

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2019
NAME OF PROVIDER OR SUPPLIER RIVER CHASE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 5090 GAUTIER VANCELEAVE ROAD GAUTIER, MS 39553		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 2/26/19 through 2/28/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 578, F 645, F 695, F 725, F 814, and F 880.	F 000			
F 578 SS=D	At the time of the survey, the census was 54, and the facility held a license for 60 beds. Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		3/28/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/26/2019

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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F 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide Advanced Directives for two (2) of 18 resident records reviewed for Advanced Directives, Resident #34 and Resident #8. Findings include: Review of the facility policy, "Advanced Directives", not dated, revealed the Advance Directives will be respected in accordance with state law and village policy. Prior to or upon admission of a resident to our village, written information will be provided to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advance Directives. Each resident will be informed that our village's policy does not condition the provision of care or discriminate against an individual based on whether or not the	F 578	1. On 2/27/2019 an Advance Directive form was provided in Resident #34 and Resident #8's resident record by the Admission Coordinator. 2. All residents at River Chase Village have the potential to be affected by the absence of an Advance Directive. A chart review was performed on all current residents by the Admission Coordinator beginning 2/27/2019 with completion on 3/3/2019 to identify any resident having the potential to be affected by the absence of an Advance Directive. Findings were noted on the Advance Directive Audit Tool. 3. The Interdisciplinary Team was in-serviced on 2/27/2019 by the Administrator regarding the development of all current residents Advance Directive		

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F 578	Continued From page 2 individual has executed an Advance Directive. Information about whether the resident has executed an Advanced Directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preference and/or Advance Directive. Advance Directives will be reviewed annually with the resident to ensure that such Advance Directives are still the wishes of the resident. The care plan team will be informed of any changes so the appropriate changes can be made in the medical record. Resident #8 Record Review of Resident #8's medical record revealed the resident did not a have an Advance Directive. During an interview on 02/28/19 at 09:56 AM, the Admission Coordinator stated the facility does not have an Advance Directive for the resident's with a full code. The facility will offer Advance Directives to all residents after this week. A review of the facility's face sheet revealed the facility admitted Resident #8 on 06/27/2008, with diagnoses, which included Dementia, Heart failure, Hypertension and Kidney Disease. A review of Resident #8 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2018, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident is cognitively intact. Resident #34 Record review of Resident #34's chart revealed the resident did not have a written Advanced Directive in the chart.	F 578	choice in the chart and their right to formulate an Advance Directive. The Interdisciplinary Team was in-serviced on 2/27/2019 by the Administrator regarding development of a new facility Advance Directive form that will be completed upon admission and updated annually for all current residents as it relates to resident/responsible party choice to formulate an Advance Directive. The Nursing Department was in-serviced on 3/7/2019 by the Director of Nursing(DON) regarding development of new facility Advance Directive form that will be completed upon admission and updated annually for all current residents and placed in advance directive tab within each residents chart. An Advance Directive Audit of all resident charts was initiated by the Admission Coordinator on 2/27/2019 and completed on 3/3/2019 to ensure all Advance Directive related forms were present and updated. Any identified discrepancies were immediately updated by the Admissions Coordinator. The Advance Directive Audit will be completed by the Admission Coordinator monthly for three consecutive months on all current residents and then monthly thereafter on all new admissions. Any identified discrepancies will be immediately updated by the Admission Coordinator. 4. The findings of the Advance Directive Audits are to be reviewed and presented by the Admission Coordinator to the Quality Assessment and Assurance(QAA)		

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F 578	Continued From page 3 During an interview on 02/27/2019 at 04:38 PM, the Administrator revealed the facility only has documented Advanced Directives on residents that have a Do Not Resuscitate(DNR) order. A review of the facility's face sheet revealed the facility admitted Resident #34 on 09/30/2018, with diagnoses which included Diabetes Mellitus, Dementia, Hypertension and Respiratory Failure. A review of Resident #34's Quarterly MDS, with an ARD of 1/18/2019, revealed Resident #34 had a BIMS score of 9, which indicated the resident is mildly cognitively impaired.	F 578	Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make any recommendations and to meet quarterly thereafter.		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		3/28/19	

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F 645	Continued From page 4 intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).			F 645			

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F 645	Continued From page 5 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete the resident Preadmission Screening (PAS) for one (1) of four (4) resident PAS screening reviewed, Resident #12. Findings include: A review of the facility's policy, "PASSR (Preadmission Screening and Resident Review) Screening and Level II Policy", undated and documented on facility letterhead, revealed under the screening section: We review all individual's documents and complete interviews with the individual in order to properly complete a PASSR screen. A review of Resident #12's PAS, dated 6/28/18, revealed "person has a diagnosis of a major mental illness" was documented "No". "Selected Active Medical Conditions" included Bipolar Disorder. The "Electronic Attestation" section was left blank and did not indicate whether a Level II was indicated or not. Review of Resident #12's admission Face Sheet, as well as the February 2019 Physician's orders, revealed the facility admitted the resident on 6/23/18, with a diagnosis of Bipolar Disorder. On 2/27/19 at 5:15 PM, an interview with Social Service Worker #1 revealed the PAS was not	F 645	1. On 3/25/2019, the Program Nurse of the Office of Mental Health Programs with the Division of Medicaid entered an electronic change in the referral criteria to the electronic case of Resident #12 to change the answer from "No" to "Yes, Person has a diagnosis of a major mental illness" noted in section IX-Part B- Level II Referral Criteria for diagnosis of Bipolar Disorder. Rationale from Ascend's Level II assessment was that a "Pre-Admission Screening(PAS) Application was submitted on 6/28/2018 for Resident #12 who has a diagnosis of Bipolar Disorder, and Dementia. A prior Level II was completed 10/2015 noting: Axis 1 Bipolar Disorder NOS, Vascular Dementia uncomplicated. He has cognitive impairment, and memory impairment with mild/moderate disorientation/confusion. Based on the information submitted and reviewed, on 7/3/2019 Resident #12 approved a negative screen due to primary Dementia." 2. Any resident of River Chase Village has the potential to be affected by failing to ensure the accurate completion of the Pre-Admission Screening(PAS)Application for Long Term Care. A chart review was initiated by the Social Service Worker #1 on 3/8/2019		

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F 645	Continued From page 6 completed accurately for Resident #12. On 2/27/19 at 5:30 PM, an interview with the Director of Nurses (DON) revealed the PAS was not completed accurately for Resident #12. A review of Resident #12's most recent quarterly MDS with an ARD of 12/17/18, revealed, Resident #12 had a Brief Interview of Mental (BIMS) score of 7, which indicted a moderately impaired cognitive status.	F 645	with planned completion date for 3/28/2019 to identify any resident having the potential to be affected. Findings will be noted on the Pre-Admission Screening Resident Review(PASRR) Audit Tool. 3. On 2/28/2019 the Administrator in-serviced the Social Worker #1, Minimum Data Set Nurse, and the Director of Nursing on ensuring the completion of the Pre-Admission Screening(PAS) Application prior to admission as well as a resident having a significant change that would require a new screening. On 2/28/2019 a process was established by the Administrator in which the Pre-Admission Screening(PAS)Application will be reviewed by the Social Worker #1 and the Director of Nursing(DON) to ensure its accurate completion before admission to River Chase Village. Any incomplete PAS will be corrected by the Screener and/or the Physician prior to admission. On 3/8/2019 a Pre-Admission Screening Resident Review(PASRR) Audit was initiated by the Social Worker #1 with expected completion date of 3/28/2019 to identify all residents have an accurate and complete Pre-Admission Screening(PAS) Application for Long Term Care. The PASSRR Audit will be completed on all new admissions monthly for three consecutive months and quarterly thereafter by Social Worker#1. 4. The Findings of the PASSRR Audit are to be reviewed and presented by		

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F 645	Continued From page 7	F 645	Social Worker#1 to the Quality Assessment and Assurance (QAA) Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make any recommendations, then meet quarterly thereafter.		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, and staff interview, the facility failed to ensure oxygen and nebulizer masks were bagged and stored to prevent to possible spread of infection for one (1) of 12 resident respiratory mask observations, Resident #21. Findings include: Review of facility policy titled, "Infection Prevention and Control Program Policy", dated February 2018 revealed, that the policy is to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The program will include, but not	F 695	1. On 2/28/2019 Director of Nursing(DON)ensured that Resident #21's nebulizer mask and oxygen tubing with the nasal cannula were properly bagged to prevent possible spread of infection. On 2/28/2019 Resident #21 was assessed by the Director of Nursing(DON) to ensure no adverse signs or symptoms due to the facility failing to properly bag/store respiratory equipment in a manner to prevent the possible spread of infection. 2. All nine(9) residents receiving respiratory care have the potential to be	3/28/19	

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F 695	Continued From page 8 limited to precautions to be followed to prevent spread of infections. An observation on 02/26/19 at 09:29 AM, revealed Resident #21's Nebulizer mask lying on the table and not in a bag. Oxygen tubing with the nasal cannula was observed lying in the resident's open drawer; not in a bag. An interview on 02/28/19 at 08:59 AM, with Registered Nurse (RN) #1/Infection Control Nurse, revealed, "We don't put the nebulizer masks and oxygen tubing in bags. I guess that is a problem. The nebulizer and the oxygen tubing not being in a bag would be an infection risk for the resident". An interview on 02/28/19 at 09:38 AM, with the Director of Nursing (DON) and the Administrator, regarding nebulizer masks and oxygen tubing not being bagged, revealed they both agreed, "It is an infection control issue for them to be lying out and not in bags". Record review of the physician orders, for Resident #21, revealed medication orders for Ipratropium-Albuterol 0.5-3 (2.5) milligram (mg) three (3)/milliliters (ml) take one (1) vial via Nebulization twice daily (BID), Albuterol Sulfate 0.63 mg/3 ml solution- take one (1) ampule by nebulization every six (6) hours as needed (PRN) wheezing, and Oxygen at two (2) liters per minute via nasal cannula PRN for Chronic Obstructive Pulmonary Disease (COPD). Record review of electronic Treatment Administration Record, for Resident #21, revealed the resident received oxygen at two (2) liters per minute by nasal cannula on February	F 695	affected by improperly storing/bagging of respiratory equipment. An audit for improper storing/bagging of respiratory equipment was done by Director of Nursing(DON)beginning 2/28/2019 with completion on 3/1/2019 on all current residents to identify any resident having the potential to be affected. 3. The Registered Nursing(RN) staff was in-serviced by the Director of Nursing(DON)on 3/1/2019 regarding new respiratory equipment checklist to be performed daily to ensure that any residents receiving respiratory care are attaining proper storing/bagging of their respiratory equipment. On 2/28/2019 the Director of Nursing(DON) provided an in-service for the contracted company for respiratory equipment regarding proper storing/bagging of respiratory equipment for River Chase Village due to the fact that the company provides such equipment and services including; cleaning, changing, and maintenance of all respiratory equipment. A Respiratory equipment Audit of all current residents receiving respiratory treatments was initiated on 2/28/2019 and completed by 3/1/2019 by the Director of Nursing(DON)to ensure all equipment was properly stored/bagged. Any identified discrepancies were immediately updated by the Director of Nursing(DON). The Respiratory Audit will be completed weekly on all current residents receiving respiratory care weekly for three		

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F 695	Continued From page 9 27, 2019, and Iprat-AIbut 0.5-3/2.5 mg/3 ml one (1) vial by nebulization two (2) times daily at 8:00 AM and 9:00 PM.	F 695	consecutive months by the Director of Nursing(DON) and monthly thereafter. All Nursing Staff was in-serviced by the Director of Nursing(DON) on 3/1/2019 and again on 3/7/2019 regarding proper respiratory storage/bagging and proper sanitation. New Nursing Hire Orientation Checklist was updated on 3/7/2019 to ensure all new nursing staff is properly trained on storage/bagging of Respiratory Equipment. Nursing Staff to be in-serviced annually by Director of Nursing(DON) to ensure River Chase maintains proper respiratory storage/bagging and proper sanitation of Respiratory Equipment. 4. The findings of the Respiratory Audit are to be reviewed and presented by the Director of Nursing(DON) to the Quality Assessment and Assurance(QAA) Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make any recommendations then quarterly thereafter.		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725		3/28/19	

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F 725	Continued From page 10 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure adequate staffing was provided for three (3) of 14 days reviewed for staffing. Findings Record review of facility policy titled, "Staffing Policy", revealed the minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct care per resident per 24 hours. Staffing requirements are based upon resident census. Record review of the schedule and staffing grid, revealed the facility failed to provide sufficient	F 725	1. The Director of Nursing(DON) reviewed staffing based on the ratio of two and eight tenths(2.80)hours of direct care per resident per twenty four hours on a daily basis from 2/28/2019 through 3/6/2019 to ensure adequate staffing was being maintained and weekly thereafter. Usual staffing is set within River Chase Village on average being between a 3.2 and 3.6 staffing ratio although the 14 days reviewed we failed to provide adequate staffing on 3 of 14 days due to new staff being on orientation. 2. All residents have the potential to be affected by the facility failing to provide adequate staffing.		

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F 725	Continued From page 11 nursing staff for three (3) of 14 days of the working schedule. The dates were; 2-16-19 (2.75), 2-17-19 (2.75), and 2-24-19 (2.76). Interview on 02/28/19 at 01:08 PM, with the Administrator and Director of Nursing (DON), after reviewing the staffing grid, revealed that the facility did not meet the staffing ratio of 2.80. The DON and the Administrator revealed they knew the staffing ratio should be at 2.80, but they did not realize they had not met it until today. The DON stated they were down four (4) Certified Nurses Aides (CNAs); they have some hired, but they haven't been working. The DON stated, "If you had come a month ago, we'd be ok." The Administrator stated she had a Registered Nurse in training and she will be out of training as of today.	F 725	3. On 3/7/2019 all Nursing Staff was in-serviced regarding the importance of adequate staffing and explained the minimum requirements for adequate nursing staff and that it shall be based on the ratio of two and eight tenths(2.80) hours of direct care per resident per 24 hours. Discussed the importance of switching shifts and covering shifts when there is a call out. During weekly Registered Nursing Staff meetings the Director of Nursing(DON), Registered Nurses, Minimum Data Set Nurse and Administrator will review facility staffing ratio beginning 3/6/2019 to ensure adequate staffing will be provided to assure resident safety and to attain the highest practicable physical, mental and psychosocial well-being of each resident. The Director of Nursing(DON), Registered Nurses, Minimum Data Set Nurse and Administrator will review facility staffing ratio weekly to ensure adequate staffing is being provided. Any discrepancies will be addressed immediately. 4. The weekly Registered Nursing Meeting notes of adequate staffing will be discussed and reviewed by the Director of Nursing(DON) to the Quality Assessment and Assurance(QAA) Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make any recommendations then quarterly		

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F 725	Continued From page 12	F 725	thereafter.		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility policy review, the facility failed to ensure garbage was contained and disposed of properly, as evidenced by garbage overflowing on top of the dumpster, on two (2) of two (2) observations. Findings include: A review of the facility's policy titled, "Garbage Disposal Policy", undated, revealed garbage must be kept in water-tight suitable containers with tight fitting covers. Garbage containers must be emptied at frequent intervals. Garbage dumpster must be kept with lids closed with no exposed garbage. On 2/27/19 at 6:45 PM, an observation of the garbage dumpster revealed the dumpster had the lid pulled open with garbage overflowing on top of the dumpster and garbage on top of the pulled back lid. On 2/28/19 at 8:15 AM an observation of the garbage dumpster revealed the lid was open and garbage was overflowing on top of the dumpster and on the pulled back lid. On 2/28/19 at 8:30 AM, an interview with Maintenance Supervisor #1 revealed she was unsure how often the garbage was being picked	F 814	1. On 2/28/2019 the dumpster was emptied by the contracted garbage disposal company for proper disposal of garbage with lids closed shut. 2. All residents have the potential to be affected by the dumpster having exposed garbage and lids not being properly closed. 3. The Maintenance Supervisor was in-serviced by the Administrator on 2/28/2019 regarding proper garbage disposal, frequency, lids being closed at all times, job duty revision and daily audit to ensure proper garbage disposal is being maintained. The Interdisciplinary Team was in-serviced by the Administrator on 2/27/2019 regarding proper garbage disposal, frequency and lids being closed at all times. All facility staff was in-serviced on 3/7/2019 by the Administrator regarding proper garbage disposal, frequency and lids being closed at all times. The contract between River Chase Village and the contract company for garbage disposal was updated by the Administrator on 3/7/2019 for an extra	3/28/19	

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F 814	Continued From page 13 up. While interviewing the maintenance supervisor, Registered Nurse #1 (RN) stated that the garbage is picked up once every week every seven (7) days. On 2/28/19 at 9:15 AM, an interview with the Administrative Assistant revealed the garbage is picked up biweekly. On 2/28/19 at 9:20 AM, the Administrative Assistant returned and stated the garbage is picked up at least once a week. On 2/28/19 at 9:30 AM, an interview with the Administer revealed the garbage is picked up about three (3) times per week. She stated she does not know why the garbage is so full now.	F 814	pick up day that puts River Chase Village at four total days a week for garbage disposal to prevent overflow of garbage. The Maintenance Supervisor will conduct a Daily Garbage Disposal Audit to ensure proper garbage disposal is being maintained. This audit was added to the Maintenance Supervisor's job duty as of 3/7/2019. Any identified discrepancies will be immediately brought to Administrator to notify contract company for garbage disposal of any disposal needs. 4. The findings of the Garbage Disposal Audit are to be reviewed and presented by the Maintenance Supervisor to the Quality Assessment and Assurance(QAA) Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make any recommendations, then quarterly thereafter.		
F 880 SS=D	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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		3/28/19	

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F 880	Continued From page 14 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 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.	F 880			

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F 880	Continued From page 15 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review, record review, and staff interview, the facility failed to prevent the possible spread of infection during medication pass for one (1) of 9 residents observed for medication administration. Resident #53. Findings Review of facility policy titled, "Infection Prevention and Control Program Policy", dated February 2018, revealed the policy is for this Village to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The program will include, but not limited to precautions to be followed to prevent spread of infections. Review of facility policy titled, "Infection Control" undated, revealed that resident care equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed.	F 880	1. On 2/27/2019 Licensed Practical Nurse(LPN) #2 was in-serviced regarding the possible spread of infection during medication pass for Resident #53 by the Director of Nursing(DON) and Registered Nurse(RN) #1/Infection Control Nurse as soon as notified regarding incidents with LPN #2. On 2/27/2019 Resident #53 was assessed by the Director of Nursing(DON)to ensure no adverse signs or symptoms due to LPN #2 failing to provide medication administration in a manner to prevent the possible spread of infection. 2. Any residents receiving blood glucose monitoring and/or receiving subcutaneous insulin has the potential to be affected by improper disinfection of glucometer machines or improper exposure of needles. 3. On 2/27/2019 LPN #2 was in-serviced		

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F 880	Continued From page 16 Review of the Assure Prism glucose machine Manual, revealed instructions: After cleaning with appropriate cleaner, allow exterior to remain wet for the corresponding contact time for each disinfectant. An observation on 02/26/19 at 11:15 AM, revealed Licensed Practical Nurse (LPN) #2 cleaned the glucometer machine, (Assure Prism) while in the medication room, with a sanitizing wipe then dried the glucometer machine with a paper towel, instead of letting it air dry. An observation on 02/26/19 at 11:30 AM, revealed LPN #2 drew 10 units of Humalog Insulin in a syringe, while standing in the Medication Room, for Resident #53. After filling the syringe with Humalog Insulin, LPN #2 placed the insulin syringe in her hand and toted the syringe, with the needle pointed towards the ground, down the hall with needle uncapped and exposed to air to Resident #53's room. LPN #2 administered the Humalog Insulin in the Resident's left abdomen. On 2/27/19 at 2:40 PM, when ask about cleaning of the glucometer machine, LPN #2 stated, "Come to think of it I probably wiped it with a paper towel, but I was trying to hurry the process along. I should have let it air dry after cleaning it." LPN #2 stated, "I could see that as an infection control issue". During an interview on 2/27/19 at 2:42 PM, LPN #2 admitted that she toted the syringe down the hall with the needle exposed to the environment. When LPN #2 was ask about taking the syringe down the hall exposed to the environment, she replied, "I wasn't sure what to do and I thought	F 880	by Director of Nursing(DON) and RN #1 of incidents with LPN #2 during medication pass for Resident #53 regarding the improper exposure of needles and the improper disinfection of glucometer machines. On 3/1/2019 and 3/7/2019 Nursing Staff was in-serviced by Director of Nursing(DON) regarding proper disinfection of glucometer machines and improper exposure of needles. New Hire Orientation Checklist for LPN's was updated on 3/7/2019 by the Administrative Assistant to ensure all new nursing staff is properly trained on disinfection of glucometer machines as well as needle safety. Nursing Staff to be in-serviced annually by the Director of Nursing(DON)for proper disinfection of glucometer machines as well as needle safety. Random Audit/Observations by the Director of Nursing(DON) beginning 2/28/2019 with planned completion on 3/25/2019 to all nurses for proper disinfection of glucometer machines and needle safety. 4. Ongoing education for nurses will be done monthly beginning 4/2019 during infection control in-service by the Director of Nursing(DON) regarding proper disinfection of glucometer machines and needle safety for three consecutive months. Director of Nursing(DON) will present infection control in-service and Observation Audit to the Quality		

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F 880	Continued From page 17 about recapping it, but I didn't know whether I should recap it or not. I know we're not supposed to recap needles". She stated she held the syringe with the need pointing down when she went down the hall to Resident #53's room, to protect it from others. LPN #2 stated, "After talking about it, I can see that it could be an infection control issue". An interview on 2/28/19 at 09:07 AM, with Registered Nurse (RN) #1/Infection Control Nurse, revealed that LPN #2 told her about the insulin syringe being toted down the hall without a cap and exposed to the air. She stated, "I told her that was incorrect and that it was not recapping if the needle had not been used on the resident. I feel it should have been covered before going down the hall. I feel it was an infection control issue with the needle exposed to the air". In an interview on 02/28/19 at 09:13 AM, RN #1/Infection Control Nurse, stated that LPN #2 should have let the glucometer meter air dry after she had cleaned it with bleach wipes. She stated LPN shouldn't have dried the glucometer with paper towels, she should have let it air dry; that is an infection control issue. During an interview on 02/28/19 at 09:26 AM, the Director of Nursing (DON) stated LPN #2 came to her about the glucometer being wiped with a paper towel and the insulin syringe being toted down the hall exposed to air. The DON stated, "I told her she should have let the glucometer air dry after cleaning it and she should have covered the needle before going down the hall. You never know what could have happened and you have an exposed needle. It definitely could be an infection control issue".	F 880	Assessment and Assurance(QAA) Team to ensure infection control issues/concerns are notified and resolved. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and to make recommendations then quarterly thereafter.		

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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 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide a properly maintained fire alarm system as required by NFPA 72 Table 14.3.1. This deficiency affected all 52 residents in the facility at the on day of survey. Findings include: On February 26, 2019 at 11:30 AM, the facility could not produce last year (2018) documentation for annual inspection fire alarm system. The last inspection of the fire alarm system was performed in 2017. The fire alarm system did function properly during the survey. The administrator was made aware of the issue during the exit conference.	K 345	1. The documentation for the 2018 annual inspection of the fire alarm system was performed on 12/26/2018. This documentation was overseen in the Life safety book provided by Maintenance Department at River Chase Village. 2. All Residents have the potential to be affected if the annual inspection of the fire alarm system is not performed. 3. On 2/28/2019 The Maintenance Director's updated and organized a 2019 binder for all requested documentation by LSC Surveyors. Beginning 2/28/2019 the Maintenance Director's will review and ensure all Life	2/28/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/26/2019

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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K 345	Continued From page 1	K 345	Safety procedures are up to date once a month.		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA section 19.7.1.2. This deficiency affected all 52 residents in the facility on the day of survey Findings Include: On February 26, 2019 at 11:50 AM, the facility	K 712	4. Any findings during monthly review of Life Safety Code procedures binder will be presented by the Maintenance Director to the Quality Assessment and Assurance(QAA) Team. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months to determine if further action is needed and quarterly thereafter. 1. On 2/26/2019 The Administrator immediately in-serviced the Maintenance Director on proper performance of fire drills as per NFPA section 19.7.1.2. The Maintenance Director began on 2/26/2019 performing proper fire drills as per NFPA section 19.7.1.2.	2/26/19	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 712	Continued From page 2 could not provide complete documentation showing fire drills performed during the four (4) quarters of last calendar year. The following fire drill documentation was not provided during the survey: 1. 2nd and 3rd shifts in the 1st quarter of 2018 2. 1st shift of the 2nd quarter of 2018 3. 1st shift of the 3rd quarter of 2018 4. 2nd shift of the 1st quarter of 2019 The administrator was made aware of the issue during the exit conference.	K 712	2. All residents have the potential to be affected by the absence of fire drills with incomplete documentation of such drills. 3. The Maintenance director began on 2/26/2019 performing proper fire drills and will continue monthly per shift. 4. The fire drills will be presented to the Quality Assessment and Assurance(QAA) Team by the Maintenance Director to notify of any discrepancies. Quality Assessment and Assurance(QAA) Team to meet monthly for three consecutive months and then quarterly thereafter.		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		3/3/19	

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K 918	Continued From page 3 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per NFPA 110 section 8.4.2. This deficiency affected all 52 residents in the facility on the day of survey. Findings include: On February 26, 2019 at 11:55 AM, the facility provided inadequate and incomplete documentation of weekly inspections and monthly load tests for the generator(s) in the facility. The documentation provided did not address and provided which of the two (2) generators were inspected and tested.	K 918	1. On 3/3/2019 Maintenance Director found the documentation for all of the 2018 weekly inspections and monthly load tests for the generator in an old binder that was the previous Maintenance Director's. 2. All residents have the potential to be affected by the incomplete and inadequate documentation of weekly inspections and monthly load tests for the generator(s) at River Chase Village. 3. Beginning on 3/3/2019 The Maintenance Director will review weekly inspections and monthly load tests every month to ensure there are no documentation discrepancies. 4. The Maintenance Director will present any discrepancies with the documentation of weekly inspection and monthly load test		

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K 918	Continued From page 4	K 918	for the generator(s) to the Quality Assessment and Assurance(QAA) Team. Quality Assessment and Assurance(QAA) Team will meet monthly for three consecutive months and quarterly thereafter.		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 2/26/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/26/2019

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.