State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0197	A. BUILDING: _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	PO BOX 370 MATHEWS, VA 23109

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicaid standard survey and bienniel State Licensure Inspection was conducted on 4/26-28/2017. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care Requirements and the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections are required for compliance. The Life Safety Code survey/report will follow. The census in this 60 bed facility was 58 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 1-13 and 16) and 2 closed records (Residents 14 and 15).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Nursing Director 12 VAC 5-371-200 (B)(1)(ii) Please cross reference to F281 Nursing Services 12 VAC 5-371-220 (A) Please cross reference to F329 12 VAC 5-371-220 (B) Please cross reference to F332	F 001	F- 281 Services Provided Meet Professional Standards 1. The DON educated licensed nurse (A) responsible for the medication error for resident #10 and #11 by review of Medication Administration policy and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The Provider and Responsible Party were notified of the medication errors for both residents on 4/27/17. No adverse event occurred for resident #10 or #11 as a result of the medication error. 2. All residents within the facility who receive oral medications and eye drops are potentially at risk for receiving the	5/31/17

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

Electronically Signed | 05/09/17

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F 001	Continued From page 1	F 001	incorrect dose. 3. DON/Designee will in-service the licensed nurses on the facility policy of medication administration and the 6 Rights of Medication Administration May 17, 2017 and May 18, 2017. 4. Medication Administration Audits will be performed by the DON/Designee for (4) nurses weekly for one month, (4) nurses monthly for three months; and then 1 per month to ensure medications are being provided per the Provider orders. The results of the audits will be reported at the QA meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. F- 329 Drug Regimen is free from Unnecessary Drugs 1. The DON educated licensed nurse (A) responsible for the medication error for resident #10 by review of Medication Administration policy and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The Provider and Responsible Party were notified of the medication error on 4/27/17. Resident #10 had no adverse outcomes from the medication error. The resident□s medications were audited and all were correct as ordered on 04/28/17. 2. All residents are at potential risk for administration of incorrect medication. DON/Designee will complete a 100% comparison of pharmacy orders to current EMR by May 12, 2017. 3. Nurse Educator will provide education to licensed staff on 6 Rights of Medication	

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F 001	Continued From page 2	F 001	Administration and process of printing all orders from the EMR, faxing and obtaining confirmation of fax to pharmacy by May 31, 2017. 4. DON/Designee is coordinating a new process with the pharmacy that will assist to review and compare all daily order changes for accuracy between the facility EMR and the pharmacy starting May 8, 2017. DON/Designee will complete med pass audit to include 6 rights of med administration and med reconciliation for (4) residents weekly for one month, (4) residents monthly for three months; and then (1) per month. The results of the audits will be reported monthly by the DON/Designee at the QA meeting for evaluation of compliance and ongoing for monitoring for continuous improvement or if any modifications to the action plan are necessary after the implementation F-332 Free of Medication Error Rates of 5% or More 1. The DON educated licensed nurse (A) responsible for the medication errors for resident #10 and resident # 11 by review of Medication Administration policy and procedure with focus on triple check of medications prior to administration and the importance of following Provider orders. The resident #10 had a discontinued medication administered during medication pass. Resident #11 received one ophthalmic medication administered in each eye instead of two during medication pass. The residents had no adverse outcome from either administration error. The residents Provider and Responsible Parties were	

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F 001	Continued From page 3	F 001	made aware of the error on 04/27/17. 2. All residents are at risk for medication errors during the medication administration. 3. Nurse Educator/ Designee will educate nursing staff on the 6 rights of medication administration, process of printing faxing all orders and obtaining confirmations of fax□s to the pharmacy by May 31, 2017. 4. DON/Designee will complete medication pass audits to include 6 rights of medication administration and reconciliations for (4) residents per week for one month, (4) residents monthly for three months; and then 1 per month. The results of the audits will be reported monthly by the DON/Designee at the QA meeting for evaluation of compliance and ongoing for monitoring for continuous improvement or if any modifications to the action plans are necessary after the implementation.	