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RIVERSIDE LIFELONG HEALTH AND REHABILITATION – MAT	**603 MAIN STREET MATHEWS, VA 23109**

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 2/21/23 through 2/23/23. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 60 certified bed facility was 59 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control and Abbreviated survey was conducted 2/21/23 through 2/23/23. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements of Nursing Facilities. The census in this 60 bed certified bed facility was 59 at the time of the survey. The survey sample consisted of 12 resident reviews. Three complaints were investigated: VA00057896 - unsubstantiated VA00054158 - substantiated with deficiency VA00053299 - substantiated with no deficiency	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		3/31/23

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

Electronically Signed | 03/15/2023

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 2 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation, the facility staff failed to ensure proper notification to the resident representative for 1 Resident (#21) in a survey sample of 12 Residents. The findings included: For Resident #21 the facility staff failed to notify family and attending physician of Resident #21 missing her dialysis appointment. On 2/21/23 a review of the clinical record revealed a progress note that read as follows: "12/30/21 3:55 PM - Resident refused to go to dialysis today. She was asked four different times and continued to refuse. The dialysis center was contacted and said they would let the doctor know." The clinical record did not document notification of the Resident Representative or MD on 12/30/21. There was no documentation at all for 12/31/21. On 2/22/23 at approximately 2:00 PM an interview was conducted with DON who stated that it is the expectation that the nurse documents notification of MD and Resident Representative. When asked if it is expected that the nurse document the Resident going out of the building	F 580	F – 580 Notify of Changes (Injury/Decline/Room) 1. Resident #21 no longer resides in the facility as of 1/24/22. 2. All residents have the potential to be affected. All current residents' charts will be audited for missed appointments since February 1, 2023, to ensure proper notification of resident representatives and attending physician. Notification will be made by the DON/designee if notification was not documented. 3. Clinical Educator/designee will provide education to the nursing staff on compliance of proper notification of missed appointments and documentation of the notification to the responsible representatives and attending physicians. 4. DON/designee will review the EMR during morning meeting to identify those residents who have had missed appointments and verify notification was communicated and documented to the responsible representative and provider. The DON/designee will conduct audits on eight residents per week for 4 weeks then four residents for 8 weeks to verify that missed appointments have been communicated and documented to the responsible representative and provider. The results of the audits will be reported at he QAPI meeting by the DON for	

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F 580	Continued From page 3 for dialysis or other appointments, she stated that it was. When asked if the facility staff should notify the attending if dialysis was missed, she stated that they should. Employee E stated that staff are supposed to fill out an "rCares" form if there is a transportation issue so that corporate can track it and file complaints with the transportation company. The Administrator submitted 2 rCares forms dated are 12/22/21 and 1/18/22. A review of the clinical record revealed that there was no progress note documentation for missing dialysis on 12/22/21 or the notification of MD and RR. On 2/23/23 during the end of day meeting the concerns were shared with the Administrator and no further information was provided.	F 580	evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective actions will be completed by 3/31/2023.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and facility documentation the facility staff failed to ensure that Residents who require dialysis receive such services for 1 Resident (#21) in a survey sample of 12 Residents. The findings included: The facility staff failed to ensure that Resident	F 698	F – 698 Dialysis 1. Resident #21 no longer resides in the facility as of 1/24/22. 2. All residents have the potential to be affected. All current residents who receive dialysis will be audited to ensure transportation was provided for the service. 3. Clinical Educator/designee will provide	3/31/23

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F 698	Continued From page 4 #21 had transportation to dialysis appointments. On 2/22/23 during clinical record review it was found that Resident #21 missed several dialysis appointments due to lack of transportation. The facility submitted 2 rCares forms for Resident #21 about not being picked up for Dialysis during the timeframe of 12/1/21 - 1/25/22. The dates of the rCares submitted are 12/22/21 and 1/18/22. In addition, there is documentation in the progress notes that read: "1/15/22 1:08 PM - resident did not received dialysis this shift due to transportation issues, dialysis rescheduled for Monday the 17th with a chair time of 3:15 PM, transportation center to pick up resident between 2:00 - 2:15 PM." On 1/17/22 at 4:53 PM the progress note read: "Noted that resident has not yet been picked up. Call being place [sic] to transportation company at [phone number redacted] for ETA. Informed that the appointment was not set up and that she is not set for Tues with her normal time. [MD name redacted] here and will be notified. Primary nurse and DON aware. [MD name redacted] to call and discuss with family. Hospital records were obtained, and the Resident was sent to the ER on 1/17/22 and returned the same night. The hospital note read: "[MD name redacted] calling from [facility name redacted] is sending pt. to [hospital name redacted] for evaluation and treatment, she was seen at the same this morning issues are positive blood cultures, missed dialysis, missed	F 698	education to the clinical staff on the process of arranging transportation for dialysis and other appointments and the process to follow when transportation fails to arrive. 4. DON/designee will review the transportation log to ensure transportation has been arranged for the resident on the scheduled dialysis day. The DON/designee will conduct audits on 2 residents who receive dialysis weekly for 12 weeks to verify that the residents scheduled for dialysis have arranged transportation and have had no missed appointments. The results of the audits will be reported at the QAPI meeting by the DON for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. All corrective actions will be completed by 3/31/2023.	

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F 698	Continued From page 5	F 698		

antibiotics, Severe aortic stenosis. Missed dialysis and overdue by 2 days."

" Patient was seen in this facility on 1/21/22 and discharged after discussion with Nephrology about need for dialysis. They said she could go to regularly scheduled dialysis. [Facility name redacted] states they have appropriate transportation and tomorrow is patients scheduled dialysis."

Excerpts from the progress note on 1/24/22 at 12:23 AM read:
"This nurse arrived for second shift and was informed of resident's situation and that she would be non-emergent brought to the [hospital name redacted] ED. She did not have dialysis."
"Resident clearly retaining fluid - face swollen - this nurse was told she did not have dialysis in approximately 2 weeks."

Emergency room note for 1/24/22 at 11:43 PM read:
"83 yr. old female presents via EMS (Emergency Medical Services) for evaluation of possible dialysis. Patient is a resident of [facility name redacted] and has missed her last 2 episodes due to transportation issues. Staff noted today increased swelling in face."

On 2/23/23 at 10:30 AM a telephone interview with the Medical Director who stated that he was aware they have had transportation issues with getting this patient to dialysis and that they did send her out to the hospital ER for evaluation and treatment when she needed it.

On 2/23/23 at approximately 2:00 PM an interview was conducted with the Administrator

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F 698	Continued From page 6	F 698		

who stated that during the timeframe in question there were a lot of problems with transportation.

The facility also submitted an email statement that read:
"The process for delays and no shows is once we are made aware we then call the payer and file a complaint and then document the complaint number in the transfer center documentation. Their communication to me is that once a vendor has a certain number of complaints the contract is terminated. Please make sure the facilities are putting transfer center as the responsible facility or we do not get the r Care. We get this report weekly. I have also been in contact with several individuals in Richmond DMAS concerning this issue and patients who have life sustaining treatments such as dialysis. Challenge is our more rural areas and lack of vendors."

A facility document named "SNF Outpatient Dialysis Service Agreement." Page 3 paragraph 4 read:

"4. The Nursing Facility shall be responsible for arranging for suitable and timely transportation of the ESRD Residents to and from the ESRD Dialysis Unit, including the selection of mode of transportation, qualified personnel to accompany the ESRD Residents, transportation equipment usually associated with this type of transfer or referral in accordance with the applicable federal and state laws and regulations and all costs or transportation expenses associated with such transfer. The Nursing Facility shall be responsible for ensuring that the ESRD Residents are medically stable to undergo such transportation and medically suitable to receive treatment at the ESRD Dialysis Unit."

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F 698	Continued From page 7 On 2/23/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 698		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility documentation the facility staff failed to ensure Residents were free from significant medication errors for 1 Resident (#21) in a survey sample of 12 Residents. The findings included: For Resident #21 the facility staff failed to ensure she received a new medication ordered while hospitalized for hypotension (1/2/22 thru 1/12/22). The Resident missed administration of the medication from 1/12/22 until 1/16/22 and was subsequently sent back to the hospital for hypotension on 1/16/22. This is harm Past Noncompliance. On 2/22/23 a review of the clinical record revealed that Resident #21 was sent to the hospital on 1/2/22 with a diagnosis of hypotension (low blood pressure). She was prescribed a new medication Midodrine for hypotension. The medication was started in the hospital on 1/10/22 and was supposed to continue this medication upon discharge back to the nursing home.	F 760	Past noncompliance: no plan of correction required.	

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A review of the hospital discharge summary dated 01/12/22, revealed an order for Midodrine 5 mg twice a day.

A review of the orders and MAR (medication administration record) from the facility revealed the medication did not begin until 1/17/22.

Please note there was no progress note in the clinical record about a hospital transfer on 1/16/22, however the hospital records were obtained, and they do state that Resident #21 was brought to the hospital for "Hypotension." The following are excerpts from the 1/16/22 Emergency Room notes:

"Patient has no complaints today but was noted to be hypotensive at the nursing home today with lowest reading 80/40"
"Patient was previously admitted on January 10" [Note the prior hospitalization was 1/2/22 - 1/12/22 and the Midodrine was started in hospital on 1/10/22]
"She was discharged on Midodrine [a medication to treat hypotension]."
"After speaking with the nursing staff at the nursing home the Midodrine was never started at the nursing home."

A review of the clinical record revealed a note from the NP (nurse practitioner) dated 1/14/22 after the Resident's hospital discharge on 1/12/22, and the Midodrine was listed on Resident #21's NP progress note. The Midodrine, however it was never put on the nursing home orders, or MAR [Medication Administration Record] and not given until after the ER visit on 1/16/22 when the hospital discovered the med had not been started on her return to the nursing

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facility from the 1/2/22 - 1/12/22 admission.

LPN A was on leave during the survey and was not available for an interview.

On 2/22/23 at approximately 4:30 PM an interview was conducted with the DON, Employee E (the corporate VP) and Administrator.

Employee E explained that the doctors do not document in the same EHR (electronic health record) system as the nurses. She explained the medication list in the system the doctors use is connected to the hospital system. She stated that the medication list is pulled from the hospital system and if the nurse verifying orders at the time of admission back to the nursing home does not enter them correctly this would explain the discrepancy between the list the MD has and the orders in the nursing home EHR.

The facility requested consideration for past noncompliance and provided the following documents as credible evidence:

The Medication Error Policy which states:
"When medication errors occur, they must be reported to provider and resident representative. Provider will give new orders for monitoring as indicated. The evaluation of these errors should be a continuous process to identify opportunities to improve practices and procedures for the med pass.
r-Cares (corporate quality improvement form) will be completed for all medication and treatment errors for quality improvement and analysis."

The r-Cares form dated 1/20/22 where the LPN self-reported the medication error.

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F 760	Continued From page 10 The facility provided documentation that on 1/20/22 LPN A signed a "1:1 Coaching Form" from the DON. The form read as follows: "[LPN A] was completing order entry for a returning resident on 1/12/22. When completing order entry, the medication Midodrine was left off the orders entered into EMR. This resulted in missed doses to resident. Reviewed requirements for safe transcription and importance of verification of orders." Proof of training dated 2/9/22, for the RN's and LPN's on Documentation and Charting. This training included but was not limited to Admissions, Missing Meds, MD and RR Notification, and Skilled and Non-Skilled charting. After review past non-compliance was granted. On 2/23/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 760		