STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. BUILDING _____ B. WING _____	03/28/2019

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

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F 000	INITIAL COMMENTS A Recertification Survey was conducted by Healthcare Management Solutions (HMS), LLC from 3/25/19 through 3/28/19, on behalf of the Mississippi State Department of Health. The facility was found not to be in substantial compliance with requirements of participation for Medicare and Medicaid and cited F580, F604, F641, F676, F679, F689, F700, F838, F880, and F947. Census at the time of survey was 64, and the facility held a license for 80 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		5/3/19

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

Electronically Signed | 05/03/2019

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's policy, the facility failed to ensure that a physician was notified of a change in status for one (1) of two (2) sampled residents, Resident (R) #29, who required the use of an indwelling urinary catheter. The resident had a "milky white" substance in the tubing of the catheter, and the physician was not notified. Findings include:	F 580	Resident #29 was assessed by the Director of Nursing on 03/27/19 and was found to have no signs or symptoms of infections nor complaints of pain or discomfort. The attending physician and the Urologist for Resident #29 was notified on 03/27/2019, at 9:17 AM. by the Assistant Director of Nursing of the sediment in the catheter tubing. Neither attending physician nor the Urologist gave new orders for this resident.	

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F 580	Continued From page 2 Review of the facility's policy titled, "Changes in a Resident's Condition or Status" dated as revised as 05/17 noted, "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition..." An observation of R #29 on 03/25/19 at 3:55 PM, revealed the resident was seated in his wheelchair. A catheter bag was noted to hung behind him, attached to the wheelchair. The tubing was observed with a milky white substance on the inside. An observation was conducted on 03/27/19 at 8:14 AM. R #29 was in bed, with the catheter bag hung at the end of the bed. The tubing contained a milky white substance. Review of the "Departmental Notes" for the months of 02/19 and 03/19, revealed there was no evidence that nursing contacted the physician or the Urologist regarding a change in the status of R #29's urine. Review of R #29's "Face Sheet" indicated R #29 was admitted to the facility on 03/04/14, with a diagnosis of Benign Prostatic Hyperplasia (BPH), with urinary retention. A "care plan" dated as initiated 03/11/14, noted R #29 had an indwelling urinary catheter and identified the resident was at risk for a urinary tract infection. One (1) of the identified approaches included for staff to monitor for signs and symptoms of urinary tract infections and changes in urine color. Review of the "Physician Orders" dated 11/12/18,	F 580	No resident suffered adverse effects from this deficient practice. The two residents with catheters have the potential to suffer adverse effects from this deficient practice. To ensure residents with indwelling catheters are monitored and assessed the facility will require the Charge Nurse to assess the residents with catheters and document their findings each shift in the treatment administration record and will communicate any changes in condition to the attending physician and document this in the nursing notes. Nursing staff was in-serviced on notification of the attending physician of changes in a resident's condition per facility policy by the Director of Nursing on 03/27/19. A 100% visual audit was conducted of the two residents with indwelling urinary catheters for any noted changes in condition of the resident on 03/27/19, by the Charge Nurse for each resident. There were no complications noted from the visual audit of both catheters. The Charge Nurse for each resident with a catheter will monitor the residents daily starting 03/27/19, for any change in condition and document in the nurses notes as well as the Electronic Medical Record. The Assistant Director of Nursing will monitor the condition of all residents with indwelling catheters for a change in condition three days a week for eight weeks and then weekly to ensure on-going compliance. Adverse findings	

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F 580	Continued From page 3 indicated, "Foley Catheter 16 French with 100 cubic centimeters (cc) to drain bladder." An interview was conducted with a Licensed Practical Nurse (LPN) #20 on 03/27/19 at 8:16 AM. LPN #20 stated the catheter tubing was changed at R #29's Urology appointment. LPN #20 stated the clinical staff do not insert a new indwelling urinary catheter, but only change the catheter bag. The Assistant Director of Nursing (ADON) was interviewed on 03/27/19 at 8:24 AM. She stated she was unaware of the change of R #29's urine and that staff had not alerted her or the physician of this change. A quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/30/19, identified R #29's Brief Interview of Mental Status (BIMS) score indicated the resident was unable to complete the interview for cognitive determination The "MDS" noted the resident had an indwelling urinary catheter. An interview was conducted with Certified Nursing Assistant (CNA) #27, on 03/27/19 at 10:30 AM. She confirmed she was aware of the change in R #29's urine and reported this last Wednesday. CNA #27 said she did not remember to whom she reported this information. An interview was conducted with the Administrator and the Director of Nursing (DON) on 03/27/19 at 4:17 PM. They stated if there was a change in the color of the urine, the expectation was to notify the physician.	F 580	will be forwarded to the Quality Assurance committee by the Director of Nursing/Assistant Director of Nursing each month. The Quality Assurance Committee will review any adverse findings presented by the Charge Nurse or Assistant Director of Nursing weekly. The Quality Assurance Committee will then determine appropriate actions to include but not limited to re-education and disciplinary actions of responsible staff.	

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F 604	Continued From page 4	F 604		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, observations, interviews, and record reviews, the facility failed to ensure two (2) of two (2) sampled residents, Residents (R) #39 and R #65, out of a	F 604	Resident #39 and #22 were assessed by the Director of Nursing on 03/26/19 in their wheelchairs, it was determined that neither resident required lap belts for	5/3/19

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F 604	Continued From page 5 total sample of 22 residents, were free of physical restraints. Specifically, the residents had lap belts in place, which neither resident could remove on demand. There was no documented evidence the facility assessed the residents, or the use of the lap belts, prior to use of the restraints. Findings include: Review of the facility's policy titled, "Use of Restraints," revised April 2017, revealed restraints would only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Continued review of the policy revealed restraints would only be used to treat the resident's medical symptom(s) and never for discipline, staff convenience, or for the prevention of falls. Further review of the policy revealed physical restraints were defined as any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The policy revealed placing a resident in a chair that prevents the resident from rising, was a practice that inappropriately utilized equipment to prevent resident mobility and was considered a restraint, which would not be permitted. Continued review of the policy revealed prior to placing a resident in restraints, there would be a pre-restraining assessment and review to determine the need for restraints, which would determine possible underlying causes of the problematic medical symptom and, to determine if there were less restrictive interventions that could have improved the symptoms. The policy also revealed restraints would only be used upon the written order of a	F 604	safety or restraint and they were utilized because lap belts were a standard accessory on their particular model of wheelchair. The lap belts that were attached to Resident #39's and Resident #22's wheelchairs were immediately released and subsequently removed by the Maintenance Supervisor on 03/26/19. No resident suffered adverse effects from this deficient practice. The two residents in wheelchairs with attached seat belts had the potential to suffer adverse effects from this deficient practice. All new wheelchairs that have safety belts attached will have the safety belts removed until the resident is assessed for the need of a safety belt. Nursing staff was in serviced on 03/26/19 by the Director of Nursing on the use of restraints per facility policy to include a resident's right to be free of unnecessary restraints. A 100% audit of residents with lap belts was conducted by the Director of Nursing on 03/26/19, to ensure the resident can release the lap belt on request or it will be considered a restraint and will be coded as such and will ensure those residents were assessed prior to the use of the belts and other interventions had been attempted prior to use. Three wheelchairs were found to have safety lap belts attached to the wheelchairs during the 100% audit. One of the three requires the seat belt as a restraint. The other safety belts were removed by the Maintenance Director on	

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F 604	Continued From page 6 physician and after obtaining consent from the resident and/or representative. Resident #39 Observation on 03/25/19 at 1:55 PM, revealed R #39 sitting in front of the "B Wing" nurses' station, in his wheelchair, with a lap belt fastened. During observation on 03/26/19 at 3:15 PM, in the dining room, Certified Nursing Assistant (CNA) #18 prompted R #39 to unbuckle his seat belt; however, the resident did not attempt to unbuckle it. Review of Resident #39's medical record revealed the "Physician Orders" dated March 2019, revealed no order for the use of a wheelchair with a lap belt. There was no assessment or consent for the lap belt for Resident #39. Review of R #39's Quarterly "Minimum Data Set (MDS)," with an Assessment Review Date (ARD) of 02/11/19, revealed a Brief Interview for Mental Status (BIMS) was not conducted, due to the resident was rarely/never understood. The facility assessed the resident to have severe cognitive impairment. The MDS specified the resident had no range of motion impairment to his lower extremities. The MDS did not specify the use of a trunk restraint. Interview, on 03/26/19 at 3:10 PM, with CNA #18, revealed she was assigned and familiar with R #39. She stated the resident had to keep his seat belt on to keep him from falling out of his wheelchair. The CNA stated she put the resident's seat belt on him at all times while he was in his wheelchair, because if not, he would	F 604	03/26/2019. The Assistant Director of Nursing will monitor the residents with lap belts three times per week for eight weeks starting 03/26/19, to ensure the lap belts are being used as ordered and if not ordered as restraints the resident can release the belt on request. Any new wheelchair purchase or obtained by the facility will be assessed for safety lap belts, and the lap belt will be removed prior to use if not required. Beginning 03/26/19, the Care Plan Coordinator will monitor all residents with lap belts weekly for eight weeks to ensure ongoing compliance and restraints will be reviewed per the Minimum Data Set schedule for quarterly resident assessments in the Restraint Reduction Committee for continued compliance. Adverse findings will be forwarded to the Quality Assurance Committee by the Care Plan Coordinator during the monthly Quality Assurance meeting. The Quality Assurance Committee will then determine appropriate actions to be taken to include but not limited to re-education and discipline of the responsible staff.	

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F 604	Continued From page 7 lean forward and fall out of it. The CNA further stated she had worked at the facility since July of 2018, and he had always had his seat belt on since she started. An interview on 03/26/19 at 3:17 PM, with Licensed Practical Nurse (LPN) #2, revealed R #39 did not have a physician's order for a seat belt; however, the CNAs may not always fasten the seat belt, but just when the resident was in an agitated mood, and for his safety. Continued interview revealed it was the LPN's expectation the CNAs would buckle the seat belt when the resident became agitated. Review of R #39's "Face Sheet," revealed the facility admitted the resident on 12/13/16, with diagnoses which included Metabolic Encephalopathy, Disease of Spinal Cord, Unspecified Lack of Coordination, Abnormalities of Gait and Mobility and Abnormal Posture. Resident #65 Observation and interview on 03/26/19 at 1:50 PM, with CNA #27, revealed R #65 had a lap belt fastened while she was in her wheelchair. During the observation, the CNA prompted the resident to take her seat belt off; however, the resident was not able to unfasten the seat belt. Interview with the CNA confirmed the resident was not able to release the seat belt. Review of R #65's "Face Sheet," revealed the facility admitted the resident on 05/09/01, with diagnoses which included Schizophrenia, Brief Psychotic Disorder, Lack of Coordination, and history of falling. Review of "Physician Orders" dated March 2019,	F 604		

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F 604	Continued From page 8	F 604		

revealed no order for the use of a wheelchair with a lap belt. Review of the medical record also revealed no assessment for the seat belt.

Review of R #65's Quarterly "MDS", with an ARD of 03/11/19, specified a BIMS was not conducted due to the resident was rarely/never understood; however, the facility assessed the resident to have severe cognitive impairment. The "MDS" specified the resident had upper and lower extremity range of motion impairments to one side. The "MDS" did not specify the resident had a trunk restraint.

Interview on 03/26/19 at 1:56 PM, with CNA #19, revealed she was assigned to R #65 and was familiar with the resident. She revealed she had never seen the resident release the seat belt. The CNA stated she fastened the resident's seat belt today because if not, the resident would tip over out of her wheelchair.

Interview on 03/26/19 at 2:05 PM, with LPN #11, revealed she was assigned and familiar with R #65. Continued interview revealed the purpose of the seat belt for R #65 was to keep the resident from moving and falling out of her wheelchair. Further interview with the LPN revealed she could not locate an order for the seat belt.

Interview on 03/26/19 at 2:41 PM, with the Director of Nursing (DON), revealed there was no physician order for either R #39 or R #65 to have a seat belt fastened while in their wheelchairs. She stated the seat belts should not have been put on the residents.

Interview on 03/28/19 at 12:23 PM, with the Medical Director, revealed it was his expectation

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F 604	Continued From page 9 the facility would contact him for an order for the use of a lap belt. Interview on 03/28/19 at 12:49 PM, with the Administrator revealed it was her expectation the staff would not have fastened the lap belts, because there was no physician's order or assessments. She revealed it was important residents were not in restraints that were not ordered for their overall safety.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure one (1) resident, Resident (R) #14, out of a survey sample of 22 residents, had an accurate Minimum Data Set (MDS) assessment. Findings include: The "Resident Assessment Instrument (RAI) Manual" dated 10/18 indicated, ". . . In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable . . . While CMS [Centers for Medicare and Medicaid Services] does not impose specific documentation procedures on nursing homes in	F 641	The Minimum Date Set assessment for Resident #14 was corrected on 04/29/19 by the Minimum Data Set Coordinator to reflect the current status of the resident and indicating the resident has a device that prevents them from rising. The resident was found not to need the device and it was removed by the Director of Nursing on 04/29/19. The resident's Physician and Responsible was notified and updated on the removal of the lap belt. Resident # 14 suffered no adverse effects from this deficient practice. All residents with restraints have the potential to suffer adverse effects from this deficient practice. Residents will be assessed prior to application of lap belt restraints by the Director of Nursing/Assistant Direct	5/3/19

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F 641	Continued From page 10 completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident . . . " Review of R #14's quarterly MDS, with an Assessment Reference Date (ARD) of 01/03/19, specified that R #14 had a Brief Mental Interview for Mental Status (BIMS), which indicated R #14's cognition was severely impaired. The MDS assessment documented R #14 did not utilize physical restraints. Observation on 03/25/19 at 10:45 AM, revealed R #14 was seated in her wheelchair with a safety belt around her waist. R #14's care plan, initiated on 01/05/17, identified the resident as unaware of safety due to her diagnosis of Dementia. One (1)of the identified approaches included to apply the safety belt when she was up in her wheelchair. A "physician's order" dated 07/03/18, indicated a safety belt was to be applied to R #14 when she was up in her wheelchair for upper body support. During an interview on 03/27/19 at 8:31 AM, the Rehabilitation Director (RD) stated R#14 was assessed for the use of a lap belt. She stated	F 641	Nursing or Register Nurse Supervisor. Resident #14 was the only resident with a restraint at the time of assessment. The Minimum Data Set Coordinator was in-serviced by the Nurse Consultant on the correct coding of restraints on the Minimum Data Set on 04/30/2019, from the current Resident Assessment Instrument Manual. A 100% audit was conducted by the MDS Coordinator on 04/30/19 of the most recent Minimum Data Set for residents with restraints for correct coding of these restraints. During the audit resident #14 was the only resident identified with a restraint. The Care Plan Coordinator will monitor five Minimum Date Sets weekly beginning 05/01/19, for eight weeks for correct coding of restraints. The Assistant Director of Nursing will monitor two Minimum Data Sets per week for eight weeks to ensure on going compliance. Restraints will be reviewed per the Minimum Data Set schedule for quarterly resident assessment, in the Restraint Reduction Committee for Compliance on-going. Adverse findings will be forwarded to the Quality Assurance Committee by the Assistant Director of Nursing monthly at the monthly Quality Assurance Committee meeting will determine appropriate action to be taken to include but not limited to re-education and disciplinary action of the responsible staff.	

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	255216	A. BUILDING _____ B. WING _____	03/28/2019

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F 641	Continued From page 11 therapy staff members tried multiple other interventions, such as different cushions and tried to drop the seat of the wheelchair for the resident, prior to ordering the customized wheelchair with the attached lap belt for the resident. During an interview on 03/27/19 at 3:55 PM, the Nurse Consultant stated the lap belt should have been coded as a restraint on R #14's MDS assessment. Review of R #14's "Face Sheet" indicated the facility admitted R #14 on 01/05/17, with a diagnosis of Dementia with Behavioral Disturbances.	F 641		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		5/3/19

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F 676	Continued From page 12 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, and review of the facility's policy, the facility failed to implement a physician's order for one (1) resident, Resident (R) #40, to provide Restorative services to help prevent decline, out of a survey sample of 22 residents. Findings Included: Review of the facility's policy titled, "Activities of Daily Living (ADLs), Supporting" revised 03/18 indicated, " . . . Residents will [sic] provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). . . Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. . . Appropriate care and services will be provided for residents who are	F 676	Resident #40 is on Restorative caseload and is provided Restorative services by their assigned Certified Nursing Assistant when the lead Restorative Certified Nursing Assistant is not available. Resident # 40 was assessed by the Therapy Department on January 30, 2019 and referred for the Restorative program. A physician's order was obtained for the resident to begin Restorative care and Restorative care was started by the Restorative Certified Nursing Assistant on February 1, 2019. No resident suffered any adverse effects from this deficient practice. A the time of survey there were three residents on Restorative caseload that had the potential to suffer adverse effects from this deficient practice.	

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F 676	Continued From page 13 unable to care out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with. . . Hygiene. . . Mobility (transfer and ambulation, including walking). . . Elimination (toileting). . . " Review of R #40's "physician order" dated 01/30/19, indicated to ambulate 60 to 150 feet with a rolling walker and gait belt six (6) times a week. In addition, the physician ordered to provide R #40 with therapeutic exercises which included three (3) repetitions of 20 leg kicks, knee rails, and hip abductions six (6) times a week. This care was to be provided by Restorative. Review of R #40's care plan, dated as initiated 08/23/18, identified R #40 had an ADL deficit. There was a hand-written note under "Approaches", without a date of the revision, which indicated to ambulate the resident 60 to 150 feet, with a rolling walker and gait belt six (6) times a week. The care plan directed the Restorative Certified Nursing Assistant (RCNA) to provide this care. The hand-written note indicated the resident was to receive therapeutic exercises, three repetitions of 20 leg kicks, knee raises, and hip abductions six (6) times a week. R #40's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/14/19, indicated R #40's Brief Mental Interview for Mental Status (BIMS) score indicated R #40's cognition was intact. Review of R #40's "Face Sheet" indicated the facility admitted R #40 on 08/23/18, with a diagnosis of Cerebral Vascular Accident.	F 676	The Lead Restorative Certified Nursing Assistant and the floor Certified Nursing Assistants were in-serviced by the Therapy Department Manager on following physician's orders and care plans that relate to providing Restorative care to residents on 04/01/19-04/03/19. including activities of daily living such as hygiene, mobility, elimination, dining and communication. A 100% audit was done by the Restorative Nurse on 03/28/2019, with orders for Restorative Service to ensure the services were being provided. No other issues were identified during the audit. The Restorative Nurse will monitor documentation five days a week for eight weeks beginning 05/01/2019, to ensure resident's with Restorative orders are receiving services as ordered The Assistant Director of Nursing will monitor Restorative documentation and the provision of Restorative services two times a week for eight weeks, then the Minimum Data Set Coordinator will review Restorative documentation quarterly per the Minimum Data Set quarterly schedule to ensure on-going compliance. Monitoring will begin 05/01/19. Any adverse findings will be forwarded to the Quality Assurance Committee by the Director of Nursing/Assistant Director of Nursing during the monthly Quality Assurance Meeting. The Quality Assurance Committee will determine appropriate action to be taken to include but not limited to re-education and disciplinary action for the responsible staff.	

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F 676	Continued From page 14 A document titled, "Therapy to Restorative Form" noted a referral for R #40 to receive restorative nursing services. The date of the signature from the therapist was dated 01/30/19, and signed by RCNA #14. A document titled, "RET (restorative)" for the month of 02/2019, identified R #40 was to be ambulated 60 to 150 feet six (6) times a week with a rolling walker and a gait belt. The treatment was signed off for 02/01/19, 02/04/9 through 02/08/19, 02/11/19 through 02/15/19, 02/18/19 through 02/22/19, and 02/25/19 through 02/28/19. The signed off dates were the same for therapeutic exercises. A document titled "RET" for the month of 03/2019, identified R #40 was to be ambulated 60 to 150 feet six (6) times a week with a rolling walker and a gait belt. The treatment was signed off on 03/04/19, and below the initials were "150." The sign off sheet noted initials on 03/05/19 through 03/08/19, 03/11/19 through 15/19, 03/18/19 through 03/22/19, and from 03/25/19 through 03/28/19. The signed off dates were the same for therapeutic exercises. The Restorative Director (RD) was interviewed on 03/27/19 at 8:36 AM. The RD stated that there was only one (1) fulltime RCNA. The RD stated that all CNAs were able to provide residents with restorative care and document accordingly. An interview was conducted with CNA #15 on 03/27/19 at 3:07 PM. She stated that she has not been directed to provide restorative services to R #40. She indicated that she works on the weekend and thought that the resident could walk on his own.	F 676		

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F 676	Continued From page 15 An interview was conducted with the Restorative Nurse on 03/27/19 at 3:10 PM. The Restorative Nurse stated that R #40 frequently refused to walk. She pointed to the "RET" document for 02/2019, and confirmed the resident refused to walk according to the way it was noted on this document. The Restorative Nurse stated R #40 only walked once on 03/04/19, and had refused on the remaining dates. An interview was conducted with R #40 on 03/28/19 at 8:56 AM. R #40 indicated that staff members have not offered to walk him. The resident denied refusing to walk. An interview was conducted with RCNA #14 on 03/28/19 at 8:58 AM. RCNA #14 stated she has not offered to walk R #40, since the resident attends activities. RCNA #14 stated she was unaware there was a physician's order to walk the resident. RCNA #14 confirmed the initials on the "RET" documents were hers. She stated that when she signs off on these documents, it means she did not complete R #40's activities for restorative. She stated that she was given this direction on how to sign off on this document by a previous nurse. The Director of Nursing (DON) was interviewed on 03/28/19 at 2:49 PM. The DON stated the RCNA was pulled to work the floor four (4) times in the month of 02/2019, and another four (4) times in 03/2019. The DON said R #40 was compliant with care.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		5/3/19

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F 679	Continued From page 16 §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, record review, staff interviews and review of the facility's policy, it was determined that the facility failed to provide an ongoing program of activities based on the identified preferences/interests of one (1) resident, Resident (R),#14, out of the sample of 22 residents. Findings include: Review of facility's policy titled, "Activities Programs" revised January 2011, indicated that activity programs are based to meet the needs of each resident daily. The facility's activity program is designed to encourage maximum individual participation and geared to resident needs. At a minimum the programs are to meet the following; stimulate intellect through activities such as current events, trivia, word games, book reviews, educational movies provided five to seven times a week; meet religious/spiritual needs; reflect the resident's choices and rights; reflect cultural and hobbies, life experiences, and resident personal preferences. Review of facility's policy titled, "Activity	F 679	Resident #14's Activity care plan was revised by the Director of Activities on April 2, 2019, to reflect the resident's individual preferences and interests. The resident responds to one on one in room activities, including hand holding, music therapy, and snacks. No resident suffered adverse effects from this deficient practice. All residents have the potential to suffer adverse effects from this deficient practice. Upon admission each resident shall be assessed and evaluated by the Director of Activities to gather information about the resident's preference and interest. The Director of Activities was in-serviced on development of an individualized activities care plan for each resident based on their current preference and interests by the Director of Clinical services on 04/27/19. A 100% audit was completed on all activity care plans by the Activity Director on 05/03/19, all care plans needing more individual activity	

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F 679	Continued From page 17 Evaluation", revised May 2013, indicated that each resident is evaluated within 14 days of admission, to develop an activity, plan that reflects the resident's choices and lifelong interests, goals, strengths, needs, and preferences. The activity evaluation is used to develop an individualized activity care plan separate from or as part of the comprehensive care plan that allows resident to participate in activities of their choice and interest. Observation of R #14 on 03/25/19 at 2:53 PM, revealed the resident was located across from the nursing station which was next to the hallway identified as "Delta Blues Alley." The resident was bent over while in her wheelchair and she was slapping her hands repeatedly. She was humming and began to slap at her legs. The resident was overheard to mumble her words. A staff member came up to her and scratched her back. During this observation period, the resident was fidgety and attempted to lift herself from the seat of the wheelchair. At 3:08 PM, R #14 was observed slapping her thighs and chatting nonsensically. At 3:19 PM, staff took the resident from the area. At 3:21 PM, the resident was observed in her room and sitting in her wheelchair. During this observation, R #14 was fidgety, slapping her left leg, and stomping her feet. At 3:56 PM, the resident was again in her room, and the television was on. There was no music playing. On 03/26/19 at 7:29 AM, R #14 was observed seated in her wheelchair, slumped over, across from the nursing station. The observation took place at the nursing station located next to the hallway identified as "Delta Blues Alley."	F 679	interventions were updated at this time. The Care Plan Nurse will review five activity care plans a week for eight weeks to ensure compliance. The Minimum Data Set Coordinator will review two activity care plans a week for eight weeks to ensure compliance. The activity care plans will be reviewed by the Interdisciplinary Care Plan Team per the Minimum Data Set quarterly schedule, ongoing to ensure the care plans for activities are individualized according to resident's specific preferences and interests. Adverse findings will be forwarded to the Quality Assurance Committee by the Care Plan Coordinator/ Minimum Data Set Coordinator. The Quality Assurance Committee will determine appropriate action to be taken to include but not limited to implementing revised interventions, re-education and disciplinary actions for the responsible staff.	

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F 679	Continued From page 18 R #14 was observed sitting, in her wheelchair and in her room on 03/27/19 at 6:20 AM. There was no music playing. There was no radio present in her room. R #14's "care plan", initiated 01/05/17, identified R #14 was at risk for social isolation and needed low stimulation social stimulation. One (1) of the approaches identified was to provide the resident with music therapy and to provide the resident with passive activities. A document titled "INDIVIDUAL RESIDENT DAILY ACTIVITIES", dated for the months of 12/18, 01/19, and 02/19 noted R #14 received music therapy three (3) times per week for each month. These documents did not identify if the music therapy was a one on one (1:1) activity or not. An interview was conducted with Registered Nurse (RN) #4 on 03/26/19 at 2:57 PM. RN #4 stated no one has directed her to play music for the resident to distract her when R #14 was agitated. RN #4 said activities will work with the resident occasionally. A Certified Nursing Assistant (CNA) #18 was interviewed on 03/27/19 at 3:04 PM, and she stated that no one shared with her R #14 liked music. An interview was conducted with the Activities Director (AD) on 03/27/19 at 12:35 PM. The AD stated that R #14 had difficulty with her attention span. The AD stated R #14 did not respond well to the use of head phones. The AD stated she provided R #14 with music as a one-to one (1:1) activity.	F 679		

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F 679	Continued From page 19 Review of R #14's "Face Sheet" indicated that R #14 was admitted to the facility on 01/05/17, with a diagnosis of Alzheimer's disease. The annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/04/18, identified R #14 enjoyed listening to music. The quarterly "MDS" with an Assessment Reference Date (ARD) of 01/03/19, revealed R #14's Brief Interview for Mental Status (BIMS) score indicated the resident was severely cognitively impaired.	F 679		
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, interview, review of the facility's policy, review of "Safety Data Sheets (SDS)", and review of "Material Safety Data Sheets (MSDS)," it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible as evidenced by a storage room, which contained chemicals, was propped open. Review of the facility's list of wandering residents revealed the facility had two (2) residents that wandered randomly throughout the facility, out of 64 residents in the facility. Neither resident was	F 689	The door to the storage room which contained chemicals, that was propped opened was closed and secured by the Director of Nursing immediately on 03/27/19. No residents were in the area at the time the deficient practice was noted. No resident suffered adverse effects from this deficient practice. All wandering residents have the potential to be affected by this deficient practice. All doors to	5/3/19

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F 689	Continued From page 20 observed trying to enter into the storage area, but had the potential. Findings include: Review of the facility's policy titled, "Hazardous Areas, Devices, and Equipment," revised July 2017, revealed all hazardous areas, devices, and equipment in the facility would be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Continued review of the policy revealed a hazard was defined as anything in the environment that had the potential to cause injury or illness which included sharp objects that were accessible to vulnerable residents, open areas or items that should be locked when not in use, and access to toxic chemicals. Observation on 03/27/19 at 3:44 PM, on the "A Wing", revealed the central supply room door was propped open with a gallon jug containing "Classic Whirlpool Disinfectant and Cleaner." The room was unattended. Continued observation revealed a resident, who the facility identified as a resident who wanders, sitting in her wheelchair, outside the central supply room. (The resident was not attempting to enter the room). At 3:49 PM, the Director of Nursing (DON) observed the surveyor in the central supply room and inquired how the surveyor had access to the room. Observation of the central supply room revealed the room contained the following hazardous and sharp materials: one (1) gallon of "Classic Whirlpool Disinfectant and Cleaner"; seven (7) containers of "PDI Sani-Cloth Plus Germicidal Disposable Cloths" containing 65 extra-large cloths per container; eight (8) containers of "PDI Super Sani-Cloth Germicidal Wipes" containing	F 689	areas that contain hazardous or potentially harmful items will be kept closed at all times to ensure residents safety from access to hazardous materials or other potentially harmful items locked behind closed doors. Nursing staff was in-serviced on 03/27/19 by the Director of Nursing on ensuring the residents environment remains free of hazards such as unsecured chemicals by ensuring that all rooms containing potentially harmful items are locked and secured. A 100% audit was conducted by the Chief Safety Officer on 03/27/19 to ensure all doors in the facility that are required to be secure to protect the residents from possible hazards were secure. The 100% audit findings concluded all doors were secured at all times. The Maintenance Assistant will monitor all doors required to be secure to ensure they are secure five times per week for eight weeks beginning 03/27/19. The Maintenance Director will monitor the secured doors two times a week for eight weeks to ensure compliance beginning 03/27/19. The Charge Nurse will monitor all doors required to be secure to protect residents from possible hazards on their shift rounds to ensure on-going compliance. Adverse findings will be forwarded to the Quality Assurance Committee for review monthly presented by the Maintenance Director. The Quality Assurance Committee will determine appropriate action to be taken to include	

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F 689	Continued From page 21 160 large disposable wipes per container; 20 boxes of "McKesson Alcohol Prep Pads" containing 200 prep pads per box; and 300 "McKesson Disposable Twin Blade Razors." Review of the "MSDS" for the "Classic Whirlpool Disinfectant Cleaner" revealed contact to the eyes and the skin could cause irritation. The "MSDS" revealed if swallowed, the "Whirlpool Disinfectant Cleaner" could be harmful and medical attention should be sought. Review of the "SDS" for the "PDI Sani-Cloth Plus Germicidal Disposable Cloths" revealed it was a pesticide product registered by the United States Environmental Protection Agency. The "SDS" revealed if contact occurred to the eye, it would cause eye irritation. The "SDS" identified ingestion was unlikely if used as directed, and that first aid was not required for small amounts transferred from the hands to the mouth. Review of the "SDS" for the "Super Sani-Cloth Germicidal Wipes" revealed it was a pesticide product registered by the United States Environmental Protection Agency. The "SDS" revealed if contact occurred to the eye, it would cause eye irritation; ingestion was unlikely if used as directed; and first aid was not required for small amounts transferred from the hands to the mouth. Review of the "MSDS" for the "McKesson Alcohol Prep Pads" revealed if eye contact occurs, it would cause eye stinging. The "MSDS" revealed if ingested, vomiting should be induced, and a physician should be notified. Interview on 03/28/19 at 12:23 PM, with the	F 689	but not limited to re-education and disciplinary actions of responsible staff.	

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F 689	Continued From page 22	F 689		

Medical Director, revealed it was his expectation that whoever was responsible for making sure doors staying closed, do what they were supposed to do.

Interview on 03/18/19 at 12:33 PM, with the Environmental Services Director (ESD), revealed the central supply room should not have been propped open and accessible to residents. He stated, it was important the room would not have been accessible to residents for the residents' safety.

Interview on 03/28/19 at 12:49 PM, with the Administrator, revealed it was her expectation the central supply room would not have been accessible to residents. The Administrator stated, it was not acceptable, and the room should have been locked at all times, due to the danger it poses to the residents.

Interview on 03/28/19 at 1:18 PM, with the Assistant Director of Nursing (ADON), revealed she was the direct supervisor of the nursing staff and the Certified Nursing Assistants (CNAs). She stated it was her expectation the central supply room would not have been accessible to residents because of the potential danger of a resident getting to the chemicals.

Interview on 03/28/19 at 3:08 PM, with CNA #32 revealed she was the person who propped the central supply room door open. She stated she got distracted by a co-worker asking for her assistance and forgot to remove the gallon of chemicals she used to prop the door open. She stated it was very important that she had not left the door propped open because residents pass by the room and if the door was open, a resident

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F 689	Continued From page 23 could get in the room and get something they were not supposed to have, putting them in harms way or danger. Interview on 03/28/19 at 3:49 PM, with the DON revealed it was important the central supply closet should not have been propped open where residents could get into the room. She stated it was important because if a resident got into the room, they could get into the hazardous chemicals in the room or even get locked in the room.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		5/3/19

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F 700	Continued From page 24 by: Based on review of the facility's policy, observation, interview, and record review, the facility failed to assess the risks versus benefits for the use of bed rails, including obtaining informed consent for the use of bedrails; and failed to have a system in place for the maintenance of the bedrails for eight (8) of 20 sampled residents, Resident (R) #5, R #14, R #26, R #32, R #33, R #39, R #51, and R #65. Findings include: Review of the facility's policy titled, "Bed Safety", revised December 2007, revealed the facility shall strive to provide a safe sleeping environment for the resident. The policy revealed to try to prevent deaths/injuries from the beds and related equipment, including side rails. The policy further revealed the facility should promote the approach of inspection by maintenance staff of all beds and related equipment as part of the facility's regular bed safety program to identify risks and problems including potential entrapment risks. The policy also revealed the maintenance department shall provide a copy of inspections to the Administrator and report results to the QA Committee for appropriate action. The bed safety policy also revealed if side rails were to be used, there would be an interdisciplinary assessment of the resident, consultation with the attending physician, input from the resident and/or legal representative, and shall obtain consent for the use of the side rails from the resident and/or their legal representative. Review of the facility's policy titled, "Proper Use of Side Rails", revised December 2016, revealed the purpose of the policy was to ensure the safe use	F 700	A Risk vs Benefits Assessment has been completed by the Director of Nursing on the affected residents #5,#14,#26,#32,#33,#39,#51,and #65, on 05/01/2019, and all were also assessed for the use of side rails and an informed consent has been signed by the resident and/or responsible party for the use of side rails. The Maintenance Supervisor has inspected the beds for resident #5,#14,#26,#32,#33,#39,#51 and #65 and found everything in accordance with physician's orders and the Manufacture's Specification. The Maintenance Department will now inspect bed rails weekly for needed maintenance beginning 04/01/2019. No resident was adversely affected by this deficient practice. All residents with side rails have the potential to suffer adverse effects from this deficient practice. Nursing staff was in-serviced on 03/28/19 by the Director of Nursing on completing the Risk versus the Benefits Assessment on each resident that requires the use of bedrails when benefits outweighed the risk and a physician's order is obtained for use of bed rails a informed consent will be signed for the use of bed rails. The Maintenance Staff was in-serviced on 04/30/19, by the Maintenance Director on ensuring that each bedrail used is in good safe working order. A 100% audit was done on 03/26/19, by the Director of Maintenance, on all bed rails to ensure the bed rails were maintained according	

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F 700	Continued From page 25 of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. Continued review of the policy revealed an assessment would be made to determine the resident's symptoms, risk of entrapment, and reason for using side rails. Further review of the policy revealed the risks and benefits of side rails would be considered for each resident and consent for side rail use would be obtained from the resident or legal representative after presenting the potential benefits and risks. Resident #5: Review of R #5's "Face Sheet", revealed the facility admitted the resident on 11/08/06, with the diagnoses which included Anoxic Brain Damage and Epilepsy. Review of R #5's "Physician Orders", dated March 2019, revealed an order for, "Bilateral 1/2 side rails x [times] 4 with head rails padded to provide safety while in bed r/t [related to] seizure disorder secondary to brain anoxia." Review of the resident's "Minimum Data Set (MDS)", with an "Assessment Reference Date (ARD)" of 12/21/18, revealed the resident was unable to complete the "Brief Interview for Mental Status (BIMS)" evaluation due to the resident was rarely/never understood; however, he was assessed by staff to be severely cognitively impaired. The MDS revealed the resident required extensive assistance from two (2) staff persons for bed mobility and required total dependence from two (2) staff persons for transfers to or from the bed.	F 700	to the manufacture's standards. No issues were noted during the audit. All residents with bed rails have now been assessed for Risk verses Benefits for the use of side rails and an informed consent obtained when it was determined that the benefits out-weigted the risk. The Maintenance Assistant will check bed rails twice a week for eight weeks starting 04/01/2019 to ensure bed rails are maintained according to manufacturer's standards. The Medical Records Clerk will monitor charts for side rail consents upon receipt of the side rail order, two times eight weeks beginning 05/01/2019 to ensure the assessment and consent was done. The Minimum Data Set Coordinator will monitor residents with side rails for side rail consents at the time the next scheduled Minimum Date Set assessment is done for eight weeks and on-going to ensure compliance. The Maintenance Director will monitor bed rails once a week for eight weeks beginning 04/01/2019 to ensure on-going compliance. Adverse findings will be forwarded to the Quality Assurance Committee. The Maintenance Supervisor will report any findings monthly to the Quality Assurance Committee, the Quality Assurance Committee will determine appropriate actions to be taken to include but not limited to insuring compliance, re-education and disciplinary actions of the responsible staff.	

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F 700	Continued From page 26 Review of R #5's "Care Plan", identified a problem of seizure disorder with an onset date of 12/29/10. The care plan documented the resident had the goal to continue to be free of seizure activity over the next 90 days with the use of Klonopin with a target date of 03/27/19. R #5's care plan included an approach for bilateral 1/2 side rails x 4 with the bed rails padded to prevent injury. Observation on 03/25/19 at 10:34 AM, revealed R #5 lying in bed, eyes open, with four (4) bed rails; two (2) half rails on each side, in the upright position. Resident #14: Review of R #14's quarterly MDS, with an ARD of 01/03/19, failed to identify the resident used side rails. The resident was identified as requiring limited assistance of one (1) staff member for bed mobility and transfers from the bed. Review of R #14's "Face Sheet", indicated the resident was admitted on 01/05/17. Review of R #14's "Physician orders", dated 03/30/18, documented to use bilateral half side rails for R #14 due to being at risk for self-injury. The associated diagnosis on the physician's orders was Frontotemporal Dementia. A document titled, "Admission Assessment & [and] Care Plan", dated 01/05/19, noted the bilateral side rails were to serve as an enabler for R #14. R #14's care plan, initiated on 01/05/17, identified the resident as being at risk for falls due to her poor safety awareness. One (1) of the identified	F 700		

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F 700	Continued From page 27 approaches included to utilize bilateral side rails to aid in turning and positioning. Review of a document titled, "Assessment of Risk for Falls", dated 01/03/19, documented R #14 scored "11", which was considered high risk for falls. On 03/25/19 at 10:45 AM, the room of R #14 was observed. The bed in the room had padded bilateral half side rails. An interview was conducted with a Certified Nursing Assistant (CNA) # 18 on 03/26/19 at 3:04 PM. CNA #18 stated that she would place R #14 in bed and raise the bilateral side rails. She stated the resident will not attempt to climb over the side rails, but instead will scoot down to the foot of the bed. CNA #18 stated that R #14 was not considered a fall risk. The Rehabilitation Director (RD) was interviewed on 03/27/19 at 8:31 AM. The RD stated that therapy does not assess residents for the use of side rails. The MDS Coordinator was interviewed on 03/27/19 at 12:53 PM. The MDS Coordinator stated R #14 cannot lower the bilateral side rails on her own. The MDS Coordinator stated the side rails were used to prevent the resident from falling out of bed. The MDS Coordinator stated R #14 could not follow directions or attempt to grab the side rails during the provision of care. Resident #26: Review of R #26's "Face Sheet", revealed the facility admitted the resident on 01/14/19, with a diagnoses of Heart Failure.	F 700		

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Review of R #26's "Physician Orders", dated March 2019, revealed a "Physician's Order" for "Bilateral half transfer bars to aide in T/P [turning/positioning.]"

Review of the resident's admission MDS, with an ARD of 01/21/19, revealed the facility assessed R #26 to have a BIMS score of 8 out of 15, which indicated the resident was moderately cognitively impaired. The MDS revealed the resident required extensive assistance from two (2) staff persons for bed mobility and required total dependence from two (2) staff persons for transfers to or from the bed.

Review of R #26's "Care Plan", revealed the resident had the problem of being at risk for fall r/t (related to) high risk fall assessment, non-ambulatory, with a problem onset date of 01/14/19. The care plan documented a goal, with a 'Target Date" of 04/24/19, that he would not sustain a fall through the next 90 days, with adherence to safety instructions. The care plan included an approach for "Bilateral half transfer bars for turning and positioning."

On 03/28/19 at 8:59 AM, the Environmental Services Director (ESD) measured the distance between R #26's mattress and the bed rails. The right bed rail measured 1.5 inches from the rail to the mattress and the left bed rail measured 2.25 inches from the mattress when the bed rails were in the upright position.

Resident #32:
Review of R #32's "Face Sheet", revealed the facility admitted the resident on 06/15/10, with a diagnosis of Alzheimer's Disease.

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F 700	Continued From page 29 Review of R #32's "Physician Orders", dated March 2019, revealed the resident had an order for "Bilateral full padded side rails on bed to prevent injury due to seizure activity while in bed." Review of R #32's quarterly MDS, with an ARD of 01/22/19, revealed the "BIMS" evaluation was not conducted due to the resident was rarely/never understood; however, the facility assessed the resident as severely cognitively impaired. The MDS revealed the resident was totally dependent upon two (2) staff persons for bed mobility and transferring to or from the bed. Review of R #32's "Care Plan", identified the resident was at risk of injury related to seizures with a problem onset date of 02/14/17. The goal identified that no seizure activity would occur over the next 90 days, with a goal date of 04/29/19. The "Care Plan revealed an approach of bilateral full padded side rails related to potential seizure activity. Observation on 03/25/19 at 2:10 PM, revealed the resident lying in bed, with her eyes closed. The two (2) full bed rails were padded and in the upright position. Resident #33: Review of R #33's "Face Sheet", revealed the facility admitted the resident on 05/03/06, with a diagnosis of Hemiplegia following a Cerebral Infarction affecting his right dominant side. Review of the "Physician Orders", dated March 2019, revealed R #33 had an order for "Bilateral transfer rails to his bed for turning and positioning."	F 700		

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F 700	Continued From page 30 Review of R #33's significant change in status MDS, with an ARD of 02/05/19, revealed the resident was unable to complete the BIMS; however, the facility assessed the resident to be moderately cognitively impaired. The MDS documented the resident required extensive assistance from two (2) staff persons for bed mobility and for transfers to or from the bed. Review of R #33's "Care Plan", identified the resident was at risk for falls related to right hemiplegia, impaired mobility, history of falls, and history of noncompliance with safety with a problem onset date of 11/12/10. The "Goal" documented the resident would remain free of falls over the next 90 days by adherence to safety instructions from staff. The approach included bilateral transfer rails on bed to aid in mobility while in bed. On 03/28/19 at 8:48 AM, the ESD measured the distance between R #33's mattress and the bed rails. The right bed rail measured 2.5 inches from the rail to the mattress. Resident #39: Review of R #39's "Face Sheet", revealed the facility admitted the resident on 12/13/16, with a diagnosis of Metabolic Encephalopathy. Review of the "Physician Orders", dated March 2019, revealed R #39 had an order for "Bilateral transfer rails to bed for turning and positioning." Review of R #39's quarterly MDS, with an ARD of 02/11/19, revealed a BIMS could not be conducted due to the resident was rarely/never understood; however, the facility assessed the	F 700		

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F 700	Continued From page 31 resident to have severe cognitive impairment. The MDS identified R #39 required extensive assistance from two (2) staff persons for bed mobility and for transfers to or from the bed. Review of R #39's "Care Plan", revealed the resident was at risk for falls related to a fall assessment, which indicated the resident was at high risk for falls with an onset date of 12/13/16. The care plan revealed the resident had a goal that he would not sustain a fall over the next 90 days through staff monitoring with a goal date of 05/20/19. Further review of the care plan revealed an approach of bilateral transfer rails to bed for T&P (turning and positioning.) On 03/28/19 at 8:51 AM, the ESD measured the distance between R #39's mattress and the bed rails. The right bed rail measured 2 inches from the rail to the mattress and 2.5 inches between the mattress and the left bed rail. Resident #51: Review of R #51's "Face Sheet", revealed the facility admitted the resident on 08/05/16, with a diagnosis of Vascular Dementia Without Behavioral Disturbance. Review of "Physician Orders", dated March 2019, revealed R #51 had an order for "Bilateral 1/2 siderails on bed to assist with T&P (turning and positioning)." Review of R #51's quarterly MDS, with an ARD of 02/28/19, revealed a "BIMS" score of 4 out of 15, which indicated the resident was severely cognitively impaired. The MDS revealed the resident required extensive assistance from two (2) staff persons for bed mobility and for transfers	F 700		

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F 700	Continued From page 32 to or from the bed. Review of R #51's "Care Plan", revealed the resident was at risk for falls related to impaired mobility with a problem onset date of 08/05/16. The "Care Plan" revealed a goal that the resident would not sustain falls over the next 90 days by allowing staff to assist with transfers, with a goal date of 06/05/19. The approach included "bilateral 1/2 siderails on bed to assist with turning and positioning." Observation and interview on 03/28/19 at 8:55 AM, with the ESD, revealed both the right and left side rails did not function properly The ESD applied pressure to the side rails, the rails gave way in a downward motion. The ESD stated the rails should not do that, they should stay in a fixed position. Resident #65: Review of R #65's "Face Sheet" revealed the facility admitted the resident on 05/09/01, with a diagnosis of Schizophrenia. Review of "Physician Orders" dated March 2019, revealed R #65 had orders for "Bilateral 1/2 siderails while in bed to aid with position change." Review of R #65's quarterly MDS, with an ARD of 03/11/19, indicated a "BIMS" could not be conducted due to the resident was rarely/never understood; however, the facility identified the resident had severe cognitive impairment. The resident required extensive assistance from two (2) staff persons for bed mobility and for transfers to or from the bed. Review of R #65's "Care Plan" revealed no	F 700		

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F 700	Continued From page 33 indication for the use of bed rails. Observation and interview on 03/28/19 at 8:54 AM, with the ESD revealed when he measured, there was a gap of 3.75 inches between the resident's mattress and the right bed rail The right bed rail was loose and not secure to the resident's bed. The ESD stated the bed rails were not supposed to be that loose and it was important that they were not loose for the resident's safety. Interview on 03/28/19 at 12:23 PM, with the Medical Director revealed it was his expectation the facility would have followed the regulations regarding residents having bed rails. Interview with the ESD on 03/28/19 at 12:33 PM, he revealed he was over the maintenance department. The ESD stated the maintenance department did randomly check the bed rails; however, he did not have any documentation to support the bed rail monitoring. Interview with the Administrator on 03/28/19 at 12:49 PM, revealed it was her expectation consents would have been obtained along with risks versus benefits being completed for the use of the bed rails; however, neither had been completed for any of the residents. Interview with the Assistant Director of Nursing (ADON) on 03/28/19 at 1:18 PM, revealed it was her expectation the residents and/or their family would have been asked prior to the bed rails being used. Interview with the Director of Nursing (DON) on 03/28/19 at 3:49 PM, revealed she was not aware	F 700		

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F 700	Continued From page 34 of the needed consents or the assessing of risks versus benefits when using a bed rail.	F 700		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838		5/3/19

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F 838	Continued From page 35 §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Legionella (a severe form of pneumonia caught by inhaling bacteria) and other waterborne pathogens polices were incorporated into the facility assessment. This had the potential to affect all 64 residents residing in the facility. The facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents during both day-to-day operations and emergencies.	F 838	The Facility Assessment was updated April 30th, 2019 by the facility Administrator to include Legionella and other Waterborne Pathogen policies and resources necessary to care for facility residents during day to day operations and in emergencies. No resident suffered adverse effects from this deficient practice. All residents have the potential to suffer adverse effects from this deficient practice. The Facility	

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F 838	Continued From page 36 Findings include: A Standards and Certification (S&C) memorandum dated as revised 06/09/17, from the Centers of Medicare Services (CMS) stated, ". . . Legionella Infections: The bacterium Legionella can cause a serious type of pneumonia called LD in persons at risk. Those at risk include persons who are at least 50 years old, smokers, or those with underlying medical conditions such as chronic lung disease or immunosuppression. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including hospitals and long-term care facilities. Transmission can occur via aerosols from devices such as showerheads. . . Facility Requirements to Prevent Legionella Infections: Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water . . . This policy memorandum applies to ...Long-Term Care (LTC)." Review of the "Facility Assessment" document failed to identify integration of a water management program that included Legionella and other waterborne pathogens. In addition, the "Facility Assessment" failed to identify how the potential of waterborne pathogens might place current or future residents, who have respiratory diseases, at risk for the development of diseases associated with waterborne pathogens. This document showed no evidence of staff competencies to ensure the resident population had its current care needs met, such as specialized training or education. There was no	F 838	Assessment Tool will be updated as necessary and annually by the facility Administrator to ensure all proper facility resources are updated. The Director of Nursing, Infection Preventionist , and Administrator were in-serviced on the completion of the Facility Assessment per facility policy on 04-30-19 by the Director of Clinical Services. The Nurse Consultant reviewed the Facility Assessment upon completion of the updated Facility Assessment. The Nurse Consultant is responsible for ensuring complete compliance of the updated Facility Assessment Tool annually. The Director of Clinical Services will review the completed Facility Assessment Tool annually upon the annual update to ensure on going compliance. Adverse findings will be forwarded to the Quality Assurance Committee by the facility Administrator monthly. The Quality Assurance Committee will review any adverse findings and appropriate actions will be taken to include but not limited to re-education and disciplinary actions.	

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F 838	Continued From page 37 evidence to show what types of equipment is available to the facility residents to render care. There was no information to show how health records were managed, either electronically or by paper. There was an area on page seven (7) of this document that identified the following: name of plan; facility-based risk assessment plan; community-based risk assessment plan; infection control emergency plan; and risk of infections. There was no additional information provided under these subsections of this document. An interview was conducted with the Administrator, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) on 03/28/19 at 11:58 AM. The Administrator confirmed the document provided was the Facility Assessment. During another interview with the Administrator, conducted on 03/28/19 at 2:19 PM, the Administrator provided an example of the care of bariatric residents and confirmed the facility had this type of residents in the facility. She was unable to identify, on this document, what types of specialized equipment that a bariatric resident was to use while in the facility, such as a bariatric wheelchair, bed, or scale.	F 838		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/3/19

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F 880	Continued From page 38 §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: (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	F 880		

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F 880	Continued From page 39 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 observation, interview, and review of facility policies, the facility failed to establish and maintain an infection prevention and control program (IPCP) to provide a safe and sanitary environment and prevent the development and transmission of communicable diseases and infections; failed to develop a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility; and failed to conduct an annual review of its IPCP and update their program, as necessary. This had the potential to affect all 64 residents of the facility. Findings include: 1. On 03/28/19 at 10:30 AM, a request for the written document identifying the specific elements of the IPCP was made to the Assistant Director of	F 880	The Infection Preventionist will go through extensive training and educational seminars, to include online training, on the day to day duties of monitoring of infections, prevention of infection, and infection control. No resident suffered adverse effects from this deficient practice. All residents have the potential to suffer adverse effects from this deficient practice. Further education of the Infection Preventionist role will benefit all residents by the knowledge she will obtain to prevent and identify infections within the facility. The Infection Preventionist was in-serviced on establishment and	

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F 880	Continued From page 40 Nursing (ADON), who is the Infection Preventionist (IP), and the Director of Clinical Services (DCS). A document was not provided for review nor could one be found. Review of the facility's policy titled, "Infection Control Committee (ICC) Overview," revised 07/2014, indicated, "The ICC oversees the surveillance, investigation, reporting, control and prevention of infections and includes the following individuals: Administrator or designee, DON, IP, Dietician/Food Service Director, Environmental Services Director/Supervisor, Maintenance Director/Supervisor, Laundry Director/Supervisor, and others as appropriate. The ICC will meet monthly or more often and minutes shall be submitted to [the] QAPI [Quality Assurance and Performance Improvement] [Committee], which will review, analyze, and act as needed on the information and recommendations of the ICC. A formal IPCP Committee responsible for surveillance, investigation, reporting, control and prevention of infections, is not a separate entity nor are formal minutes maintained." During an interview on 03/28/19 at 10:35 AM, the ADON stated the following people meet and discuss infections in the building: ADON, Director of Nurses (DON), Dietary Manager, Minimum Data Sheet (MDS) Nurse, Maintenance Director, Administrator, Housekeeping Director, and the Medical Director if he is in the building. The Pharmacist is not a member, but the Pharmacy Consultant reviews the information found on reports, the antibiotic stewardship program and infections in the building. Information noted during any surveillance conducted by DCS during an onsite visit, is placed in a report but the rates of compliance with the surveillance is not submitted	F 880	maintenance of an Infection Prevention and Control Program (IPCP) per facility policies as well as State and Federal Regulations on 05/01/19 by the Director of Clinical Services. The Director of Nursing will review the monitoring of a safe, sanitary environment beginning 05/01/2019, the recording of incidents under the Infection Prevention and Control Program (IPCP), and the corrective actions taken by the facility, weekly, for eights weeks. The Facility Nurse Consultant will monitor each month for two months the Infection Prevention and Control Program (IPCP), and review the program annually to ensure on-going compliance beginning 05/01/2019. Adverse findings will be forwarded to the Quality Assurance Committee by the Infection Preventionist monthly during the Quality Assurance meeting. The Quality Assurance Committee will review any adverse findings and appropriate actions will be taken to include but not limited to re-education and disciplinary actions.	

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F 880	Continued From page 41 to QAPI or discussed. There are no documented rates of compliance with handwashing or any other surveillance. During an interview on 03/28/19 at 3:04 PM, the infection log, control mapping, trending and tracking information by unit was reviewed with the DON. The infection log included the following: resident's name; room number; nosocomial or community acquired; symptom onset; infection category (example: urinary, vaginal, etc.); pathogen; related diagnosis, whether an antibiotic is prescribed; disposition or outcome (example: successfully treated); and status (resolved or open). The mapping consisted of an outline of the units where the residents with infections reside. This information is reviewed in QAPI, but no detailed analysis of possible cross contamination or other possible infection control related issues such as staff assigned to areas are identified as possible causes of cross contamination. 2. During an interview on 03/28/19 at 10:30 AM, the DON and DCS stated that the IC Manuals were present on all the units and the IC policies and procedures are available on the computer system. Review of the IC policies and procedures provided no evidence to indicate they are reviewed and revised on an annual basis. Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" indicated a glucometer is classified as a reusable item that needs to be disinfected or sterilized between residents. The policy directed that reusable equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. Review of the manufacturer's instructions for cleaning the	F 880		

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F 880	Continued From page 42 "Assure Prism Multi Blood Glucose Meter" used by the facility permit Super Sani-Cloths Germicidal Disposable Wipes to be used on the glucometer. Guidelines for cleaning and disinfecting the machine included: use of approved wipe; wiping the meter using the towelette at least three (3) times vertically and three (3) times horizontally to clean blood and other body fluids from the meter; dispose of the towelette; allow the exterior to remain wet for one (1) minute then wipe dry. The Super Sani-Cloth Germicidal Disposable Wipes are available in the facility and have a two (2)-minute wet contact time indicated on the label. Observation on 03/27/19 at 5:30 AM revealed Licensed Practical Nurse (LPN) #1 used a Sani-Cloth Wipe and wiped the glucometer three (3) times on the front and back then stated that it is supposed to dry for a few minutes. Observation on 03/27/19 at 6:45 AM, revealed LPN #3 cleaned a glucometer with a Sani-Cloth Wipe stating that it is to be wiped with cloth "real good" for 15 seconds, then placed on barrier to dry. Neither LPN #1 nor LPN #3 were aware of wet contact time of Sani-Cloth Wipes. 3. During an observation on 03/26/19 at 11:24 AM, Certified Nursing Assistant (CNA)#14 fed Resident (R) #12 and R #66 at a restorative dining table. The CNA fed each resident a few spoonful's of food and then fed the other resident. The CNA did not wash her hands between the residents. CNA #14 was also noted leaving the restorative dining room after feeding residents without performing hand hygiene. Observation on 03/25/19 at 11:36 AM, revealed	F 880		

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F 880	Continued From page 43 an unidentified CNA entered residents' rooms and picked up lunch trays for residents in the B wing without performing hand hygiene when entering or exiting the rooms or prior to or removing gloves. During interview on 03/28/19 at 10:12 AM, with the ADON and DCS, the DCS stated that during monthly visits to the facility, she observes the following infection control practices: medication pass, disinfecting of blood glucometer machines, inspection of the laundry room, food temperatures and handwashing compliance. Handwashing compliance is conducted monthly at a minimum. The DCS states that the procedure for disinfecting the glucometers is taught in orientation. She states that she monitored the staff a month ago and staff "were perfect" in their technique, but results of the monitoring was not presented to the IC or QAPI committees nor trended from month to month. The DCS states that the process for cleaning the glucometers is that the machine is wiped with a manufacturer's recommended wipe three (3) times on every surface and allowed to air dry for five (5) minutes. The wet contact time indicated on the wipes is two (2) minutes. During interview the DCS stated that all staff had received education on infection control, handwashing, universal precautions, glucometer cleaning, and urinary tract infections. Per the ADON, she has not been able to initiate any infection control education in the 10 weeks she has been at the facility. During an interview on 03/28/19 at 1:00 PM, the Administrator stated that she was not aware of the lack of education among staff on infection control. The expectation would be that infection control policy would come from the DCS and that	F 880		

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F 880	Continued From page 44 it would be communicated with her and the DON at the same time. Policies and procedures are reviewed annually by the DON, NHA and MD who signs off on them. The Administrator was not aware that infection control manuals were not on the units.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, the facility failed to ensure three (3) of six (6) Certified Nursing Assistants (CNA), whose personnel files were reviewed, (CNA #3, CNA #14, and CNA #24), received at least 12 hours of in-service training per year. This failure had the potential to affect the 64 residents	F 947	Certified Nursing Assistant's (C.N.A.) #3,#14 and #24 have now completed the required number of hours of in-service training. The Director of Nursing and Assistant Director of Nursing worked with the Certified Nursing Assistants to ensure all hours were completed by 04/30/2019.	5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. BUILDING _____ B. WING _____	03/28/2019

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

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F 947	Continued From page 45 in the facility who may have been provided care by the CNAs. Findings include: Review of the facility's policy titled, "In-Service Training Program, Nurse Aide," revised October 2017, revealed all nurse aide personnel would participate in regularly scheduled in-service training classes. Continued review of the policy revealed annual in-services must be no less than 12 hours per employment year and the employee's in-service records would be filed in the employee's personnel file or would be maintained by the department supervisor. Review of CNA #3's personnel file revealed the CNA was hired on 03/03/02. Review of the "Student and Group Transcript Report", dated 03/28/19, documented for the CNA's annual training period of 03/2018 until 03/2019, the CNA received 3.75 hours of the minimum 12 hours required. Review of CNA #14's personnel file revealed the CNA was hired on 09/14/00. Review of the "Student and Group Transcript Report", dated 03/28/19, documented for the CNA's annual training period of 09/2017 until 09/2018, the CNA received 5.75 hours of the minimum 12 hours required. Review of CNA #24's personnel file revealed the CNA was hired on 05/18/15. Review of the "Student and Group Transcript Report", dated 03/28/19, documented for the CNA's annual training period of 05/2017 until 05/2018, the CNA received 6.50 hours of the minimum 12 hours required.	F 947	No resident suffered adverse effects from this deficient practice. All residents have the potential to suffer adverse effects from this deficient practice. Staff that are not properly in-serviced can prevent residents from getting proper care. The Human Resource Coordinator and Director of Nursing were in-serviced on the required yearly Certified Nursing Assistants hours per Facility Policy, State and Federal Regulations by the Administrator on 04/30/19. A 100% audit of all facility Certified Nursing Assistants in-service hours by the Human Resource Coordinator was completed on 05/01/19, and revealed that all Certified Nursing Assistants were compliant with the in-service hours. The Director of Nursing will review the Certified Nursing Assistants in-service hours weekly for eight weeks starting 04/30/2019, to ensure in service hours are completed as required. The Administrator will review Certified Nursing Assistant in-service hours monthly for two months starting 04/30/2019, to ensure compliance. The Nurse Consultant will review in-service hours quarterly to ensure on-going compliance. Adverse findings will be forwarded to Quality Assurance by the Human Resource Director during the monthly Quality Assurance Meeting. The Quality Assurance Committee will review any adverse findings presented and will then determine appropriate actions to be taken to include but not limited to	

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F 947	Continued From page 46 Interview on 03/28/19 at 3:44 PM, with the Director of Nursing (DON), revealed she had been training CNAs and nursing staff for a long time. She stated she could not locate the required documentation to show the CNAs had received the required training. Interview on 03/28/19 at 4:18 PM, with the Administrator, revealed the DON was responsible for ensuring the CNAs received the required minimum 12 hours of training each year. The Administrator stated it was her expectation the CNAs would have received their required training hours. She stated it was important the CNAs received the required training to ensure the staff are competent to provide direct care to the residents.	F 947	re-education and disciplinary actions.	

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	255216	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2019**

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

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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 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923		5/3/19

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

Electronically Signed | 05/03/2019

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

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	255216	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2019**

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K 923	Continued From page 1 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide secured "free standing cylinders" to be properly chained or supported in a proper cylinder stand or cart as required by NFPA 101 Chapter 19 section 19.3.2.4, NFPA 101 Chapter 8 section 8.7.3 and NFPA 99 Chapter 11 section 11.6.2.3. This deficient practice has the potential of affecting one (1) of five (6) smoke compartments in the facility on the day. Findings include: On March 26, 2019 at 10:45 AM, observation revealed unsecured, oxygen cylinder located in the Physical Therapy room. This oxygen cylinder was free standing and had the potential of being knocked over. The finding was acknowledged by the Administrator and Maintenance Supervisor during the exit interview on March 26, 2019.	K 923	No resident suffered any adverse affects due to the deficient practice. On 03/26/19 the free standing gas cylinder that was identified in the therapy department was immediately removed and secured in the proper storage unit. All residents in the one of five smoke compartment area of the facility have the potential to be affected by the deficient practice. Therapy staff has been in-serviced by the Therapy Supervisor and Riverview Safety Director on 03/26/19 on the proper storage of Gas Cylinders. The Occupational Therapist will monitor the storage of the gas cylinders 5 times per week for 8 weeks. The Safety Coordinator will monitor the gas cylinders 3 times per week times 4 weeks, then monitor once weekly times 4 weeks. any adverse findings will be forwarded to the Quality Assurance Committee.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/26/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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