STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495383	A. BUILDING _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE LIFELONG HEALTH & REHABILITATION SANDERS	7385 WALKER AVE GLOUCESTER, VA 23061

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/18/23 through 7/20/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 7/18/23 through 7/20/23. 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. The census in this 55 certified bed facility was 51 at the time of the survey. The survey sample consisted of 28 resident reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		8/25/23

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

Electronically Signed | 08/04/2023

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F 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to develop a comprehensive plan of care directing measurable goals and interventions related to pain for one (Resident (R) 6) of two sampled residents reviewed for pain in a total sample of 20. This failure placed the resident at risk of unmet care needs and a diminished quality of life.	F 656	1. On 7/19/23 resident #6□s comprehensive care plan was updated to include a pain care plan by the MDS Coordinator. The audit of her care plan was completed to ensure that all Care Area Assessments (CAAs) were addressed. 2. Long Term Care residents will be audited to ensure they address all	

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F 656	Continued From page 2 Findings include: Review of the facility policy titled, "Comprehensive Care Planning," dated 07/01/23 revealed, " ...The facility must work with the resident and their representative, if applicable, to understand and meet the resident's preferences, choices, and goals while they are at the facility. The facility must establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicability quality of life. The facility must develop care plans that describe the resident's medical, nursing, physical, mental, and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences. Care plans must include person-specific, measurable objectives and timeframes in order to evaluate the resident's progress toward their goals ..." Review of the admission "Minimum Data Set (MDS)" located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 02/09/23 revealed, R6 had a "Brief Interview of Mental Status (BIMS)" score of 15 out of 15 which indicated R6 was cognitively intact for daily decision-making. In addition, she was not administered pain medication, however, had almost constant pain in which she rated her pain level at a five out of 10 but did not limit her day-to-day activity or keep her awake at night. Review of the "Care Area Assessment (CAA)" revealed that pain was a triggered care area, as determined by the admission "MDS" and a "Pain Care Plan" would be developed. Review of the "Comprehensive Care Plan," dated	F 656	triggered CAAs based on the most recent Comprehensive Assessment. 3. The DON/designee will educate the MDS Coordinators to ensure that all triggered CAAs are appropriately care planned. 4. The DON/designee will audit 3 residents per week for 4 weeks and 2 residents per week for 8 weeks to ensure all triggered CAAs from the comprehensive care plan from the most recent comprehensive Assessment are addressed. 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. To further monitor compliance, triggered CAAs will be reviewed and compare to the resident Comprehensive Care plan with each comprehensive MDS by the MDS Coordinator. 5. All corrective actions will be completed by August 25, 2023.	

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F 656	Continued From page 3 02/14/23, did not show a "Pain Care Plan" had been developed. During an interview on 07/18/23 at 10:02 AM, R6 stated, "I have had pain a long time, it's mostly in my back. I have had bad posture most of my life. They only give me Tylenol, but it doesn't help." During an interview on 07/19/23 at 2:34 PM, the Director of Nursing (DON) was asked if a "Pain Care Plan" had been developed for R6's complaints of pain. The DON confirmed and verified that a "Pain Care Plan" had not been developed despite the CAA summary indicating that a "Pain Care Plan" would be developed.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the "Recreational Therapy Director's" job description, the facility failed to consistently provide a program of meaningful activities in accordance with the resident's preferences as identified in the resident assessment for two (Residents (R)39 and R27) of	F 679	1. The Administrator provided 1:1 education on 8/1/23 with the Recreational Therapy Director on providing meaningful activities in accordance with resident #39 and #27 preferences as identified in the resident's assessment. 2. All residents' activities assessment	8/25/23

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F 679	Continued From page 4 four residents reviewed for activities in a total sample of 20. This failure placed the residents at risk of a diminished quality of life. Findings include: Review of an undated "Recreational Therapy Director" job description, provided by the Administrator, revealed, " ...Implements, and evaluates activity programs which provide leisure opportunities that will meet the interests and needs of the resident, adapted to his/her medical limitations ...Contributing to and/or directing/delegating the contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident ..." 1. Review of a significant change "Minimum Data Set (MDS)" assessment, located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of 06/15/23 revealed R27 had a "Brief Interview of Mental Status (BIMS)" score of two out of 15 which indicated she was severely impaired in cognition for daily decision-making. In addition, the assessment showed that staff had assessed R27 for her activity preferences, which included: group activities, pets, books, music and going outside. Review of the 06/17/22 "Activity Care Plan" located in the "Care Plan" tab of the EMR, revealed R27 was at risk for activity deficit due to her move and new surroundings. Interventions included: will provide a monthly activity calendar; Staff will assist her to activities; Staff will assist with activities when needed; and cue her through the activity (06/17/23) and Staff will encourage outdoor activities when weather allows	F 679	will be audited and reviewed to ensure each resident has the opportunity to participate in meaningful activities in accordance with their preferences. 3. Administrator/designee will educate the Recreational Therapy team on providing all residents consistent and meaningful activities in accordance with their preferences as identified in the resident assessment. 4. Administrator/designee will audit 3 residents per week for 4 weeks and 2 residents per week for 8 weeks to ensure all residents are having consistent and meaningful activities in accordance with their preferences as identified on the resident assessment. The results of the audits will be reported at the QAPI meeting by the Administrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by August 25, 2023.	

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F 679	Continued From page 5 (07/04/23).	F 679		

Review of the "July 2023 Activity Calendar" located on the bulletin board across from the household two's dining room, revealed on 07/18/23 the activity would be: "9:30 AM Beauty Parlor," and "2:00 PM Happy Hour."

During an observation on 07/18/23 at 10:14 AM, R27 was dressed and alert, however, was only able to answer simple questions. R27 was observed sitting in her wheelchair at the dining table. There was no activity occurring at this time. Further observation revealed the resident did not attend any activities from 07/18/23 to 07/20/23.

2. Review of the quarterly "MDS" assessment located in the "MDS" tab of the EMR with an ARD of 06/13/23 revealed R39 had a "BIMS" score of nine out of 15 which indicated she was moderately impaired in cognition for daily decision-making.

During an observation on 07/18/23 at 12:00 PM, R39 was sitting in her wheelchair at the dining table. She was very drowsy and did not awaken to questions.

According to R39's "Activity Care Plan" located in the "Care Plan" tab of the EMR dated 07/19/23 revealed R39 was at risk for activity deficit due to her poor hearing and cognitive decline. Interventions included: music, family visits, playing cards, bingo, talking with others, and entertainment. Staff were to invite R39 to activities daily and assist as needed.

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F 679	Continued From page 6	F 679		

During an interview on 07/19/23 at 9:40 AM, Family Member (FM) 1 was asked about activities. FM 1 stated, "I do feel they could do a better job (with activities). Yesterday there was supposed to be "Happy Hour," but they did not have it. I stayed and played cards with the ladies until 5:00 PM as there was nothing else for them to do." FM 1 further stated, "I do feel the calendar is often wrong and the activities don't happen. Many days, especially Saturday, nothing happens."

Review of the "Activity Documentation," provided by the facility revealed R39 had one visit documented for the past 30 days. No other activities were listed for R39.

During an interview on 07/20/23 at 8:51 AM, the Recreational Therapy Director (RTD) was asked about the activities program. The RTD stated, "Since I was made the Director, and I lost my assistant in May, things have been kind of thin. The RTD was asked what happens when you cannot do an activity. She stated, "Sometimes, if I have a volunteer and they can't come, then I have to improvise with something else. I do hate it when that happens, but it does happen." The RTD was asked about weekend activities. She stated, "I agree there is not much on the weekend. I usually will do a movie and popcorn one evening and I am trying to get volunteers back in the facility to church, but it's been hard."

During an interview on 07/20/23 at 11:30 AM, the Director of Nursing (DON) was told about the current findings regarding the lack of activities. The DON confirmed that the activity program had been something that Administration was working on to improve.

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility staff failed to properly store, label and date food items, and clean the floors within the facility's main kitchen. This failure had the potential to affect all 51 residents who consumed food prepared from the facility's kitchen. The findings included: 1. Facility staff failed to cover stored food and discard expired milk located in walk-in Refrigerator #4. On 7/18/23 at approximately 10:45 AM, observations during the initial tour of the kitchen	F 812	1. On 7/18/23 the two clear plastic tubs of shuck cord located in the main kitchen refrigerator and the expired unopened gallon of milk was disposed of by the Food Service Director. On 7/18/23 the food items that appeared to be chicken nuggets, onion rings and French fries in the freezer that were not labeled and dated were discarded by the Food Service Director. On 7/19/23 the food item that appeared to be angel food cake that was not labeled or dated in the walk-in freezer was disposed of by the Food Service Director. On 7/19/23 the Food Service Director removed the dirt and debris, including an	8/25/23

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F 812	Continued From page 8 revealed 2 clear plastic tubs which held approximately 4 dozen ears of shucked corn on the cob located in walk-in Refrigerator #4. The tubs were labeled and dated, however there was no lid or covering to protect the exposed corn from any potential contaminants. There was also an unopened gallon of milk with an expiration date of 7/16/23 sitting on the shelf with other gallons of milk that were not expired. On 7/18/23 at approximately 11:00 AM, an interview and kitchen tour was conducted with the facility's Dietary Director (DD) who confirmed he was in charge of the kitchen, kitchen staff, and food procurement. The DD observed the tubs of corn and stated, "Those tubs should be covered with something, plastic wrap, I will take of this". The DD observed the expired gallon of milk and stated, "This milk should not be sitting here available for use, it should have been discarded, it is out of date". The DD removed the expired milk from the shelf. 2. Facility staff failed to label and date food items located in the walk-in freezer. On 7/18/23 at approximately 11:00 AM, an interview and kitchen tour was conducted with the DD. There were several bags of different food items, located within the walk-in freezer, that had been previously opened, however the bags were not labeled or dated. The food items included a partial bag of crinkle-cut french fries, a partial bag of breaded onion rings, and a partial bag of breaded nuggeted food pieces. The DD stated, "These bags should be labeled and dated, those nuggets look like chicken	F 812	overturned plastic cup from behind the icemaker. 2. The system Directors for Food and Nutrition conducted 100% audit of the main kitchen to ensure that all items were labeled, dated, stored and cleanliness of the kitchen was followed according to the policy on 7/19/23. 3. The Director of System Clinical Nutrition and Quality/designee will provide education to the food services team on properly labeling, dating, storing, and cleaning of the kitchen. 4. The Administrator/designee will audit the kitchen 2 times per week for 4 weeks then weekly for 8 weeks to ensure proper labeling, dating, storage and cleaning has been completed in accordance with the policy and schedule. The results of the audits will be reported at the QAPI meeting by the Adminstrator/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by August 25, 2023.	

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nuggets but I cannot be sure of that, I will dispose of these things right now". The DD also stated, "Labels are needed to identify food items so that potential food allergens can be identified before serving it to people and dating food lets us know when it may no longer be safe to serve".

On 7/19/23 at approximately 10:30 AM, an additional observation was made of the kitchen freezer with the DD and revealed 2 frozen cake items which appeared to be angel food cake, however there was no label and no date. These items were not observed on inspection the previous day. The DD stated, "Some items were taken out of their original boxes last night when we were organizing the freezer but I see there is no label or date on the cakes and there should be, this was an oversight".

3. Facility staff failed to ensure the floor behind and around the icemaker, located within the facility kitchen, was free from dirt and debris.

On 7/18/23 at approximately 11:00 AM, an interview and kitchen tour was conducted with the DD. Observations of the icemaker located in the kitchen revealed dirt and debris, including an overturned plastic cup, had collected behind the icemaker which stood approximately 10-12 inches away from the kitchen wall. The DD stated, "It looks like this area is being missed, it is filthy back there, I be sure that it gets cleaned up".

On 7/19/23 at approximately 10:30 AM, an additional observation was made of the kitchen floor behind the icemaker with the DD. The dirt and debris remained the same as the day before.

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The DD confirmed the observation and had no further statement.

On 7/18/23 at approximately 11:15, the Facility Administrator was informed of the initial findings. A facility policy was requested and received.

The facility policy titled, "Food and Nutrition Services Infection Control, Food Safety, and Sanitation Policy, revised 5/30/23, subtitle, "Food Storage, Service, and Holding Temperatures", item G, read, "All Time/Temperature Controlled for Safety (TCS) foods prepared on-site or opened must be stored in clean containers or wrappings and labeled (as to content) and dated...".

On 7/19/23 at approximately 11:00 AM, the Facility Administrator was updated on the additional findings on the second kitchen walk-through. At approximately 11:30, the Facility Administrator reported that the kitchen floor around the icemaker had been swept, mopped, and sanitized which was confirmed by observation at 11:45 AM. No additional information was provided.