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RIVERVIEW NURSING & REHABILITATION CENTER	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

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F 000	INITIAL COMMENTS The State Agency (SA)conducted an annual survey at the facility on 1/12/2020 to 1/15/2020. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited deficiencies at F550, F656, F688, F689, F695, F759, F761 and F880. The census at the time of the survey was 68, and the facility was certified for 91 beds at the time.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		2/14/20

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

Electronically Signed | 02/17/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to provide privacy for Resident #2 during the administration of medications through a Percutaneous Endoscopic Gastrostomy (PEG) Tube, for one (1) of nine (9) residents observed for medication administration. Findings include: Record review of the facility's "Quality of Life - Dignity" policy, revised August 2009, revealed: Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation: 1. Residents shall be treated with dignity and respect at all times; 2. Treated with Dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth; 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during	F 550	1. Licensed Practical Nurse (LPN) #4 was one on one in-serviced on Resident Rights by the Director of Nursing on 1/12/2020, to ensure the privacy and dignity is given to the residents. Resident #2 is unable to be interviewed due to cognitive deficits. 2. Residents receiving medication by Percutaneous Endoscopic Gastrostomy tube and have a roommate have the potential to be affected. Nursing staff was in-serviced on 1/15/2020, on Resident Rights by the Director of Nursing to ensure privacy and dignity of residents. 3. Beginning 1/17/2020, the Director of Nursing will monitor nurses providing Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration three (3) times a week for four (4) weeks,	

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F 550	Continued From page 2 treatment procedures. On 1/12/2020, at 3:17 PM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) tube medication administration, Licensed Practical Nurse (LPN) #4, did not pull the privacy curtain between Resident #2 and her roommate. Resident #2's roommate was sitting up in her wheelchair facing Resident #2's bed. Resident #2's abdomen and PEG tube medication administration was exposed to her roommate during the procedure. On 1/13/2020, at 4:32 PM, an interview with the Interim Director of Nursing (IDON), revealed she stated that would be a privacy issue and a dignity issue for sure and that staff should always pull the curtain when performing care. On 1/15/2020, at 1:29 PM, during an interview with LPN #4 she stated she should have pulled the curtain between the residents to ensure Resident #2's privacy. Record review of Resident #2's Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 9/26/19, revealed in Section C, Item C1000, Cognitive Skills for Daily Decision Making was coded a 3, which indicated severe cognitive impairment-never/rarely made decisions.	F 550	then weekly for four (4) weeks and monthly for three (3) months to ensure services are being given per the care plans. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		2/14/20

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F 656	Continued From page 3 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident	F 656	1. Licensed Practical Nurse (LPN) #5	

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F 656	Continued From page 4 interviews, record review and facility policy review, the facility failed to develop a care plan to address Resident #27's hospital return with a new medication and diagnosis; to implement Resident #45's care plan for Passive Range of Motion (PROM) exercises, to implement Resident #40's use of an alarm only while in bed, and to store and change Residents #24 and #50's oxygen (O2) tubing. This concern was identified for five (5) of 19 residents reviewed. Findings include: Review of the facility's "Care Plan - Comprehensive" policy, dated September 2010, revealed: Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. 6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes. 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Each resident's comprehensive care plan is designed to incorporate identified problem areas and incorporate risk factors	F 656	updated Resident #27□s Care Plan on 1/14/2020 to reflect the new medication of Eliquis and the new diagnosis of a Pulmonary Emboli. Certified Nursing Assistant (C.N.A.) #2 was one on one in-serviced by Occupational Therapist on 1/17/2020, on performing the restorative exercise according to the care plan for Resident #45. Resident #24□s O2 tubing was replaced, bagged and labeled by the Director of Nursing on 1/15/2020. Resident 40□s body alarm was removed from resident□s wheelchair by the Director of Nursing on 1/12/2020, and placed on the bed according to the resident□s care plan. Resident #50□s O2 tubing was replaced, bagged and labeled on 1/13/2020, by the Director of Nursing. 2. All residents have the potential to be affected. 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing on implementation, developing and updating care plans as needed for residents. A 100% audit of care plans was conducted by the Minimum Data Set Coordinator, beginning on 1/17/2020, and being concluded on 1/21/2020, to ensure all active diagnosis and all current medications were care planned. There were no additional issues found. Beginning 1/17/2020, the Assistant Director of Nursing will audit three (3) residents' care plans three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure care plans are being	

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F 656	Continued From page 5 associated with identified problems. Resident #27 Record review revealed upon Resident #27's return to the facility, on 1/2/2020, from the hospital, the Comprehensive Care Plan did not develop a care plan for the new medication Eliquis or its possible side effects and the new diagnosis of a Pulmonary Emboli. On 01/14/2020, at 11:41 AM, an interview with Licensed Practical Nurse (LPN) #5 revealed she was responsible for revising and developing care plans for residents when they return from the hospital. LPN #5 revealed the nurses on the floor do not revise or develop care plans when they write new orders or readmit a resident to the facility. LPN #5 confirmed she did review the new readmit orders on Resident #27 when he returned to the facility on 1/2/20. LPN #5 confirmed she did not update the comprehensive care plan for Resident #27 to include the new medication Eliquis or the diagnosis from the hospital of Pulmonary Emboli. LPN #5 revealed she had no idea why she did not include the Eliquis or the diagnosis of Pulmonary Emboli. LPN #5 revealed it is important to update the care plan with blood thinners and history of a Pulmonary Embolus because the resident could have complications. Record review of the Admission Orders, dated 1/2/2020, revealed Resident #27 returned to the facility from the hospital with a new order for Eliquis 5 milligrams (mg) tablet two (2) times a day. Record review of the Hospital Discharge Summary, dated 1/2/2020, revealed a chest x-ray	F 656	implemented and updated as needed. The Assistant Director of Nursing will inspect residents with orders for O2 three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure the tubing is labeled and stored per care plan. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations.	

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impression of a right pulmonary emboli filling defects in the branches of the descending right pulmonary arteries.

Resident #45

Record review of the Care Plan, dated 11/11/2019, revealed the Problem/Need for Restorative Nursing for contracture management/right upper extremity (RUE) functional strength training. The Goal stated to maintain current level of function for dressing using the right extremity. Next Resident will maintain level of function assisting with dressing using the right extremity times (x) 12 weeks, 2/11/20. The Approaches included: Perform Right Upper Extremity (RUE) shoulder flexion exercises four (4) sets of 15 reps (repetitions) pain free. Perform Passive Range of Motion (PROM) to the Left Upper Extremity (LUE) shoulder flexion/abduction four (4) sets with 15 second holds pain free. Perform Restorative six (6) days weekly. Notify Occupational Therapy (OT) of changes or decline in function. The Restorative Certified Nursing Assistant (RCNA) was the staff assigned to these approaches.

Record review of the January 2020 Physician's Orders, revealed an order, dated 11/14/19, to admit Resident #45 to Restorative Nursing Program: 1) AROM (Active Range of Motion) to the right shoulder flexion exercises, four (4) sets of 15 reps (repetitions) 2) PROM to the left shoulder Flexion/Abduction four (4) sets 15 second holds six (6) days weekly.

On 1/12/2020, at 3:40 PM, in an interview with Resident #45, he stated he is supposed to have Restorative Nursing for exercises for his

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F 656	Continued From page 7 shoulders, but "they don't do it". On 01/14/2020, at 10:46 AM, during an interview with Certified Nursing Assistant (CNA) #2, she stated she had been doing Resident #45's restorative exercises because sometimes the Restorative CNA (RCNA) would have a section to work. She stated she performed Range of Motion (ROM) with his shoulders and arms and that the left arm is PROM. She stated she did PROM 15 times to the left shoulder and arm which included one set of 15 or sometimes 10. This Surveyor asked CNA #2 to read the order for PROM to the left shoulder. CNA #2 read it from the Kiosk and she stated, "I do it 10 sometimes 15 times, I thought it means hold it a couple of seconds and let it go rest on the bed". In an interview, on 01/14/2020, at 11:00 AM, the Occupational Therapist (OT) stated the order for PROM to the left shoulder for four (4) sets of 15 second holds was for contracture management and pain management. The OT stated he goes over the exercises with the Restorative Aide, have them return a demonstration and sign the competency sheet. The OT stated it should be the four (4) sets of 15 second holds with the PROM, the key word is pain free with the hold. He stated the CNA should be holding the extremity in the pain free position for 15 seconds four (4) times. He stated the important part was the hold for 15 seconds and that reps and holds get a little confusing. On 1/15/2020 at 3:00 PM, an interview with the Director of Nursing (DON), confirmed the Restorative Care Plan for Resident #45 was not followed due to the PROM exercises were not performed correctly.	F 656		

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F 656	Continued From page 8 Resident #24 Review of Resident #24's Comprehensive Care Plan revealed the Problem/Need, dated 1/31/2019, for the diagnosis Chronic Obstructive Pulmonary Disease (COPD) and at risk for Shortness of Breath (SOB). The Approaches included: Change the nebulizer and O2 tubing weekly, on Wednesdays. An observation in Resident #24's room, on 1/12/2020 at 5:01 PM, revealed the resident's O2 tubing was on the floor beside the bed, with the bed wheel on the tubing. The O2 tubing was dated 1/8/2020. Further observation revealed there was no storage bag or container for the O2 tubing. An observation of Resident #24's room, on 1/13/2020 at 10:30 AM and 4:20 PM, revealed the O2 tubing was still on the floor beside the bed, and there was no storage bag/container in the room. On 1/14/2020 at 9:15 AM and 3:45 PM, observations of Resident #24's room revealed the O2 tubing was on the floor beside the bed, and there was no storage bag/container in the room. On 1/15/2020 at 9:15 AM, an observation of Resident #24's room revealed the O2 tubing was on the floor beside the bed, and these still was no storage bag/container in the room. An interview with Resident #24, on 1/12/2020 at 5:05 PM, revealed she doesn't remember ever having a bag to put the O2 tubing. Resident #24 stated just throws it wherever.	F 656		

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Review of the Physician's Order List revealed an order, dated 10/3/19, for Oxygen at 2L/min (liters per minute) via nasal cannula as needed for shortness of breath, change oxygen tubing out weekly on Wednesday, Check O2 sat (saturation) every shift. Notify MD (Medical Doctor) if <90% for Shortness of Breath.

An interview with Director of Nursing (DON), on 1/15/2020 at 9:30 AM, revealed the floor nurses on the day shift was responsible for changing the O2 tubing on Wednesdays and should be ensuring there is a bag in there to store the tubing. Record review of the Face Sheet revealed Resident #24 was admitted by the facility, on 1/31/2019, with the included diagnoses of Rhabdomyolysis, Heart Failure, Insomnia, Shortness of Breath, Chronic Obstructive Pulmonary Disease, Essential Hypertension.

Resident #40

Record review of Resident #40's Comprehensive Care Plan revealed the Problem/Need, dated 3/16/19, for risk for fall related to (R/T) history of fall, impaired mobility. The Approaches included a body alarm to be worn when in bed. Further review of the care plan revealed the Problem/Need, dated 3/23/18, for resident wanders daily and exhibits repetitive verbalizations in the form of questions. She has a history of sleep disturbance, agitation, restlessness including repetitive attempts to get out of bed or chair without assistance. The Approaches included the use a body alarm as ordered.

Review of Resident #40's January 2020

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Physician's Orders revealed an order, dated 11/21/18, for a body alarm on when in bed R/T resident unaware of safety.

On 1/12/2020 at 5:00 PM, an observation revealed Resident #40 was observed to wheel herself into the dining room with a body alarm on and attached to her wheelchair.

On 1/12-2020 at 5:10 PM, an observation revealed an alarm was heard from the hallway. Upon entering the dining room, a staff member was observed reattaching Resident #40's body alarm to her wheelchair to stop the alarm noise.

Review of Resident #40's Resident Incident Report, dated 12/09/19 at 2:30 PM, revealed: "While sitting at desk this nurse was alerted by chair alarm was lead to room 127 where resident had entered another resident room threw covers back and attempted to crawl in bed".

During an interview with the Director of Nursing (DON), she was informed about Resident #40's body alarm being on in the dining room on 1/12/2020 at 5:00 PM, the alarm sounding at 5:10 PM, with a CNA intervening to reattach the alarm to Resident #40's wheelchair, and the documented statement on the Resident's Incident Report, dated 12/09/19 at 2:30 PM, when Resident #40's body alarm sounded when she attempted to climb into another resident's bed, where the nurse documented she "was alerted by chair alarm, and was lead to room 127". When the DON was asked if the body alarm should have been present on Resident #40's wheelchair on those dates and times, if the care plan stated the body alarm was to be on when in bed. The DON the alarm should not have been on her

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F 656	Continued From page 11 during the day, the staff probably saw it on her bed and thought she was supposed to have it all the time.` Resident #50 Review of Resident #50's Comprehensive Care Plan revealed a Problem/Need, dated 9/29/19, for Congestive Heart Failure (CHF) and risk for dehydration and SOB. The Approaches included: Check O2 SAT PRN (as needed) and notify the physician if < 90%, change O2 tubing Q (every) Wednesday, and O2 at 2L/M per nasal cannula PRN. The care plan was last reviewed/ updated on 1/02/2020. Observations in Resident #50's room, on/12/2020 at 4:40 PM, 1/13/2020 at 8:45 AM, and on 1/13/2020 at 2:10 PM, revealed the O2 tubing and nasal cannula was hanging over the O2 concentrator, uncovered and undated. Review of Resident #50's Electronic Treatment Administration Record (eTAR), revealed an order was noted to change O2 tubing weekly every Wednesday, however, there were no signatures on the eTAR for the entire months of October 2019, November 2019, December 2019, or on Wednesday, the 1st of January, 2020, nor Wednesday, the 8th of January, 2020. On 1/13/2020 at 2:47 PM, an interview with the Director of Nursing (DON), revealed when she was asked about no signatures being present on the eTAR for the months of October 2019 through January 2020, she pulled up the eTARs on her computer, and verified there were no signatures for the months of October 2019 through January 13, 2020.	F 656		

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F 656	Continued From page 12 On 1/13/2020 at 2:55 PM, an interview with the DON revealed, "the nurse that put in the admission order marked it as a PRN medication and should have assigned a day and time to the oxygen tubing change order for it to fire for the nurses to sign. The nurse that put in the order did not do the special requirements section correctly." When asked if there was any way she could verify the tubing was being changed according to the physicians order and care plan, from October 2019, through 1/13/2020, and she stated "no".	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §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 §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. §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. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility policy review and record review, the facility failed to provide Resident #45's Passive Range of	F 688	1. Certified Nursing Assistant (C.N.A.) #2 was one on one in-serviced on 1/17/2020 by Occupational Therapist on performing	2/14/20

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F 688	Continued From page 13 Motion (PROM) exercises correctly to prevent the potential decline in range of motion for one of three (1 of 3) residents reviewed receiving restorative services. Findings include: Review of the facility's policy titled, "Restorative Nursing Services", revised July 2017, revealed, "Policy Statement: Residents will receive restorative nursing care as needed to help promote optimal safety and independence". On 1/12/19, at 3:40 PM, during an interview with Resident #45, he stated he was supposed to have Restorative Nursing for exercises to his shoulders but "they don't do it". Record review of the January 2020 Physician's Orders revealed an order, dated 11/14/19, to admit Resident #45 to the Restorative Nursing Program for 1) Active Range of Motion (AROM) right shoulder flexion exercises four (4) sets 15 repetitions (reps) 2) Passive Range of Motion (PROM) left (L) Shoulder Flexion/Abduction 4 sets 15 second holds six (6) days weekly. On 1/14/2020 at 10:25 AM, an interview revealed Restorative Certified Nursing Assistant (CNA) #1, stated, the CNA who gets him up does it for me and they just tell me. Other than that, he gets done. He has AROM to the left and PROM to the right shoulder. CNA #1 stated CNA #2 has him four (4) days and she usually does it for me. CNA #1 said normally by the time I get down there she will have already done his exercises, dressed him and got him up. This morning he got up at 8:15 because he had to be at the dentist at 9:00. CNA #2 did it this morning. CNA #1 stated therapy	F 688	the restorative exercise according to the care plan for Resident #45. Resident #45 assessed by the Director of Nursing on 1/17/2020, with no negative affects due to the alleged deficient practice. 2. Four (4) residents receiving restorative services have the potential to be affected. 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing on following the orders for restorative services. Beginning 1/17/2020, the Restorative Nurse will monitor Certified Nursing Assistants providing restorative services three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure services are being provided according to the orders. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations.	

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F 688	Continued From page 14	F 688		

explains and tells her about new orders for each individual. CNA #1 said she did not know if the CNAs on the floor got the instructions when she got them or when they are discharged to the floor CNAs. CNA #1 states a man from therapy did go over a lot of things with all the CNAs recently.

Record review of the Therapy to Restorative Form for Resident #45 revealed the resident was discharged from Occupational Therapy on 11/11/19 with "Goals for Restorative Program: 1. Resident will perform RUE shoulder flexion exercises 4 sets of 15 reps pain free range. 2. Perform PROM to LUE in shoulder flexion and shoulder abduction 4 sets of 15 second holds. Pain free range." Restorative CNA #1 signed the form on 11/14/19.

On 1/14/2020, at 10:46 AM, an interview with CNA #2 revealed she stated, she does Resident #45's exercises because sometimes CNA #1 has a section and I don't know if she has a section or not. CNA #2 said Resident #45 does look for CNA #1 because he knows she's the restorative aide. CNA #2 said she did ROM with his shoulders and arms. Just a little exercise up and down with his shoulders, the left is passive. CNA #2 said she did PROM 15 times to the left shoulder and arm, and one set of 15 or sometimes 10. CNA #2 said they had an in-service a good while ago where they took us in there (therapy room) and showed us dressing, ROM and stuff. No one goes over exercises for individual residents with us when they are discharged to restorative from therapy. We are responsible for making sure Restorative exercises get done if Restorative CNA #1 is assigned to a section. CNA #2 stated that CNA #1 has a lot of different assignments from working on the floor to transportation. CNA #2 stated she

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F 688	Continued From page 15 does have access to Restorative Nursing Program (RNP) Care Task in the Kiosk as she demonstrated by opening it in the Kiosk and this surveyor observed that the exercises for Resident #45 were documented as completed for January 2020. CNA #2 stated sometimes she charts it's done and sometimes she just tells CNA #1 that it's done and she charts it. CNA #2 reviewed the order at this time for PROM to the left shoulder from the Kiosk and she stated she does it 10 sometimes 15 times, and she thought it meant to hold it a couple of seconds and let it go rest on the bed". On 1/14/2020, at 11:00 AM, an interview with the Occupational Therapist (OT), revealed PROM to the left shoulder for 4 sets of 15 second holds, that's for contracture management. and pain management. The PT stated he goes over the exercises with the Restorative Aide, have them return demonstrations and sign the competency sheet. The OT stated we try to word it so that if another aide comes in he/she will know what to do as well. If they have any questions about it they can consult with us. It should be the 4 sets of 15 second hold with the passive, key word is pain free with the hold. The CNA should be holding the extremity in the pain free position for 15 seconds 4 times. I think sometimes it gets confusing with the wording. Active ROM should be 4 sets of 15. Probably there are communication issues with that. The important part is the hold for 15 seconds. Reps and holds get a little confusing. We have in-serviced the CNAs on different exercises, AROM, PROM, a list of things that they would be doing actually in the restorative program". On 1/14/20, at 2:26 PM, an interview with the OT	F 688		

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F 688	Continued From page 16	F 688		

revealed he stated he just evaluated Resident #45 and there were no changes found with ROM of bilateral shoulders since discharge from therapy.

An interview with Licensed Practical Nurse (LPN) #3/Restorative Nurse, on 1/15/2020, at 9:06 AM, revealed LPN #3 stated all Certified Nursing Assistants (CNA) staff are aware of how to do the restorative. They were in-serviced by a therapist because when CNA #1 is not here, the floor CNA picks it up, We do six (6) days a week, Monday-Saturday. CNA #1 wears many hats, she drives the van, works a section and when she works a section the CNAs are required to do their people. LPN #3 stated she was not aware that CAN #2 was not aware of how to interpret the PROM order of 4 sets of 15 second holds.

On 1/15/2020 at 9:40 AM, an interview with the Interim Director of Nursing (IDON), revealed a consequence of not getting the correct restorative exercises could be a regression of the resident's ability to move instead of a progression toward his goals. The IDON stated she believed that CNA #2 truly did not understand the order. She said she felt that the RCNA should be the one to do the restorative exercises because she is the one who was trained to do them. The IDON stated she did not know that the floor CNAs were doing the exercises on a regular basis. She stated there were three (3) residents on the Restorative Nursing Program at this time and even though the RCNA has other duties, she should be able to cover those residents She stated the facility just hired a new RCNA and that she felt like having a backup RCNA would be a good idea.

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F 688	Continued From page 17 Record review of the Face Sheet for Resident #45 revealed the resident was admitted by the facility, on 8/28/19, with diagnoses including but not limited to Other Seizures, Muscle Wasting and Atrophy, not elsewhere classified (NEC), left upper arm, Hemiplegia following Cerebral Infarction Affecting Left Non-dominant Side. Record review of the Quarterly Minimum Date Set, with an Assessment Reference Date of 12/2/19, revealed in Section C, Resident #45 had a Brief Interview for Mental Status score of 15, indicating intact cognition. Record review of the Occupational Therapy Plan of Care (Evaluation Only) performed by the Occupational Therapist, on 1/14/2020, revealed no decline in function since discharge from OT on 11/11/19.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to address Resident #40's care plan after a fall with an intervention to prevent the potential for another fall. Resident #40 was assessed a high risk for falls by the facility, on 11/15/2019, and experienced another	F 689	1. Resident #40□s fall care plan was updated on 1/13/2020, by the Care Plan Nurse with a new fall intervention for staff to monitor resident when up in wheelchair. 2. Residents at risk for falls have the	2/14/20

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F 689	Continued From page 18 fall on 12/9/2019. This concern was identified for one (1) of two (2) residents reviewed for falls. Findings include: Review of Resident #40's Resident Incident Report, dated 12/09/2019 at 2:30 PM, revealed Resident #40 had a fall, in which she entered another resident's room, threw the covers back on the bed and attempted to crawl in bed. She was found laying on the floor next to the bed with her knees bent and asking for a pillow so she could put it under her head. Review of Resident #40's care plan, with the reviewed/update of 11/20/19, revealed the Problem/Need for risk for fall related to (r/t) a history (HX) of falls, and impaired mobility. The Approaches included: call light within reach, bed in lowest position and wheels are locked, non-skid footwear, fall assessment quarterly and as needed (PRN), Physical Therapy (PT) to evaluate after each fall, body alarm when in bed, bilateral safety transfer bars on bed for turning and positioning. Resident # 40's care plan did not address fall interventions dated after the fall on 12/9/19. During an interview with the Director of Nursing (DON), on 1/13/2020 at 4:30 PM, she revealed the staff had attempted another intervention after Resident #40's recent fall, she stated therapy had screened the resident, according to the care plan, and they recommended no therapy due to her cognitive impairment. When asked if any of the interventions currently listed on Resident #40's care plan would have helped to prevent the fall on 12/09/2019, in which resident #40 had wandered into another resident's room to try to get in their	F 689	potential to be affected. 3. The Interdisciplinary Team was in-serviced on 1/17/2020, by the Administrator to ensure interventions are put in to place for residents with falls. A 100% care plan audit was conducted by the Minimum Data Set Coordinator beginning 1/17/2020, and concluding 1/21/2020, with no additional issues found. Beginning 1/17/2020, the Director of Nursing will audit fall incidents three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure interventions are put in to place to help prevent to potential another fall. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations.	

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F 689	Continued From page 19 bed, the DON stated "no". When asked why the staff didn't attempt an additional intervention to address the cause of the fall, which was wandering into another resident's room in search of a place to lay down, the DON "We didn't put another intervention in place, when therapy didn't pick her up because she doesn't usually get up and move around a lot out of her chair. She is always on the move up and down the halls in her wheelchair, and she is hard to keep track of." When asked if another intervention to address the cause of the fall should have been put into place for Resident #40, she stated "yes". Review of Resident #45's Fall Risk Evaluation revealed a score of "12". The assessment indicated "A score of 10 or GREATER indicates a potential FALL RISK". Review of Resident #45's Assessment of Risk for Falls revealed a score of "8" on 11/15/19. This assessment indicated a score of "07-18 Resident is high risk". Review of the Face Sheet revealed Resident #40 was admitted by the facility, on 3/16/18, with the included diagnoses of Unspecified Dementia without behavioral disturbance, Personal HX of TIA (Trans Ischemic Attack) and Cerebral Infarction without residual deficits and Major Depressive Disorder, single episode, unspecified. Review of Resident #40's Quarterly Minimum Data Assessment, dated 11/15/19, revealed the resident's BIM score was 99 due to the resident was not interviewable.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		2/14/20

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F 695	Continued From page 20 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to store and change oxygen (O2) tubing to prevent the possibility of infection/cross contamination, for two (2) of 17 residents reviewed on oxygen therapy. Resident #50 and Resident #24 Findings include: Review of the facility's policy titled, "Changing of Oxygen Supplies", dated September 2019, revealed: Policy Statement: Riverview Nursing and Rehabilitation Center incorporates procedures to maintain an environment as free of infection as possible for our residents. Policy Interpretation and Implementation: 1. Designated nursing staff will change oxygen tubing, mask, and cannulas at least every (7) days and PRN (as needed), 2. Designated nursing staff will label oxygen tubing, cannulas and oxygen humidifier water containers with date of change in a visible site. 3. Designated nursing staff will place opened oxygen tubing, mask and cannulas in	F 695	1. Resident #24□s oxygen (O2) tubing was replaced, bagged and labeled by the Director of Nursing on 1/15/2020. Resident #50□s O2 tubing was replaced, bagged and labeled on 1/13/2020, by the Director of Nursing. Neither resident has had any adverse finding from this deficient practice. 2. Eighteen (18) residents with orders to receive oxygen have the potential to be affected. 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing to ensure oxygen tubing was labeled and stored according to policy. Beginning 1/17/2020, the Assistant Director of Nursing will inspect residents with orders to receive oxygen three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure the tubing is labeled and stored according to the facility□'s policy and procedures. 4. The Administrator is responsible for on-going monitoring and compliance.	

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F 695	Continued From page 21 labeled/dated container/covering while not in use. An observation, on 1/12/2020 at 5:01 PM, in Resident #24's room, revealed the resident's O2 tubing was on the floor beside the bed, with the bed wheel on the tubing. The O2 tubing was dated 1/8/2020, and there was no storage bag or container for the O2 tubing. On 1/13/2020 at 10:30 AM and 4:20 PM, an observation of Resident #24's room revealed the O2 tubing was still on the floor beside the bed, and there was no storage bag/container in the room. Observations, on 1/14/2020 at 9:15 AM and 3:45 PM, of Resident #24's room, revealed the O2 tubing was on the floor beside the bed, and there was no storage bag/container in the room. On 1/15/2020 at 9:15 AM, an observation of Resident #24's room revealed the O2 tubing was on the floor beside the bed, and these still was no storage bag/container in the room. On 1/12/2020 at 5:05 PM, an interview with Resident #24, on revealed she doesn't remember ever having a bag to put the O2 tubing, so she just throws it wherever. Review of the Physician's Order List revealed an order, dated 10/3/19, for Oxygen at 2L/min (liters per minute) via nasal cannula as needed for shortness of breath, change oxygen tubing out weekly on Wednesday, Check O2 sat (saturation) every shift. Notify MD (Medical Doctor) if <90% for Shortness of Breath. On 1/15/2020, at 9:30 AM, an interview with the	F 695	Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Assistant Director of Nursing for three (3) months for review and recommendations.	

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F 695	Continued From page 22	F 695		

Director of Nursing (DON), revealed the floor nurses on the day shift was responsible for changing the O2 tubing on Wednesdays and should be ensuring there is a bag in there to store the tubing.

Record review of the Face Sheet revealed Resident #24 was admitted by the facility, on 1/31/2019, with the included diagnoses of Rhabdomyolysis, Heart Failure, Insomnia, Shortness of Breath, Chronic Obstructive Pulmonary Disease, Essential Hypertension.

Resident #50

On 1/12/2020 at 4:40 PM, 1/13/2020 at 8:45 AM, 1/13/2020 at 10:42 AM and on 1/13/2020 at 2:10 PM, observations of Resident #50's room revealed the O2 tubing and nasal cannula was hanging over the O2 concentrator, uncovered and undated.

On 1/13/2020, at 2:15 PM, the Director of Nursing (DON) verified Resident #50's O2 tubing was not dated, and there was no container visible or in the resident's night stand to place the nasal cannula in when it was not in use. The DON stated, "there should be a bag in each resident's nightstand drawer that is dated, with the resident's name on it to put the cannula in when it is not being used, and I don't see one in here anywhere".

Review of Resident #50's Electronic Treatment Administration Record (eTAR), revealed an order was noted to change O2 tubing weekly every Wednesday, however, there were no signatures on the eTAR for the entire months of October 2019, November 2019, December 2019, or on Wednesday, the 1st of January, 2020, nor

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F 695	Continued From page 23 Wednesday, the 8th of January, 2020. An interview, on 1/13/2020 at 2:47 PM, revealed the Director of Nursing (DON), revealed when she was asked about no signatures being present on the eTAR for the months of October 2019 through January 2020, she pulled up the eTARs on her computer, and verified there were no signatures to document the resident's O2 tubing was changed weekly for the months of October 2019 through January 13th, 2020. An interview, on 1/13/2020 at 2:55 PM, with the DON revealed, "the nurse that put in the admission order marked it as a PRN medication and should have assigned a day and time to the oxygen tubing change order for it to fire for the nurses to sign. The nurse that put in the order did not do the special requirements section correctly." When asked if there was any way she could verify the tubing was being changed according to the physician's order and care plan, from October 2019, through 1/13/2020, and she stated "no". Review of the Face Sheet revealed Resident #50 was admitted by the facility, on 9/25/19, with the included diagnoses Congestive Heart Failure (CHF), Diabetes Type II, Shortness of Breath (SOB), Cough and Wheezing.	F 695		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		2/14/20

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F 759	Continued From page 24 by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure a medication error rate of less than five percent (5%), out of 27 medication administrations observed. The medication error rate was 14.81%. Findings include: Review of the facility's policy titled, "Administering Medications through an Enteral Tube", revised March 2015, revealed, Purpose: The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Steps in the Procedure: 21. When correct tube placement and acceptable GRV have been verified, flush tubing with 15-30 ml warm sterile water (or prescribed amount). 23. Dilute the crushed or split medication with 15-30 ml room temperature purified water (or prescribed amount). 26. If administering more than one medication, flush with 5 ml (or prescribed amount) room temperature purified water between medications. 27. When the last of the medication begins to drain from the tubing, flush the tubing with 5 ml of room temperature purified water (or prescribed amount). An observation, on 1/12/2020 a 3:17 PM, revealed Licensed Practical Nurse (LPN) #4 administered Resident #2's medications via his Percutaneous Endoscopic Gastric (PEG) tube. LPN #4 turned on the water faucet in the resident's room and allowed 5 cubic centimeters (CC) of water to pour into two (2) medicine cups. LPN #4 added the crushed Keppra 1,000 milligram (mg) tablet to one of the medicine cups,	F 759	1. Residents #2 and #52 were assessed by the Director of Nursing on 1/13/2020, for any adverse reaction to the alleged deficient practice with no negative findings noted. Licensed Practical Nurse (LPN) #1 and #4 were one on one in-serviced by the Director of Nursing on 1/15/2020, on administering medication by Percutaneous Endoscopic Gastrostomy (PEG) tube according to the physician□s orders. 2. All residents have the potential to be affected. 3. Nurses were in-serviced on 1/17/2020 by the Director of Nursing on administering medications per the attending physician□s orders and in compliance with facility infection control practices. Beginning 01/17/2020, the Director of Nursing will observe Medication Pass three (3) times a week for four (4) weeks, and then weekly for four (4) weeks and monthly for three (3) months to ensure medication is being administered through Percutaneous Endoscopic Gastrostomy (PEG) tube as ordered and infection control practices are being observed. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations.	

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F 759	Continued From page 25 and she added the crushed Coreg 6.25 mg tablet to the second medicine cup. LPN #4 poured up 30 cc of Pro-Stat into a third medicine cup. LPN #4 administered the medications via Resident #2's PEG tube without flushing with the prescribed 5 ml of water between the medications. LPN #4 also did not add the 15 to 30 ml of water to dissolve the crushed/split medications. Review of Resident #2's Physician Orders List, printed 1/13/2020 at 4:38 PM, revealed the following orders: (1) 3/13/19, flush the PEG tube with 60 milliliters (ml) of water before and after (AC/PC) medications and with 5 ml between meds. (2) 2/15/17 Keppra 1000 mg tablet, give one tablet via the PEG tube twice a day. (3) 12/19/17 Pro-Stat Sugar Free Liquid 30 cc per the PEG tube twice a day. (3) 4/24/18 Coreg 6.25 mg tablet via the PEG tube twice a day. On 1/15/2020, at 1:21 PM, an interview with LPN #4, revealed she stated she knew the order said 5 ml between meds, but she thought the 5 ml that she mixed the medication with was the 5 ml ordered. LPN #4 stated it was just a misunderstanding. LPN#4 confirmed she had mixed the Coreg and Keppra with 5 ml of water, and she did not know the amount of water that should be used to dissolve the medications. An interview with the Director of Nursing (DON), on 1/13/20, at 4:40 PM, revealed LPN #4 should have flushed Resident #2's PEG tube with 5 ml of water between the medications, and dissolved the medications with 15-30 ml of water per agency policy. Record review of the Face Sheet revealed	F 759		

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F 759	Continued From page 26 Resident # 2 was admitted by the facility, on 10/25/16, with diagnoses including Essential (primary) Hypertension, Alzheimer's Disease, and Dysphagia. Resident #52 On 1/13/2020 at 8:10 AM, Licensed Practical Nurse (LPN) #1, was observed administering a medication via a PEG tube for Resident #52. LPN #1 pulled the medication, Klonopin 0.5 mg tablet, from the cart, crushed the medication and placed it in a medicine cup. LPN #1 obtained 120 cc of water from an unopened water bottle. LPN #1 stated at this time, "I give 60 cc of water before and after the medication". LPN #1 mixed 5 cc of water with the medication and stirred it to dissolve it. LPN #1 disconnected the syringe, removed the plunger and reconnected the syringe to the enteral tube and poured the medication dissolved in 5 cc of water into the syringe. Once it went through, she administered a 120 cc water flush into the syringe and waited for it to all run in. LPN #1 then removed the syringe, clamped the PEG tube and reattached the enteral feeding, secured it, and started the feeding pump. Review of Resident #52's January 2020 Physician's Orders, revealed an order, dated 3/13/19, to flush the PEG tube with 60 cc of water AC and PC medications, and with 5 ml of water between the medications. Further review of the Physician's Orders revealed an order, dated 5/29/17, to administer Klonopin 0.5 mg tablet per the PEG tube daily.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/14/20

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F 761	Continued From page 27 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to properly label medications for two of four (2 of 4) medication carts and one (1) of two (2) medication storage rooms. Findings include: Review of the facility's policy titled, "Labeling of Medication Containers", revised April 2007, revealed the Policy Statement: All medications maintained in the facility shall be properly labeled	F 761	1. The bottle of Artificial Tears with no open date noted, the two bottles of Opsumit without pharmacy prescription label, four tablets of Imodium loose in the cart without a container or labeling were removed by the Director of Nursing on 1/14/2020. The one bottle of Dorzolomide Hydrochloride (HCL) two percent (2%) eye drops with no date on the bottle or the box it was stored in was removed from Licensed Practical Nurse (LPN) #2□s cart by the Director of Nursing on 1/14/2020.	

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F 761	Continued From page 28 in accordance with current state and federal regulations. Under a section titled Policy Interpretation and Implementation it stated: 2. Any medication packaging or containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy. 3. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use. Review of the facility's "Storage of Medications" policy, revised April 2007, revealed under the section Policy Interpretation and Implementation: 1. Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. On 01/14/2020 at 4:00 PM, an observation of Registered Nurse (RN) #1's medication cart, revealed: The medication cart was unlocked and the following items observed: One bottle of Artificial Tears, opened, no open date on the bottle or box, and without a designated resident name. Two bottles of Opsumit, (a medication	F 761	The one vial of multi-dose Tubersol five (5) units/0.1 milliliter, opened, with flip top removed, and no date opened on the vial or box it was stored in was removed from the medication storage room by the Director of Nursing on 1/14/2020. The Director of Nursing had one on one in-service by the Nurse Consultant on 1/17/2020, on labeling medication upon opening and maintaining the pharmacy prescription labels are maintained on the bottles. 2. All residents have the potential to be affected. 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing to ensure all medication is labeled and stored according to facility's policy and procedures. A 100% audit was conducted of all medication storage areas on 1/16/2020, by the Director of Nursing with no other issues found. Beginning 1/17/2020, the Director of Nursing will inspect the nursing carts and medication storage rooms three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure medication is labeled according to the facility's policy and procedures. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations.	

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F 761	Continued From page 29 used to treat pulmonary arterial hypertension), without a pharmacy prescription label of any kind. Four tablets of Imodium (an over the counter (OTC) medication), loose in the cart without a container, prescription label, or expiration date. An interview with RN #1 at this time revealed she did not know who these medications belonged to because there was no names on the bottles. On 01/14/2020, at 4:30 PM, an observation of Licensed Practical Nurse (LPN) #2's medication cart revealed one bottle of Dorzolomide HCL 2% eye drops, opened, partially used, with no open date on the bottle or box it was stored in. An interview at this time with LPN #2 revealed there was a lot of new nurses working at the facility now, and he keeps telling them they need to date the medications when they open them. An observation, on 1/14/2020 at 4:45 PM, with the Director of Nurses (DON), revealed one vial of multi-dose Tubersol 5T units/0.1 milliliter (ml), opened, with flip top removed, and no date opened on the vial or the box it was stored in. An interview at this time with the DON revealed the findings from the two medication cart checks and the medication storage room. The DON stated, "That the Tubersol vial is 100 percent my fault, I opened it and didn't mark the date I opened it. That one is 100 percent on me." When asked about the storage and labeling of medications in the facility, the DON indicated they should all be labeled appropriately from the pharmacy, and the date opened should be written on the label or box it is stored in for eye drops, insulin and multiple use vials.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		2/14/20

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F 880	Continued From page 30 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 31 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review, and facility policy review, the facility failed to ensure measures to prevent the possible spread of infection and/or cross contamination for five (5) of nine (9) residents observed during the medication administration observations, Residents #2, #13, #15, #29, and #52. Findings include: Review of the facility's "Infection Prevention and	F 880	1. The medication cart for Licensed Practical Nurse (LPN) #4 was sanitized by the Assistant Director of Nursing on 1/13/2020. On 1/15/2020, LPN #6□s cart drawer containing the contaminated container was sanitized by LPN #6. License Practical Nurses #1, #4 and #6 was one on one in-serviced on infection prevention by the Director of Nursing on 1/15/2020, to ensure all three LPNs maintain a sanitary environment to	

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F 880	Continued From page 32 Control Program" policy, revised October 2018, revealed the Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy Interpretation and Implementation: The infection prevention and control program is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. The program is based on national infection prevention and control standards. The infection control prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program includes prevention of infection. Policies and Procedures included: (2) Assessment of staff compliance with existing policies and regulations. Prevention of Infection included: (3) Educating staff and ensuring they adhere to proper techniques and procedures. (4) Communicating the importance of standard precautions. (8) Following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). Review of the facility's policy titled, "Administering Medication Through an Enteral Tube", revised March 2015, revealed the Steps in the Procedure included wash your hands before the procedure begins and when the procedure is completed. Resident # 29	F 880	prevent the development and transmission of communicable diseases and infections. Residents #2, #13, #15, #29, and #52 were assessed by the Director of Nursing on 1/13/2020, for any adverse reaction to the alleged deficient practice with no negative findings noted. 2. All residents have the potential to be affected. 3. The nursing staff was in-serviced on 1/17/2020, by the Director of Nursing on Infection Prevention in regards to using barriers and gloves to prevent contamination, washing hands before and after medication administration, and sanitizing containers and equipment before storing them on or in the medication cart. Beginning 1/17/2020, the Director of Nursing will watch Medication Pass three (3) times a week for four (4) weeks, then weekly for four (4) weeks and monthly for three (3) months to ensure infection prevention practices are being followed according to policy and procedures. 4. The Administrator is responsible for on-going monitoring and compliance. Beginning 1/24/2020 findings will be reported to the Quality Assurance Performance Improvement Committee by the Director of Nursing for three (3) months for review and recommendations.	

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F 880	Continued From page 33	F 880		

On 1/12/2020, at 3:06 PM, an observation of Resident #29's finger stick blood glucose testing performed by Licensed Practical Nurse (LPN) #4, revealed LPN #4 placed a white tray which contained the blood glucose testing supplies on the resident's over bed table without a barrier. LPN #4 then returned to her cart at the resident's door to obtain the bottle of blood glucose test strips which she then placed on top of the resident's over bed table without a barrier. After completing the test, LPN #4 placed the bottle of test strips into the top drawer of the medication cart and placed the tray into the bottom right drawer of medication (med) cart. LPN #4 did not disinfect the tray or bottle prior to returning them to the cart.

In an interview with LPN #4, on 1/13/2020, at 1:17 PM, LPN # 4 confirmed she had contaminated the medication cart and it was an infection control issue.

During an interview with the Director of Nursing (DON), on 01/13/2020, at 4:36 PM, the DON confirmed this was an infection control issue and agreed the medication cart was contaminated by the tray and bottle.

Resident # 2

On 1/12/2020, at 3:17 PM, during an observation of medication administration for Resident #2, Licensed Practical Nurse (LPN) # 4 took a white tray from the medication (med) cart, placed it on top of the med cart and prepared Resident #2's mediations. This was the same tray which was used for Resident # 29. LPN # 4 then placed the white tray on Resident #2's bedside table. LPN #

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	255216	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW NURSING & REHABILITATION CENTER	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 4 placed gloves in her uniform pocket which she used during the administration of medications. After administering medications, LPN # 4 took the white tray and set it on the sink in Resident # 2's room while she washed her hands. She then took the tray and placed it on top of the med cart. On 01/13/2020, at 4:40 PM, an interview with the Director of Nurses (DON) revealed this was an infection control issue. On 01/15/2020, at 1:21 PM, in an interview with LPN #4, she confirmed she did put the gloves in her pocket and that they were contaminated because the pocket is considered a dirty area. LPN #4 confirmed that by placing the tray on the sink it contaminated the tray and the top of the medication cart. Resident #13 On 1/15/2020 at 11:25 AM, an observation revealed Licensed Practical Nurse (LPN) #6 prepared medications for Resident #13. LPN #6 obtained a Sani Cloth Plus wipe from the container to clean the resident's inhaler when she dropped the red plastic top to the wipes on the floor. The red plastic top hit the floor and rolled under the medication cart. LPN #6 picked up the plastic top, placed it on top of the med cart, then placed it on top of the wipe container, and then placed the wipe container with the contaminated plastic top in the medication cart drawer. The plastic top was not wiped off or cleaned before placing it back on the medication cart, on top of the wipe container or in the medication cart drawer. On 1/15/2020 at 11:45 AM, an interview with LPN	F 880		

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F 880	Continued From page 35 #6 confirmed she did not clean the red plastic top to the Sani Cloth Plus container before placing it on the medication cart, on the container or in the drawer of the medication cart. LPN #6 confirmed the top was contaminated and could cause the spread of infection. On 1/15/20 at 2:15 PM, an interview with the DON confirmed the plastic top to the wipe container was contaminated after falling on the floor and should have been cleaned before it was placed on the medication cart or in the drawer in the medication cart. Resident # 15 On 1/12/20, at 3:49 PM, an observation revealed LPN #4 as she prepared medications for Resident #15. LPN #4 placed a bottle of Lantanoprost 0.005% eye drops on the over bed table without a barrier. LPN #4 administered the medications and eye drops and walked over to the sink to wash her hands. LPN #4 then placed the eye drop bottle on the sink and then back into the eye drop box in the cart. During an interview with LPN #4, on 01/15/20, at 1:25 PM, LPN #4 stated the eye drop bottle was contaminated when she sat it on the over bed table and the sink. LPN #4 stated it could be a risk of taking germs from one resident to another. In an interview, on 01/13/2020, at 4:52 PM, the DON confirmed that it was an infection control issue. Resident #52 On 01/13/20 at 8:10 AM, Licensed Practical Nurse (LPN) #1 was observed administering	F 880		

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F 880	Continued From page 36 medication per Resident #52's Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 did not wash her hands prior to beginning the medication administration. LPN # 1 placed a paper towel barrier on the bedside table and sat all her supplies on the barrier except for the medication cup with the crushed medication, which she sat on the bedside table, off of the barrier. LPN #1 obtained an unopened bottle of water, and poured out 120 cc to use for the PEG tube water flushes. LPN #1 mixed five cubic centimeters (5cc) of water with the medication and stirred it to dissolve it. LPN #1 put her gloves on and cleaned the stethoscope that was on the bedside table. LPN #1 checked the PEG tube placement by auscultation with the stethoscope. LPN #1 completed the medication administration via the PEG tube, and resumed the PEG tube feeding via the feeding pump. LPN #1 discarded all of her used supplies, removed her gloves and threw them in the trash. LPN #1 walked over and obtained the plunger and syringe she used to administer Resident #52's medication and washed them off with water, in the sink, with her bare hands. She dried them and placed them in a newly dated bag and hung them on the enteral feeding pole. LPN #1 then cleaned the stethoscope and placed it on her medication cart, came back in to wash her hands and left Resident #52's room.	F 880		

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	255216	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/16/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire extinguishers as per NFPA 10 sections 7.3.1.2.1, 7.3.3.2 and 7.3.1.1.2. The deficient practice affected three (3) of seven (7) smoke compartment in the facility on day of survey. Findings include: On January 16, 2020 11:45 AM, observation revealed ABC fire extinguishers in the following areas of the facility were due and late for 12-year inspection: 1. Kitchen, 2. Maintenance Area 3. Dining Area 4. Near Rooms 118, 218 On January 16, 2020 12:05 PM, observation also revealed the K Class fire extinguisher in the	K 355	1. The ABC fire extinguishers in the kitchen, maintenance area, dining area, near rooms 118 and 218 were inspected and serviced by a contracted vendor on 1/17/2020. The K Class fire extinguisher was ordered by the Maintenance Director on 1/16/2020, to be replaced and was replaced on 1/22/2020. 2. All residents have the potential to be affected. 3. The Maintenance Staff was in-serviced on 1/17/2020, by the Administrator to ensure fire extinguishers are inspected and maintained according to regulation. Beginning 1/17/2020, the Maintenance Director will inspect all fire extinguishers weekly for eight (8) weeks then monthly for three (3) months to ensure all fire	2/14/20

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K 355	Continued From page 1 kitchen had not received a six-year inspection. The K Class fire extinguisher was last inspection in the calendar year 2012.	K 355	extinguishers are maintained according to NFPA 10, Standard for Portable Fire Extinguishers. 4. The Administrator is responsible for on-going monitoring and compliance. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for three (3) months for review and recommendations.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		2/14/20

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K 363	Continued From page 2 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 sections 19.3.6.3.5 and 19.3.6.3.13. The deficient practice affected two (2) of seven (7) smoke compartment in the facility on day of survey. Findings include: On January 16, 2020 between 9:35 AM and 10:55 AM, observation revealed no corridor door and no hard-wired smoke detector protection in the Break Room of the facility. On January 16, 2020 at 10:25 AM, observation also revealed no positive latching on the top leaf of the Dutch doors to the Cubix Room of the facility.	K 363	1. The Maintenance Director installed a corridor door to the breakroom on 2/17/2020. The top leaf of the Dutch door to the Cubex room was permanently attached to the bottom leaf by the Maintenance Director on 1/16/2020, to ensure the top and bottom act as one door. 2. All residents have to potential to be affected. 3. The Maintenance Staff was in-serviced on 1/17/2020, by the Administrator on protecting corridors by maintaining doors and/or smoke detectors in common areas. Beginning 1/17/2020, the Maintenance Director will inspect all common areas weekly for eight (8) weeks then monthly for three (3) months to ensure the protection of the corridors. 4. The Administrator is responsible for on-going monitoring and compliance.	

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K 363	Continued From page 3	K 363	Findings will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for three (3) months for review and recommendations.	
K 364 SS=D	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly protect corridor openings as directed by NFPA 101 section 19.3.6.4.1. The deficient practice affected two (2) of seven (7) smoke compartment in the facility on day of survey. Findings include: On January 16, 2020 between 9:35 AM and 10:55 AM, observation revealed transfer grilles installed	K 364	1. On 1/16/2020, the Maintenance Director removed one side of the transfer grille, installed a piece of sheet rock sealing the edges with fire caulk then reinstalled vent grille to the A and B wing kitchenette doors making those areas smoke sealed compartments. 2. All residents have the potential to be affected.	2/14/20

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K 364	Continued From page 4 in the corridor doors to the kitchenette on A and B wings of the facility.	K 364	3. The Maintenance Staff was in-serviced on 1/16/2020, by the Administrator to ensure corridor openings are sealed to maintain smoke compartments. Beginning 1/17/2020, the Maintenance Director will inspect all corridors weekly for eight (8) weeks then monthly for three (3) months to ensure transfer grilles are not used in doors. 4. The Administrator is responsible for on-going monitoring and compliance. Findings will be reported to the Quality Assurance Performance Improvement Committee by the Maintenance Director for three (3) months for review and recommendations.	

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E 000	Initial Comments ********** Survey conducted on 01/16/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.