STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/6/21 through 7/9/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/06/21 through 07/09/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 60 certified bed facility was 51 at the time of the survey. The survey sample consisted of 31 resident reviews.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		8/2/21

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

Electronically Signed | 08/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, the facility failed to ensure 1 Resident (Resident #54) was free from neglect, in a survey sample of 31 Residents. For Resident #54, the facility staff were negligent in their immediate response when he was found unresponsive. The facility staff failed to provide CPR (cardiopulmonary resuscitation) or any other emergency medical treatment, until after Resident #54 had been pronounced deceased and postmortem care had been provided, resulting in harm at past non-compliance. The findings included: Resident #54, diagnosis included but were not limited to: CAD (coronary artery disease), HTN (hypertension), old myocardial infarction, diabetes, and anxiety disorder. Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/8/21 was coded as a quarterly assessment. Resident #54 was coded as having had cognitive impairment and moderately impaired cognitive skills for daily decision making. He was also coded as having required extensive assistance of one staff member for activities of daily living. On 7/7/21, during a clinical record review it was determined that Resident #54 had elected to be a Full Code, wishing to have CPR in the event of cardio pulmonary arrest. Resident #54, had a physician order entered into	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 2	F 600		

his electronic clinical record on 1/19/21, the day of admission that read, "Full Code".

The Social Worker, Employee H, entered a progress note into the clinical record on 1/19/21 at 16:14, that read, "....Resident is a FULL CODE".

Review of the care plan for Resident #54 revealed an entry that read, "Resident and RR [responsible representative] desire FULL CODE status", the associated goal for this care plan read, "Resident's FULL CODE status designation, will be honored, through next review".

Review of the nursing notes dated 6/11/21 at 6:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "Resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 3	F 600		

#54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she did not initiate CPR despite being CPR certified. CNA A went on to state, "they did a huddle afterwards and asked questions but it hasn't been talked about since that day".

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. Nobody started CPR until after I had cleaned and bathed him. He had been laying there an hour". When asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 4	F 600		

where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21 an interview was conducted with LPN A. LPN A confirmed that Resident #54 was a full code and CPR should have been performed. LPN A further acknowledged that despite several staff who were CPR certified responding to check Resident #54 CPR was not immediately initiated and RN A pronounced the Resident deceased.

On 7/7/21, a group interview was conducted with the Facility Administrator, the DON, the Corporate Staff Educator, and the Corporate Clinical Services Director whom all concurred that CPR (cardiopulmonary resuscitation) should have been initiated when Resident #54 was found unresponsive by CNA A and not stopped until either EMT's took over care or the MD ordered CPR to stop. The Corporate Staff Educator stated that when they realized that he (Resident #54), was a full code they did start CPR. The physician then ordered that it (CPR) be stopped. She further stated that following the incident, all staff were educated. The survey team requested that the facility provide any and all evidence of the facilities' response to this event.

Review of employee records revealed that all four of the responding staff (CNA A, CNA B, LPN A and RN A) held current and active CPR certification, which included training in when to initiate CPR.

On 7/8/21 at approximately 8:45 AM, the Facility Administrator stated that she had begun an investigation on 7/7/21 and submitted a timeline of events for Resident #54 that occurred on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 5	F 600		

6/11/21 which read as follows:

Approx. [approximately] 6:30am: per clinical note, nurse states resident not feeling well, rectal temp 99.0

Approx. 0700: [CNA B] arrived at work at approximately 0700 and was told in shift change that [name redacted, Resident #54] had a low grade fever overnight and was not feeling well and had been snoring loudly

Approx. 0715-0720: Resident [54] noted by [CNA B], to have turned himself over in bed on right side

Approx. 0800: [LPN A] reports seeing him laying on right side

Approx. 0900-0915: [CNA A] went in to give him breakfast and found him lying in the bed unresponsive, she states that she was unable to wake him, she immediately got [CNA B] and they went into the resident's room, then notified [LPN A] who contacted [LPN B], [LPN A] also reports that resident was laying partially on right side, with discoloration to skin noted

Approx. 0930: [RN A] pronounced and [LPN B] notified provider, emergency contact for resident was notified, and message was left to call the facility

Approx. 0930-1000: The clinical support team onsite were alerted the resident was a full code, the team immediately went to his room and CPR was initiated by [Employee J, RN clinical educator], [MD name redacted] was called by [LPN B], who was on the phone with provider in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 6	F 600		

the hallway and provider gave a verbal order via speaker phone to stop CPR

Approx. 1030-1100: Director of Education conducted a huddle to debrief and educated the staff on advanced directives, color coded dots and code blue procedures and if a resident is found without vital signs, the process of what needs to occur, Social Worker pulled current list of all code statuses in the facility and those listed as a full code were reviewed with team members at the huddle, time was allowed for staff to ask questions, and individual team members were followed up with by members of leadership, Social Worker completed 100% audit of resident code status and no discrepancies were noted.

On 7/8/21, the survey team conducted approximately 10 randomly sampled clinical staff interviews to assess their response to the question, "What would you do if you found a resident not breathing"? The staff members were able to provide sufficient answers.

On 7/8/21 at 8:50 AM, an interview was conducted with the facility Administrator. The Administrator was asked to define neglect, she stated, "it is any action, it can be many things, not providing medications, food, safe situations, not providing care someone needs". She was asked if, the failure to provide CPR or emergency medical treatment to a Resident who is not responsive is considered negligent, she stated, "I would not say that, I would say it was a lack of education". During this interview the facility Administrator stated she had begun a formal investigation on 7/7/21.

On 7/9/21 at 9:02 AM, an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 7	F 600		

conducted with Employee H, the Social Worker. Employee H, the social worker defined neglect as, "not being tended to, not providing what is needed". Employee H was asked, "If a Resident is a full code and is found unresponsive and staff do not perform CPR, is that neglect"? Employee H said, "Yeah". She was asked if this has happened and she immediately said "yes" and called the name of Resident #54. When asked to recall the events on 6/11/21, with regards to Resident #54. She stated, "When I came in that morning some said [Resident #54 name redacted] had died, my first thought was, Oh my God, did they do CPR. I said, I hope they did CPR, he's a full code. I don't remember who I said it to, but I think others were realizing it at the same time, when I went down there [to his room] people were scattering and there was a lot of confusion".

On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code.

The facility policy titled, "Abuse Prevention and Management Policy" with a review date of 2/19/21, read, "neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress".

The facility policy titled, "Cardio-Pulmonary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 600	Continued From page 8 Resuscitation (CPR) with a revision date of 1/2/20, read "Prior to the arrival of emergency medical services (EMS), the staff must initiate CPR when cardiac arrest (cessation of respirations and/or pulse) occurs for residents unless: A Resident has a valid DNR order, or A Resident presents with a completed, Durable Do Not Resuscitate Order form, or A resident presents with a POST form indicating Do not Attempt Resuscitation, or A Resident presents with approved jewelry indicating Do Not Resuscitate, or A physician orders otherwise, A resident shows American Heart Association signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care 2015. Obvious signs of clinical death, e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition. *** Only a physician can pronounce if unanticipated death. Not an RN, NP or PA". The Administrator and DON (Director of Nursing) were informed of the facility staff's negligence to provide emergency medical treatment to include CPR for Resident #54 being considered negligent at a harm level on 7/8/21 at 12 noon, during a mid-day debriefing. This deficiency is cited at past non-compliance as it was evidenced through document review and staff interview that the facility corrected the deficient practice on 6/11/21. No further information was provided.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 9 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to implement their abuse policy for 7 certified nursing assistants (CNA) (CNA C, CNA D, CNA E, CNA F, CNA G, CNA H, and CNA I) out of a staff sample size of 16 CNA's and for one Resident (Resident #54) out of a sample size of 31 residents. 1. For CNA C, CNA D, CNA E, CNA F, CNA G, CNA H, the facility staff failed to complete license verification upon hire. For CNA I, the facility staff failed to verify CNA I's license renewal which resulted in CNA I working at the facility without verifying license renewal (and having an expired license on file). 2. On 06/11/21, Resident #54, who was a full code was found unresponsive. Four staff members, (CNA A, CNA B, LPN A, RN A), all of which were CPR certified, neglected to provide any type of emergency medical care, to include CPR. This was neglegnt, as well as an unusual occurence; and the facility staff failed to implement their abuse policy in such an event by failing to conduct an investigation and report the	F 607	F607 (SS=E) 12VAC5-371-140 (E) (3) (a) 1. License verification for CNAs C, D, E, F, G, and H was completed on 7/29/21. CNA1 license renewal was completed on 7/29/21. The facility provided 1:1 coaching to CNAs A, B, LPNA, LPN B and RNA on providing emergency care (CPR) on unresponsive resident on 8/1/21 and 8/2/21. An investigation was completed on 6/11/21 and a FRI was submitted on 7/7/21. Resident #54 no longer resides in the facility as of 6/11/21. 2. 100% audit of current licensed staff was audited for license verification upon hire and that staff have a current active license on 7/29/21. No residents have required CPR since 6/11/21. 3. Education was provided to the Business Office Manager and Human Resource team member by the Administrator/designee on 7/29/21 of the requirement to verify licensure verification upon hire by a weekly report with licensure details and verification of license	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 10 incident, until after the survey began. The findings included: 1. For CNA C, CNA D, CNA E, CNA F, CNA G, CNA H, the facility staff failed to complete license verification upon hire. For CNA I, the facility staff failed to verify CNA I's license renewal which resulted in CNA I working at the facility without verifying license renewal (and having an expired license on file). On 07/07/21 at approximately 11:45 A.M., the employee files were reviewed with Employee G, Business Office Director, and this surveyor. When asked about the process for on-boarding new employees, Employee G stated that a recruiter does the on-boarding and checking results. Employee G then called Employee I, a Human Resources Generalist at another facility within their corporation. When asked about the expectation for license verification for new hires, Employee I stated that license verification should be completed before the new employee begins interacting with Residents. When asked why that was important, Employee I stated "for resident safety." Upon review of the employee files, there were 6 CNA's (CNA C, CNA D, CNA E, CNA F, CNA G, CNA H) that did not have license verification upon hire. When Employee G was asked about the expectation for completing licensure verification, Employee G stated the licensure verification should be completed before they hired. When asked why, Employee G stated it was important "to make sure they don't have anything on their license." On 07/07/2021 at approximately 12:15 P.M., the review of CNA I's employee file revealed the	F 607	renewal by daily alerts from the Board of Nursing. Education was provided to Administrator, DON and Medical Director on 8/2/21 by Nurse Executive/designee on the requirement to immediately review and fully investigate all allegations mistreatment, abuse or neglect per facility Abuse Prevention and Management Policy, and requirement to report results of all investigations to the State Survey Agency. The clinical staff will be educated by the DON/designee on the procedure to follow if an unresponsive resident is found. 4. Will review 100% of all licensed staff for verification of current license upon hire and active license for 8 weeks and ongoing. Will audit all residents found unresponsive to ensure emergency medical care was provided, as indicated for 8 weeks and ongoing. Will audit all allegations of neglect to ensure the event was investigated and reported to the state agency as indicated for 8 weeks and ongoing. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis 5. All corrective actions will be completed by August 18, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 11	F 607		

following: CNA I was employed with the facility from 12/02/2019 through 05/23/2021. A license verification was completed on 11/12/19. Under the header, "Expire Date", it was documented, "03/21/2020." Another license verification was completed on 05/26/2020 (56 days after the license expiration date). Under the header, "Expire Date", it was documented, "03/31/2021." A third license verification was completed on 04/19/2021 (19 days after the previous license expiration date). Employee G confirmed that the license renewal verifications for CNA I were completed late.

On 07/08/2021 at approximately 9:15 A.M., the Director of Nursing (DON) was notified of findings and provided a copy of the staffing schedule for April 2020 as requested. The DON and this surveyor observed that CNA I was scheduled to work in April and May of 2020. When asked about the expectation for license verification, the DON indicated that staff should not work unless their license is verified. When asked why this was important, the DON stated "to make sure they are licensed and competent."

On 07/08/2021, the facility's policy entitled, "Abuse Prevention and Management Policy" was reviewed. Under the header, "Specific Procedure/Requirements" in Section 1 (b) (i) documented, "State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry."

On 07/09/2021 at approximately 2:45 P.M., the administrator and DON were notified of findings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 12	F 607		

and submitted no further documentation or information by the end of survey.

2. On 06/11/21, Resident #54, who was a full code was found unresponsive. Four staff members, (CNA A, CNA B, LPN A, RN A), all of which were CPR certified, neglected to provide any type of emergency medical care, to include CPR. This was neglegnt, as well as an unusual occurence; and the facility staff failed to implement their abuse policy in such an event by failing to conduct an investigation and report the incident, until after the survey began.

Resident #54, diagnosis included but were not limited to: CAD (coronary artery disease), HTN (hypertension), old myocardial infarction, diabetes, and anxiety disorder.

Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/8/21 was coded as a quarterly assessment. Resident #54 was coded as having had cognitive impairment and moderately impaired cognitive skills for daily decision making. He was also coded as having required extensive assistance of one staff member for activities of daily living.

On 7/7/21, during a clinical record review it was determined that Resident #54 had elected to be a Full Code, wishing to have CPR in the event of cardio pulmonary arrest.

Resident #54, had a physician order entered into his electronic clinical record on 1/19/21, the day of admission that read, "Full Code".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 13	F 607		

The Social Worker, Employee H, entered a progress note into the clinical record on 1/19/21 at 16:14, that read, "....Resident is a FULL CODE".

Review of the careplan for Resident #54 revealed an entry that read, "Resident and RR [responsible representative] desire FULL CODE status", the associated goal for this careplan read, "Resident's FULL CODE status designation, will be honored, through next review".

Review of the nursing notes dated 6/11/21 at 6:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 14	F 607		

#54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified. CNA A went on to state, "they did a huddle afterwards and asked questions but it hasn't been talked about since that day".

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. No body started CPR until after I had cleaned him and he had been laying there an hour". When asked where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 15	F 607		

the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21 an interview was conducted with LPN A. LPN A confirmed that Resident #54 was a full code and CPR should have been performed. LPN A further acknowledged that despite several staff who were CPR certified responding to check Resident #54 CPR was not immediately initiated and RN A pronounced the Resident deceased.

On the afternoon of 7/7/21, an interview was conducted with the facility Administrator and Corporate Clinical Director/Employee D. When asked if this event on 6/11/21, involving Resident #54 was considered an unusual occurrence, the Administrator said "yes". When asked if a FRI (facility reported incident) report had been submitted, the Corporate Clinical Director stated, "we decided not to do a FRI after we talked to our counterparts" [later identified as Corporate Office Staff/ Employees E and Employee F]. The Administrator was asked if the event had been discussed with the Medical Director and she stated, "no, I have not talked with him about it". When asked if the facility QA (Quality Assurance) team had met to discuss the event, the Administrator stated, "no we had our quarterly meeting in May and we did an Ad hoc meeting in June just to approve the facility assessment because it wasn't done when we met in May". The Administrator was asked if any type of root cause analysis had been conducted and she stated, "no". She did indicate "all staff were educated".

On 7/8/21 the facility Administrator provided the survey team with a FRI that had been submitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 16	F 607		

to the OLC (Office of Licensure and Certification), APS (Adult Protective Services), and the Ombudaman on 7/7/21. This report read, "July 7, 2021 re: First and Final Facility Reported Incident of June 11, 2021. Findings: After investigation, it was determined that CPR was not initiated to the Resident timely. Actions: .... All corrective actions will be completed 7/23/21." Additionally, the facility provided evidence that only the staff working the day of the incident had been trained, not 100% of clinical staff.

On 7/8/21 at 8:50 AM, an interview was conducted with the facility Administrator. The Administrator was asked to define neglect, she stated, "it is any action, it can be many things, not providing medications, food, safe situations, not providing care someone needs". She was asked if, the failure to provide CPR or emergency medical treatment to a Resident who is not responsive is considered negligent, she stated, "I would not say that, I would say it was a lack of education". When asked if she would describe her interactions with staff following the incident, the Administrator stated and described her interactions with CNA A as a "welfare check, I wanted to see how she was and talk about the situation". The Administrator further acknowledged that the facility staff was still "conducting investigations" as of 7/7/21.

On 7/9/21 at 9:02 AM, an interview was conducted with Employee H, the Social Worker. Employee H, the social worker defined neglect as, "not being tended to, not providing what is needed". Employee H was asked, "if a Resident is a full code and is found unresponsive and staff do not perform CPR, is that neglect"? Employee H said, "yeah". She was asked if this has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 17	F 607		

happened and she immediately said "yes" and called the name of Resident #54. When asked to recall the events on 6/11/21, with regards to Resident #54. She stated, "when I came in that morning some said [Resident #54 name redacted] had died, my first thought was, Oh my God, did they do CPR. I said, I hope they did CPR, he's a full code. I don't remember who I said it to, but I think others were realizing it at the same time, when I went down there [to his room] people were scattering and there was a lot of confusion".

On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code. The Medical Director went on to state that he fully anticipated such an event "should have been reported to the health department and an investigation conducted". He stated that the facility has a good leadership team and he doesn't have to ask that a FRI be submitted, they automatically send them when needed and he expected a FRI to be submitted following this incident as well as an in-depth investigation conducted. The Medical Director did confirm that he had attended an Ad Hoc QA meeting on 7/9/21, where the incident was discussed but was not aware of the details of a full investigation or root cause analysis being conducted.

The facility policy titled, "Abuse Prevention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 607	Continued From page 18 Management Policy" with a review date of 2/19/21, read, "neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..... 4. Investigation. Designated staff will immediately review and investigate all allegations or observations of abuse. a.) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officals in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.....b) The organizaiton will conduct analysis for trends and patterns related to incidents...c) Outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee ....d) The Quality Assurance/Performance Improvement Committee will monitor trends and patterns for needed changes in facility policy, practice or protocols. 6. The Administrator and DON (Director of Nursing) were informed of the facility staff's negligence to provide emergency medical treatment to include CPR for Resident #54 being considered negligent on 7/8/21 at 12 noon during a mid-day debriefing. During this meeting the Corporate Clinical Director asked if this could be considered for past non-compliance. However, this request is not able to be upheld as the facility was still conducting their invesigiation during the survey and had not completed their plan of correction prior to the start of the survey. No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations	F 609		8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 19 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility failed to report an incident of neglect, which was also an unusual occurence for 1 Resident (Resident #54) in a survey sample of 31 Residents.	F 609	1. A Facility Reported Incident was submitted on 7/7/21 and resident #54 no longer resides in the facility as of 6/11/21. The facility provided education by the Director of Clinical Education to CNAs A, B, LPNA, LPN B and RNA on providing emergency care (CPR) on unresponsive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 20 On 6/11/21, Resident #54, who was a full code was found unresponsive. Four staff members, (CNA A, CNA B, LPN A, RN A), all of which were CPR certified, neglected to provide any type of emergency medical care, to include CPR. The staff response was neglegnt, as well as an unusual occurence; and the facility staff failed to report the event to the OLC (Office of Licensure and Certification), APS (Adult Protective Services), and other authorities as required. The findings included: Resident #54, diagnosis included but were not limited to: CAD (coronary artery disease), HTN (hypertension), old myocardial infarction, diabetes, and anxiety disorder. Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/8/21 was coded as a quarterly assessment. Resident #54 was coded as having had cognitive impairment and moderately impaired cognitive skills for daily decision making. He was also coded as having required extensive assistance of one staff member for activities of daily living. On 7/7/21, during a clinical record review it was determined that Resident #54 had elected to be a Full Code, wishing to have CPR in the event of cardio pulmonary arrest. Resident #54, had a physician order entered into his electronic clinical record on 1/19/21, the day of admission that read, "Full Code".	F 609	resident on 6/11/2021. 2. All residents who experience an incident of neglect will have an immediate investigation and the facility will report the incident to the state agency. No residents have required CPR since 6/11/21. 3. The leadership will be educated by the Nurse Executive/designee on the reporting requirements that meets the definition of abuse and/or neglect by 8/2/21. Staff will be educated by the DON/designee on abuse, neglect, reporting requirements, and procedure to follow if unresponsive resident is found, and 'mock code drills' will be completed to validate performance. 4. All incidents of neglect occurring at the facility will be audited to validate that they were fully investigated and reported in accordance with facility Abuse Prevention and Management Policy weekly for 8 weeks and ongoing. Will audit all residents found unresponsive and have full code status to ensure emergency medical care was provided as indicated for 8 weeks and ongoing. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis 5. All corrective actions will be completed on 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 21	F 609		

The Social Worker, Employee H, entered a progress note into the clinical record on 1/19/21 at 16:14, that read, "....Resident is a FULL CODE".

Review of the careplan for Resident #54 revealed an entry that read, "Resident and RR [responsible representative] desire FULL CODE status", the associated goal for this careplan read, "Resident's FULL CODE status designation, will be honored, through next review".

Review of the nursing notes dated 6/11/21 at 6:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident #54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 22	F 609		

name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified. CNA A went on to state, "they did a huddle afterwards and asked questions but it hasn't been talked about since that day".

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. No body started CPR until after I had cleaned him and he had been laying there an hour". When asked where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 23	F 609		

not responding, but I also dropped the ball".

On 7/7/21 an interview was conducted with LPN A. LPN A confirmed that Resident #54 was a full code and CPR should have been performed. LPN A further acknowledged that despite several staff who were CPR certified responding to check Resident #54 CPR was not immediately initiated and RN A pronounced the Resident deceased.

In the afternoon of 7/7/21, an interview was conducted with the facility Administrator and Corporate Clinical Director/Employee D. When asked if this event on 6/11/21, involving Resident #54 was considered an unusual occurrence, the Administrator said "yes". When asked if a FRI (facility reported incident) report had been submitted, the Corporate Clinical Director stated, "we decided not to do a FRI after we talked to our counterparts" [later identified as Corporate Office Staff/ Employees E and Employee F].

On 7/8/21 the facility Administrator provided the survey team with a FRI that had been submitted to the OLC (Office of Licensure and Certification), APS (Adult Protective Services), and the Ombudaman on 7/7/21. This report read, "July 7, 2021 re: First and Final Facility Reported Incident of June 11, 2021. Findings: After investigation, it was determined that CPR was not initiated to the Resident timely. Actions: .... All corrective actions will be completed 7/23/21."

On 7/8/21 at 8:50 AM, an interview was conducted with the facility Administrator. The Administrator was asked to define neglect, she stated, "it is any action, it can be many things, not providing medications, food, safe situations, not providing care someone needs". She was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 24	F 609		

if, the failure to provide CPR or emergency medical treatment to a Resident who is not responsive is considered negligent, she stated, "I would not say that, I would say it was a lack of education". When asked if she would describe her interactions with staff following the incident, the Administrator stated and described her interactions with CNA A as a "welfare check, I wanted to see how she was and talk about the situation". The Administrator further acknowledged that the facility staff was still "conducting investigations" as of 7/7/21.

On 7/9/21 at 9:02 AM, an interview was conducted with Employee H, the Social Worker. Employee H, the social worker defined neglect as, "not being tended to, not providing what is needed". Employee H was asked, "if a Resident is a full code and is found unresponsive and staff do not perform CPR, is that neglect"? Employee H said, "yeah". She was asked if this has happened and she immediately said "yes" and called the name of Resident #54. When asked to recall the events on 6/11/21, with regards to Resident #54. She stated, "when I came in that morning some said [Resident #54 name redacted] had died, my first thought was, Oh my God, did they do CPR. I said, I hope they did CPR, he's a full code. I don't remember who I said it to, but I think others were realizing it at the same time, when I went down there [to his room] people were scattering and there was a lot of confusion".

On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 25	F 609		

confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code. The Medical Director went on to state that he fully anticipated such an event "should have been reported to the health department and an investigation conducted". He stated that the facility has a good leadership team and he doesn't have to ask that a FRI be submitted, they automatically send them when needed and he expected a FRI to be submitted following this incident as well as an in-depth investigation conducted. The Medical Director did confirm that he had attended an Ad Hoc QA meeting on 7/9/21, where the incident was discussed but was not aware of the details of a full investigation or root cause analysis being conducted.

The facility policy titled, "Abuse Prevention and Management Policy" with a review date of 2/19/21, read, "neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..... 4. Investigation. Designated staff will immediately review and investigate all allegations or observations of abuse. a.) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officals in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.....b) The organizaiton will conduct analysis for trends and patterns related to incidents...c) Outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee ....d) The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 609	Continued From page 26 Quality Assurance/Performance Improvement Committee will monitor trends and patterns for needed changes in facility policy, practice or protocols". No further information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility failed to investigate an incident of neglect, which was also an unusual occurence, for 1 Resident (Resident #54) in a survey sample of 31 Residents.	F 610	1. A Facility Reported Incident was submitted on 7/7/21 and resident #54 no longer resides in the facility as of 6/11/21. The facility provided education to CNAs A, B, LPNA, LPNB and RNA on providing emergency care (CPR) on unresponsive residents on 6/11/2021. 2. Residents and staff will be interviewed	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 27 On 6/11/21, Resident #54, who was a full code was found unresponsive. Four staff members, (CNA A, CNA B, LPN A, RN A), all of which were CPR certified, neglected to provide any type of emergency medical care, to include CPR. The staff response was neglegnt, as well as an unusual occurence; and the facility staff failed to conduct an investigation of the event. The findings included: Resident #54, diagnosis included but were not limited to: CAD (coronary artery disease), HTN (hypertension), old myocardial infarction, diabetes, and anxiety disorder. Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/8/21 was coded as a quarterly assessment. Resident #54 was coded as having had cognitive impairment and moderately impaired cognitive skills for daily decision making. He was also coded as having required extensive assistance of one staff member for activities of daily living. On 7/7/21, during a clinical record review it was determined that Resident #54 had elected to be a Full Code, wishing to have CPR in the event of cardio pulmonary arrest. Resident #54, had a physician order entered into his electronic clinical record on 1/19/21, the day of admission that read, "Full Code". The Social Worker, Employee H, entered a progress note into the clinical record on 1/19/21	F 610	to determine if there are other cases of neglect or unusual occurrence to ensure they were investigated and reported. No residents have required CPR since 6/11/21. 3. The leadership will be educated by the Director of Education/designee on 8/2/21 on the process for collaborating with medical director, administrator, DON and Clinical Quality team after any unusual occurrence to ensure all required investigation and reporting is completed. Staff will be educated by the DON/designee on procedure to follow if unresponsive resident is found and process for reporting unusual occurrences that require investigation. 4. All incidents of neglect and unusual occurrences occurring at the facility will be audited to validate that they were fully investigated and reported in accordance with facility Abuse Prevention and Management Policy weekly for 8 weeks and ongoing. Will audit all residents found unresponsive with full code status to ensure emergency medical care was provided as indicated for 8 weeks and ongoing. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis 5. All corrective actions will be completed on 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 28	F 610		

at 16:14, that read, "....Resident is a FULL CODE".

Review of the careplan for Resident #54 revealed an entry that read, "Resident and RR [responsible representative] desire FULL CODE status", the associated goal for this careplan read, "Resident's FULL CODE status designation, will be honored, through next review".

Review of the nursing notes dated 6/11/21 at 6:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident #54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 29	F 610		

the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified. CNA A went on to state, "they did a huddle afterwards and asked questions but it hasn't been talked about since that day".

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. No body started CPR until after I had cleaned him and he had been laying there an hour". When asked where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21 an interview was conducted with LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 30	F 610		

A. LPN A confirmed that Resident #54 was a full code and CPR should have been performed. LPN A further acknowledged that despite several staff who were CPR certified responding to check Resident #54 CPR was not immediately initiated and RN A pronounced the Resident deceased.

On 7/7/21, during the afternoon, an interview was conducted with the facility Administrator and Corporate Clinical Director/Employee D. When asked if this event on 6/11/21, involving Resident #54 was considered an unusual occurrence, the Administrator said "yes". When asked if a FRI (facility reported incident) report had been submitted, the Corporate Clinical Director stated, "we decided not to do a FRI after we talked to our counterparts" [later identified as Corporate Office Staff/ Employees E and Employee F].

On 7/8/21 the facility Administrator provided the survey team with a FRI that had been submitted to the OLC (Office of Licensure and Certification), APS (Adult Protective Services), and the Ombudaman on 7/7/21. This report read, "July 7, 2021 re: First and Final Facility Reported Incident of June 11, 2021. Findings: After investigation, it was determined that CPR was not initiated to the Resident timely. Actions: .... All corrective actions will be completed 7/23/21."

On 7/8/21 at 8:50 AM, an interview was conducted with the facility Administrator. The Administrator was asked to define neglect, she stated, "it is any action, it can be many things, not providing medications, food, safe situations, not providing care someone needs". When asked if she would describe her interactions with staff following the incident, the Administrator stated and described her interactions with CNA A as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 31	F 610		

"welfare check, I wanted to see how she was and talk about the situation". The Administrator further acknowledged that the facility staff was still "conducting investigations" as of 7/7/21.

On 7/9/21 at 9:02 AM, an interview was conducted with Employee H, the Social Worker. Employee H, the social worker defined neglect as, "not being tended to, not providing what is needed". Employee H was asked, "if a Resident is a full code and is found unresponsive and staff do not perform CPR, is that neglect"? Employee H said, "yeah". She was asked if this has happened and she immediately said "yes" and called the name of Resident #54. When asked to recall the events on 6/11/21, with regards to Resident #54. She stated, "when I came in that morning some said [Resident #54 name redacted] had died, my first thought was, Oh my God, did they do CPR. I said, I hope they did CPR, he's a full code. I don't remember who I said it to, but I think others were realizing it at the same time, when I went down there [to his room] people were scattering and there was a lot of confusion".

On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code. The Medical Director went on to state that he fully anticipated such an event "should have been reported to the health department and an investigation conducted". He stated that the facility has a good

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 610	Continued From page 32	F 610		

leadership team and he doesn't have to ask that a FRI be submitted, they automatically send them when needed and he expected a FRI to be submitted following this incident as well as an in-depth investigation conducted. The Medical Director did confirm that he had attended an Ad Hoc QA meeting on 7/9/21, where the incident was discussed but was not aware of the details of a full investigation or root cause analysis being conducted.

The facility policy titled, "Abuse Prevention and Management Policy" with a review date of 2/19/21, read, "neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..... 4. Investigation. Designated staff will immediately review and investigate all allegations or observations of abuse. a.) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officals in accordance with State law, including to the State Survey Agency, within 5 working days of the incident.....b) The organizaiton will conduct analysis for trends and patterns related to incidents...c) Outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee ....d) The Quality Assurance/Performance Improvement Committee will monitor trends and patterns for needed changes in facility policy, practice or protocols".

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 641	Continued From page 33	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to accurately reflect status of resident on assessments for 1 Resident (#42) in a survey sample of 31 Residents. The findings included: For Resident #42 the facility documentation and assessments do not accurately reflect the Resident's condition. Resident #42, a 69 year old man admitted to the facility on 3/12/21 with diagnoses of but not limited to wedge compression fracture 5th lumbar vertebra, Brown-Sequard Syndrome, autonomic neuropathy, muscle spasm, fracture of neck, non-displaced fracture of 5th cervical vertebra, and injury of cervical spinal cord. Resident #42's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/16/21, a Quarterly Review coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. The MDS also coded the Resident as requiring extensive assistance of 2 staff physical assistance and the mechanical lift for all transfers, and extensive assistance of 2 staff for all aspects of ADL care. He can feed himself can bear some weight with the sit to stand lift however he is unable to stand	F 641	12VAC 5-371-250(A)(1)(6) and 12VAC5-371-250(D) 1. Resident #42 documentation and assessment was corrected to reflect the resident's condition by the DON/designee on 7/31/21. Resident #42's MDS assessment was completed and submitted to reflect current findings on or before 8/18/21. 2. Skin observations were completed on all residents on or before 8/3/21. MDS assessments will be completed to reflect new pressure injuries on/or before 8/18/2021. 3. LPN B and DON were provided education by the Director of Education/designee on ¬¬¬¬8/2/21 regarding the requirement for LPN wound findings to be reviewed by RN and/or Provider. MDS Coordinator was educated on ensuring MDSs are current and consistent with wound status documentation by the Director of Clinical Reimbursement/designee on 7/30/2021. 4. Two resident charts will be audited weekly for 8 weeks to validate accuracy and completion of wound assessments by the RN or provider. Two residents' charts will be audited weekly for 8 weeks for	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 641	Continued From page 34 or walk, and has an electric wheelchair for mobility. On 7/6/21 at approximately 1:00 PM during initial tour of the facility, Resident #42 was observed sitting in his room in a shower chair about to be transported by mechanical lift to his wheelchair. It was noted that the resident had a towel at his heel with blood on it. After his being transferred an interview was conducted with #42 who stated, "The nurses and staff here are great but the Doctor comes in with his Hollywood attitude and talks about his electric car outside my door for 30 minutes but doesn't have time to look at my wounds? That's just not right. He came in here the other day and said he would be right back and came back over an hour later and told me he would see me next week. I told him to get out of here if he couldn't see me now." The Resident explained that he has been at the facility since March and has developed wounds on his right and left foot and his calf and blisters on different parts of his body at different times. He said "Right now I have 3 areas I'm concerned about my right calf and my feet. The one wound on my leg was really bad at one point the smell was horrible, but it's getting better now." On 7/7/21 a review of the clinical record revealed the following: MDS on admission dated 3/19/21 "Section M - 0210 - Does the resident have any unhealed pressure ulcers stage 1 or higher - 0. NO" MDS (Quarterly) dated 6/16/21 read: "Section M 0300 F. Number of unstageable wounds due to slough or eschar - 4"	F 641	accurate MDS wound coding by the Director of Clinical Reimbursement/designee. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis 5. All corrective actions will be completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 641	Continued From page 35	F 641		

"M 0300 G - Number of unstageable wounds with suspected deep tissue injury in evolution -1"
"M 1030 - Total number of venous and arterial ulcers - 0"

The information on all skin and wound issues for this resident was submitted by the facility as a time line. They also submitted the "Wound assessment sheets" to coincide with each listed wound.

Per the document entitled Wounds, Resident #42 developed wounds as follows:

Assessment # 47937912 - 3/24/21 at 11:48 AM - blisters to right wrist (1.5 cm x .5 cm)
Assessment # 47978458 - 3/27/21 at 12:38 PM - Blister to right outer anterior wrist
Assessment # 47978470 - 3/27/21 at 12:41 PM- blisters to right elbow (2 cm x 1.5 cm)
Assessment # 47978479 - 3/3:27 PM/21 at 12:44 -Blisters to left groin
Assessment # 48035076 - 3 /31/21 at 3:32 PM -DTI Sacrum
Assessment # 48035080 - 3/31/21 at 3:35 PM - Deep Tissue Injury to R Sacrum
Assessment # 48035084 - 3/31/21 at 3:38 PM- Deep Tissue Injury to Sacrum area
Assessment # 48122818 - 4/7/21 at 12:35 PM - DTI left Heel - (found at DTI 7 cm x 6 cm)
Assessment # 48196729 - 4/12/21 at 9:59 AM - Blister right upper thigh (recorded as Stage II partial thickness 0.9 cm x 0.6 cm)
Assessment # 41896745 - 4/12/21 at 10:03 AM - Blister unstageable
Assessment # 48196760 - 4/12/21 at 10:08 AM - DTI right upper posterior calf (found 4/9/21 6 cm x 2 cm)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 641	Continued From page 36	F 641		

Assessment # 48298406 - 4/19/21 at 3:25 PM - open area in DTI unstageable calf (2.5 x .5) [no depth recorded to this open area]
Assessment # 48601073 - 5/12/21 at 1:47 PM -DTI to Right Heel (1 cm x 1 cm)
Assessment # 48601161 - 5/12/21 at 1:52 PM - DTI to 5th toe (1.0 cm x 0.5 cm)
Assessment # 48601204 -5/12/21 at 1:57 PM - Blister stage II to left upper thigh (3.0 x 0.5 cm)
Assessment # 48601263 - 5/12/21 at 2:06 PM - DTI's and blister
Assessment # 48650949 - 5/16/21 at 2:29 PM - Blister due to catheter tubing (recorded as Stage II partial thickness 1 cm x 2 cm no depth recorded)
Assessment # 48670103 - 5/17/21 at 2:45 PM _ Blister upper left thigh
Assessment # 48670743 - 5/17/21 at 2:59 PM - Blister to lateral left thigh (recorded as Stage II partial thickness 7 cm x 0.5 cm no depth recorded)

A review of the "Wound Assessment Sheets" on page 2 of each wound sheet labeled all of the wounds listed above as "Vascular" in nature. All assessments for wounds to include the initial assessments were conducted and signed off by LPN B.

On 7/8/21 at 10:13 AM an interview was conducted with the DON (employee B) who stated that skin assessments are performed weekly. She was asked who was in charge of doing the wound assessments and wound care she stated LPN B is our "Wound Champion" and she "advises the other nurses." When asked if the facility has a wound protocol she stated yes they did. She stated that LPN B would do the initial assessment and that she has credentials

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 641	Continued From page 37 for wound care. She further stated that if the wound does not get better or if it worsens the provider (MD or NP) will come and look at it. On 7/8/21 at approximately 10:30 an interview was conducted with the Clinical Services Director (employee D) who stated that we have a "Wound Champion" and indicated LPN B was that person. When asked if it was the expectation that LPN B would have an RN sign off on the initial assessments and staging of the wounds she stated that it would be an expectation. On 7/8/21 at approximately 11:00 AM an interview with the "Wound Champion" LPN B who stated that when the Resident developed blisters the doctor told her it was probably vascular, which is why she wrote vascular on the wound assessment sheets. When asked if she was the person who did the initial assessments and staging she stated that she was. At 11:30 AM the wounds were observed by Surveyor and LPN B. The areas are in various stages of the healing, the calf wounds have merged into 1 wound, and the left foot has heavy amount of drainage the right heel wound is dry and scabbed over. LPN B stated "I started using calcium alginate today due to copious amount of drainage from the left heel." On 7/9/21 during the end of day meeting the Administrator was made aware of the concerns and no new information was provided.	F 641		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		8/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 38	F 656		

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 39 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement the comprehensive care plan for 1 resident (Resident #54) in a survey sample of 31 residents. For Resident #54, the facility staff failed to implement resuscitation interventions as indicated on his comprehensive care plan when he was found unresponsive and not breathing, resulting in harm at past non-compliance. The findings include: Resident #54 was admitted to the facility on 1/19/21 for long term care due to increasing confusion and decline in cognitive and physical function. Resident #54 was a "full code" status which indicated resuscitation efforts would be provided if the heart stopped beating or breathing stopped. Review of Resident #54's clinical record revealed an Admission Note dated 1/19/21 which read, "Resident is a FULL CODE", and a physician's order which read, "FULL CODE". Review of the Comprehensive Care Plan, effective date 1/24/21-Present [6/11/21], page 1, "Advance Directives", read "Full Code". Excerpts from page 13 of the Care Plan read, "Resident and RR [Resident Representative] desire FULL CODE status, STATUS: Active (Current), Goals--Resident's FULL CODE status designation will be honored" and "Interventions" included "Staff will respect resident's wishes and	F 656	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 40	F 656		

preferences and will make all reasonable efforts to carry out his/her wishes" and "In the event of cardiopulmonary arrest, resident WILL receive CPR per his/her request, STATUS: Active (Current)".

Review of the nursing notes dated 6/11/21 at 5:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at approximately 3:15 PM, an interview was conducted with LPN A, who was assigned to take care of Resident #54 on 6/11/21. LPN A stated, "When I came to work that day, I was told that [name redacted, Resident #54] had not been feeling well earlier that morning, I went to check on him around 8 o'clock and he was ok, there didn't appear to be anything wrong with him, he was sleeping on his side, I did not wake him since he wasn't feeling well earlier, I wanted to let him sleep a little bit more, around 9:30ish [name redacted, CNA B] came to let me know that something was not quite right with [Resident #54], when I got to the room he was lying on his right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 41	F 656		

side and looked discolored, I hollered out for [RN A] and checked my clipboard to check his code status, he was full code but [RN A] said he was gone, I got my Unit Manager, [LPN B] and she called the doctor, [MD, name redacted] said [Resident #54] was already deceased, not to do CPR ...I know now that we should have started CPR first".

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident #54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified.

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 42	F 656		

A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. Nobody started CPR until after I had cleaned him and he had been laying there an hour". When asked where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21, a group interview was conducted with the Facility Administrator, the DON, the Staff Educator, and the Clinical Services Director whom all concurred that CPR (cardiopulmonary resuscitation) should have been initiated when Resident #54 was found unresponsive by CNA A and not stopped until either EMT's took over care or the MD ordered CPR to stop.

On 7/8/21 at approximately 8:45 AM, the Facility Administrator stated that she had begun an investigation on 7/7/21 and submitted a timeline of events for Resident #54 that occurred on 6/11/21 which read as follows:

Approx 6:30am: per clinical note, nurse states resident not feeling well, rectal temp 99.0

Approx 0700: [CNA B] arrived at work at approximately 0700 and was told in shift change that [name redacted, Resident #54] had a low grade fever overnight and was not feeling well and had been snoring loudly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 43	F 656		

Approx 0715-0720: Resident [54] noted by [CNA B], to have turned himself over in bed on right side

Approx 0800: [LPN A] reports seeing him laying on right side

Approx 0900-0915: [CNA A] went in to give him breakfast and found him lying in the bed unresponsive, she states that she was unable to wake him, she immediately got [CNA B] and they went into the resident's room, then notified [LPN A] who contacted [LPN B], [LPN A] also reports that resident was laying partially on right side, with discoloration to skin noted

Approx 0930: [RN A] pronounced and [LPN B] notified provider, emergency contact for resident was notified, and message was left to call the facility

Approx 0930-1000: The clinical support team onsite were alerted the resident was a full code, the team immediately went to his room and CPR was initiated by [Employee J, RN clinical educator], [MD name redacted] was called by [LPN B], who was on the phone with provider in the hallway and provider gave a verbal order via speaker phone to stop CPR

Approx 1030-1100: Director of Education conducted a huddle to debrief and educated the staff on advanced directives, color coded dots and code blue procedures and if a resident is found without vital signs, the process of what needs to occur, Social Worker pulled current list of all code statuses in the facility and those listed as a full code were reviewed with team members

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 656	Continued From page 44 at the huddle, time was allowed for staff to ask questions, and individual team members were followed up with by members of leadership, Social Worker completed 100% audit of resident code status and no discrepancies were noted. On 7/8/21, the survey team conducted approximately 10 randomly sampled clinical staff interviews to assess their response to the question, "What would you do if you found a resident not breathing"? The staff members were able to provide sufficient answers. Review of employee records revealed that all four of the responding staff (CNA A, CNA B, LPN A and RN A) held current and active CPR certification, which included training for determining when to initiate CPR. Review of the facility's policy entitled, "Resident Care Planning", last revision date 12/15/2020, read, "Purpose:....the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being". This deficiency is cited at past non-compliance as it was evidenced through document review and staff interview that the facility corrected the deficient practice on 6/11/21.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 657	Continued From page 45 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to develop and implement a comprehensive care plan that is patient centered with measurable goals and objectives for 1 Resident (#42) in a survey sample of 31 Residents. The findings included For Resident #42 the facility staff failed to develop and implement a comprehensive care plan that is patient centered with measurable goals and objectives.	F 657	) 12VAC5-371-250(F) 1. Care plan for Resident #42 was reviewed and updated to accurately reflect resident's skin status with resident centered focused interventions and measurable goals and objectives on 7/16/21. 2. 100% audit of all residents in facility who have pressure injuries will have resident centered care plans with measurable goals and objectives. 3. The Director of Clinical Reimbursement/designee will educate the Interdisciplinary Team including MDS Coordinator, Director of Nursing, Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 657	Continued From page 46 For Resident #42 the facility documentation and assessments do not accurately reflect the Resident's condition. Resident #42, a 69 year old man admitted to the facility on 3/12/21 with diagnoses of but not limited to wedge compression fracture 5th lumbar vertebra, Brown-Sequard Syndrome, autonomic neuropathy, muscle spasm, fracture of neck, non-displaced fracture of 5th cervical vertebra, and injury of cervical spinal cord. Resident #42's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/16/21, a Quarterly Review coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. The MDS also coded the Resident as requiring extensive assistance of 2 staff physical assistance and the mechanical lift for all transfers, and extensive assistance of 2 staff for all aspects of ADL care. He can feed himself can bear some weight with the sit to stand lift however he is unable to stand or walk, and has an electric wheelchair for mobility. On 7/6/21 at approximately 1:00 PM during initial tour of the facility, Resident #42 was observed sitting in his room in a shower chair about to be transported by mechanical lift to his wheelchair. It was noted that the resident had a towel at his heel with blood on it. After his being transferred an interview was conducted with #42 who stated, "The nurses and staff here are great but the Doctor comes in with his Hollywood attitude and talks about his electric car outside my door for 30 minutes but doesn't have time to look at my wounds? That's just not right. He came in here the other day and said he would be right back and came back over an hour later and told me he	F 657	Services Director, Activities Director, and Director of Rehabilitation on developing comprehensive care plans that are resident centered with measurable goals and objectives by 8/6/21. 4. Will audit 2 care plans weekly for 8 weeks for residents with wounds to validate care plans are patient centered and include measurable goals and objectives. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 657	Continued From page 47	F 657		

would see me next week. I told him to get out of here if he couldn't see me now." The Resident explained that he has been at the facility since March and has developed wounds on his right and left foot and his calf and blisters on different parts of his body at different times. He said "Right now I have 3 areas I'm concerned about my right calf and my feet. The one wound on my leg was really bad at one point the smell was horrible, but it's getting better now."

On 7/7/21 at approximately 1:15 PM an interview was conducted with LPN B who stated the purpose of the care plan was to direct the care of the patient. To address each of his needs and to inform the staff of how

A review of the care plan revealed the care plan objectives were not specific and did not address all aspects of care often the discipline (who was to perform the care) was left blank and the frequency of the interventions was also left blank, excerpts are as follows:

"Use preventive measures for positioning and pressure relief in accordance with facility policy. STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM [RN name redacted]"
"Frequency" Column left blank
"Discipline" Column left blank. .

"Encourage resident to re-position or provide assistance with turning and repositioning as needed STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM [RN name redacted]"
"Frequency" Column left blank
"Discipline" Column left blank.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 657	Continued From page 48	F 657		

"Encourage resident to re-position or provide assistance with turning and repositioning as needed
STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM (RN name redacted)"
"Frequency" Column left blank
"Discipline" Column left blank.

"Apply skin barrier cream per order/protocol
STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present
CREATED: 3/22/2021 3:27:24 PM (RN, name redacted)"
"Frequency" Column left blank
"Discipline" Column left blank.

"Staff education concerning he is to be transferred in and out of his Power chair using the mechanical lift. STATUS: Active (Current) EFFECTIVE: 4/2/2021 - Present CREATED: 4/5/2021 4:59:55 PM [RN name redacted]
"Frequency -" column left blank
"Discipline Nursing CREATED: 4/5/2021 4:59"

"Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. STATUS: Active (Current) EFFECTIVE: 3/24/2021 - Present CREATED: 3/24/2021 7:17:48 AM" (RN name redacted)
"Frequency" Column left blank
"Discipline" Column left blank.

"Elevate RLE, positional changes frequently due to edema STATUS: Active (Current) EFFECTIVE: 3/24/2021 - Present CREATED: 3/24/2021 8:30:36 AM"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 657	Continued From page 49 "Frequency" Column left blank "Discipline" Column left blank. "Place low air loss mattress to bed to assist with pressure reduction. STATUS: Active (Current) EFFECTIVE: 6/9/2021 - Present CREATED: 6/10/2021 11:45:14 AM" (RN name redacted) "Frequency" Column left blank "Discipline" Column left blank. A review of the physicians orders do not show any boots for heel protection however it does reflect an order on 6/22/21 for circular foot lift pillow to right lower extremity as tolerated this was after the wound appeared. On 7/9/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
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, facility documentation review and clinical record review, the facility staff failed to provide care in accordance with professional standards of practice for 4 Residents (Resident #54, Resident #42, Resident #7, Resident #23) in a survey sample of 31 Residents. 1. For Resident #54, who was a full code, the	F 658	1. Resident #54 no longer resides in the facility as of 6/11/21. Resident #7 received the medication on 7/6/21 with no adverse effect. The resident representative and provider were made aware of the delay in medication administration. Resident #23 received the medications on 7/6/21 with no adverse effect. The resident representative and provider were made	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 50 facility staff failed to provide any emergency medical treatment, including CPR, when he was found unresponsive. 2. For Resident #7, the facility failed to administer narcotic pain medication timely as ordered by a physician. 3. For Resident #23, the facility failed to administer 5 medications, including a narcotic pain medication timely as ordered by a physician. 4. For Resident #42 the facility failed to provide care according to professional standards of care by having an LPN perform the wound assessments and staging, which is out of the scope of practice for an LPN. The findings included: 1. For Resident #54, who was a full code, the facility staff failed to provide any emergency medical treatment, including CPR as per professional standards when he was found unresponsive. Resident #54, diagnosis included but were not limited to: CAD (coronary artery disease), HTN (hypertension), old myocardial infarction, diabetes, and anxiety disorder. Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 4/8/21 was coded as a quarterly assessment. Resident #54 was coded as having had cognitive impairment and moderately impaired cognitive skills for daily	F 658	aware of the delay in medications administered. On 8/2/21 the DON/designee provided education to the LPN B on wound observation and staging related to her scope of practice. 2. No residents who are a full code have required any emergency medical treatment, including CPR since 6/11/21. 100% of all residents will have an audit of medication pass times to ensure for appropriate scheduling/timing by pharmacist, nursing and/or provider. All residents with pressure injuries will have a wound assessment and staging completed by an RN and/or Provider. 3. Staff will be educated by the DON/designee on procedure to follow if unresponsive resident found by team members. Licensed nurses will be educated by DON/designee on requirement for ordered medications to be administered timely as ordered by physician, including narcotic pain medication. Licensed nurses will be educated by DON/designee on professional standards of care including tasks such as wound observation and staging. 4. Will audit all residents found unresponsive and have full code status to ensure emergency medical care was provided as indicated for 8 weeks and ongoing. Will audit 10% of Resident Medication Administration Records weekly to validate that medications/narcotics were administered timely as ordered by physician. Will audit pressure injury documentation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 51 decision making. He was also coded as having required extensive assistance of one staff member for activities of daily living. On 7/7/21, during a clinical record review it was determined that Resident #54 had elected to be a Full Code, wishing to have CPR in the event of cardio pulmonary arrest. Resident #54, had a physician order entered into his electronic clinical record on 1/19/21, the day of admission that read, "Full Code". The Social Worker, Employee H, entered a progress note into the clinical record on 1/19/21 at 16:14, that read, "....Resident is a FULL CODE". Review of the careplan for Resident #54 revealed an entry that read, "Resident and RR [responsible representative] desire FULL CODE status", the associated goal for this careplan read, "Resident's FULL CODE status designation, will be honored, through next review". Review of the nursing notes dated 6/11/21 at 6:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.	F 658	weekly to validate that that wound observation, including staging were completed by an RN and/or Provider. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 52	F 658		

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident #54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified. CNA A went on to state, "they did a huddle afterwards and asked questions but it hasn't been talked about since that day".

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 53	F 658		

verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. No body started CPR until after I had cleaned him and he had been laying there an hour". When asked where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21 an interview was conducted with LPN A. LPN A confirmed that Resident #54 was a full code and CPR should have been performed. LPN A further acknowledged that despite several staff who were CPR certified responding to check Resident #54 CPR was not immediately initiated and RN A pronounced the Resident deceased.

Review of employee records revealed that all four of the responding staff (CNA A, CNA B, LPN A and RN A) held current and active CPR certification from the American Heart Association, which included training in when to initiate CPR.

On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code.

On 7/8/21 the facility Administrator provided the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 54	F 658		

survey team with a FRI (Facility Reported Incident) that had been submitted to the OLC (Office of Licensure and Certification), APS (Adult Protective Services), and the Ombudaman on 7/7/21. This report read, "July 7, 2021 re: First and Final Facility Reported Incident of June 11, 2021. Findings: After investigation, it was determined that CPR was not initiated to the Resident timely".

The facility policy titled, "Cardio-Pulmonary Resuscitation (CPR) with a revision date of 1/2/20, read "Prior to the arrival of emergency medical services (EMS), the staff must initiate CPR when cardiac arrest (cessation of respirations and/or pulse) occurs for residents unless: A Resident has a valid DNR order, or A Resident presents with a completed, Durable Do Not Resuscitate Order form, or A resident presents with a POST form indicating Do not Attempt Resuscitation, or A Resident presents with approved jewelry indicating Do Not Resuscitate, or A physician orders otherwise, A resident shows American Heart Association signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care 2015. Obvious signs of clinical death, e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition. *** Only a physician can pronounce if unanticipated death. Not an RN, NP or PA".

On 7/8/21, the facility staff provided the survey team with the training from the American Heart Association that is used during CPR training of their staff. The American Heart Association defines the following "Critical Skills" in their Basic Life Support training, which each of the responding staff had successfully completed. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 55	F 658		

read, "1. Assesses victim and activates emergency response system (this must precede starting compressions) within 30 seconds. After determining the scene is safe: checks for responsiveness by tapping and shouting, shouts for help/directs someone to call for help and get AED/defibrillator, checks for no breathing or no normal breathing, checks carotid pulse. 2. Performs high-quality chest compressions (initiates compressions immediately after recognition of cardiac arrest). 3. Provides 2 breaths by using a barrier device. 4. Performs same steps for compressions and breaths for cycle 2. 5. AED use. 6. Resumes compressions".

The Administrator and DON (Director of Nursing) were informed of the facility staff's negligence to provide emergency medical treatment to include CPR for Resident #54 being considered failure to follow professional standards on 7/8/21 at 12 noon, during a mid-day debriefing. During this meeting the Corporate Clinical Director asked if all tags surrounding this incident could be considered for past non-compliance. However, this request for past non-compliance is not able to be upheld due to the facility was still conducting their investigation during the survey, had not completed their plan of correction prior to the start of the survey, and the QA (Quality Assurance) committee had not meet until 7/9/21.

No further information was provided.

Based on Observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain professional standards of practice for medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 56	F 658		

administration involving two Residents (Residents #7, and #23) in a survey sample of 31 Residents.

2. For Resident #7, the facility failed to administer narcotic pain medication timely as ordered by a physician.

3. For Resident #23, the facility failed to administer 5 medications, including a narcotic pain medication timely as ordered by a physician.

The findings included:

2. Resident #7, was admitted to the facility on 12-18-12. Diagnoses included; Parkinson's disease, and right shoulder dislocation with pain, contracture right hand, osteoarthritis, and chronic back pain.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-14-21 was coded as a quarterly assessment. Resident #7 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or, no cognitive impairment. Resident #7 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, hygiene, locomotion, and toileting.

On 7-6-21 from 1:00 p.m., until 2:00 p.m., medication pour and pass observations were conducted with Licensed Practical Nurse (LPN) A. Resident #7 received medications at 1:40 p.m. The Resident received tramadol, a narcotic pain reliever and LPN A stated "these are the morning meds, I am just getting them finished."

Review of the "Medication Administration Record"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 57	F 658		

(MAR) revealed that no time was documented as to the exact time the medication was administered, therefore, the oncoming evening nurse could administer the narcotic pain medication again as soon as 3:00 p.m., and the Resident could experience over sedation.

Review of Resident #7's clinical record revealed valid physician's orders for the pain medication given late. That order was as follows:

Tramadol 50 milligrams one tablet by mouth three times per day.

Those 3 times per day to give the medication, were each listed as a range of time, and are as follows. (1) 8:00 a.m. to 10:00 a.m., (2) 4:00 p.m. to 5:00 p.m., and (3) 9:00 p.m. to 10:00 p.m.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order timely, and signed/documented by the administering individual as soon as the medication is given.

The facility staff stated "Mosby's" as their clinical standard of practice reference. The reference review revealed the following excerpt;

Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.
" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 58 " Check the order. 3. Right dose " Check the order. " Confirm appropriateness of the dose using a current drug reference. " If necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route " Again, check the order and appropriateness of the route ordered. " Confirm that the patient can take or receive the medication by the ordered route. 5. Right time " Check the frequency of the ordered medication. " Double-check that you are giving the ordered dose at the correct time. " Confirm when the last dose was given. 6. Right documentation " Document administration AFTER giving the ordered medication. " Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason " Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? " Revisit the reasons for long-term medication use. 8. Right response " Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? " Be sure to document your monitoring of the patient and any other nursing interventions that	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 59	F 658		

are applicable.

When interviewed on 7-6-21 at 4:00 p.m., the DON (director of nursing), and Corporate Liason stated that the range was going to be changed, and the medications were administered late, which could cause over sedation if given too closely together, and could allow break through pain for the Resident if spaced too far apart. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to administer them timely.

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered timely, on 7-6-21 at 4:00 p.m. No further information was provided by the facility.

3. Resident #23, was admitted to the facility on 1-28-20. Diagnoses included; Acute respiatory failure with hypoxia, sacral pressure ulcer, protein deficiency, diabetes, and cardiac/heart disease.

Resident #23's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-12-21 was coded as a significant change assessment. Resident #23 was coded as having a BIMS (brief interview of mental status) score of "unable to complete", or, severe cognitive impairment. Resident #23 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, hygiene, locomotion, and toileting.

On 7-6-21 from 1:00 p.m., until 2:00 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 60	F 658		

medication pour and pass observations were conducted with Licensed Practical Nurse (LPN) A. Resident #23 received medications at 1:30 p.m. The Resident received the following 5 medications which were ordered to be administered more than once per day, and were to be given during a range of time. They are as follows;

1. Albuterol metered dose inhaler one to two puffs three times per day at 8:00 a.m. to 10:00 a.m., 12:00 p.m. to 2:00 p.m., and 6:00 p.m. to 8:00 p.m.

2. Flonase nasal steroid one spray in each nare twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

3. Liquicell protein 30 milliliters twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

4. Metoprolol heart medication 50 milligrams twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

5. Hydrocodone narcotic pain reliever 5 milligrams/325 milligrams twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

Other medications were also administered at the time, however, they were only ordered to be administered once per day, and so were not added to the deficient practice. LPN A stated "these are the morning meds, I am just getting them finished."

Review of the "Medication Administration Record" (MAR) revealed that no time was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 61	F 658		

to the exact time the medication was administered, therefore, the oncoming evening nurse could administer the medications early or late, and the Resident could experience poor respiratory, and cardiac results, over sedation, and or lack of pain control.

Review of Resident #23's clinical record revealed valid physician's orders for the multiple significant medications given late.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order timely, and signed/documented by the administering individual as soon as the medication is given.

The facility staff stated "Mosby's" as their clinical standard of practice reference. The reference review revealed the following excerpt;

Rights of Medication Administration
1. Right patient
" Check the name on the order and the patient.
" Use 2 identifiers.
" Ask patient to identify himself/herself.
" When available, use technology (for example, bar-code system).
2. Right medication
" Check the medication label.
" Check the order.
3. Right dose
" Check the order.
" Confirm appropriateness of the dose using a current drug reference.
" If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 62	F 658		

" Again, check the order and appropriateness of the route ordered.
" Confirm that the patient can take or receive the medication by the ordered route.
5. Right time
" Check the frequency of the ordered medication.
" Double-check that you are giving the ordered dose at the correct time.
" Confirm when the last dose was given.
6. Right documentation
" Document administration AFTER giving the ordered medication.
" Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.
7. Right reason
" Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
" Revisit the reasons for long-term medication use.
8. Right response
" Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
" Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

When interviewed on 7-6-21 at 4:00 p.m., the DON (director of nursing), and Corporate Liason stated that the range was going to be changed, and the medications were administered late, which could cause non-therapeutic side effects, over sedation if given too closely together, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 63	F 658		

could allow break through pain for the Resident if spaced too far apart. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to administer them timely.

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered timely, on 7-6-21 at 4:00 p.m. No further information was provided by the facility.

4. For Resident #42 the facility failed to provide care according to professional standards of care by having an LPN perform the wound assessments and staging, which is out of the scope of practice for an LPN.

For Resident #42 the facility documentation and assessments do not accurately reflect the Resident's condition.

Resident #42, a 69 year old man admitted to the facility on 3/12/21 with diagnoses of but not limited to wedge compression fracture 5th lumbar vertebra, Brown-Sequard Syndrome, autonomic neuropathy, muscle spasm, fracture of neck, non-displaced fracture of 5th cervical vertebra, and injury of cervical spinal cord. Resident #42's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/16/21, a Quarterly Review coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. The MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 64	F 658		

also coded the Resident as requiring extensive assistance of 2 staff physical assistance and the mechanical lift for all transfers, and extensive assistance of 2 staff for all aspects of ADL care. He can feed himself can bear some weight with the sit to stand lift however he is unable to stand or walk, and has an electric wheelchair for mobility.

On 7/6/21 at approximately 1:00 PM during initial tour of the facility, Resident #42 was observed sitting in his room in a shower chair about to be transported by mechanical lift to his wheelchair. It was noted that the resident had a towel at his heel with blood on it. After his being transferred an interview was conducted with #42 who stated, "The nurses and staff here are great but the Doctor comes in with his Hollywood attitude and talks about his electric car outside my door for 30 minutes but doesn't have time to look at my wounds? That's just not right. He came in here the other day and said he would be right back and came back over an hour later and told me he would see me next week. I told him to get out of here if he couldn't see me now." The Resident explained that he has been at the facility since March and has developed wounds on his right and left foot and his calf and blisters on different parts of his body at different times. He said "Right now I have 3 areas I'm concerned about my right calf and my feet. The one wound on my leg was really bad at one point the smell was horrible, but it's getting better now."

On 7/7/21 a review of the clinical record revealed the following:
MDS on admission dated 3/19/21
"Section M - 0210 - Does the resident have any unhealed pressure ulcers stage 1 or higher - 0.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 65 NO" MDS (Quarterly) dated 6/16/21 read: "Section M 0300 F. Number of unstageable wounds due to slough or eschar - 4" "M 0300 G - Number of unstageable wounds with suspected deep tissue injury in evolution -1" "M 1030 - Total number of venous and arterial ulcers - 0" The information on all skin and wound issues for this resident was submitted by the facility as a time line. They also submitted the "Wound assessment sheets" to coincide with each listed wound. Per the document entitled Wounds, Resident #42 developed wounds as follows: Assessment # 47937912 - 3/24/21 at 11:48 AM - blisters to right wrist (1.5 cm x .5 cm) Assessment # 47978458 - 3/27/21 at 12:38 PM - Blister to right outer anterior wrist Assessment # 47978470 - 3/27/21 at 12:41 PM- blisters to right elbow (2 cm x 1.5 cm) Assessment # 47978479 - 3/3:27 PM/21 at 12:44 -Blisters to left groin Assessment # 48035076 - 3 /31/21 at 3:32 PM -DTI Sacrum Assessment # 48035080 - 3/31/21 at 3:35 PM - Deep Tissue Injury to R Sacrum Assessment # 48035084 - 3/31/21 at 3:38 PM- Deep Tissue Injury to Sacrum area Assessment # 48122818 - 4/7/21 at 12:35 PM - DTI left Heel - (found at DTI 7 cm x 6 cm) Assessment # 48196729 - 4/12/21 at 9:59 AM - Blister right upper thigh (recorded as Stage II partial thickness 0.9 cm x 0.6 cm	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 66	F 658		

Assessment # 41896745 - 4/12/21 at 10:03 AM - Blister unstageable
Assessment # 48196760 - 4/12/21 at 10:08 AM - DTI right upper posterior calf (found 4/9/21 6 cm x 2 cm)
Assessment # 48298406 - 4/19/21 at 3:25 PM - open area in DTI unstageable calf (2.5 x .5) [no depth recorded to this open area]
Assessment # 48601073 - 5/12/21 at 1:47 PM -DTI to Right Heel (1 cm x 1 cm)
Assessment # 48601161 - 5/12/21 at 1:52 PM - DTI to 5th toe (1.0 cm x 0.5 cm)
Assessment # 48601204 -5/12/21 at 1:57 PM - Blister stage II to left upper thigh (3.0 x 0.5 cm)
Assessment # 48601263 - 5/12/21 at 2:06 PM - DTI's and blister
Assessment # 48650949 - 5/16/21 at 2:29 PM - Blister due to catheter tubing (recorded as Stage II partial thickness 1 cm x 2 cm no depth recorded)
Assessment # 48670103 - 5/17/21 at 2:45 PM _ Blister upper left thigh
Assessment # 48670743 - 5/17/21 at 2:59 PM - Blister to lateral left thigh (recorded as Stage II partial thickness 7 cm x 0.5 cm no depth recorded)

A review of the "Wound Assessment Sheets" on page 2 of each wound sheet labeled all of the wounds listed above as "Vascular" in nature. All assessments for wounds to include the initial assessments were conducted and signed off by LPN B.

On 7/8/21 at 10:13 AM an interview was conducted with the DON (employee B) who stated that skin assessments are performed weekly. She was asked who was in charge of doing the wound assessments and wound care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 67	F 658		

she stated LPN B is our Wound Champion and she "advises the other nurses." When asked if the facility has a wound protocol she stated yes they did. She stated that LPN B would do the initial assessment and that she has credentials for wound care. She further stated that if the wound does not get better or if it worsens the provider (MD or NP) will come and look at it.

On 7/8/21 at approximately 11:00 AM an interview with the "Wound Champion" LPN B who stated that when the Resident developed blisters the doctor told her it was probably vascular, which is why she wrote vascular on the wound assessment sheets. When asked if she was the person who did the initial assessments and staging she stated that she was.

Excerpts from the VA Code 54.1 3000 LPN's Role are as follows:
"Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board."

According to the Virginia Department of Health Professions Website [www.dhp.virginia.gov]

"Assessments: RN vs. LPN"
"LPN - focused assessment -gathers data to contribute to assessment and reports findings/results to RN."
"RN - comprehensive, initial & ongoing - synthesizes the information based on professional nursing judgment and knowledge base."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 658	Continued From page 68 On 7/8/21 at approximately 10:30 an interview was conducted with the Clinical Services Director (employee D) who stated that we have a "Wound Champion" and indicated LPN B was that person. When asked if it was the expectation that LPN B would have an RN sign off on the initial assessments and staging of the wounds she stated that it would be an expectation. The facility submitted copies of the "Credentials" for LPN B they are as follows: Certificate of Participation dated 10/27/2011 - "Nursing insight Pressure Ulcers Taking a Comprehensive look" Certificate of Completion dated 7/27/2015 - "Pressure Ulcers and Differentiation of Non-Pressure Areas: Measuring and Documenting" Certificate of completion dated 4/29/2020 - Wound Dressing Consideration and Categories" Certificate of Completion 11/17/2020 - The Skin and Pressure Injuries (1.0 Training hours) Certificate of Completion dated 5/23/2021 - "Wound dressing Consideration and Categories On 7/9/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.	F 658		
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's	F 678		8/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 69 advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide resuscitation interventions for 1 resident (Resident #54) in a survey sample of 31 residents. For Resident #54, who was a full code, the facility staff failed to provide resuscitation interventions when he was found unresponsive and not breathing. This resulted in harm cited at past non-compliance. The findings include: Resident #54 was admitted to the facility on 1/19/21 for long term care due to increasing confusion and decline in cognitive and physical function. Resident #54 was a "full code" status which indicated resuscitation efforts would be provided if the heart stopped beating or breathing stopped. Review of Resident #54's clinical record revealed an Admission Note dated 1/19/21 which read, "Resident is a FULL CODE", and a physician's order which read, "FULL CODE". Review of the Comprehensive Care Plan, effective date 1/24/21-Present [6/11/21], page 1, "Advance Directives", read "Full Code". Excerpts from page 13 of the Care Plan read, "Resident and RR [Resident Representative] desire FULL CODE status, STATUS: Active (Current), Goals--Resident's FULL CODE status designation will be honored" and "Interventions" included "Staff will respect resident's wishes and	F 678	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 70	F 678		

preferences and will make all reasonable efforts to carry out his/her wishes" and "In the event of cardiopulmonary arrest, resident WILL receive CPR per his/her request, STATUS: Active (Current)".

Review of the nursing notes dated 6/11/21 at 5:30 AM, an entry read, "resident was noted to be shivering stated was cold temp 99.0 rectal denied discomfort or pain given blanket and will continue to observe". The next entry read, "resident expired 0930, no heart nor lung sounds heard upon auscultation, no response to verbal or painful stimuli" that was entered at 9:48 AM, on 6/11/21, by RN A. There was no evidence in the clinical record of CPR being initiated, 911 being called, or any emergency medical treatment being provided to Resident #54 when he was found unresponsive and without vital signs.

Throughout the entire clinical record, there was no evidence to suggest that any emergency medical treatment, to include but not limited to, CPR was attempted or initiated on Resident #54.

On 7/7/21 at approximately 3:15 PM, an interview was conducted with LPN A, who was assigned to take care of Resident #54 on 6/11/21. LPN A stated, "When I came to work that day, I was told that [name redacted, Resident #54] had not been feeling well earlier that morning, I went to check on him around 8 o'clock and he was ok, there didn't appear to be anything wrong with him, he was sleeping on his side, I did not wake him since he wasn't feeling well earlier, I wanted to let him sleep a little bit more, around 9:30ish [name redacted, CNA B] came to let me know that something was not quite right with [Resident #54], when I got to the room he was lying on his right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 71	F 678		

side and looked discolored, I hollered out for [RN A] and checked my clipboard to check his code status, he was full code but [RN A] said he was gone, I got my Unit Manager, [LPN B] and she called the doctor, [MD, name redacted] said [Resident #54] was already deceased, not to do CPR ...I know now that we should have started CPR first".

On 7/7/21 at 3:19 PM, an interview was conducted with CNA A. CNA A was asked about the events involving Resident #54 on 6/11/21. CNA A stated, she had his meal tray and when she attempted to deliver it she didn't find Resident #54 in the common areas, where he normally sits. CNA A then stated, "I went and asked [CNA B name redacted] where he was, she said he wasn't feeling well so he was still in bed. CNA A proceeded to state she went to take the tray into the room and "he wouldn't answer, I'm still fairly new and had never experienced anything like that so I went and got [CNA B name redacted]. She (CNA B) went in, checked his pulse and tried to wake him, she said "oh my God, I think he's gone and went to get [LPN A name redacted], I didn't go back, until I helped [CNA B name redacted] clean him up afterwards". CNA A confirmed that she neglected to initiate CPR despite being CPR certified.

On 7/7/21 at 3:22 PM, an interview was conducted with CNA B. CNA B stated, "[CNA A name redacted] asked where he was and went to take his breakfast tray to him, then she came to me and said "I'm trying to wake him and he won't wake up", so I went in. I could tell he was deceased so I went to get the nurse. [LPN A name redacted] came into the room and she looked him over, she was checking him and [RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 72	F 678		

A name redacted] came to check for a pulse, they said he wasn't alive, he's gone, that was it, so I verified they were done and [CNA A name redacted] and I cleaned him up, gave him a bath and changed him. I didn't even think to check he wasn't a DNR [do not resuscitate], had I known he was a full code I would have started CPR. It was about 3-4 extra people here that day from corporate and they came and said he was a full code and we had to start CPR. Nobody started CPR until after I had cleaned him and he had been laying there an hour". When asked where the breakdown was, CNA B stated, "initially it should have started with the CNA that found him not responding, but I also dropped the ball".

On 7/7/21, a group interview was conducted with the Facility Administrator, the DON, the Staff Educator, and the Clinical Services Director whom all concurred that CPR (cardiopulmonary resuscitation) should have been initiated when Resident #54 was found unresponsive by CNA A and not stopped until either EMT's took over care or the MD ordered CPR to stop.

Review of employee records revealed that all four of the responding staff (CNA A, CNA B, LPN A and RN A) held current and active CPR certification, which included training for determining when to initiate CPR.

The facility policy titled, "Cardio-Pulmonary Resuscitation (CPR)", with a revision date of 1/2/20, read, "Prior to the arrival of emergency medical services (EMS), the staff must initiate CPR when cardiac arrest (cessation of respirations and/or pulse) occurs for residents unless: A Resident has a valid DNR order, or A Resident presents with a completed, Durable Do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 73	F 678		

Not Resuscitate Order form, or A resident presents with a POST form indicating Do not Attempt Resuscitation, or A Resident presents with approved jewelry indicating Do Not Resuscitate, or A physician orders otherwise, or A resident shows American Heart Association signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care 2015. Obvious signs of clinical death, e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition. *** Only a physician can pronounce if unanticipated death. Not an RN, NP or PA".

On 7/7/21, at the end of day meeting, the Facility Administrator, DON, Staff Educator, and the Clinical Services Director were notified that current findings for Resident #54 were being considered at a level 3 severity.

On 7/8/21 at approximately 8:45 AM, the Facility Administrator stated that she had begun an investigation on 7/7/21 and submitted a timeline of events for Resident #54 that occurred on 6/11/21 which read as follows:

Approx 6:30am: per clinical note, nurse states resident not feeling well, rectal temp 99.0

Approx 0700: [CNA B] arrived at work at approximately 0700 and was told in shift change that [name redacted, Resident #54] had a low grade fever overnight and was not feeling well and had been snoring loudly

Approx 0715-0720: Resident [54] noted by [CNA B], to have turned himself over in bed on right side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 74	F 678		

Approx 0800: [LPN A] reports seeing him laying on right side

Approx 0900-0915: [CNA A] went in to give him breakfast and found him lying in the bed unresponsive, she states that she was unable to wake him, she immediately got [CNA B] and they went into the resident's room, then notified [LPN A] who contacted [LPN B], [LPN A] also reports that resident was laying partially on right side, with discoloration to skin noted

Approx 0930: [RN A] pronounced and [LPN B] notified provider, emergency contact for resident was notified, and message was left to call the facility

Approx 0930-1000: The clinical support team onsite were alerted the resident was a full code, the team immediately went to his room and CPR was initiated by [Employee J, RN clinical educator], [MD name redacted] was called by [LPN B], who was on the phone with provider in the hallway and provider gave a verbal order via speaker phone to stop CPR

Approx 1030-1100: Director of Education conducted a huddle to debrief and educated the staff on advanced directives, color coded dots and code blue procedures and if a resident is found without vital signs, the process of what needs to occur, Social Worker pulled current list of all code statuses in the facility and those listed as a full code were reviewed with team members at the huddle, time was allowed for staff to ask questions, and individual team members were followed up with by members of leadership, Social Worker completed 100% audit of resident code status and no discrepancies were noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 678	Continued From page 75 On 7/8/21, the survey team conducted approximately 10 randomly sampled clinical staff interviews to assess their response to the question, "What would you do if you found a resident not breathing"? The staff members were able to provide sufficient answers. On 7/9/21 1:28 PM, an interview was conducted with the survey team and the Medical Director. During this conversation the Medical Director stated that CPR had not been initiated immediately as it should have been. He confirmed that Resident #54 was a full code and staff had not performed any emergency medical treatment measures until at least 30 minutes later after realizing he was a full code. No further information was provided. This deficiency is cited at past non-compliance as it was evidenced through document review and staff interview that the facility corrected the deficient practice on 6/11/21.	F 678		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 76 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to adequately prevent and treat pressure ulcers for 1 Resident (#42) in a survey of 31 Residents. The findings included: For Resident #42 the facility failed to provide heel protection boots to a non-ambulatory resident until after he developed pressure areas to bilateral heels, and right calf. Resident #42 a 69 year old man admitted to the facility on 3/12/21 with diagnoses of but not limited to wedge compression fracture 5th lumbar vertebra, Brown-Sequard Syndrome, autonomic neuropathy, muscle spasm, fracture of neck, non-displaced fracture of 5th cervical vertebra, and injury of cervical spinal cord. Resident #42's MDS (minimum data set) with an ARD (assessment reference date) of 6/16/21 a Quarterly Review coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 14 indicating no cognitive impairment. The MDS also coded the Resident as requiring extensive assistance of 2 staff physical assistance and the mechanical lift for all transfers, and extensive assistance of 2 staff for all aspects of ADL care. He can feed himself and has an electric wheelchair for mobility. On 7/6/21 at approximately 1:00 PM during initial tour of the facility, Resident #42 was observed	F 686	12VAC5-371-220(C)(1) 1. Resident #42 received specialty air mattress on 3/13/2021, which was changed to a low air loss mattress as of 6/9/2021. Resident currently has king size pillows in place on mattress to float heels to prevent development of pressure injuries as of 7/15/21. Resident's care plan was updated with additional preventive measures as of 7/27/21. 2. 100% of non-ambulatory residents were evaluated for interventions to prevent pressure injuries, which includes heel protection boots, and resident care plans were updated as indicated. Residents at risk for skin breakdown continue to be discussed in weekly IDT to ensure appropriate interventions are implemented. 3. Education by the DON/designee will be provided to licensed nurses on ensuring risk interventions for pressure injury prevention and treatment are documented and in place for non-ambulatory residents. 4. Will audit 10% of non-ambulatory residents weekly for 8 weeks to ensure pressure injury prevention and treatment interventions are in place and documented. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 77 sitting in his room in a shower chair about to be transported by mechanical lift to his wheelchair. It was noted that the resident had a towel at his heel with blood on it. After his being transferred an interview was conducted with #42 who stated, "The nurses and staff here are great but the Doctor comes in with his Hollywood attitude and talks about his electric car outside my door for 30 minutes but doesn't have time to look at my wounds? That's just not right. He came in here the other day and said he would be right back and came back over an hour later and told me he would see me next week. I told him to get out of here if he couldn't see me now." The Resident explained that he has been at the facility since March and has developed wounds on his right and left foot and his calf and blisters on different parts of his body at different times. He said "Right now I have 3 areas I'm concerned about my right calf and my feet. The one wound on my leg was really bad at one point the smell was horrible, but it's getting better now." On 7/7/21 a review of the clinical record revealed the following: MDS on admission dated 3/19/21 "Section M - 0210 - Does the resident have any unhealed pressure ulcers stage 1 or higher - 0. NO" MDS (Quarterly) dated 6/16/21 read: "Section M 0300 F. Number of unstageable wounds due to slough or eschar - 4" "M 0300 G - Number of unstageable wounds with suspected deep tissue injury in evolution -1" "M 1030 - Total number of venous and arterial ulcers - 0"	F 686	completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 78	F 686		

The information on all skin and wound issues for this resident was submitted by the facility as a time line. They also submitted the "Wound assessment sheets" to coincide with each listed wound.

Per the document entitled Wounds, Resident #42 developed wounds as follows:

Assessment # 47937912 - 3/24/21 at 11:48 AM - blisters to right wrist (1.5 cm x .5 cm)
Assessment # 47978458 - 3/27/21 at 12:38 PM - Blister to right outer anterior wrist
Assessment # 47978470 - 3/27/21 at 12:41 PM- blisters to right elbow (2 cm x 1.5 cm)
Assessment # 47978479 - 3/3:27 PM/21 at 12:44 -Blisters to left groin
Assessment # 48035076 - 3 /31/21 at 3:32 PM -DTI Sacrum
Assessment # 48035080 - 3/31/21 at 3:35 PM - Deep Tissue Injury to R Sacrum
Assessment # 48035084 - 3/31/21 at 3:38 PM- Deep Tissue Injury to Sacrum area
Assessment # 48122818 - 4/7/21 at 12:35 PM - DTI left Heel - (found at DTI 7 cm x 6 cm)
Assessment # 48196729 - 4/12/21 at 9:59 AM - Blister right upper thigh (recorded as Stage II partial thickness 0.9 cm x 0.6 cm
Assessment # 41896745 - 4/12/21 at 10:03 AM - Blister unstageable
Assessment # 48196760 - 4/12/21 at 10:08 AM - DTI right upper posterior calf (found 4/9/21 6 cm x 2 cm)
Assessment # 48298406 - 4/19/21 at 3:25 PM - open area in DTI unstageable calf (2.5 x .5) [no depth recorded to this open area]
Assessment # 48601073 - 5/12/21 at 1:47 PM -DTI to Right Heel (1 cm x 1 cm)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 79	F 686		

Assessment # 48601161 - 5/12/21 at 1:52 PM - DTI to 5th toe (1.0 cm x 0.5 cm)
Assessment # 48601204 -5/12/21 at 1:57 PM - Blister stage II to left upper thigh (3.0 x 0.5 cm)
Assessment # 48601263 - 5/12/21 at 2:06 PM - DTI's and blister
Assessment # 48650949 - 5/16/21 at 2:29 PM - Blister due to catheter tubing (recorded as Stage II partial thickness 1 cm x 2 cm no depth recorded)
Assessment # 48670103 - 5/17/21 at 2:45 PM _ Blister upper left thigh
Assessment # 48670743 - 5/17/21 at 2:59 PM - Blister to lateral left thigh (recorded as Stage II partial thickness 7 cm x 0.5 cm no depth recorded)

A review of the "Wound Assessment Sheets" on page 2 of each wound sheet labeled all of the wounds listed above as "Vascular" in nature. All assessments for wounds to include the initial assessments were conducted and signed off by LPN B.

On 7/8/21 at 10:13 AM an interview was conducted with the DON (employee B) who stated that skin assessments are performed weekly. She was asked who was in charge of doing the wound assessments and wound care she stated LPN B is our Wound Champion and she "advises the other nurses." When asked if the facility has a wound protocol she stated yes they did. She stated that LPN B would do the initial assessment and that she has credentials for wound care. She further stated that if the wound does not get better or if it worsens the provider (MD or NP) will come and look at it.

On 7/8/21 at approximately 10:30 an interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 80	F 686		

was conducted with the Clinical Services Director (employee D) who stated that we have a "Wound Champion" and indicated LPN B was that person.

On 7/8/21 at approximately 11:00 AM an interview with the "Wound Champion" LPN B who stated that when the Resident developed blisters the doctor told her it was probably vascular, which is why she wrote vascular on the wound assessment sheets. When asked if she was the person who did the initial assessments and staging she stated that she was.

On 7/8/21 a review of the physician notes revealed:
On 4/2/21 "He developed a rash and blisters from the splints he wears to RUE therapy has removed for time being."
"Skin: General: skin is warm and dry
Comments: 2 open blisters to the right inner wrist. Excoriation to right elbow, right lateral back."

4/9/21 "He has been followed by OT who recommended discontinuing his splints d/t skin breakdown from irritation in certain areas."

4/27/21 "Patient has 3 open areas to right posterior calf and DTI to left heel. Current orders are for oil emulsion dressing. Top lower open area without slough, and Vashe and Santyl to areas with slough. Patient reports right leg painful, concerned about wounds."
"Skin - General skin is warm and dry"
"Comments: Right posterior calf with 3 open areas, superior area approx. 2.5 cm x 2 cm, mid area 5.5 cm x3 cm, lower 1.5 cm x 2 cm. Approx. 40% slough, 80% slough and no slough in lower wound peri wound with erythema, greatest in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 81	F 686		

lower wound."
"Open Areas right leg increased drainage and erythema continue Santyl to areas with slough, non-adherent dressing to lower wound. Keflex 500 mg po TID x 7 days." [Keflex antibiotic 500 mg give 3 times a day for 7 days]

"5/12/21 Resident noted to have a DTI to his right heel measuring 1 cm x 1 cm; a DTI to his right 5th toe 1 cm x 0.5 cm; a blister to his left upper right from catheter tubing measuring 3 cm x 0.5 cm and a mole to left mid back that is irritated and bleeding."

"5/14/21 - Wounds - New wounds right heel DTI 1 cm x 1 cm; DTI to his right 5th toe 1 cm x 0.5 cm; a blister to his left upper right from catheter tubing measuring 3 cm x 0.5 cm.
"Resident is a total care for all ADL's. He has an indwelling Foley catheter and is continent of bowel with episodes of incontinence. He currently has 3 new wounds see above. He uses and air mattress and had has heel boots on at all times to help reduce risk of pressure areas. Patient is alert and oriented. He is doing generally well he is concerned about his leg wounds."

6/4/21 - Patient has eschar to left heel. He has open wounds to right leg. Current treatment orders left heel Santyl covered with moist 2 x 2 and foam boarder dressing, skin prep right heel DTI, right upper posterior calf, right mid posterior calf lower posterior calf treat with damp 22 dressing over each of the wounds with ABD pad and wrap with Kling bid. [Twice daily] Patient was seen by wound nurse and orders placed earlier this week."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 82	F 686		

On 7/9/21 at approximately 12:45 PM an interview was conducted with the Medical Director who stated that on Monday he had another Resident who was very ill and he told Resident #42 he would come back to him. When he came back to the room the Resident was upset because he told him he had another appointment he had to get to. He said the Resident became upset and he left the room because the Resident was not having a "good interaction with him." He stated he did not remember the conversation in the hallway but the Resident has "Gone through a lot of trauma and he becomes frustrated with staff. When asked about the wounds he stated that "He has had a lot of wounds of various etiologies." When asked if they were all Vascular in nature he stated that they weren't sure of the thigh blister etiology and the LPN must have "made the leap to vascular and venous ulcers" because I said the swelling and edema could create pressure and form blisters. He indicated that the wounds were not in fact vascular wounds.

A review of the care plan revealed the care plan did not address preventative measures for pressure reduction were measurable or specific excerpts from the care plan read:

"Use preventive measures for positioning and pressure relief in accordance with facility policy. STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM [RN name redacted]"
"Frequency" Column left blank
"Discipline" Column left blank. .

"Encourage resident to re-position or provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 83	F 686		

assistance with turning and repositioning as needed STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM [RN name redacted]"
"Frequency" Column left blank
"Discipline" Column left blank.

"Encourage resident to re-position or provide assistance with turning and repositioning as needed
STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present CREATED: 3/22/2021 3:27:24 PM (RN name redacted)"
"Frequency" Column left blank
"Discipline" Column left blank.

"Apply skin barrier cream per order/protocol
STATUS: Active (Current) EFFECTIVE: 3/19/2021 - Present
CREATED: 3/22/2021 3:27:24 PM (RN, name redacted)"
"Frequency" Column left blank
"Discipline" Column left blank.

"Staff education concerning he is to be transferred in and out of his Power chair using the mechanical lift. STATUS: Active (Current) EFFECTIVE: 4/2/2021 - Present CREATED: 4/5/2021 4:59:55 PM [RN name redacted]
"Frequency -" column left blank
"Discipline Nursing CREATED: 4/5/2021 4:59"

Check skin for redness, skin tears, swelling, or pressure areas. Report any signs of skin breakdown. STATUS: Active (Current) EFFECTIVE: 3/24/2021 - Present CREATED: 3/24/2021 7:17:48 AM" (RN name redacted)
"Frequency" Column left blank

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 686	Continued From page 84 "Discipline" Column left blank. "Elevate RLE, positional changes frequently due to edema STATUS: Active (Current) EFFECTIVE: 3/24/2021 - Present CREATED: 3/24/2021 8:30:36 AM" "Frequency" Column left blank "Discipline" Column left blank. "Place low air loss mattress to bed to assist with pressure reduction. STATUS: Active (Current) EFFECTIVE: 6/9/2021 - Present CREATED: 6/10/2021 11:45:14 AM" (RN name redacted) A review of the physicians orders do not show orders for heel protection boots however it does reflect an order on 6/22/21 for circular foot lift pillow to right lower extremity as tolerated, and an order for low airless mattress for pressure relief on 6/9/21, however this was after wounds developed and worsened. On 7/9/21 during the end of day meeting the Administrator was made aware of the concerns with the development and care of the pressure wounds. No further information was provided.	F 686		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on Observation, staff interview, facility documentation review, and clinical record review,	F 760	12VAC5-371-220 (B) 1. Resident #7 received the medication	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 760	Continued From page 85 the facility staff failed to ensure two Residents were free from significant medication errors (Residents #7, and #23) in a survey sample of 31 Residents. 1. For Resident #7, the facility failed to administer narcotic pain medication timely as ordered by a physician. 2. For Resident #23, the facility failed to administer 5 medications, including a narcotic pain medication timely as ordered by a physician. The findings included: 1. Resident #7, was admitted to the facility on 12-18-12. Diagnoses included; Parkinson's disease, and right shoulder dislocation with pain, contracture right hand, osteoarthritis, and chronic back pain. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4-14-21 was coded as a quarterly assessment. Resident #7 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or, no cognitive impairment. Resident #7 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, hygiene, locomotion, and toileting. On 7-6-21 from 1:00 p.m., until 2:00 p.m., medication pour and pass observations were conducted with Licensed Practical Nurse (LPN) A. Resident #7 received medications at 1:40 p.m. The Resident received tramadol, a narcotic pain reliever and LPN A stated "these are the morning meds, I am just getting them finished."	F 760	on 7/6/21 with no adverse effect. The resident representative and provider were made aware of the delayed time of the medication on 7/27/21. Resident #23 received the medications on 7/6/21 with no adverse effect. The resident representative and provider were made aware of the delayed time of the medications on 7/27/21. 2. 100% of all residents will have an audit of medication pass times to ensure for appropriate scheduling/timing by pharmacist, nursing and/or provider. 3. Licensed nurses will be educated by DON/designee on requirement for ordered medications to be administered timely as ordered by physician, including narcotic pain medication. 4. Will audit 10% weekly of Resident Medication Administration Records to validate that medications/narcotics were administered timely as ordered by the physician. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 760	Continued From page 86	F 760		

Review of the "Medication Administration Record" (MAR) revealed that no time was documented as to the exact time the medication was administered, therefore, the oncoming evening nurse could administer the narcotic pain medication again as soon as 3:00 p.m., and the Resident could experience over sedation.

Review of Resident #7's clinical record revealed valid physician's orders for the pain medication given late. That order was as follows:

Tramadol 50 milligrams one tablet by mouth three times per day.

Those 3 times per day to give the medication, were each listed as a range of time, and are as follows. (1) 8:00 a.m. to 10:00 a.m., (2) 4:00 p.m. to 5:00 p.m., and (3) 9:00 p.m. to 10:00 p.m.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order timely, and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 7-6-21 at 4:00 p.m., the DON (director of nursing), and Corporate Liason stated that the range was going to be changed, and the medications were administered late, which could cause over sedation if given too closely together, and could allow break through pain for the Resident if spaced too far apart. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to administer them timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 760	Continued From page 87	F 760		

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered timely, on 7-6-21 at 4:00 p.m. No further information was provided by the facility.

2. Resident #23, was admitted to the facility on 1-28-20. Diagnoses included; Acute respiatory failure with hypoxia, sacral pressure ulcer, protein deficiency, diabetes, and cardiac/heart disease.

Resident #23's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-12-21 was coded as a significant change assessment. Resident #23 was coded as having a BIMS (brief interview of mental status) score of "unable to complete", or, severe cognitive impairment. Resident #23 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, hygiene, locomotion, and toileting.

On 7-6-21 from 1:00 p.m., until 2:00 p.m., medication pour and pass observations were conducted with Licensed Practical Nurse (LPN) A. Resident #23 received medications at 1:30 p.m. The Resident received the following 5 medications which were ordered to be administered more than once per day, and were to be given during a range of time. They are as follows;

1. Albuterol metered dose inhaler one to two puffs three times per day at 8:00 a.m. to 10:00 a.m., 12:00 p.m. to 2:00 p.m., and 6:00 p.m. to 8:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 760	Continued From page 88	F 760		

2. Flonase nasal steroid one spray in each nare twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

3. Liquicell protein 30 milliliters twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

4. Metoprolol heart medication 50 milligrams twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

5. Hydrocodone narcotic pain reliever 5 milligrams/325 milligrams twice per day at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 p.m.

Other medications were also administered at the time, however, they were only ordered to be administered once per day, and so were not added to the deficient practice. LPN A stated "these are the morning meds, I am just getting them finished."

Review of the "Medication Administration Record" (MAR) revealed that no time was documented as to the exact time the medication was administered, therefore, the oncoming evening nurse could administer the medications early or late, and the Resident could experience poor respiratory, and cardiac results, over sedation, and or lack of pain control.

Review of Resident #23's clinical record revealed valid physician's orders for the multiple significant medications given late.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 760	Continued From page 89 to be given according to the prescriber's order timely, and signed/documented by the administering individual as soon as the medication is given. When interviewed on 7-6-21 at 4:00 p.m., the DON (director of nursing), and Corporate Liason stated that the range was going to be changed, and the medications were administered late, which could cause non-therapeutic side effects, over sedation if given too closely together, and could allow break through pain for the Resident if spaced too far apart. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to administer them timely. The administrator and DON were informed of the failure of the staff to ensure significant medications were administered timely, on 7-6-21 at 4:00 p.m. No further information was provided by the facility.	F 760		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;	F 887		8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 887	Continued From page 90	F 887		

(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 887	Continued From page 91 related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to offer the COVID immunization for 8 Residents (Resident #3, #21, #22, #27, #28, #32, #38, #43) in a survey sample of 31 Residents. The facility staff failed to provide evidence that they offered the COVID vaccination to 8 Residents when they were eligible, despite the facility having vaccines available to administer. The findings included: On 7/7/21 at approximately 11:00 AM, Surveyor A met with the facility Director of Nursing (DON) who is also serving as the facility's Infection Preventionist. During this review Surveyor A asked for a copy of the immunization logs for staff and Residents with regards to COVID immunizations. On 7/7/21, a review of the clinical records were performed to find evidence of immunizations, to include the COVID vaccine. Surveyor A was having difficulty finding the information and asked the facility staff for assistance. The facility staff were reminded at the end of the day meeting on 7/7/21 and again on 7/8/21, that evidence of the vaccine being offered, administered or declined was needed for Residents #3, #21, #22, #27, #28, #32, #38, #43.	F 887	1. Resident #3 no longer resides in the facility as of 7/4/21. Resident #21 no longer resides in the facility as of 7/11/21. Resident #22 refused COVID vaccine on 7/8/21. Resident #27's RR was contacted on 7/8/21 and expressed wanting to discuss further with extended family. Resident #28 received the vaccine on 7/9/21. Resident #31 refused the COVID vaccine on 7/8/21. Resident #38 received the vaccine on 7/9/21. 2. 100% of all new residents and current residents at facility, who have not previously received all doses of COVID vaccine, will be audited to ensure vaccine was offered and documented. 3. Licensed nurses will receive education by the DON/designee on process for offering all new residents the COVID vaccine on admission and to offer the COVID vaccine to all residents who have not previously received all doses of the COVID vaccine at least quarterly. 4. All newly admitted residents and current residents, who have not been fully vaccinated, will be audited to ensure vaccine was offered and discussion was documented in the medical record. The results of the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 887	Continued From page 92 On 7/8/21 at 5:53 PM, the facility DON provided the survey team with the following data: 1. Resident #3 is currently hospitalized and unable to be asked about/offered the COVID vaccine. 2. Resident #21 refused the vaccine on 7/8/21. No further evidence was provided to indicate Resident #21 had been offered the vaccine previously. Resident #21 was admitted to the facility on 11/11/2020. 3. Resident #22 refused the vaccine on 7/8/21. No further evidence was provided to indicate Resident #21 had been offered the vaccine previously. Resident #21 was admitted to the facility on 3/22/2019. 4. Resident #27 indicated "7/8/21 will discuss with extended family". Resident #27 was admitted to the facility on 9/19/2016 and there was no evidence that the COVID vaccine had been discussed or offered previously. 5. Resident #28 on 7/7/21, consented to receive the first dose of the COVID vaccine on 7/9/21. 6. Resident #32 refused the vaccine on 7/8/21. No further evidence was provided to indicate Resident #32 had been offered the vaccine previously. Resident #32 was admitted to the facility on 8/25/2014. 7. Resident #38 on 7/8/21 consented to receive the first dose of the COVID vaccine on 7/9/21. There was no evidence provided to suggest that Resident #38 had been offered or educated on the COVID vaccine prior to 7/8/21, despite she had resided in the facility since 5/27/21. 8. Resident #43 refused the vaccine on 7/8/21. No further evidence was provided to indicate Resident #43 had been offered the vaccine previously. Resident #43 was admitted to the facility on 1/23/2020.	F 887	analysis. 5. All corrective action will be completed by 8/18/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 887	Continued From page 93	F 887		

On 7/9/21 at 10:02 AM, an interview was conducted with the DON. The DON was advised that the documents she submitted suggested that the above referenced Residents had not been offered the vaccine until 7/7 and 7/8. The DON stated that [Resident #28 name redacted] was not eligible for the vaccine in January when they held their vaccine clinic, because she had been COVID positive in December 2021. Surveyor A asked for evidence that following her 90 days of recovery she was offered the vaccine. The DON stated that she didn't have any further information. She said "I know they are offered it on admission and verbally declined but I can't find it". The DON further stated that when vaccines are offered that she does expect this to be documented in the clinical record.

On 7/9/21, during the interview with the DON she was made aware of the concerns regarding the lack of evidence of the COVID vaccine had been offered on the 8 Residents aforementioned.

On 7/9/21 at 12:22 PM, the facility DON confirmed, "COVID vaccine supply is stored centrally at one of our hospitals, and we request doses weekly, which are delivered on Fridays. We have had no difficulty obtaining vaccines for residents or staff who have agreed to receive the vaccine".

Review of the facility policy titled "COVID-Vaccine Documentation" it read, "COVID-19 Vaccinations will be offered to residents/representatives and staff and all staff and residents/representatives will be educated on the COVID-19 vaccine they are offered in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVAL CENTER-MATHEW	603 MAIN STREET 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) COMPLETION DATE
F 887	Continued From page 94 manner they can understand including information on the benefits and risks consistent with the CDC and/or FDA information..... Staff and residents/representatives will be provided the opportunity to refuse the vaccine and/or change their decision about vaccination at any time. Residents: 1. All current residents will be offered the COVID-19 vaccinations well as corresponding fact sheets to the specific vaccination they will receive. 2. During the nursing admission assessment, residents will be provided education on the COVID-19 vaccinations and dates vaccine will be offered at the facility..... 3. Documentation is maintained in the resident's electronic medical record or in the paper chart. A. Resident vaccination information will be documented on the [Company name initials redacted] COVID-19 Vaccine Record. B. COVID-19 Vaccine Education, Consent/Declination Form will be reviewed with the Resident and/or Resident representative as appropriate." No further information was provided to the survey team prior to exit.	F 887		