RICHFIELD

October 21, 2016

Rodney Miller
LTC Supervisor
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1485

Re: Richfield Recovery and Care Center
Provider Number 495013

Dear Mr. Miller:

Please find the enclosed plan of correction from the unannounced standard survey ending on September 29, 2016. If there is any additional information needed, please contact me at your convenience at (540) 380-6530.

Sincerely,

Sue Devine

Sue Devine, RN
Administrator
Richfield Recovery & Care Center
3615 West Main Street
Salem, VA 24153-0647

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD RECOVERY & CARE CENT	3615 WEST MAIN STREET SALEM, VA 24153

(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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 9/27/16 through 9/29/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow.

The census in this 315 certified bed facility was 238 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents 1 through 27) and 3 closed record reviews (Residents 28 through 30).

F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, facility staff failed to maintain a clean, comfortable, homelike environment in one of 5 dining rooms in the facility.

On 9/28/26 at approximately 8:30 AM, the surveyor entered the dining room on 3 East after asking the housekeeping staff member if cleaning was complete. The surveyor sat in one of the blue vinyl upholstered chairs to conduct a chart review. The surveyor noticed a strong odor like stale urine. No other person was in the room.

1. Chairs in the 3 East dining room were cleaned 9/28/16
2. Furniture that residents sit in while eating have the potential to be affected. Other chairs in the dining rooms were cleaned 11/13/16

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Devine — TITLE: Administrator — (X6) DATE: 10/21/16

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 252	Continued From page 1 The surveyor walked around the room trying to find the source of the odor and confirmed that it was the chair. There were white spots on the back and seat and what appeared to be dried drips of liquid. The left chair arm had dry and sticky material on it. The crack between the cushion and the frame appeared to contain crumbs of food. A second chair had dried food on the seat and both sides of the cushion. A third chair had stains on the back and a sticky substance on the left arm. A fourth chair appeared to have dried food on the back, seat, and on the left side of the frame. A fifth chair had dried matter on the chair back and the frame appeared to be dirty. A sixth chair was not visibly stained, but smelled of dried urine. The surveyor returned at 11:15 as residents were being seated fro lunch. The chairs' appearance was unchanged. The concern was reported to the administrator and director of nursing during a summary meeting on 11/28/16. The administrator reported on 9/29/16 that the chairs had been cleaned.	F 252	3. A- Staff on 3 East were educated to report unclean furniture to their supervisor B- The housekeeping staff were educated to clean the 3 East dining room chairs after each meal C- The housekeeping supervisor/ designee will complete a weekly audit in the 3E dining room to ensure the chairs are cleaned D- The regional housekeeping director will complete random monthly audits, in the 3 East dining room, to ensure the chairs are clean 4. Results of the weekly/ monthly audits will be reported to QA for review, analysis, and recommendations	11/13/16 11/13/16 11/13/16 11/13/16 11/13/16
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F323 1. The alarm for resident #17 was repaired on 9/28/16 and replaced on 10/4/16 , when the new alarm arrived	10/4/16

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to keep seat belt alarm in working order for 1 of 30 residents (Resident #17). The findings included: Resident #17 was admitted to the facility on 7/31/14 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, Parkinson ' s disease, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/2/16, the resident was coded as having a BIMS score of 2 out of a possible score of 15. The resident required extensive assistance of one staff member for personal hygiene and bathing. During the clinical record review, it was noted by the surveyor that on the resident ' s care plan the resident had a self- releasing belt on when up in the wheelchair. On 9/28/16 at 1:15 pm, the surveyor went into the resident ' s room and asked the resident if she could unhook her belt that she had on. The daughter replied, " Oh, yes she can. She does it often. " The resident stated, I ' ll show you that I can. " The resident proceeded to unhook the seat belt but the belt did not alarm when it was released. The resident hooked the seat belt back and the daughter of the resident remained in the room with the resident. The surveyor went out into the hallway and asked for a CNA to come into the resident ' s room. The surveyor asked the resident again if she could unhook the belt again. The resident unhooked	F 323	2. Residents with self - releasing belts, with an alarm, have the potential to be affected. No other residents currently have a self- releasing belt with an alarm. 3. A. Staff on 4W were educated to report equipment not properly functioning to their supervisor and to put the repair into the help desk ticket system B. Residents orders for self-releasing seat-belt with alarms will be noted on the treatment records (TAR) for monitoring C. Residents with self-releasing seat belts with alarms will be checked for working order by the Unit Manager/designee weekly for 4 weeks, every other week for 4 weeks and then monthly for 4 months.	11/13/16 11/13/16 11/13/16 11/13/16

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F 323	Continued From page 3 the belt again and the alarm did not go off. The CNA stated, " Let me take a look at the alarm box. She picked up the alarm box attached to the seat belt and there was tape noted to be wrapped around the alarm box. The CNA removed the tape and the alarm went off. The unit manager on 4 East was notified of the above documented findings. The unit manager stated, " They should not have put tape around the alarm box. If it was noted that the alarm wasn ' t working properly, they should had taken it off and replaced it with one that did work. " The administrator, director of nursing and assistant director of nursing was notified of the above documented findings on 9/28/16 at 3:40 pm. No further information was provided to the surveyor prior to the exit conference on 9/29/16.	F 323	4. Results of the audits will be reported to QA for review, analysis, and recommendations	11/13/16
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain the correct physician ordered lab tests for 2 of 30 Residents, Residents #11 and #8. The findings included.	F 502		

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F 502	Continued From page 4 1. For Resident #11, the facility staff obtained a BMP (basic metabolic panel) lab test instead of a CMP (comprehensive metabolic panel) as ordered by the physician. The record review revealed that Resident #11 was admitted to the facility 05/26/11. Diagnoses included, but were not limited to, dysphagia, muscle weakness, anxiety, anemia, depression, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/11/16 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The clinical record included a physicians order for a CMP to be obtained on 04/19/16. When reviewing the clinical record the surveyor was able to find the results of a BMP lab test dated 04/19/16 but not a CMP. On 09/28/16 at approximately 1:35 p.m. the unit manager reviewed the order for the CMP and the clinical record with the surveyor. The unit manager verbalized to the surveyor that she would see what she could find. The unit manager was unable to find the results for the CMP. The administrative staff were notified of the missing CMP lab test during an end of the day meeting with the survey team on 09/29/16 at approximately 3:35 p.m. No further information regarding this issue was	F 502	#1- 1. Resident #11 had a BMP ordered instead of CMP in April, 2016. Resident #11 had a CMP ordered on 8/10/16, so no further orders received. Results reviewed by MD, with no further recommendations	8/10/16

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F 502	Continued From page 5 provided to the survey team prior to the exit conference. 2. The facility staff failed to obtain physician ordered laboratory tests for Resident #8. The facility staff failed to obtain a BK virus, viral load, Vitamin D, PTH, Intact level in April 2016 (ordered every 6 months), failed to obtain an IPTH level in July 2016 (ordered every month) and failed to obtain a CMP (comprehensive metabolic panel) ordered on July 31, 2016. The clinical record of Resident #8 was reviewed 9/27/16 and 9/28/16. Resident #8 was admitted to the facility 12/22/14 with diagnoses that included but not limited to infantile cerebral palsy, idiopathic normal pressure hydrocephalus, kidney transplant, epilepsy, anemia, hyperlipidemia, esophageal reflux, allergic rhinitis, and schizoaffective disorder. Resident #8's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/5/16 assessed the resident with a cognitive summary score of 14 out of 15. The September 2016 physician orders were reviewed. Beginning 1/7/16, Resident #8 had orders for a BK virus, viral load, Vitamin D, PTH (parathyroid hormone), intact level only to be done every 6 months in October and April. After reviewing the laboratory section, the surveyor was unable to locate the October 2015 or April 2016 laboratory results and requested assistance from the unit manager licensed practical nurse #1 on 9/28/16 at 9:15 a.m. L.P.N. #1 was able to locate the October 2015 laboratory test results but stated the April 2016 laboratory tests were not obtained. L.P.N. #1 stated the physician was	F 502	2. A. Residents with an order for a CMP have the potential to be affected B. Residents records with an order for a CMP, in the last 3 months, were reviewed to ensure accuracy of the lab draws 3. A. Licensed Nurses and Unit Secretaries were educated regarding accuracy of lab slip requests when ordering a CMP or BMP. B. Unit Secretaries will complete weekly lab audits to ensure a CMP was drawn instead of a BMP. The Clinical Compliance manager / designee will verify the weekly lab audits for accuracy, weekly for 4 weeks, every other week for 4 weeks and then monthly for 4 months.	11/13/16 11/13/16 11/13/16

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F 502	Continued From page 6 informed and "we are obtaining them today." The September 2016 physician orders also revealed an order that read beginning 4/14/16 obtain a "CBC (complete blood count), CMP (comprehensive metabolic profile), IPTH (immunoreactive parathyroid hormone), Magnesium, Phosphorus, Hepatic Panel, Platelet, Uric Acid, Prograf level every month and fax results to transplant lab." After reviewing the laboratory section of the clinical record, the surveyor was unable to locate the results of the IPTH for July 2016 and requested the assistance of the unit manager licensed practical nurse #1 on 9/28/16 at 9:15 a.m. The unit manager reviewed the clinical record, contacted the contracting laboratory and reported to the surveyor that the IPTH level was not obtained in July 2016. The clinical record of Resident #8 also contained a telephone order dated 7/31/16 at 1459 (2:59 p.m.) that read "Stat CBC, CMP, UA (urinalysis) and blood cultures." The clinical record revealed the results of a BMP (basic metabolic panel) obtained on 7/31/16. The physician order was for a CMP. The unit manager licensed practical nurse #1 was informed of the physician order for a CMP to be done on 7/31/16 and a BMP was done instead. L.P.N. #1 stated after reviewing the nurse's note dated 7/31/16 at 15:05 (3:05 p.m.), that the physician order should have been written for a BMP instead of a CMP. L.P.N. #1 stated "the nurse wrote an incorrect order. When I called the lab, the lab request was marked for a BMP-not a CMP." She stated the order read to do a CMP but a BMP was done.	F 502	4. Results of the audits will be reported to QA for review, analysis, and recommendations #2 1.Resident #8 had routine transplant labs drawn on 9/29, and a CMP on 10/5. Results reviewed by MD, with no further recommendations 2. A. Residents with orders for a CMP and routine labs have the potential to be affected. B. A 100% audit of residents with CMP and routine ordered labs was completed for the past 3 months, to ensure accuracy of lab draws 3. A. Licensed Nurse and Unit secretaries were educated regarding accuracy of lab slips when requesting a CMP or BMP and ensuring all physician orders are followed for routine labs B. Unit secretaries complete weekly lab audits to ensure a CMP was drawn instead of a BMP and routine lab orders were followed and results obtained. The Clinical Compliance manager/designee will verify the accuracy of the weekly audits weekly for 4 weeks, every other week for 4 weeks, and then monthly for 4 months.	11/13/16 9/29/16 10/5/16 11/13/16 11/13/16 11/13/16 11/13/16

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F 502	Continued From page 7 The surveyor informed the administrative staff of the failure of the facility staff to obtain the physician ordered laboratory tests for Resident #8 in the end of the day meeting on 9/28/16 at 2:50 p.m. No further information was provided prior to the exit conference on 9/29/16.	F 502	4. Results of the audits will be reported to QA for review, analysis and recommendations	11/13/16
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 3 of 30 residents (Resident #1, # 9 and # 17). The findings included: 1. The facility staff failed to document baths for Resident #1.	F 514		

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F 514	Continued From page 8	F 514	1. The CNA/shower aide documented that resident #1, #9, and #17 had a bed bath, shower, or refusal on bath days	10/3/16

Resident #1 was admitted to the facility on 11/8/13 with the following diagnoses of, but not limited to anemia, pneumonia, depression, cardiovascular disease and subdural hematoma. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/1/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident required extensive assistance of 2 staff members for personal hygiene and bathing.

During the clinical record review on 9/28/16, it was noted by the surveyor that under the bathing section of the CNA documentation for the month of September, there were only 4 notations made in the clinical record. These notations did not tell if the resident received a bed bath, shower or if he had refused to have a bath on those days.

The administrator was notified of the above documented finings and stated that she would look into this. The administrator returned at 11:10 am and stated, " We have found the problem. The CNAs only have the options to pick on the computer screen if the bath was refused or non-applicable. These were the only options. But we have fixed this now as of 5 minutes ago. It now has the option for them to choose if a bath was given and what type it was. "

The administrator, director of nursing and assistant director of nursing was notified of the above at the end of the day conference on 9/28/16 at approximately 3:30 pm.

No further information was provided to the surveyor prior to the exit conference on 9/29/16.

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F 514	Continued From page 9 2. The facility staff failed to document baths for Resident #9. Resident #9 was admitted to the facility on 9/19/16 with the following diagnoses of, but not limited to dementia, muscle weakness, encephalopathy and wound infection. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/12/16, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. The resident was also coded as requiring extensive assistance of one staff member for eating and dressing. During the clinical record review on 9/28/16, it was noted by the surveyor that under the bathing section of the CNA documentation for the month of September, there were only 4 notations made in the clinical record. These notations did not tell if the resident received a bed bath, shower or if he had refused to have a bath on those days. The administrator was notified of the above documented finings and stated that she would look into this. The administrator returned at 11:10 am and stated, " We have found the problem. The CNAs only have the options to pick on the computer screen if the bath was refused or non-applicable. These were the only options. But we have fixed this now as of 5 minutes ago. It now has the option for them to choose if a bath was given and what type it was. " The administrator, director of nursing and assistant director of nursing was notified of the above at the end of the day conference on 9/28/16 at approximately 3:30 pm.	F 514	2.Residents being bathed have the potential for documentation to not include bed bath, shower, or refusal if the notations are not present	11/13/16

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F 514	Continued From page 10 No further information was provided to the surveyor prior to the exit conference on 9/29/16. 3. The facility staff failed to document baths for Resident #17. Resident #17 was admitted to the facility on 7/31/14 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, Parkinson ' s disease, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/2/16, the resident was coded as having a BIMS score of 2 out of a possible score of 15. The resident required extensive assistance of one staff member for personal hygiene and bathing. During the clinical record review by the surveyor on 9/28/16, there was 1 notation made in the clinical record that stated on 8/29/2016 the bathing preference of Resident #17 was " Not Applicable. " There was no further documentation noted in the clinical record on bathing for this resident. The administrator was notified of the above documented finings and stated that she would look into this. The administrator returned at 11:10 am and stated, " We have found the problem. The CNAs only have the options to pick on the computer screen if the bath was refused or non-applicable. These were the only options. But we have fixed this now as of 5 minutes ago. It now has the option for them to choose if a bath was given and what type it was. " The administrator, director of nursing and	F 514	3 A. The CNA documentation tool, Point of Care (POC), was updated to include a.Did the resident receive a bath/ shower? The following responses are provided: yes-resident not available-resident refused-not applicable b.Type of bathing provided? The following responses are provided: shower-bed bath-whirlpool-resident not available-not applicable B. CNA's/shower aides were educated on the new information in POC and the documentation needed to address the type of bathing provided. 3. Unit manager/designee will complete a random audit of 25% of residents to ensure documentation of bathing occurred weekly for 4 weeks, every other week for 4 weeks and then monthly for 4 months.	9/28/16 11/13/16 11/13/16

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F 514	Continued From page 11 assistant director of nursing was notified of the above at the end of the day conference on 9/28/16 at approximately 3:30 pm. No further information was provided to the surveyor prior to the exit conference.	F 514	4. Results of the audits will be reported to QA for review, analysis, and recommendations.	11/13/16