| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E215 | A. BUILDING _____ B. WING _____ | 09/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERSIDE CONVAL CENTER-MATHEW | 603 MAIN STREET MATHEWS, VA 23109 |

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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 09/10/19 through 09/11/19. 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<br><br>An unannounced Medicaid standard survey was conducted 09/10/19 through 09/11/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.<br><br>The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 35 resident reviews. | F 000 | | |
| F 576 SS=E | Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9)<br><br>§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.<br><br>§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:<br>(i) A telephone, including TTY and TDD services;<br>(ii) The internet, to the extent available to the | F 576 | | 10/18/19 |

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

Electronically Signed | 10/03/2019

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| F 576 | Continued From page 1<br>facility; and<br>(iii) Stationery, postage, writing implements and the ability to send mail.<br><br>§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:<br>(i) Privacy of such communications consistent with this section; and<br>(ii) Access to stationery, postage, and writing implements at the resident's own expense.<br><br>§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.<br>(i) If the access is available to the facility<br>(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.<br>(iii) Such use must comply with State and Federal law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview and staff interview the facility staff failed to uphold Resident Rights with regard to the right to receive mail for 15 Residents (Resident #45, #56, #2, #49, #51, #25, #19, #41, #46, #42, #24, #40, #16, #18, and Resident #20) in a survey sample of 35 Residents.<br><br>The findings included:<br><br>On 9/10/19 during a Resident Council meeting held at 3 PM, all of the Residents in attendance, stated they did not receive any mail on Saturdays, | F 576 | 1. A facility staff member was designated by the Administrator/designee on 9/11/19 to obtain the mail for all residents at the nursing facility on Saturdays. The mail will be distributed to the residents upon return. Residents #45, #56, #2 #49, #51, #25, #19, #41, #46, #42, #24, #40, #16, #18 and #20 have had delivery of all mail received on Saturday since 9/11/19.<br>2. All residents who reside at the center have the potential to be affected. All current residents who receive mail will | |

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| F 576 | Continued From page 2<br>despite being accustomed to receiving mail on Saturdays prior to coming to the facility.<br><br>During the Resident Council meeting the Residents identified that the receptionist goes to the post office to pick up the mail, in her absence, Employee F gets the mail and delivers it to Residents.<br><br>Following the Resident Council meeting an interview was conducted with Employee F. When asked about the mail delivery for Residents, Employee F stated, "to my knowledge no, they don't get mail on Saturdays".<br><br>On 9/10/19 at 4:05 PM an interview was conducted with the facility Administrator. The Administrator was advised that during the Resident council meeting the 15 Residents in attendance state they do not receive mail on Saturdays. The Administrator stated, "the post office has been resistant to delivering mail here". When asked if someone goes to the post office to pick up the mail on Saturdays and distribute it to Residents, the Administrator stated, "no, we have no one to do it".<br><br>On 9/11/19 at 10:17 AM, the facility Administrator stated, "I sense we didn't meet the requirements. I put a call into the post master this morning to see if they can get that delivery for us [referring to mail delivery at the facility]."<br><br>On 9/11/19 at 1:07 PM an interview was conducted with the facility's local U. S Postal Service Post Master, in the presence of 4 surveyors. The Post Master was asked if there is any reason the facility could not have mail delivered to the facility, the Post Master stated, | F 576 | have it delivered on Saturday.<br>3. Facility staff and leadership have been re-educated on the centers policy regarding Resident Rights to Forms of Communication with privacy by the Administrator/designee on 10/4/19. At resident council meeting on 10/16/19 the Activity Director will review with residents the new process for Saturday mail delivery. A letter will be provided to all resident and RR□s to notify them of this change.<br>4. The Administrator/designee will audit 4 residents weekly for 12 weeks ensuring mail delivery occurred on the weekend. The results of the audit will be reported at the QAPI meeting by the Administrator/designee for evaluation of compliance and on-going monitoring for continuous improvement analysis. | |

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| F 576 | Continued From page 3<br>"no, if they had a box [mail receptacle] at the facility we would deliver there". When asked how the facility currently receives mail, the post master stated "they have a post office box here, and someone comes about every day or two, to pick it up". When asked if facility staff would be able to pick up mail on Saturdays, the post master stated "sure". When asked if there are any restrictions to who can pick up the mail, the post master stated "that is for the facility to determine, anyone with the key to the box [post office mail box] can come in and get it." The post master went on to say, "they approached me about the mail delivery, about 3 months ago. I have told them where to put the box. I haven't heard back from them until this morning, when the Administrator called me stating he wanted to move forward with the process."<br><br>No further information was provided. | F 576 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; | F 600 | | 10/18/19 |

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| F 600 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff neglected to provide goods and services to prevent an elopement for one Resident (Resident #36), who had been identified to be at risk for elopement, in a survey sample of 35 Residents.<br><br>The findings included:<br><br>Resident #36, was admitted to the facility on 3/4/16. Her diagnosis included but were not limited to: psychosis, hallucinations, dementia, hypertension and diabetes.<br><br>Resident #36's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/7/19 was coded as a quarterly assessment. Resident #36 was coded as having a BIMS (Brief Interview for Memory Status) score of 7, which indicated severe cognitive impairment. Resident #36 was also coded as requiring extensive assistance of staff for her activities of daily living which included: transfers, locomotion on and off of the unit, dressing, toilet use, and personal hygiene.<br><br>An observation of Resident #36 on 9/11/19 revealed that she had a wander guard bracelet in place on her wrist. \<br><br>However, a review of Resident #36's careplan revealed that on 2/21/19 the wander guard alarm was discontinued.<br><br>Resident #36's clinical record also revealed an "elopement/unsafe wandering evaluation" | F 600 | 1. A facility reported incident was filed and an investigation was initiated regarding the elopement involving resident #36 on 9/25/19. At the time of the incident a wander guard was placed and determined to be functional followed by an elopement reassessment. The care plan was updated for wander guard placement on 6/29/19. No elopements for resident #36 have occurred since 9/11/19.<br>2. All residents will remain free from abuse and neglect and failure to provide goods. Elopement risk assessments for all residents will be reviewed and updated by the DON/designee by 10/14/19. All doors were checked for proper closure and locking by the Director of Environmental Services on 9/23/19. Door alarms and wanderguard devices were checked using a scanning/testing device to ensure they were working properly.<br>3. The DON/designee will re-educate the clinical, including Rehab, non-clinical staff and licensed staff on neglect to provide goods and services to prevent an elopement by 10/8/19. All residents will be reviewed weekly at the At Risk Meeting by the IDT team to ensure elopement prevention devices are in place as appropriate.<br>4. The DON/designee will audit 2 residents at risk for elopement per week per MDS schedule and or any change in condition as indicated for 4 weeks then 1 for 8 weeks to ensure that all interventions are appropriate. The results of the audit will be reported at the QAPI meeting by | |

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| F 600 | Continued From page 5 | F 600 | | |

completed on 2/27/19 that indicated, Resident #36 was assessed to be at risk for elopement and at risk for unsafe wandering.

Review of Resident #36's nursing notes revealed an entry on 4/4/19 at 22:45 [10:45pm] that read, "redirected from attempts to exit door to lobby x 2 this shift. Noted to be able to push door open but was unable to propel her wheelchair thought [sic] into the lobby. Stated "I'm leaving". Able to redirect without difficult [sic]. Noted to continue to roll about facility in her wheelchair until placed in bed by staff at appropriate time."

Another nursing note entry on 6/29/19 at 21:27 [9:27pm] that read, "resident noted wandering around building in her wheelchair. Approximately 1930 [7:30pm] this nurse seen [sic] resident approach exit door by dd's salon, resident redirected from door. At approximately 1945 [7:45pm] Resident was found outside, in front of the building right outside the double doors. When staff questioned Resident on what she was doing, resident stated "waiting for you" with a smile on her face. A wander guard was placed on resident's right wrist, family agreed that this would be a good idea to place wander guard again."

Review of the clinical record for Resident #36 revealed that on 6/29/19 a wander guard was placed on the Resident following the elopement and the careplan was reviewed and revised on 6/30/19 to reflect the implementation of the wander guard bracelet.

On 9/11/19 at approximately 3:00 PM an interview was conducted with the DON and Employee E, Director of Clinical Services. The 2 of them, DON and Employee E, reviewed the careplan for

the Director of Nursing/designee for evaluation of compliance and on-going monitoring for continuous improvement analysis.

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| F 600 | Continued From page 6<br>Resident #36 and agreed that no revisions or interventions had been implemented following the identification of the wandering risk to prevent the elopement which occurred.<br><br>Review of the facility policy titled, "Abuse Prevention and Management Policy" read on page 2, "neglect is the failure of the facility ,its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress".<br><br>No further information was provided. | F 600 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident and staff interview, facility documentation and clinical record review the facility staff failed to implement abuse policies for 2 Residents (#3 and #4) in a survey sample of 35 Residents.<br><br>The findings included: | F 607 | 1. The facility reported the injury of unknown origin involving resident #3 on 9/24/19 and resident #4 on 9/25/19. An investigation was initiated on residents #3 and #4. No injuries of unknown origin have been noted with resident #3 and #4 since 9/11/19. | 10/18/19 |

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| F 607 | Continued From page 7<br><br>1. For Resident #3 the facility staff failed to implement abuse policy for injury of unknown origin.<br><br>The findings included:<br><br>Resident #3 an 85 year old woman admitted to the facility on 4/26/16 with diagnoses of but not limited to chronic kidney disease, abnormalities of gait and movement, memory loss, cognitive dysfunction, aphasia following cerebral infarction, muscle weakness, dementia, vascular dementia, epilepsy, and history of left femur fracture. Most recent MDS (Minimum Data Set) codes Resident as having a BIMS (Brief Interview of Mental Status) score of 11 indicating moderate cognitive impairment. Resident was coded as extensive assistance of 2 person physical assistance for bed mobility, transfers and bathing and extensive assistance of 1 person physical assistance for other ADL's.<br><br>On 9/11/19 during clinical record review it was found that Resident #3 had an injury of unknown origin.<br><br>An excerpt from the progress notes read:<br><br>" 08/23/19 at 4:36 PM - CNA reports finding purple bruise on r [right] side of resident's face (cheek) measuring 1.5 cm X 3 cm, denies pain, any harm done, or how it got there verbalized to nurse that she may have been too close to the bedrail, or possibly laying on her hands during the night. Will continue observe MD and RR aware."<br><br>Three days later another progress note read: | F 607 | 2. All residents who reside at the center have the potential to be affected. All current residents with skin tears and bruising occurring since 9/11/19 will be reviewed by the DON/Designee to ensure any injury of unknown origin were reported.<br>3. Facility staff in all departments and leadership have been re-educated on the centers policy titled abuse prevention and management, mandated reporting, and on investigating injuries of unknown origin by the Administrator/designee on 10/4/19.<br>4. The DON/designee will review the 24 hour report at Morning Meeting for all documentation of impaired skin integrity to monitor for injuries of unknown origin and the need to complete a Facility Reportable Incident (FRI). DON/designee will audit 4 impaired skin integrity concerns per week for 4 weeks and then 2 concerns for 8 weeks to ensure immediate investigation was completed and for timely completion of a facility reported incident (FRI) for injuries of unknown origin The results of these findings will be reported at the QAPI meeting by the Director of Nursing/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. | |

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| F 607 | Continued From page 8 | F 607 | | |

"8/26/19 at 12:33 PM - Resident was interviewed regarding bruising to the right side of her face. Denied anyone harming her, denied fear of anyone, and expressed understanding of who she can go to in case of concern. When asked what had happened to cause the bruising resident shrugged her shoulders and said " I was asleep" She then put her hands to her face, indicating she might have laid on her hands, scratched her face or hit the side rail during the night which may have caused the bruising. Nails not in need of trimming and side rails have been padded to prevent future occurrence."

An excerpts from the facility abuse policy read:

"Page 4, Paragraph 4

4) Investigation
Designated staff will immediately review and investigate all allegations or observations of abuse.
a) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident (7 calendar days for incidents in Assisted living), and if the alleged violation is verified appropriate corrective action must be taken.
b) The organization will conduct analysis for trends and patterns related to incidents (i.e. falls, skin tears, bruising, or injury of unknown origin, unusual occurrences, reportable incidents, etc,)
c) Outside investigative bodies, such as local police will be contacted as directed by the Administrator or his or her designee and in accordance with federal, state, and local law.
d) The Quality Assurance / Performance

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| F 607 | Continued From page 9 | F 607 | | |

Improvement Committee will monitor trends and patterns for needed changes in facility policy or protocols."

"Page 5 - Reporting

6) The organization will maintain systems to ensure that all alleged violations involving abuse neglect exploitation or mistreatment including injuries of unknown source, and misappropriation of resident property are reported Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury: porno later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."

On 9/11/19 at 4:00 PM In an interview with the DON she stated that " When we find an injury of unknown origin we do a full body assessment and then we investigate what we think could have happened." When asked if they notified the State first before the investigation was done she stated "Well we investigate and if we think its abuse we will report it." The DON could not produce any documents of investigation or notification of OLC.

9/11/2019 at 5: 20 P.M., Administrator and DON came into the conference room to discuss with the surveyors about why the facility staff did not report bruises of unknown origin for Resident #3.

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| F 607 | Continued From page 10 | F 607 | | |

The Administrator stated "Based on the understanding of the regulation and our assessment of the situation, it did not meet the requirement of being a reportable incident."

He also stated that Resident #3 was not able to verbalize due to her aphasia but she agreed that no one had harmed her and she was not afraid of anyone. They had determined the bruises were not suspicious and could be explained by the fact that Resident could have lain on her hands or bumped against the side rail.

On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided

2. For Resident # 4, the facility staff failed to operationalize the abuse policies after discovery of bruises and a skin tear in April 2019 and bruises in June 2019.

Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder and Psychosis.

The most recent MDS (Minimum Data Set), was a Quarterly Assessment with an Assessment Reference Date of 6/26/2019. The MDS coded Resident #4 as having a BIMS (Brief Interview of Mental Status) Score of 12, indicating moderate cognitive impairment. Resident # 4 was coded as requiring extensive assistance of one to two staff

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persons for Activities of Daily Living (ADLs) except she required total assistance of one staff person for bathing.

Review of the clinical record was conducted on 9/11/2019. Review of the Nurses Notes revealed documentation:

Nurses Notes dated 4/28/19 at 3:52 a.m.-"CNA summoned me to residents room to see a bruise to her left upper arm bark (sic) blue in color measuring at 2 cm x 2 cm. Asked if she knew where the bruise came from. Resident stated "I don't know." Asked if anyone hurt her which she denied. Resident propels herself all throughout the facility MD Medical Doctor) and RR (Responsible Representative) -------- made aware."

4/30/2019 at 9:16 a.m. -Resident noted to have a skin tear just above bruise to left arm, previously noted, 0/1 x 0.4 cm, resident states that she does not what happened, but CNA (Certified Nursing Assistant) reports that she not (sic) the resident scratching at the bruise on 4/29/19. Protocol implemented, MD/RR (Medical Doctor/Responsible Representative) aware.

Further review of the nurse's notes revealed documentation on 6/30/19 of "several small bruises noted to top of residents right hand measuring 8.6 x 4.5 cm. And two bruises noted to right upper arm near elbow measuring 6.0 X 2.5 cm. Resident denies pain. Does not recall how the bruises occurred. Denies anyone harmed her. No tx (treatment) needed."

On 9/11/2019 at 3:15 p.m., an interview was conducted with the Director of Nursing (DON)

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who stated the facility staff did not report the bruises or skin tear to State Agency because they investigated it and determined that the bruises were probably caused by her bumping into the walls or rails. The DON stated Resident # 4 stated that she was not afraid and that nobody had hurt her. The DON stated there were no witness statements obtained. When asked about Resident # 4's BIMS (Brief Interview for Memory Status) Score, the DON stated she would check the clinical record to determine the score. The DON replied that Resident # 4 was not her own responsible party. The DON stated Resident # 4 did have a diagnosis of Dementia and Psychiatric diagnoses.

Review of the Facility policy on Abuse Prevention and Management Policy Last Revision Date 06/13/2019, last Date of Review: 08/15/2019:
3. Identification: a) .....Staff are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and to determine the direction of the investigation.

4. Investigation
Designated staff will immediately review and investigate all allegations or observations of abuse.
a) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.....

b) The organization will conduct analysis for

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trends and patterns related to incidents [i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc]

6. Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to the administrator of the facility, or his or her designee, and to other official (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

c. The team members of the organization will immediately report all alleged violations involving neglect, abuse, including injuries of unknown source,"

Thorough review of the facility documentation and clinical record revealed no initial report, no investigation and no 5 day follow up report, were ever conducted and submitted to the state agency by the facility, as per regulation. There were no witness statements obtained for either incident.

During the end of day debriefing on 9/11/2019 at 4:50 p.m., the facility Administrator, Corporate Nurse Consultant and Director of Nursing were

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| F 607 | Continued From page 14<br>informed of the findings.<br><br>On 9/11/2019 at 5: 20 P.M., the Administrator and the DON came into the conference room to discuss with the surveyors about why the facility staff did not report bruises of unknown origin for Resident # 4 to the State Agency. The Administrator stated, "Based on the understanding of the regulation and our assessment of the situation, it did not meet the requirement of being a reportable incident." The Administrator also stated they agreed that the origin of the bruises was not known but because Resident # 4 often bumped into walls and denied having been harmed by anyone, the facility staff determined it was not reportable. The Administrator stressed that the second part of the regulation was where they determined there was no need to report the bruises. They had determined the bruises were not suspicious and could be explained by the fact that Resident # 4 propelled herself through the halls and often was seen bumping into things. The Administrator stated Resident # 4 did not know how she had gotten the bruise but had a high BIMS score and could state if something happened to her.<br><br>No further information was provided. | F 607 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown | F 609 | | 10/18/19 |

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| F 609 | Continued From page 15<br>source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident and staff interview, facility documentation and clinical record review the facility staff failed to report allegations of abuse for 2 Residents (#3 and #4) in a survey sample of 35 Residents.<br><br>The findings included:<br><br>1. For Resident #3 the facility staff failed to report an injury of unknown source.<br><br>Resident #3 an 85 year old woman admitted to the facility on 4/26/16 with diagnoses of but not limited to chronic kidney disease, abnormalities of gait and movement, memory loss, cognitive dysfunction, aphasia following cerebral infarction, | F 609 | 1. The facility reported the injury of unknown origin involving resident #3 on 9-24-19 and resident #4 on 9/25/19. No injuries of unknown origin have been noted with residents #3 or #4 since 9/11/19.<br>2. All residents who reside at the center have the potential to be affected. All current residents with skin tears and bruising occurring since 9/11/19 will be reviewed by the DON/Designee to ensure any injury of unknown origin were reported.<br>3. Facility staff in all departments and leadership have been re-educated on the centers policy titled abuse prevention and | |

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| F 609 | Continued From page 16<br>muscle weakness, dementia, vascular dementia, epilepsy, and history of left femur fracture. The most recent MDS (Minimum Data Set) codes Resident as having a BIMS (Brief Interview of Mental Status) score of 11 indicating moderate cognitive impairment. Resident was coded as extensive assistance of 2 person physical assistance for bed mobility, transfers and bathing and extensive assistance of 1 person physical assistance for other ADL's.<br><br>On 9/11/19 during clinical record review it was found that Resident #3 had an injury of unknown source.<br><br>An excerpt from page 4 of the facility abuse policy read:<br><br>"Page 5 - Reporting<br>6) The organization will maintain systems to ensure that all alleged violations involving abuse neglect exploitation or mistreatment including injuries of unknown source, and misappropriation of resident property are reported Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury: porno later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The reports will be made to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."<br><br>On 9/11/19 at 4:00 PM, in an interview with the | F 609 | management, investigating injuries of unknown origin, and mandated reporting by the Administrator/designee on 10/4/19.<br>4. The DON/designee will review the 24 hour report at Morning Meeting for all documentation of impaired skin integrity to monitor for injuries of unknown origin and need to complete a Facility Reportable Incident (FRI). DON/designee will audit 4 impaired skin integrity concerns per week for 4 weeks and then 2 concerns for 8 weeks to ensure immediate investigation was completed and for timely completion of facility reported incidents for injuries of unknown origin The results of these findings will be reported at the QAPI meeting by the Director of Nursing/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. | |

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DON she stated that " When we find an injury of unknown origin we do a full body assessment and then we investigate what we think could have happened." When asked if they notified the State first before the investigation was done she stated "Well we investigate and if we think its abuse we will report it." The DON could not produce any documents of investigation or notification that the injury of unknown source was reported to the state agency.

On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided.

2. For Resident # 4, the facility staff failed to report the discovery of bruises and a skin tear in April 2019 and bruises in June 2019.

Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder and Psychosis.

The most recent MDS (Minimum Data Set), was a Quarterly Assessment with an Assessment Reference Date of 6/26/2019. The MDS coded Resident #4 as having a BIMS (Brief Interview of Mental Status) Score of 12, indicating moderate cognitive impairment. Resident # 4 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living (ADLs) except she required total assistance of one staff person for bathing.

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| F 609 | Continued From page 18 | F 609 | | |

Review of the clinical record was conducted on 9/11/2019.

Review of the Nurses Notes revealed:

Nurses Notes dated 4/28/19 at 3:52 a.m.-"CNA summoned me to residents room to see a bruise to her left upper arm bark (sic) blue in color measuring at 2 cm x 2 cm. Asked if she knew where the bruise came from. Resident stated "I don't know." Asked if anyone hurt her which she denied. Resident propels herself all throughout the facility MD Medical Doctor) and RR (Responsible Representative) -------- made aware."

Nurses note 4/30/2019 at 9:14 -Resident noted to have a skin tear just above bruise to left arm, previously noted, 0/1 x 0.4 cm, resident states that she does not

Review of the clinical record revealed no documentation of the State Agency being notified of the bruises and skin tear.

Further review of the nurse's notes revealed documentation on 6/30/19 of "several small bruises noted to top of residents right hand measuring 8.6 x 4.5 cm. And two bruises noted to right upper arm near elbow measuring 6.0 X 2.5 cm. Resident denies pain. Does not recall how the bruises occurred. Denies anyone harmed her. No TX (treatment) needed."

On 9/11/219 at 3:15 p.m., an interview was conducted with the Director of Nursing who stated the facility staff did not report the bruises or skin tear to the State Agency because " I feel that the

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| F 609 | Continued From page 19<br>resident propels herself throughout the facility and bumps into things and with her BIMS (Brief Interview for Mental Status) score, she could tell us if she was afraid or if something happened." When asked about the facility's expectations and policies about reporting injuries of unknown origin, the DON stated the facility staff would report, investigate and then report the results of the investigations. The DON again stated that she felt the bruises and skin tear could be explained since Resident # 4 was observed often bumping into things.<br><br>Thorough review of the facility documentation and clinical record revealed no initial report, no investigation and no 5 day follow up report, were ever conducted and submitted to the state agency by the facility.<br><br>During the end of day debriefing on 9/11/2019 at 4:50 p.m., the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings.<br><br>No further information was provided. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. | F 610 | | 10/18/19 |

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| F 610 | Continued From page 20<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident and staff interview, facility documentation and clinical record review the facility staff failed to investigate abuse for 2 Residents (#3 and #4) in a survey sample of 35 Residents.<br><br>The findings included:<br><br>1. For Resident #3 the facility staff failed to investigate injury of unknown source.<br><br>Resident #3 an 85 year old woman admitted to the facility on 4/26/16 with diagnoses of but not limited to chronic kidney disease, abnormalities of gait and movement, memory loss, cognitive dysfunction, aphasia following cerebral infarction, muscle weakness, dementia, vascular dementia, epilepsy, and history of left femur fracture. Most recent MDS (Minimum Data Set) codes Resident as having a BIMS (Brief Interview of Mental Status) score of 11 indicating moderate cognitive impairment. Resident was coded as extensive assistance of 2 person physical assistance for bed mobility, transfers and bathing and extensive assistance of 1 person physical assistance for other ADL's.<br><br>On 9/11/19 during clinical record review it was found that Resident #3 had an injury of unknown | F 610 | 1. The facility reported and investigated the injury of unknown origin involving resident #3 on 9/24/19 and resident #4 on 9-25-19. No injuries of unknown origin have been noted with resident #1, resident # 3 and #4 since 9/11/19.<br>2. All residents who reside at the center have the potential to be affected. All current residents with skin tears and bruises occurring since 9/11/19 will be reviewed by the DON/Designee to ensure all injuries of unknown origin were investigated and reported as appropriate.<br>3. Administrator/designee will re-educate clinical, including rehab and licensed staff, non-clinical and leadership on the centers policy titled abuse prevention, investigating injuries of unknown origin, and mandated reporting by 10/14/19. The facility will investigate and immediately report all impaired skin integrity concerns and will report all injuries of unknown origin.<br>4. The DON/designee will review the 24 hour morning report at Morning Meeting for all documentation of impaired skin integrity for investigation and etiology. Events involving impaired skin integrity that occur on the weekend and off hours | |

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| F 610 | Continued From page 21<br>source.<br><br>On 9/11/19 at approximately 2:00 PM, a request for FRI (Facility Reported Incident) and Investigation documents for Resident # 1 in regards to the bruises found on 7/21/19 was made known.<br><br>Approximately 2:45 PM the DON returned to the conference room and stated " I could not find any FRI's for this resident." When asked about the investigation documents she stated there are none.<br><br>On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided.<br><br>2. For Resident # 4, the facility staff failed to thoroughly investigate the discovery of bruises and a skin tear in April 2019 and bruises in June 2019.<br><br>Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder and Psychosis.<br><br>The most recent MDS (Minimum Data Set), was a Quarterly Assessment with an Assessment Reference Date of 6/26/2019. The MDS coded Resident #4 as having a BIMS (Brief Interview of Mental Status) Score of 12, indicating moderate cognitive impairment. Resident # 4 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living (ADLs) | F 610 | will be communicated to the On-call Nurse Manager or Administrator. All injuries of unknown origin will have a Facility Reported Incident (FRI) completed. The DON/designee will audit 4 impaired skin integrity concerns per week for 4 weeks and then 2 impaired skin integrity concerns weekly for 8 weeks to ensure immediate investigation was completed and for timely completion of a facility reported incident (FRI) for injuries of unknown origin. The results of the audits will be reported by the DON/designee at the QAPI meetings for evaluation of compliance, ongoing monitoring for continuous improvement analysis. | |

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except she required total assistance of one staff person for bathing.

Review of the clinical record was conducted on 9/11/2019.

Review of the Nurses Notes revealed injuries of unknown source on 4/25/19, 5/1/19, and 6/30/19.

On 9/11/2019 at 3:15 p.m., an interview was conducted with the Director of Nursing (DON) who stated the facility staff did not report the bruises or skin tear to State Agency because they "investigated it and determined that the bruises were probably caused by her bumping into the walls or rails." The DON stated Resident # 4 stated that she was not afraid and that nobody had hurt her. The DON stated there were no witness statements obtained. When asked about Resident # 4's BIMS (Brief Interview for Memory Status) Score, the DON stated she would check the clinical record to determine the score. The DON replied that Resident # 4 was not her own responsible party. The DON stated Resident # 4 did have a diagnosis of Dementia and Psychiatric diagnoses.

Thorough review of the facility documentation and clinical record revealed no investigation and no 5 day follow up report, were ever conducted and submitted to the state agency by the facility, as per regulation. There were no witness statements obtained for either incident.

During the end of day debriefing on 9/11/2019 at 4:50 p.m., the facility Administrator, Corporate Nurse Consultant and Director of Nursing were informed of the findings.

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| F 610 | Continued From page 23<br>No further information was provided. | F 610 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the careplan for one Resident (Resident #36) in a survey sample of 35 Residents. | F 657 | 1. On 2/27/19 resident # 36 was assessed as an elopement risk by the MDS Coordinator. On 6/29/19 the care plan was updated to include wandering behavior and elopement risk. | 10/18/19 |

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| F 657 | Continued From page 24<br><br>The findings included:<br><br>For Resident #36 the facility staff failed to review and revise the careplan following identification of wandering behavior and identification of an elopement risk.<br><br>Resident #36, was admitted to the facility on 3/4/16. Her diagnosis included but were not limited to: psychosis, hallucinations, dementia, hypertension and diabetes.<br><br>Resident #36's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/7/19 was coded as a quarterly assessment. Resident #36 was coded as having a BIMS (Brief Interview for Memory Status) score of 7, which indicated severe cognitive impairment. Resident #36 was also coded as requiring extensive assistance of staff for her activities of daily living which included: transfers, locomotion on and off of the unit, dressing, toilet use, and personal hygiene.<br><br>Review of Resident #36's nursing notes revealed an entry on 4/4/19 at 22:45 [10:45pm] that read, "redirected from attempts to exit door to lobby x 2 this shift. Noted to be able to push door open but was unable to propel her wheelchair thought [sic] into the lobby. Stated "I'm leaving". Able to redirect without difficult [sic]. Noted to continue to roll about facility in her wheelchair until placed in bed by staff at appropriate time."<br><br>Another nursing note entry on 6/29/19 at 21:27 [9:27pm] that read, "resident noted wandering around building in her wheelchair. Approximately 1930 [7:30pm] this nurse seen [sic] resident | F 657 | 2. All residents are at risk for elopement. The DON/designee will complete an audit for those residents who have had a behavior of wandering/elopement since 9/11/19 to ensure required care planning and interventions are complete and accurate.<br>3. The Director of Clinical Reimbursement will educate the MDS Coordinator on updating comprehensive care plans to include wandering and elopement risk. The MDS Coordinator/designee will educate the IDT on updating comprehensive care plans to include wandering and elopement risk by 10/14/19.<br>4. The DON/designee will audit 2 residents for 4 weeks and then 1 per week for 8 weeks for wandering/elopement risk and interventions including the use of wander guards to comprehensive care plans. The results of the audits will be reported at the QAPI meeting by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. | |

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| F 657 | Continued From page 25<br>approach exit door by dd's salon, resident redirected from door. At approximately 1945 [7:45pm] Resident was found outside, in front of the building right outside the double doors. When staff questioned Resident on what she was doing, resident stated "waiting for you" with a smile on her face. A wander guard was placed on resident's right wrist, family agreed that this would be a good idea to place wander guard again."<br><br>Resident #36's clinical record also revealed an "elopement/unsafe wandering evaluation" completed on 2/27/19 that indicated, Resident #36 was assessed to be at risk for elopement and at risk for unsafe wandering.<br><br>Review of the careplan for Resident #36 revealed no revisions or interventions in response to the following:<br>* identification of being an elopement risk as identified on 2/27/19<br>* wandering and attempt to exit into the lobby on 4/4/19<br>* wandering on 6/29/19 at 19:30.<br><br>On 9/11/19 at approximately 3:00 PM an interview was conducted with the DON and Employee E, Director of Clinical Services. The 2 of them, DON and Employee E reviewed the careplan for Resident #36 and agreed that no revisions or interventions had been implemented following the identification of the wandering risk to prevent the elopement which occurred.<br><br>No further information was provided. | F 657 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) | F 658 | | 10/18/19 |

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| F 658 | Continued From page 26<br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview, and clinical record review, the facility staff failed to provide care and services in accordance with professional standards of practice for one resident (Resident #43) in a sample size of 35 residents.<br><br>The findings include:<br><br>For Resident #43, LPN A signed off that palm guards were administered when in fact the palm guards had not been administered.<br><br>Resident #43, an 89-year old female, was admitted to the facility on 08/31/2016. Diagnoses included but not limited to Alzheimer's disease. Resident #43 also has contractures of both hands.<br><br>Resident #43's most recent Minimum Data Set with an Assessment Reference Date of 08/14/2019 was coded as a quarterly review. The Brief Interview for Mental Status was not coded. Cognitive skills for daily decision-making was coded as severely impaired. Functional status for bed mobility and dressing was coded as requiring extensive assistance from staff. Eating, toileting, and personal hygiene were coded as total dependence on staff.<br><br>On 09/10/2019 at approximately 12:00 PM, Resident #43 was observed sitting in her | F 658 | 1. Resident #43 had the palm protector re-applied by the unit nurse on 9/11/19. The Director of Nursing provided 1:1 education to LPN A and LPN B on 9/11/19 who failed to comply with the order on 9/11/19. Resident #43 has had no negative outcome from the palm protector not being in place.<br>2. On 9/11/19 rounds were made by the DON on all other residents to ensure placement of ordered adaptic/orthotic devices. Any adaptive/orthotic devices not in place were immediately addressed. All adaptive/orthotic equipment since 9/11/19 will be audited for application of compliance by DON/designee by 10/8/19. All omissions will have 1:1 education provided to nursing staff by DON/designee.<br>3. Clinical Educator/Designee will educate the licensed and clinical staff on the process of providing care and services in accordance to provider orders by 10/4/19.<br>4. The DON/Designee will audit for placement of adaptive orthotic equipment on 2 residents per week for 4 weeks then 1 resident weekly for 8 weeks. The results of the audit will be reported at the QAPI meeting by the Director of Nursing/designee for evaluation of compliance and on-going monitoring for | |

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| F 658 | Continued From page 27<br>specialized wheelchair watching TV. It was noted that she had contractures to both hands and there were no palm guards applied. Subsequent observations at 1:30 PM and 3:06 PM, Resident #43 was observed and there were no palm guards applied.<br><br>On 09/10/2019 at approximately 4:30 PM, the clinical record was reviewed.<br>A Physician's Order with a start date of 10/19/2017 documented, "Bilateral palm protectors on at all times except bathing D/T [due to] contractures of the hands."<br><br>On the Treatment Administration Record for September 2019, a treatment initiated on 10/19/2017 entitled, "Bilateral palm protectors on at all times except bathing D/T contractures of the hands" was signed of as administered each shift. On 09/10/2019 for the 7a-3p shift, Licensed Practical Nurse A (LPN A) signed off the palm guards as administered.<br><br>On 09/11/2019 at 10:30 AM, LPN B was asked if she was caring for Resident #43 yesterday (09/10/2019). LPN B stated that she was caring for Resident #43 and she was also precepting LPN A. This surveyor shared concern with LPN B that Resident #43 was observed yesterday without palm guards applied and asked if she knew anything about that. She stated she did see later in her shift that Resident #43 did not have palm guards on yesterday but did not know why and added that they may have been dirty and needed to go to the laundry. When asked about the process when replacement palm guards are needed, LPN B stated they have extras in the supply room and again stated she didn't know why the palm guards were not applied. | F 658 | continuous improvement analysis. | |

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| F 658 | Continued From page 28<br><br>On 09/11/2019 at approximately 3:45 PM, an audit of the Treatment Administration Record for 09/10/19 to include times was requested and the facility provided a copy of the administration history. LPN A signed off the palm guards as administered on 11:08 AM on 09/10/2019. This was just before there were 3 subsequent observations of Resident #43 without palm guards on by this surveyor on 09/10/19 at 12:00 PM, 1:30 PM, and 3:06 PM. There were no notes addressing if the palm guards were removed for some reason.<br><br>On 09/11/2019 at approximately 5:45 PM, the administrator and the DON had no further information or documentation to offer. | F 658 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. | F 688 | | 10/18/19 |

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| F 688 | Continued From page 29<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview, and clinical record review, the facility staff failed to provide assistance to maintain mobility for one resident (Resident #43) in a sample size of 35 residents.<br><br>The findings include:<br><br>1. For Resident #43, the facility staff failed to apply palm guards as ordered by the physician.<br><br>Resident #43, an 89-year old female, was admitted to the facility on 08/31/2016. Diagnoses included but not limited to Alzheimer's disease. Resident #43 also has contractures of both hands.<br><br>Resident #43's most recent Minimum Data Set with an Assessment Reference Date of 08/14/2019 was coded as a quarterly review. The Brief Interview for Mental Status was not coded. Cognitive skills for daily decision-making was coded as severely impaired. Functional status for bed mobility and dressing was coded as requiring extensive assistance from staff. Eating, toileting, and personal hygiene were coded as total dependence on staff.<br><br>On 09/10/2019 at approximately 12:00 PM, Resident #43 was observed sitting in her specialized wheelchair watching TV. It was noted that she had contractures to both hands and there were no palm guards applied. Subsequent observations at 1:30 PM and 3:06 PM, Resident #43 was observed and there were no palm guards applied. | F 688 | 1. Resident #43 had the palm protector re-applied by the unit nurse on 9/11/19. The Director of Nursing provided 1:1 education to LPN A and LPN B on 9/11/19 who failed to comply with the order on 9/11/19. Resident #43 has had no negative outcome from the palm protector not being in place.<br>2. On 9/11/19 rounds were made on all other residents by the DON to ensure placement of ordered Adaptec/orthotic devices. Any adaptive/orthotic devices not in place were immediately addressed. All adaptive/orthotic equipment since 9/11/19 will be audited for application of compliance by DON/designee by 10/8/19. All omissions will have 1:1 education provided to nursing staff by DON/designee.<br>3. Clinical Educator/ Designee will educate the licensed and clinical staff on the process of providing care and services in accordance to provider orders by 10/4/19.<br>4. The DON/designee will audit for placement of adaptive orthotic equipment on 2 residents per week for 4 weeks then 1 resident weekly for 8 weeks. The results of the audit will be reported at the QAPI meeting by the Director of Nursing/designee for evaluation of compliance and on-going monitoring for continuous improvement analysis. | |

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| F 688 | Continued From page 30 | F 688 | | |

On 09/10/2019 at approximately 4:30 PM, the clinical record was reviewed.
A Physician's Order with a start date of 10/19/2017 documented, "Bilateral palm protectors on at all times except bathing D/T [due to] contractures of the hands."

On the Care Plan, a problem area initiated on 09/01/2016 documented, "At risk for skin integrity compromise D/T skin fragility ...". An intervention associated with this problem initiated on 03/24/2017 documented, "Bilat [bilateral] palm protectors to hands at all times except for bathing."

On the Treatment Administration Record for September 2019, a treatment initiated on 10/19/2017 entitled, "Bilateral palm protectors on at all times except bathing D/T contractures of the hands" was signed of as administered each shift. On 09/10/2019 for the 7a-3p shift, Licensed Practical Nurse A (LPN A) signed off the palm guards as administered.

On 09/11/2019 at 8:05 AM, Resident #43 was observed lying in her bed. She had palm guards on both hands.

On 09/11/19 at approximately 09:00 AM, an interview with LPN B was conducted. LPN B confirmed she was caring for Resident #43. LPN B and this surveyor entered Resident #43's room to perform a skin assessment of the palms. As LPN B removed the palm guards, she indicated that there was a left handed palm guard on both the left hand and the right hand and stated she would get the correct palm guard for the right hand.

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| F 688 | Continued From page 31 | F 688 | | |

On 09/11/2019 at 10:30 AM, Resident #43 was observed with the correct palm guards on each hand. This surveyor asked LPN B if she was caring for Resident #43 yesterday (09/10/2019). LPN B stated that she was caring for Resident #43 and she was also precepting LPN A. This surveyor shared concern with LPN B that Resident #43 was observed yesterday without palm guards applied and asked if she knew anything about that. She stated she did see later in her shift that Resident #43 did not have palm guards on yesterday but did not know why and added that they may have been dirty and needed to go to the laundry. When asked about the process when replacement palm guards are needed, LPN B stated they have extras in the supply room and again stated she didn't know why the palm guards were not applied.

On 09/11/2019 at 1:35 PM, the DON was notified of findings. The DON stated she saw that the palm guards were not on (Resident #43) yesterday and when she asked the staff about it, they stated that the palm guards were either in the laundry or (Resident #43) would not tolerate the palm guards. When asked about the expectation of what staff should do when there is a change in condition, the DON stated she expects staff to address resident's pain and notify physician and RR (resident representative). When asked what was done for Resident #43 pertaining to the palm guards, the DON stated that the physician's order was changed to wear palm guards as tolerated instead of at all times. When asked to observe the order in the electronic health record (EHR), the DON looked in the Resident #43's EHR but was unable to locate the order. There was a clinical note by the DON on 09/10/2019 at 6:41 PM that documented,

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| F 688 | Continued From page 32<br>"OT [occupational therapy] requested for palm protectors." When asked why palm guards were important for (Resident #43), the DON stated (Resident #43) has contractures and palm guards "keep her from getting further contracted and skin moisture."<br><br>On 09/11/2019 at approximately 3:45 PM, an audit of the Treatment Administration Record for 09/10/19 to include times was requested and the facility provided a copy of the administration history. LPN A signed off the palm guards as administered on 11:08 AM on 09/10/2019. This was just before there were 3 subsequent observations of Resident #43 without palm guards on by this surveyor on 09/10/19 at 12:00 PM, 1:30 PM, and 3:06 PM.<br><br>On 09/11/2019 at approximately 5:45 PM, the administrator and the DON had no further information or documentation to offer. | F 688 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide adequate supervision to prevent an elopement for one | F 689 | 1. The unit nurse applied a wander-guard to resident #36 on 6-29-19 and then the completion of the elopement risk assessment was completed on 9-24- | 10/18/19 |

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| F 689 | Continued From page 33<br>Resident (Resident #36), who had been identified to be at risk for elopement, in a survey sample of 35 Residents.<br><br>The findings included:<br><br>Resident #36, was admitted to the facility on 3/4/16. Her diagnosis included but were not limited to: psychosis, hallucinations, dementia, hypertension and diabetes.<br><br>Resident #36's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/7/19 was coded as a quarterly assessment. Resident #36 was coded as having a BIMS (Brief Interview for Memory Status) score of 7, which indicated severe cognitive impairment. Resident #36 was also coded as requiring extensive assistance of staff for her activities of daily living which included: transfers, locomotion on and off of the unit, dressing, toilet use, and personal hygiene.<br><br>Observation of Resident #36 on 9/11/19 revealed that she did have a wanderguard bracelet in place on her wrist.<br><br>Review of Resident #36's nursing notes revealed an entry on 4/4/19 at 22:45 [10:45pm] that read, "redirected from attempts to exit door to lobby x 2 this shift. Noted to be able to push door open but was unable to propel her wheelchair thought [sic] into the lobby. Stated "I'm leaving". Able to redirect without difficult [sic]. Noted to continue to roll about facility in her wheelchair until placed in bed by staff at appropriate time."<br><br>Another nursing note entry on 6/29/19 at 21:27 [9:27pm] that read, "resident noted wandering | F 689 | 19 by the DON. The care plan was updated on 6-29-19. There have been no further elopements of resident # 36 since 9/11/19.<br>2. All residents at risk for elopement will be audited by the DON/Designee for accuracy of the elopement risk assessments and wander guard placement by 10/8/19 and any variances will be corrected.<br>3. Clinical Educator/designee will educate the licensed and clinical nursing staff on adequate supervision and notification to leadership to prevent elopement on those identified at risk with new exit seeking behaviors by 10/4/19. All newly identified elopement risks will be reviewed in morning meeting and at the IDT At Risk Meeting weekly starting 10/7/19<br>4. DON/designee will review and update all elopement assessments per MDS schedule and any change in condition as indicated followed by auditing 2 residents at risk for elopement per week for 4 weeks, then 1 for 8 weeks to ensure all interventions are appropriate. The results of the audit will be reported at the QAPI meeting by the Director of Nursing/Designee for evaluation of compliance and on-going monitoring for continuous improvement analysis. | |

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| | 49E215 | A. BUILDING _____ B. WING _____ | 09/11/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIVERSIDE CONVAL CENTER-MATHEW | 603 MAIN STREET MATHEWS, VA 23109 |

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| F 689 | Continued From page 34 | F 689 | | |

around building in her wheelchair. Approximately 1930 [7:30pm] this nurse seen [sic] resident approach exit door by dd's salon, resident redirected from door. At approximately 1945 [7:45pm] Resident was found outside, in front of the building right outside the double doors. When staff questioned Resident on what she was doing, resident stated "waiting for you" with a smile on her face. A wander guard was placed on resident's right wrist, family agreed that this would be a good idea to place wander guard again."

Review of Resident #36's careplan revealed that on 2/21/19 the wanderguard alarm was discontinued. Resident #36's clinical record also revealed an "elopement/unsafe wandering evaluation" completed on 2/27/19 that indicated, Resident #36 was assessed to be at risk for elopement and at risk for unsafe wandering. Review of the careplan revealed no revisions or interventions in response to the following:
* identification of being an elopement risk as identified on 2/27/19
* wandering and attempt to exit into the lobby on 4/4/19
* wandering on 6/29/19 at 19:30.

On 9/11/19 at 9:20 AM, an interview was conducted with the DON and the DON stated, "she was found right outside the door". The DON was asked if the lobby had a receptionist on duty or any staff in the lobby at the time of the elopement of Resident #36. The DON stated, "no, it happened on the evening shift". The DON was asked what the process/procedure for such an unusual occurrence is, she stated, "we would bring them back in, do a full body assessment, make sure they are ok, let the physician and resident representative know, call administration

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| F 689 | Continued From page 35<br>and put a wanderguard on". The DON was asked if this process was followed for Resident #36, the DON stated, "yes, we did a full body assessment on her".<br><br>On 9/11/19 at 1:48 PM, an interview was conducted with Employee C, the (RDO) Regional Director of Operations. When asked what she would expect to see done when a resident exits the facility unsupervised, the RDO stated, "we would get statements from staff regarding what occurred, when the resident was last seen, assess the resident, put an intervention in place to prevent reoccurrence."<br><br>No further information was provided. | F 689 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. | F 812 | | 10/18/19 |

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| F 812 | Continued From page 36<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to serve food in accordance with professional standards for food service safety for 3 Residents (Resident #14, Resident #18, and Resident #29) in a survey sample of 35 Residents.<br><br>The findings included:<br><br>Resident #14 was admitted to the facility on 3/22/19. Resident #18 was admitted to the facility on 2/1/19. Resident #29 was admitted to the facility on 9/15/15.<br><br>On 09/10/19, at 12:28 PM CNA B was observed setting up the meal tray for Resident #14. CNA B grasped the top of the corn cob with her bare hand and cut the corn off of the cob. CNA B then flipped the ear of corn over, and cut off the corn that she had been touching with her bare hands, onto the plate of Resident #14.<br><br>On 09/10/19, at 12:35 PM CNA B was observed setting up the meal tray for Resident #29. CNA B grasped the top of the corn cob with her bare hand and cut the corn off of the cob. CNA B then flipped the ear of corn over, and cut off the corn that she had been touching with her bare hands, onto the plate of Resident #29. CNA B was also observed to touch the dinner roll with her bare hands and buttering the roll.<br><br>On 09/10/19, at 12:35 PM CNA A was also observed setting up the meal tray for Resident #18. CNA A grasped the top of the corn cob with her bare hand and cut the corn off of the cob. | F 812 | 1. The Director of Nursing immediately provided 1:1 education to CNA A and CNA B regarding the proper handling and preparation of food for the compliance of food safety requirements for resident #14, #18 and #29 on 9/10/19.<br>2. All residents are at risk for failure to serve food in accordance with professional standards for food service safety. Director of Food Services/designee will observe all 3 meals for food service safety by 10/8/19. All variances will have immediate 1:1 education provided.<br>3. The Director of Food Services/designee will re-educate the licensed, clinical, including Rehab staff, and non-clinical staff on proper handling of residents prepared food in a safe manner by 10/8/19.<br>4. The Director of Food Services/designee will audit meal delivery service 3 times per week for 4 weeks then 2 times per week for 8 weeks to ensure compliance of food safety requirements. The results of the audit will be reported at the QAPI meeting by the Director of Nursing/designee for evaluation of compliance and on-going monitoring for continuous improvement analysis. | |

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CNA A then flipped the ear of corn over, and cut off the corn that she had been touching with her bare hands, onto the plate of Resident #18.

On 09/11/19, at 01:34 PM, an interview was conducted with CNA B. CNA B was advised that she and CNA A were observed to touch Resident's food with their bare hands and was asked if it is routine for them to touch food when serving residents. CNA B stated, "they say not to, but it was an ear of corn and I didn't know what else to do."

On 09/11/19, at 03:05 PM, an interview was conducted in the conference room with Employee D, the Dietary Manager. When asked if he expects facility staff to touch Resident's food with their bare, un-gloved hands when serving, the dietary manager stated: "that would be a negative, yesterday would be a special occasion, the resident's shucked the corn. Since it is in season they wanted it and it is not an every day event." When asked how he would expect staff to cut the corn off of the cob, the dietary manager stated "use a fork to hold and cut it." He was asked if staff are permitted to wear gloves if needed while preparing Resident food he stated "yes" and indicated they have access to gloves. The dietary manager was asked what the risk are of facility staff touching food with their bare hands, the dietary manager stated, "contamination and everything."

Review of the facility policy titled "Handling Resident Food (Serving)" read, "staff should not handle food with bare hands. To the extent possible, food is handled with utensils; when this is not possible, gloves may be used and changed when potentially contaminated."

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| F 812 | Continued From page 38<br><br>According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-301.11, page 69 stated: "3-301.11 Preventing Contamination from Hands. FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT."<br><br>The facility Administrator and Director of Nursing were made aware of the failure of facility staff to serve food in accordance with professional standards for food service safety during an end of day meeting on 9/11/19 at 4:54 PM.<br><br>No further information was provided. | F 812 | | |