STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495332	A. BUILDING ______ B. WING ______	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD	**101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430**

(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 03/06/19 through 03/08/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Emergency Preparedness Program, the facility staff failed to identify the current resident population in the facility to ensure their needs would be meet in the event of an emergency. The findings included: On 3/7/19 at approximately 4:30 PM the Emergency Preparedness Plan was reviewed	E 007	1. On 3/20/2019, all residents were identified and evaluated of their mobility/immobility, assistive devices and various diagnoses and documented on a dashboard/graph. 2. All information will be updated daily by Administrator/designee during AM huddle as changes occur in all residents. New admissions will be added and discharges will be removed from the dashboard.	4/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/22/2019

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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E 007	Continued From page 1 with the Administrator and three other members of the Cooperate Emergency Planning Team. When the Administrator was asked about the resident population that would be at risk during an emergency she provide a copy of Facility Assessment Tool dated 7/2/2018. The Administrator stated, "We used out MDS (Minimum Data Set) RUGS (Resource Utilization Source) data to identify our resident population, its right here under "Acuity" in our Facility Assessment." The Acuity section of the Facility Assessment was reviewed. The data for the Acuity section was dated October 1, 2016 through September 30, 2017 and under Rehabilitation 172 residents were identified. The current facility census was 25. The Administrator was asked if the information in the Acuity section of the Resident Assessment was accurate for the current resident population if an emergency occurred. The Administrator stated, "No, that data was from October 1, 2016 through September 30, 2017, and my census is only 25 now. I understand why this information need to reflect my current resident census." On 3/8/19 at 4:46 PM a pre-exit interview was conducted with the Administrator, the Director of Nursing, the Nurse Executive, and the Director of Facility Operations and Compliance were the above information was shared. No further information was provided prior to exit.	E 007	3. By 3/29/2019, leadership and frontline team will be educated by Administrator on new practice of the resident dashboard, to include location and process to update resident dashboard. 4. Administrator/designee will submit the updated dashboard electronically to the QA team weekly for monitoring for four (4) weeks, then monthly thereafter. The results of the audits will be reported monthly at the QA Meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. Corrective action will be completed by 4/8/2019.	
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 03/06/19 through 03/08/19. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code	F 000		

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F 000	Continued From page 2 survey/report will follow. No complaints were investigated during the survey. The census in this 34 certified bed facility was 25 at the time of the survey. The survey sample consisted of 14 current Resident reviews and 3 closed record reviews.	F 000		
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	F 690		4/8/19

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F 690	Continued From page 3 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to provide the appropriate care and services to prevent indwelling catheter complications for 1 of 17 residents (Resident #5), in the survey sample. The facility staff failed to assure Resident #5's indwelling catheter was anchored/secured. The findings included: Resident #5 was originally admitted to the facility 8/31/18, and readmitted 11/23/18 after an acute care hospital stay. The current diagnoses included; benign prostatic hyperplasia with urinary retention, obstructive uropathy, and phimosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/28/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring set-up with eating, extensive assistance of 1 person with locomotion and personal hygiene, extensive assistance of 2 people with bed mobility and dressing, and total	F 690	1. On 3/8/19, LPN on duty was reeducated on the appropriate indwelling catheter anchoring techniques/devices by the DON. An anchoring device was placed on Resident #5s thigh to secure his indwelling catheter on 3/8/2019. 2. Residents with indwelling catheters are identified for potential risk. There were no other residents with indwelling catheters in the facility. 3. The DON provided an in-service on 3/14/19 to nursing staff on Urinary Catheter Care and use of anchoring devices with indwelling catheters. 4. Nurse Mentor/designee will audit resident/residents with indwelling catheters for anchoring of catheter two (2) times weekly for four (4) weeks and then weekly for eight (8) weeks. The results of the audits will be reported monthly at the QA Meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. Corrective action will be completed by 4/8/19.	

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F 690	Continued From page 4	F 690		

care of 2 people with transfers, toileting, and bathing. In section "H" Bladder and Bowel, the resident was coded as having an indwelling catheter and always incontinent of bowels.

A Physician's order dated 11/27/18, read; Indwelling catheter 16 french, 10 milliliter balloon due to urinary retention, failed voiding trial. Cath care two times daily. Empty catheter bag and record output two times daily.

The current care plan dated 11/27/18 had a problem which read at risk for infection related to an indwelling catheter. (name of resident) has retention. He failed the voiding trail and the Foley had to be put back in. The care plan goal read (name of resident) will remain free of Urinary Tract Infections (UTI) during period of catheterization. The interventions included; Clean around Foley with soap and water. Keep tubing below the level of the bladder and free of kinks and twist. Record output per shift. Report any signs of infection (temperature, pain, urine that looks cloudy, dark or with blood). Wash hands before and after procedure. Foley catheter as ordered. Voiding trial as ordered. Administer medications for benign prostatic hyperplasia as ordered.

On 3/6/19, at approximately 8:05 p.m., Resident #5 was interviewed while in bed. The catheter bag and drainage bag were observed on the lower frame of the bed. It was draining clear yellow urine.

On 3/8/19 at approximately 10:30 a.m., another interview was conducted with Resident #5. The resident stated "I have never had the catheter tubing attached to my thigh/leg or body."

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F 690	Continued From page 5 An interview was conducted on 3/8/19 at approximately 1:40 p.m., with the Director of Nursing, she stated the expectation is for the resident's indwelling catheter to be anchored. Guidance for care of the catheter was provided by the facility from https://point-of-care.elsevierperformancemanager.com. It was titled Urinary Catheter: Indwelling (Foley) Catheter Care, published: August 2018. Adapted from Perry, A.G., Potter, P. A. Ostendorf, W.R. (Eds). (2018). Clinical nursing skills and techniques (9th ed.). St Louis: Elsevier. At 19c; the guidance read; Resecure the catheter in the catheter securement device. Avoid pulling on or tension on the catheter. On 3/8/19, at approximately 4:30 p.m., the above findings were shared with the Administrator, Director of Nursing and two corporate consultants. No additional comments were made regarding the indwelling catheter.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		4/8/19

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F 812	Continued From page 6 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to ensure the food was prepared, distributed and served under sanitary conditions. The finding included; On 03/06/19 at approximately 6:55 PM an initial tour was conducted with Other Staff # 4. She stated that she was scheduled to get off at 7 PM, but will stay until the Food Service Director arrives. The following was observed during the tour. 1. Food substances on the floors, counters, carts, stoves, burner, steam craft machine and refrigerator throughout the main kitchen. 2. Tilt Skillet grill with moderate amounts of hardened cheese drippings down the side. 3. Cell phone on the counter plugged in beside the three compartment sink. 4. Located in the salad bar refrigerator were two separate packs of "American" single cheese with use by dates of 02/19/19 and 02/18/19 and 1 stick of butter with use by date of 03/02/19. 5. Paper towel dispenser located over open box	F 812	1. On 3/8/3019 the Food Services Director cleaned the floors, counters, cart, stoves, burners, steam craft machine and refrigerator. On 3/8/2019 the Food Services Director cleaned the Tilt Skillet grill. The expired American cheese, butter, milk and open Kosher salt container were discarded on 3/8/2019 by the Food Services Director. The personal items to include cell phones and drinks were removed from the kitchen by the Food Services Director on 3/8/2019. The plastic wrap was relocated by the Food Services Director on 3/8/2019. 2. All residents within the facility are at potential risk for cleanliness of the kitchen as it relates to the professional standards of food services safety. The Food Services Director/Designee will complete 100% audit of the sanitation list cleaning list for accuracy and completeness by 4/8/2019. The Food Services Director/Designee will complete 100% audit of labels and expiration dates by 4/8/2019. 3. Kitchen floors were cleaned and power washed on 3/18/2019 by kitchen staff. Kitchen equipment was cleaned and detailed on 3/18/2019 by kitchen staff. Food Services Director updated cleaning	

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F 812

Continued From page 7

of plastic wrap. (Due to the location, water dripping from wet hands fall inside of the plastic wrap used to cover food).

On 03/07/19 at approximately 10:14 AM an inspection was conducted with the Food Service Director (FSD) present. The following was observed:

1. Food substances were still on the floors, counters, carts, stoves, burner, steam craft machine and the refrigerator throughout the main kitchen.

2. While inspecting the walk in refrigerator, 1 gal. unopened milk with expiration date of 03/06/19 and 1 pint of milk with an expiration date of 03/04/19.

3. A plastic bottle filled with a brownish, liquid substance was on the shelf of the walk in refrigerator. (The bottle was without a name, date and label). The FSD (Food Service Director) stated that it was a bottle of tea that belongs to one of her kitchen staff. She said that they keep their drinks in the refrigerator because they would have too far to walk.

4. Lid left open on a "Kosher" salt box. (Located on shelf in the main kitchen).

A review of the facility's policy titled "Dating and Labeling Food Supplies", effective revision date of 10/25/17. Under the "Ready To Eat" TCS Foods section states: Products will be labeled by using a "Use By Date. Foods that are not labeled, or exceeds the expiration date will be discarded. The section under Monitoring/Subheading Outcomes Monitoring states: A designated

F 812

schedules on 3/22/2019. Food Services Director will provide re-education to 100% of kitchen staff on the procedure of maintaining the cleanliness for the kitchen, updating kitchen cleaning schedules, cell phone policy, personal food storage policy and food labeling/storage policy by 3/29/2019.
4. Food Services Director/Designee will complete audits two (2) times weekly for four (4) weeks and then weekly for eight (8) weeks. Audits will verify compliance with cleaning schedules, cleanliness of the kitchen to include equipment, floors, dating/food storage and personal items in the kitchen. The results of the audits will be reported monthly at the QA Meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation.
5. Corrective action will be completed by 4/8/2019.

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F 812	Continued From page 8 employee shall be responsible for checking refrigerators daily to verify that foods are date marked and that foods exceeding the determined time period are not being used or stored. On 03/08/19 11:16 AM a brief interview was conducted with the Food Service Director (FSD) and the Administrator concerning the kitchen inspection. FSD states that the staff is designated to clean and mop the kitchen. The FSD also commented on employee having an unlabeled, unnamed bottle of tea in the walk in freezer saying "that's where we keep our drinks to keep from walking too far." No other comments were made. On 03/08/19 A review of the facility cleaning scheduled dated from 03/03/19 and 03/06/19-03/07/19 showed no one checked off on sweeping and mopping the kitchen. On 03/08/19 at approximately 4:45 PM a pre-exit interview was conducted. Present were the Administrator, The Director of Nursing, The Nurse Executive and The Director of Facility Operations and Compliance.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		4/8/19

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F 880	Continued From page 9 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880		

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F 880	Continued From page 10 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility document review the facility staff failed to follow infection prevention practices to ensure a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections during the dispensing of ice to residents. The facility staff follow infection control practices to ensure a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections during the dispensing of ice to residents on 3/7/19. The findings included: On 3/7/19 at approximately 10:00 AM two facility volunteers were observed passing ice to the residents. The ice was contained in a large blue cooler on top of a rolling cart with a shelf noted at the bottom. On the bottom shelf of the ice cart	F 880	1. On 3/7/2019, both volunteers were educated on maintaining infection control practices during the passing of ice. 2. All residents who are served from the ice cart are identified for potential risk. 3. DON/Designee will provide education to staff and volunteers on infection prevention when passing ice by 3/29/2019. 4. The facility purchased an ice cart with scoop holder. The new ice cart with scoop arrived at the facility on 3/18/2019 and was placed into use on 3/19/2019. Staff and volunteers will be audited for correct procedure for passing ice two (2) times weekly for four (4) weeks, then weekly for eight (8) weeks. The results of the audits will be reported monthly at the QA Meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the	

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F 880	Continued From page 11 there was a one gallon open empty zip-lock bag. While the volunteers were in a room the ice cart was opened and the ice scoop was observed sitting straight down in the ice with the handle up. The two volunteers were observed 3 times opening the ice cart, placing the ice scoop back in to the ice and shutting the ice cart. During one of the observations the Director of Facility Operations and Compliance was standing beside the surveyor and also observed the two volunteers obtaining the ice and placing the ice scoop back into the ice chest. Director of Facility Operations and Compliance was asked if she saw anything wrong with the way the ice was being passed. The Director of Facility Operations and Compliance stated, "They are putting the ice scoop back into the ice, it should be placed in the bag, its an infection control issue." On 3/7/19 at approximately 10:45 AM the Director of Activities who oversees the volunteers was interviewed. The Director of Activities was asked if the two volunteers passing ice to the residents had been inserviced on proper infection control practice while passing ice. The Director of Activities stated, "I give each volunteer a Lifelong Health Center Volunteer Handbook before they start working with the residents. In the handbook we review infection control and preventing the spread of infection, but there is no specific education provided for passing ice. One of the volunteers was trained over at the hospital over 20 years ago." The facility policy titled "Food and Nutrition Services Ice Preparation and Use Policy last revised 8/30/17 was reviewed and is documented in part, as follows:	F 880	implementation. 5. Corrective action will be completed by 4/8/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495332	A. BUILDING ______ B. WING ______	03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12 POLICY STATEMENT: Ice is prepared, stored and used in a manner consistent with good sanitation practices. To ensure proper methods are used to prevent contamination in making, storing and dispensing ice. 2. Ice is dispensed as needed, either automatically or using a clean scoop which is placed in covered containers located near the ice machine. On 3/8/19 at 4:46 PM a pre-exit conference was held with the Administrator, the Director of Nursing, the Nurse Executive, and the Director of Facility Operations and Compliance were the above information was shared. No further information was provided prior to exit .	F 880		