STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING _____ B. WING _____	C 10/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVALESCENT CNTR WE	2960 CHELSEA ROAD WEST POINT, VA 23181

(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 An unannounced Medicare/Medicaid abbreviated standard survey was conducted 10/28/19 through 10/29/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 4 resident reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to deliver care and services according to professional nursing standards for 1 resident (Resident #4) in a sample size of 4 residents. For Resident #4, the facility staff failed to verify the physician's order before replacing a gastrostomy tube resulting in the wrong size being inserted on 07/26/2019. Resident #4, a 72-year old female, was admitted to the facility on 08/16/2016 and expired at the facility while on hospice on 10/05/2019. Diagnoses included but not limited to cerebrovascular accident and dementia.	F 658	1. Resident #4 no longer resides in the facility as of 10/5/2019. Resident #4 had no adverse effect from the incorrect gastrostomy tube size being inserted. Employee F was provided 1:1 education on not having an order for insertion of the 18FR gastrostomy tube on 7/26/19 by the Director of Clinical Education on 10/31/19. 2. On 10/31/2019 all residents who have gastrostomy tubes were observed to ensure the proper size tube were in place according to the physician order by the DON/Designee. 3. The clinical educator will educate the licensed nursing staff on verifying the physician order to replace the gastrostomy tube using the correct size.	11/20/19

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

Electronically Signed | 11/15/2019

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F 658	Continued From page 1 Resident #4's most recent Minimum Data Set with an Assessment Reference Date of 09/16/2019 was coded as a quarterly assessment. The Brief Interview for Mental Status was not coded. Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility and dressing were coded as requiring extensive assistance from staff. Eating was coded as total dependence on staff. On 10/28/2019, the closed record was reviewed. A nurse's note written by Employee F, the facility's former Director of Nursing (Registered Nurse) now on the Quality Assurance team, dated 07/26/2019 at 3:55 PM documented, "PEG tube with broken edges of main portion of tube, causing leakage of feeding formula onto resident's skin and clothing. Discussed with resident's responsible person, who acknowledge [sic] tube needed to be replaced and could be accomplished at facility. Orders obtained and continuous feeding placed on hold and present tube removed. New 18 Fr [French] gastrostomy tube inserted into existing stoma. Skin inferior to stoma reddened. Area cleaned with normal saline and dry split gauze dressing placed. Gastric contents aspirated from gastrostomy tube and replaced, continuous feeding restarted. Resident tolerated procedure with episodes of rapid breathing and audible wheeze that resolved without intervention. Resident exhibits similar response to transfer in total body lift and being turned over in bed." The review showed a physician's order dated 03/02/2019 documented, "Change PEG [percutaneous endoscopic gastrostomy] tube	F 658	4. The DON/ Designee will audit all gastrostomy tubes weekly for 8 weeks to ensure proper size as indicated by physician order. The results of the audit will be reported to the QA Committee by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective action will be completed by November 20, 2019.	

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F 658	Continued From page 2	F 658		

every three months per protocol - 24 FR [French]." There were no physician's orders associated with the insertion of the 18 FR gastrostomy tube on 07/26/2019.

On 10/29/2019 at 1:10 PM, an interview with Employee F was conducted. When asked the size of the PEG tube that was removed in reference to the nurse's note dated 07/26/2019, Employee F stated that PEG and gastrostomy tube terms were used interchangeably. Employee F stated [Resident #4] had a gastrostomy tube that was removed but the size could not be determined because of damage to the tube. When asked how she determined what size tube to insert, Employee F stated, "That is what the GI [gastrointestinal physician's office] sent." Employee F also stated that "Since they provided it, I thought that's what they wanted her to have." Employee F stated that [Resident #4]'s primary nurse gave her the 18 FR gastrostomy tube and said it came from the GI office. Employee F also stated, "Looking back in hindsight, I should've verified the order."

According to the American Nurse's Association publication entitled, "Scope and Standards of Practice", 3rd Edition, 2015, under the header "Standards of Practice" on page 4, it was documented, "Standard 1. Assessment. The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation."

A policy on replacing gastrostomy tubes was requested and the facility staff provided a copy of their policy entitled, "Gastrostomy Tube Replacement" with a review date of 07/2019. Under the header entitled "Procedure", in Section

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F 658	Continued From page 3 6, it was documented, "Remove correct size ordered G [gastrostomy] tube from the package." On 10/29/19 at approximately 9:00 PM, the administrator and DON were notified of findings and had no further documentation or information to offer.	F 658		