| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 10/23/2018 through 10/25/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicaid standard survey was conducted 10/23/2018 through 10/25/2018. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey.<br><br>The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 20 resident reviews. | F 000 | | |
| F 565 SS=D | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written | F 565 | | 11/26/18 |

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

Electronically Signed | 11/15/2018

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 565 | Continued From page 1<br>requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and staff interview, the facility staff failed to ensure that residents were able to meet privately without staff present.<br><br>The facility staff failed to ensure that staff attended the group meeting only at the group's invitation.<br><br>The Findings included:<br><br>On 10/24/18 at 10:30 A.M., a Group meeting with residents was conducted. Fifteen residents attended the group. Prior to the group meeting starting, the doors were closed. In addition, the Activities Director (CNA B) taped signs to both of the room doors which stated that a Resident Meeting was in session "Do Not Disturb" was | F 565 | 1. On October 24, 2018 the DON provided 1:1 education to the CNA who entered the room to complete her charting. The Activities Director was educated by the Administrator on November 9, 2018 to ensure that the television is off and those not participating in the meeting are relocated prior to having a Resident Council Meeting.<br>2. A special resident council meeting will be held on November 20, 2018 by the Administrator/Activities Director to reassure residents concerns during survey council meeting are being addressed and ask if they have any other concerns about privacy in meetings.<br>3. The Resident Council Meeting will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 565 | Continued From page 2<br>written in red ink in very large letters.<br><br>The facility staff failed to turn off the television, and escort out a group of identified people who were watching television in the corner of the room. In addition, at 10:45:A.M. a Certified Nursing Aide (CNA A) entered the room and stated that she wanted to do her charting (documentation) activity in the room during the meeting. When asked why she interrupted the meeting, she stated that she knew that she shouldn't enter a resident's meeting uninvited and that she saw the signs on the door. She further stated, "you're not gonna tell on me, are you?"<br><br>The residents expressed discontent and said that the staff member had not been invited, and they stated that the television was distracting.<br><br>On 10/24/18 at 3:00 P.M. the Administrator (Employee A) was informed of the findings. No further information was received. | F 565 | held in the great room with the doors shut with appropriate signage, the television off and only residents participating in the meeting allowed to be present. Staff members in all departments will be provided education on respecting privacy during resident group meetings by the Clinical Educator/Designee by November 23, 2018.<br>4. The privacy of the Resident Council Meeting with be audited by the Administrator/Designee for three months to ensure compliance. The results of the audits will be reported monthly at the QA Meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and | F 755 | | 11/26/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 755 | Continued From page 3<br>biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide oversight of the drug records for controlled substances for 1 of 20 residents (Resident #109).<br><br>Findings include:<br><br>Resident #109 was admitted to the facility on 10/18/2018 with diagnoses of dementia, impaired mobility, impaired gait, and depression. Due to her recent admission, the Minimum Data Set assessment was not yet completed for this resident.<br><br>On 10/23/18 at 3 PM, a medical record review was conducted for Resident #109's medical record. The medical record contained a paper prescription for Zolpidem, which is a Schedule IV controlled substance classified as a hypnotic. | F 755 | 1. The hard copy prescription for Zolpidem was immediately removed from resident #109□s medical record by the DON on October 24, 2018.<br>2. The DON/Designee completed a 100% audit of all active paper charts on October 24, 2018 to identify other residents at possible risk for hard copy prescriptions in the charts.<br>3. The Clinical Educator/Designee will provide an in-service to the licensed nurses on the process of stamping the hard prescription to include date and time once the prescription has been faxed to the pharmacy by November 23, 2018.<br>4. The DON/Designee will audit 10 active paper charts for unstamped hard prescriptions weekly for 4 weeks and then 2 per week for 8 weeks. The results of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 755 | Continued From page 4<br>This prescription was dated, signed by the physician, and ready to be filled at any pharmacy. It was kept in the hard chart by a hole punch through the ring of the binder, and could be easily removed.<br><br>On 10/23/18 at 3:10 PM, the medical record was carried to Administration staff A, the Administrator. When shown the hard copy prescription and asked if there were any issues with the medical record, the Administrator replied "That shouldn't be in the chart. It could be stolen." The Administrator took the medical record to rectify it.<br><br>On 10/24/18, a copy of the Facility Controlled Substances Policy, #7.1 was reviewed. This policy does not address the facility's responsibility to protect prescriptions from theft or misuse.<br><br>On 10/25/18 at 1 PM, the Administrator stated there were no other policies regarding hard copies of prescriptions.<br><br>No other information was provided prior to exit. | F 755 | the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program. | F 880 | | 11/26/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 880 | Continued From page 5 | F 880 | | |

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 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 880 | Continued From page 6<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility documentation, the facility failed to provide dining assistance in a manner that prevents the spread of infection for 1 Resident (# 109 ) in a survey sample of 20 Residents.<br><br>For Resident # 109 staff assisting with meal buttered Resident's roll using bare hands.<br><br>The findings include:<br><br>Resident #109 a 74 year old woman was admitted to the facility on 10/18/2018 with diagnoses of but not limited to Dementia with behavioral disturbance, muscle weakness, abnormal posture, impaired gait and mobility and depression. Due to her recent admission she did not have an MDS (Minimum Data Set) completed as of yet.<br><br>On 10/23/2018 at 12:15 PM, during meal | F 880 | 1. On October 24, 2018, the Administrator educated CNA □B□ on the proper method for assisting a resident while preventing spread of infection. Nurses and certified nursing assistants were educated on October 24, 2018 by the Clinical Educator/designee on proper ways to serve and set up resident food without direct contact.<br>2. All residents within the facility are at potential risk for staff assisting with meals not using best practice infection control techniques. There have been no facility food borne illnesses at the facility in the past year.<br>3. The Administrator/Designee will complete education with staff members in all departments on infection control regarding safe handling of food by November 23, 2018.<br>4. Service Director Food /designee will audit meal service 3 times per week for 4 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 49E185 | A. BUILDING _____ B. WING _____ | C 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVERSIDE CONVAL CENTER-SALUDA | PO BOX 303 US 17 SALUDA, VA 23149 |

| (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 880 | Continued From page 7<br>observation in the dining room, CNA B was observed assisting Resident #109 with her meal. CNA B was observed asking the Resident if she wanted butter on her roll and the Resident #109 responded that she did.<br><br>CNA B was then observed taking the roll from the wrapper and holding it in her bare hands slicing it open and placing butter on it and then she handed it to Resident #109.<br><br>On 10/23/2018 at 1:25 PM an interview was conducted with Employee C (Corporate Nurse). She was asked the correct way to assist a resident with buttering a roll and she stated that staff should either use a fork and knife, or they could use the wrapper over their hand as to not touch the food with their bare hands or the third option is to get some gloves from the kitchen.<br><br>On 10/25/2018 at 11:30 AM an interview with the Administrator was conducted and she produced a facility document showing that the Employee was counseled by the Administrator on safe food handling on 10/24/2018 with the signature of both the staff and the Administrator.<br><br>No further information was provided. | F 880 | weeks and 1 time per week for 8 weeks for proper food handling. All audits will be reported to the QA meeting by Administrator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis after the implementation. | |