable by 12/7/18. 4. The DON/Designee will audit 4 residents weekly for 4 weeks and then 2 per week for 8 weeks to ensure all medications are given as ordered by the physician. The results of the audits will be reported quarterly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.	

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RIVERSIDE CONVALESCENT CNTR WE	2960 CHELSEA ROAD WEST POINT, VA 23181

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F 755	Continued From page 23 during the observation. Resident #107's medication orders were reviewed. Included was an order dated 10/30/18 for Cyanocobalamin (vit B-12) 1000 micrograms/ milliliter injection give every day for seven days starting 10/31/18. The October Medication Administration Record was reviewed. Documentation for the 10/31/18 dose of Vitamin B-12 read "Not Administered (Order On Hold)" and included LPN A's initials. At the end of day meeting on 11/1/18, the Director of Nursing, Administrator and corporate staff were notified that Vitamin B-12 was unavailable for Resident #107 during the medication pour and pass observation. No further information was provided.	F 755		