PRINTED: 08/30/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-MATHEW  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  F 000 INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 07/06/21 through 07/09/21. Significant corrections are required for	TATEMENT OF DEFICIENCII ND PLAN OF CORRECTION		ED:	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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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.  F 000  An unannounced Medicare/Medicaid standard survey was conducted 07/06/21 through 07/09/21. Significant corrections are required for	E 000 Initial Com	omments	E	000			
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.  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.	F 600 SS=G S483.12 Fi Exploitation The reside neglect, m and exploir includes bi corporal pu any physic	was conducted 7/6/21 through 7/9/2 ility was in substantial compliance want 483.73, Requirement for Long-Teacilities. No complaint(s) were ated during the survey.  COMMENTS  Innounced Medicare/Medicaid standwas conducted 07/06/21 through 1. Significant corrections are requirements. The Life Safety Coreport will follow. No complaints we ated during the survey.  Insus in this 60 certified bed facility was in this 60 certified bed facility was ed of 31 resident reviews.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated of 31 resident reviews.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.  Insus in this 60 certified bed facility was ated during the survey.	1. ith 42 rm  F (  ard  ed for .ong code re  as 51 le  F (  f   buse, ty, This and			8/2/21	
§483.12(a) The facility must-							
§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) I	physical al involuntary	I abuse, corporal punishment, or tary seclusion;				(X6) DATE	

Electronically Signed

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

Facility ID: VA0197

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49E215	B. WING _		<del></del>	07/	09/2021
A BUILDING  49E215  NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-MATHEW  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.			REET ADDRESS, CITY, STATE, ZIP CODE 3 MAIN STREET ATHEWS, VA 23109				
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	This REQUIREMENT by: Based on staff interv review, clinical record ensure 1 Resident (R neglect, in a survey s For Resident #54, the in their immediate resurresponsive. The face CPR (cardiopulmonal emergency medical transition of the control of t	iew, facility documentation I review, the facility failed to esident #54) was free from ample of 31 Residents.  e facility staff were negligent sponse when he was found acility staff failed to provide ry resuscitation) or any other reatment, until after en pronounced deceased had been provided, ast non-compliance.  :  sis included but were not hary artery disease), HTN yocardial infarction, disorder.  recent MDS (minimum data tool) with an ARD be date) of 4/8/21 was coded ment. Resident #54 was cognitive impairment and cognitive skills for daily was also coded as having sistance of one staff of daily living.  linical record review it was dent #54 had elected to be a have CPR in the event of	F6	600	Past noncompliance: no plan of correction required.		

I S /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		TE SURVEY MPLETED
		49E215	B. WING		0	7/09/2021
	ROVIDER OR SUPPLIER	ATHEW		STREET ADDRESS, CITY, STATE, ZIP COD 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	of admission that real The Social Worker, E progress note into th at 16:14, that read, " CODE".  Review of the care p revealed an entry tha [responsible represe status", the associate read, "Resident's FU will be honored, thro  Review of the nursin AM, an entry read, "I shivering stated was discomfort or pain gi to observe". The ne expired 0930, no hea upon auscultation, no painful stimuli" that v 6/11/21, by RN A. Ti clinical record of CPI	record on 1/19/21, the day ad, "Full Code".  Employee H, entered a e clinical record on 1/19/21Resident is a FULL  lan for Resident #54 at read, "Resident and RR ntative] desire FULL CODE ed goal for this care plan LL CODE status designation,	F 60	,		
	Throughout the entire no evidence to suggemedical treatment, to CPR was attempted  On 7/7/21 at 3:19 PN conducted with CNA the events involving CNA A stated, she has	e clinical record, there was est that any emergency include but not limited to, or initiated on Resident #54.  M, an interview was A. CNA A was asked about Resident #54 on 6/11/21.  ad his meal tray and when iver it she didn't find Resident				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCT		, ,	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING			07/09/2021
NAME OF PROVIDER		THEW		STREET ADDRESS, CITY, STATE, ZIP COD 603 MAIN STREET MATHEWS, VA 23109		3173372021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
#54 in CNA A name wasn' proce the ro new a so I w (CNA wake and w go baclean she di certific huddle hasn't On 7/ conduname take h me ar wake decean name looked A name said h verifieredact and col wasn' he wa was a corpo	A then stated, "I redacted] when the feeling well so eded to state show and "he wound had never event and got [Ch. B) went in, che him, she said "lent to get [LPN ck, until I helpe him up afterward in the feel. CNA A went event and said "I'm trying up", so I went in the feel went to get [went to get in the feel went to get [went	reas, where he normally sits. went and asked [CNA B re he was, she said he re he was still in bed. CNA A re went to take the tray into re he was still in bed. CNA A re went to take the tray into re went to take that re went to take that re went to take that re was and went to re to wake him and he won't re was checking him and [RN re to check for a pulse, they re was checking him and [RN re to check for a pulse, they re was checking him a bath re was checking him a bath re was check for a pulse, they re signe, that was it, so I re and [CNA A name red him up, gave him a bath re would have started CPR. It re people here that day from re and said he was a full re went to check he re suscitate], had I known re would have started CPR. It re people here that day from re and said he was a full re went to check he re was and bathed him. He	F 6	00		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE SURVEY COMPLETED			
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	·	STREET ADDRESS, CITY, STATE, ZIP C 603 MAIN STREET MATHEWS, VA 23109	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	it should have started him not responding, to the not responding to the not responding to the responding stand RN A) held curre certification, which indinistrator stated investigation on 7/7/21 at approximation of the responding stand RN A) held curre certification, which indinistrator stated investigation on 7/7/21.	was, CNA B stated, "initially with the CNA that found but I also dropped the ball".  w was conducted with LPN hat Resident #54 was a full dhave been performed. Wedged that despite several certified responding to check as not immediately initiated do the Resident deceased.  terview was conducted with ator, the DON, the Corporate ne Corporate Clinical form all concurred that CPR suscitation) should have Resident #54 was found A A and not stopped until for care or the MD ordered for porate Staff Educator or realized that he (Resident they did start CPR. The fed that it (CPR) be stopped. For the stopped was following the incident, all the survey team requested the any and all evidence of the this event.	F6	500		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-N	IATHEW	60	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET ATHEWS, VA 23109	,
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 600	Continued From pa	<u>~</u>	F 600		
	Approx. [approxima	ntely] 6:30am: per clinical note, nt not feeling well, rectal temp			
	approximately 0700 that [name redacted	A B] arrived at work at and was told in shift change d, Resident #54] had a low ht and was not feeling well ng loudly			
		: Resident [54] noted by [CNA nimself over in bed on right			
	Approx. 0800: [LPN on right side	I A] reports seeing him laying			
	breakfast and found unresponsive, she wake him, she imm went into the reside A] who contacted [I	: [CNA A] went in to give him d him lying in the bed states that she was unable to ediately got [CNA B] and they ent's room, then notified [LPN LPN B], [LPN A] also reports lying partially on right side, to skin noted			
	notified provider, er	A] pronounced and [LPN B] nergency contact for resident essage was left to call the			
	onsite were alerted the team immediate was initiated by [En educator], [MD nam	: The clinical support team the resident was a full code, ely went to his room and CPR nployee J, RN clinical ne redacted] was called by on the phone with provider in			

			DATE SURVEY COMPLETED			
		49E215	B. WING			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнем		STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 600	Approx. 1030-1100: It conducted a huddle is staff on advanced dir and code blue proces found without vital signeeds to occur, Soci of all code statuses in as a full code were reat the huddle, time we questions, and indivision followed up with by medical Worker complicated with the survey approximately 10 rar interviews to assess question, "What wou resident not breathin able to provide sufficient of the fallure to providing medication providing care some if, the failure to provide would not say that, I education". During the	Director of Education to debrief and educated the ectives, color coded dots dures and if a resident is gns, the process of what al Worker pulled current list in the facility and those listed eviewed with team members as allowed for staff to ask dual team members were members of leadership, eted 100% audit of resident iscrepancies were noted.  If their response to the id you do if you found a g"? The staff members were ient answers.  If, an interview was acility Administrator. The ked to define neglect, she on, it can be many things, not as, food, safe situations, not one needs". She was asked de CPR or emergency a Resident who is not ered negligent, she stated, "I would say it was a lack of nis interview the facility she had begun a formal 21.	F 60			

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E215	B. WING			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CC 603 MAIN STREET MATHEWS, VA 23109	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	Employee H, the socials, "not being tended needed". Employee is a full code and is for do not perform CPR, H said, "Yeah". She happened and she in called the name of R recall the events on the Resident #54. She is morning some said [I redacted] had died, redacted had confusion".  On 7/9/21 1:28 PM, a with the survey team During this conversa stated that CPR had immediately as it sho confirmed that Resid staff had not perform treatment measures after realizing he was The facility policy title Management Policy" 2/19/21, read, "negle its employees or serve goods and services to necessary to avoid panguish, or emotional and the redaction of the reda	oyee H, the Social Worker. ial worker defined neglect it to, not providing what is H was asked, "If a Resident ound unresponsive and staff is that neglect"? Employee was asked if this has nmediately said "yes" and esident #54. When asked to 6/11/21, with regards to stated, "When I came in that Resident #54 name ny first thought was, Oh my R. I said, I hope they did s. I don't remember who I others were realizing it at the ent down there [to his room] ng and there was a lot of  an interview was conducted and the Medical Director not been initiated ould have been. He ent #54 was a full code and ed any emergency medical until at least 30 minutes later is a full code.  ed, "Abuse Prevention and with a review date of ct is the failure of the facility, vice providers to provide o a resident that are hysical harm, pain, mental	F 60	0		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP COL 603 MAIN STREET MATHEWS, VA 23109	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 600	1/2/20, read "Prior to medical services (EM CPR when cardiac ar respirations and/or puuless: A Resident ha Resident presents with Not Resuscitate Ordersents with a POST Attempt Resuscitation with approved jewelry Resuscitate, or A phyresident shows Americal death as defor CPR and Emerger 2015. Obvious signs mortis, dependent livit transection, or decomphysician can pronou Not an RN, NP or PA The Administrator and were informed of the provide emergency m CPR for Resident #54 at a harm level on 7/8 mid-day debriefing.	with a revision date of the arrival of emergency S), the staff must initiate rest (cessation of ulse) occurs for residents as a valid DNR order, or A th a completed, Durable Do the form, or A resident form indicating Do not a, or A Resident presents or indicating Do Not sician orders otherwise, A can Heart Association signs offined in the AHA Guidelines forcy Cardiovascular Care of clinical death, e.g., rigor dity, decapitation, aposition. *** Only a nnce if unanticipated death.  The desired in the death The desired in the death The desired in the arrival and the death The arrival and the death The desired in the arrival and the death The desir	F	600			
F 607 SS=E	No further information Develop/Implement A CFR(s): 483.12(b)(1): §483.12(b) The facilit	buse/Neglect Policies -(3)	F 6	507			8/18/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING	<u></u>	07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		1 01/03/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 607	§483.12(b)(1) Prohibit neglect, and exploitate misappropriation of results in sappropriation of results in investigate any successive services and sale investigate any successive services and facility (a) Include paragraph §483.95, This REQUIREMENT by:  Based on staff intervand facility document failed to implement the certified nursing assist D, CNA E, CNA F, CN out of a staff sample services Resident (Resident #31 residents.  1. For CNA C, CNA E, CNA H, the facility staverification upon hire failed to verify CNA I's resulted in CNA I work verifying license renelicense on file).  2. On 06/11/21, Resident was found unremembers, (CNA A, C) which were CPR certain type of emergency CPR. This was negled occurrence; and the faimplement their abused.	t and prevent abuse, ion of residents and esident property, sh policies and procedures the allegations, and training as required at is not met as evidenced iews, clinical record reviews, ation review, the facility staff eir abuse policy for 7 stants (CNA) (CNA C, CNA NA G, CNA H, and CNA I) size of 16 CNA's and for one 54) out of a sample size of  CONA E, CNA F, CNA G, aff failed to complete license For CNA I, the facility staff is license renewal which king at the facility without wal (and having an expired  CONA E, CNA F, CNA G, aff failed to complete license For CNA I, the facility without wal (and having an expired  CONA E, CNA F, CNA G, aff failed to complete license For CNA I, the facility without wal (and having an expired	F 60	F607 (SS=E) 12VAC5-371-14 (a)  1. License verification for CNAs F, G, and H was completed on 7/2 CNA1 license renewal was comple 7/29/21. The facility provided 1:1 coaching to CNAs A, B, LPNA, LPRNA on providing emergency care on unresponsive resident on 8/1/2 8/2/21. An investigation was compon 6/11/21 and a FRI was submitte 7/7/21. Resident #54 no longer resthe facility as of 6/11/21. 2. 100% audit of current licensed was audited for license verification hire and that staff have a current a license on 7/29/21. No residents he required CPR since 6/11/21. 3. Education was provided to the Business Office Manager and Hum Resource team member by the Administrator/designee on 7/29/21 requirement to verify licensure veri upon hire by a weekly report with licensure details and verification of	C, D, E, 9/21. eted on  N B and e (CPR) 1 and bleted ed on sides in  d staff i upon ictive ave enan  of the iffication	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/	09/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RIVERSID	E CONVAL CENTER-MA	THEW			03 MAIN STREET			
				M	IATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	÷ 10	F 6	607				
	incident, until after the	e survey began.			renewal by daily alerts from the Board	of		
	The findings included	:			Nursing.  Education was provided to Administrate  DON and Medical Director on 8/2/21 by			
	CNA H, the facility staverification upon hire failed to verify CNA I's resulted in CNA I wor verifying license rene license on file).  On 07/07/21 at approximate memory of the file of th	then called Employee I, a eneralist at another facility in. When asked about the everification for new hires, at license verification should the new employee begins ents. When asked why that oyee I stated "for resident of the employee files, there C, CNA D, CNA E, CNA F, did not have license When Employee G was ectation for completing Employee G stated the should be completed before ed why, Employee G stated take sure they don't have			Nurse Executive/designee on the requirement to immediately review and fully investigate all allegations mistreatment, abuse or neglect per fact Abuse Prevention and Management Policy, and requirement to report result of all investigations to the State Survey Agency.  The clinical staff will be educated by the DON/designee on the procedure to foll if an unresponsive resident is found.  4. Will review 100% of all licensed st for verification of current license upon the and active license for 8 weeks and ongoing.  Will audit all residents found unresponse 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.	ility ss e ow aff nire sive s		
		proximately 12:15 P.M., the ployee file revealed the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	STREET ADDRESS, CITY, STATE, ZIP C 603 MAIN STREET MATHEWS, VA 23109	ODE		
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F 607	from 12/02/2019 thro verification was completed on 05/26/2 license expiration dat "Expire Date", it was A third license verifica 04/19/2021 (19 days expiration date). Emplicense renewal verific completed late.  On 07/08/2021 at applicator of Nursing (Dand provided a copy April 2020 as request surveyor observed the work in April and May the expectation for licindicated that staff shicense is verified. Whimportant, the DON slicensed and competed.  On 07/08/2021, the fall "Abuse Prevention ar reviewed. Under the Procedure/Requiremedocumented, "State I agencies, and application contacted, prior to hir licensure or certificatid determine if the poten standing with the region of the poten standing with the region	employed with the facility ugh 05/23/2021. A license pleted on 11/12/19. Under pate", it was documented, or license verification was 2020 (56 days after the e). Under the header, documented, "03/31/2021." ation was completed on after the previous license ployee G confirmed that the cations for CNA I were considered to the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following of the staffing schedule for ed. The DON and this at CNA I was scheduled to the following the following schedule for ed. The DON and this at CNA I was scheduled to the following schedule for ed. The DON and this at CNA I was scheduled to the following schedule for ed. The DON and this at CNA I was scheduled to the following schedule for ed. The DON and this was tated "to make sure they are ent."  actility's policy entitled, and Management Policy" was neader, "Specific ents" in Section 1 (b) (i) censure and certification able registries, will be et, to validate current on requirements and to not it all employee is in good	F6	607			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
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F 607	Continued From pag	e 12	F 6	607			
	and submitted no fur information by the er	ther documentation or and of survey.					
	code was found unremembers, (CNAA, Change of the control of the co	the policy in such an event by investigation and report the e survey began.  The policy in such an event by investigation and report the e survey began.  The policy in such and report the e survey began.  The policy in such and report the e survey began.  The policy in such and report the e survey began.  The policy in such and report the e survey began.  The policy in such and report the event by investigation and report the event of the event of the survey began.  The policy in such an event by investigation and report the event by investigation and report the event of the event by investigation and report the event and report the					
		physician order entered into record on 1/19/21, the day d, "Full Code".					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW	STREET ADDRESS, CITY, STATE, ZIP CODE  603 MAIN STREET  MATHEWS, VA 23109			
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F 607	Continued From pag	ne 13	F 607			
	progress note into th	Employee H, entered a le clinical record on 1/19/21 Resident is a FULL				
	an entry that read, "I representative] desir associated goal for t	DDE status designation, will				
	AM, an entry read, "I shivering stated was discomfort or pain gi to observe". The ne expired 0930, no her upon auscultation, n painful stimuli" that v 6/11/21, by RN A. T clinical record of CP called, or any emerg being provided to Refound unresponsive  Throughout the entir no evidence to sugg	g notes dated 6/11/21 at 6:30 resident was noted to be cold temp 99.0 rectal denied ven blanket and will continue xt entry read, "resident art nor lung sounds heard or response to verbal or vas entered at 9:48 AM, on here was no evidence in the R being initiated, 911 being rency medical treatment resident #54 when he was and without vital signs.  The clinical record, there was rest that any emergency or include but not limited to,				
		o include but not limited to, or initiated on Resident #54.				
	the events involving CNA A stated, she h	M, an interview was A. CNAA was asked about Resident #54 on 6/11/21. ad his meal tray and when iver it she didn't find Resident				

	OF DEFICIENCIES CORRECTION			(X	3) DATE SURVEY COMPLETED	
		49E215	B. WING			07/09/2021
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F 607	CNA A then stated name redacted] w wasn't feeling well proceeded to state the room and "he new and had never so I went and got (CNA B) went in, of wake him, she sai and went to get [L go back, until I held clean him up after she neglected to in certified. CNA A whuddle afterwards hasn't been talked.  On 7/7/21 at 3:22 conducted with CN name redacted] as take his breakfast me and said "I'm to wake up", so I went deceased so I went name redacted] can looked him over, so I went deceased so I went name redacted and redacted said he wasn't aliv verified they were redacted and I clean changed him. wasn't a DNR [do he was a full code was about 3-4 ext corporate and the code and we had CPR until after I here.	age 14 In areas, where he normally sits. It, "I went and asked [CNA B here he was, she said he so he was still in bed. CNA A eshe went to take the tray into wouldn't answer, I'm still fairly er experienced anything like that [CNA B name redacted]. She checked his pulse and tried to d "oh my God, I think he's gone PN A name redacted], I didn't ped [CNA B name redacted] wards". CNA A confirmed that nitiate CPR despite being CPR ent on to state, "they did a and asked questions but it about since that day".  PM, an interview was NAB. CNAB stated, "[CNA A sked where he was and went to tray to him, then she came to rying to wake him and he won't not in. I could tell he was not to get the nurse. [LPN A ame into the room and she she was checking him and [RN came to check for a pulse, they be, he's gone, that was it, so I done and [CNA A name eaned him up, gave him a bath I didn't even think to check he not resuscitate], had I known I would have started CPR. It are people here that day from y came and said he was a full to start CPR. No body started and cleaned him and he had an hour". When asked where	F 60	07		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY PLETED			
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F 607	Continued From page	e 15 CNA B stated, "initially it	F 6	607			
	not responding, but I On 7/7/21 an intervie A. LPN A confirmed the code and CPR should LPN A further acknows taff who were CPR of Resident #54 CPR wand RN A pronounced.  On the afternoon of 7 conducted with the factor Corporate Clinical Direct asked if this event on #54 was considered a Administrator said "yee (facility reported incided submitted, the Corpo "we decided not to do counterparts" [later in the control of the control of the counterparts [later in the corporate of the counterparts] [later in the control of the counterparts] [later in the counterparts	rate Clinical Director stated, o a FRI after we talked to our lentified as Corporate Office					
	Staff/ Employees E a Administrator was as discussed with the Mistated, "no, I have no When asked if the facteam had met to disc Administrator stated, meeting in May and volume just to approve because it wasn't don The Administrator was cause analysis had be stated, "no". She did educated".	nd Employee F]. The ked if the event had been edical Director and she t talked with him about it". cility QA (Quality Assurance)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
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F 607	Continued From pag		F 60	707			
	APS (Adult Protective Ombudaman on 7/7/2021 re: First and Fir of June 11, 2021. Fir was determined that Resident timely. Act will be completed 7/2 facility provided evide working the day of the not 100% of clinical seconducted with the fact Administrator was as stated, "it is any action providing medication providing medication providing care some if, the failure to provide medical treatment to responsive is consider would not say that, I education". When as her interactions with the Administrator state interactions with the Administrator state interactions with CNA wanted to see how seconducted to see how seconducted with Employee H, the social as full code and is for the failure of the social seconducted with Employee is a full code and is for the failure of the social seconducted with Employee is a full code and is for the failure of the social seconducted with Employee is a full code and is for the failure of the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full code and is for the social seconducted with Employee is a full s	21. This report read, "July 7, hal Facility Reported Incident indings: After investigation, it CPR was not initiated to the ions: All corrective actions (3/21." Additionally, the ence that only the staff is incident had been trained, staff.  M, an interview was excility Administrator. The eleked to define neglect, she on, it can be many things, not is, food, safe situations, not one needs". She was asked de CPR or emergency a Resident who is not ered negligent, she stated, "I would say it was a lack of ked if she would describe staff following the incident, ted and described her in a welfare check, I he was and talk about the inistrator further the facility staff was still actions" as of 7/7/21.  M, an interview was oyee H, the Social Worker, it is worker defined neglect it to, not providing what is H was asked, "if a Resident ound unresponsive and staff is that neglect"? Employee					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 607	called the name of recall the events or Resident #54. She morning some said redacted] had died God, did they do CCPR, he's a full corsaid it to, but I think same time, when I people were scatter confusion".  On 7/9/21 1:28 PM with the survey tean During this convers stated that CPR has immediately as it is confirmed that Resistaff had not perfor treatment measure after realizing he with Director went on to such an event "show health department conducted". He state leadership team are a FRI be submitted when needed and submitted following in-depth investigation for the state of the submitted following in-depth investigation of the submitted following in-depth investigation of the submitted of the submitted of the submitted following in-depth investigation of the submitted following in-depth investig	immediately said "yes" and Resident #54. When asked to a 6/11/21, with regards to a stated, "when I came in that I [Resident #54 name, my first thought was, Oh my PR. I said, I hope they did de. I don't remember who I cothers were realizing it at the went down there [to his room] ring and there was a lot of an interview was conducted mand the Medical Director. It is a full code and med any emergency medical suntil at least 30 minutes later as a full code. The Medical state that he fully anticipated hold have been reported to the and an investigation ated that the facility has a good and he doesn't have to ask that I, they automatically send them the expected a FRI to be a this incident as well as an on conducted. The Medical in that he had attended an Ad in 7/9/21, where the incident was not aware of the details of our root cause analysis being the state of the cause of the details of our root cause analysis being	F	907		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CC A. BUILDING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
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F 607	its employees or services to necessary to avoid planguish, or emotional Designated staff will investigate all allegat abuse. a.) The results be communicated to her designated represofficals in accordance the State Survey Age the incidentb) The analysis for trends an incidentsc) Outside as the local police will the administrator or house dead changes in faprotocols. 6.  The Administrator and were informed of the provide emergency in CPR for Resident #50 on 7/8/21 at 12 noon During this meeting to be upheld as conducting their investigation.	with a review date of ct is the failure of the facility, rice providers to provide of a resident that are hysical harm, pain, mental I distress 4. Investigation. In mediately review and ions or observations of its of all investigations are to othe administrator or his or sentative and to other ewith State law, including to ency, within 5 working days of a organizaiton will conduct and patterns related to investigative bodies, such I be contacted as directed by his or her designeed) The enformance Improvement for trends and patterns for acility policy, practice or acility policy, practice or ded DON (Director of Nursing) facility staff's negligence to nedical treatment to include 4 being considered negligent during a mid-day debriefing. The Corporate Clinical could be considered for past wever, this request is not the facility was still sigiation during the survey ed their plan of correction	F 6	07		
F 609 SS=D	No further information Reporting of Alleged	•	F 6	09		8/18/21

(X3) DATE SURVEY COMPLETED	
7/09/2021	
(X5) COMPLETION DATE	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 609	was found unrespons (CNA A, CNA B, LPN CPR certified, negled emergency medical of staff response was not unusual occurence; a report the event to the and Certification), AP Services), and other at The findings included Resident #54, diagnol limited to: CAD (corol (hypertension), old m diabetes, and anxiety Resident #54's most set) (an assessment reference as a quarterly assess coded as having had moderately impaired decision making. He required extensive as member for activities  On 7/7/21, during a codetermined that Resident Union pulmonary are Resident #54, had a process of the corollar	#54, who was a full code sive. Four staff members, A, RN A), all of which were ted to provide any type of are, to include CPR. The eglegnt, as well as an and the facility staff failed to e OLC (Office of Licensure S (Adult Protective authorities as required.  : sis included but were not mary artery disease), HTN yocardial infarction, disorder.  recent MDS (minimum data tool) with an ARD be date) of 4/8/21 was coded ment. Resident #54 was cognitive impairment and cognitive skills for daily was also coded as having esistance of one staff of daily living.  Ilinical record review it was dent #54 had elected to be a have CPR in the event of est.	F 6	resident on 6/11/2021.  2. All residents who exincident of neglect will have stigation and the fact incident to the state ager have required CPR since 3. The leadership will be the Nurse Executive/des reporting requirements the definition of abuse and/o 8/2/21. Staff will be educ DON/designee on abuse reporting requirements, a follow if unresponsive reand 'mock code drills' win validate performance.  4. All incidents of negle the facility will be audited they were fully investigating accordance with facility Prevention and Manager weekly for 8 weeks and will audit all residents for and have full code status emergency medical care indicated for 8 weeks and results of the audits will be QAPI committee by the Devaluation of compliance monitoring for continuous analysis  5. All corrective actions completed on 8/18/21.	ave an immedia illity will report the ncy. No residence 6/11/21. De educated by ignee on the hat meets the or neglect by cated by the expendence of the sident is found, and procedure to sident is found, and procedure to the to courring at do to validate that ted and reporter by Abuse ment Policy ongoing. und unresponsis to ensure to was provided and do ongoing. The be reported to to DON/designee to and ongoing is improvement	to to to to describe the for	

AND DI AN OF CORRECTION IN IMPER		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		,	07/09/2021	
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F 609	Continued From pag	e 21	F 60	09			
	progress note into th at 16:14, that read, ". CODE".  Review of the carepl an entry that read, "F representative] desir associated goal for the	Employee H, entered a e clinical record on 1/19/21Resident is a FULL an for Resident #54 revealed Resident and RR [responsible e FULL CODE status", the his careplan read, DDE status designation, will					
	AM, an entry read, "r shivering stated was discomfort or pain give to observe". The next expired 0930, no heat upon auscultation, no painful stimuli" that we 6/11/21, by RN A. The	next review".  g notes dated 6/11/21 at 6:30 esident was noted to be cold temp 99.0 rectal denied ven blanket and will continue at entry read, "resident art nor lung sounds heard o response to verbal or vas entered at 9:48 AM, on here was no evidence in the R being initiated, 911 being					
	called, or any emergored being provided to Refound unresponsive a	ency medical treatment sident #54 when he was and without vital signs.					
	no evidence to sugge medical treatment, to	est that any emergency include but not limited to, or initiated on Resident #54.					
	the events involving CNA A stated, she has she attempted to deli #54 in the common a	I, an interview was A. CNAA was asked about Resident #54 on 6/11/21. ad his meal tray and when ver it she didn't find Resident ireas, where he normally sits. I went and asked [CNAB					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUC	CTION		E SURVEY PLETED
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F 609	wasn't feeling well so proceeded to state sh the room and "he won new and had never e so I went and got [CN (CNA B) went in, che wake him, she said "c and went to get [LPN go back, until I helped clean him up afterwarshe neglected to initial certified. CNA A went huddle afterwards an hasn't been talked ab On 7/7/21 at 3:22 PN conducted with CNA name redacted] aske take his breakfast traime and said "I'm tryir wake up", so I went in deceased so I went to name redacted] came looked him over, she A name redacted] came looked him over, she A name redacted] came looked him over, she A name redacted] and I clean and changed him. I do wasn't a DNR [do not he was a full code I went to not he	he he was, she said he he was still in bed. CNA A he went to take the tray into coldn't answer, I'm still fairly experienced anything like that like and pulse and tried to so he my God, I think he's gone and redacted]. I didn't he colon from the	F	009	DEFICIENCY)		
	corporate and they ca code and we had to s CPR until after I had been laying there an the breakdown was,	people here that day from ame and said he was a full start CPR. No body started cleaned him and he had hour". When asked where CNA B stated, "initially it with the CNA that found him					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E215	B. WING		0.	7/09/2021
	ROVIDER OR SUPPLIER  DE CONVAL CENTER-M	ATHEW	STREET ADDRESS, CITY, STATE, ZIP CODE  603 MAIN STREET  MATHEWS, VA 23109			
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F 609	On 7/7/21 an intervit A. LPN A confirmed code and CPR should LPN A further acknows taff who were CPR Resident #54 CPR wand RN A pronounce. In the afternoon of 7 conducted with the flashed if this event of the flashed if the fla	I also dropped the ball".  Lew was conducted with LPN that Resident #54 was a full lid have been performed. Wiedged that despite several certified responding to check was not immediately initiated ed the Resident deceased.  Lettified responding to check was not immediately initiated ed the Resident deceased.  Lettified responding to check was not immediately initiated ed the Resident deceased.  Lettified responding to check was not immediately initiated ed the Resident deceased.  Lettified responding to check was not imitated and the resident and unusual occurrence, the resident and unusual occurrence, the resident lident occurrence, the responsibility of the resident lident in a FRI after we talked to our identified as Corporate Office and Employee F].  Lettified responding to check was not initiated to the tions: All corrective actions 23/21."	F 6	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 609	medical treatment responsive is consive would not say that, education". When a her interactions with the Administrator s interactions with Cl wanted to see how situation". The Administrator interactions with Cl wanted to see how situation". The Administrator in	vide CPR or emergency to a Resident who is not idered negligent, she stated, "I I would say it was a lack of asked if she would describe th staff following the incident, tated and described her NAA as a "welfare check, I she was and talk about the	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			7/09/2021	
	ROVIDER OR SUPPLIER	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	staff had not perform treatment measures after realizing he was Director went on to s such an event "shou health department ar conducted". He state leadership team and a FRI be submitted, when needed and he submitted following t in-depth investigation Director did confirm to the QA meeting on was discussed but we start of the submitted following to the properties of the start of the submitted following to the submitted following to the submitted following the su	ent #54 was a full code and led any emergency medical until at least 30 minutes later is a full code. The Medical tate that he fully anticipated ld have been reported to the	F 60	09			
	Management Policy" 2/19/21, read, "negle its employees or sengoods and services to necessary to avoid panguish, or emotional Designated staff will investigate all allegates abuse. a.) The result be communicated to her designated represofficals in accordance the State Survey Age the incidentb) The analysis for trends at incidentsc) Outside as the local police with the state of the state	ed, "Abuse Prevention and with a review date of ect is the failure of the facility, vice providers to provide to a resident that are hysical harm, pain, mental al distress 4. Investigation. immediately review and tions or observations of es of all investigations are to the administrator or his or esentative and to other e with State law, including to ency, within 5 working days of eroganizaiton will conduct and patterns related to envestigative bodies, such all be contacted as directed by his or her designeed) The					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 609	Committee will monit	e 26 erformance Improvement or trends and patterns for acility policy, practice or	F 609		
F 610 SS=D	CFR(s): 483.12(c)(2) §483.12(c) In respon	Correct Alleged Violation	F 610		8/18/21
	§483.12(c)(3) Prever neglect, exploitation, investigation is in prospective states and investigations to the designated represent accordance with States Survey Agency, with incident, and if the all appropriate corrective This REQUIREMENT by:  Based on staff interview, and clinical refailed to investigate as	nt further potential abuse, or mistreatment while the orgress.  It the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified to action must be taken.  It is not met as evidenced wiew, facility documentation the cord review, the facility an incident of neglect, which occurence, for 1 Resident		<ol> <li>A Facility Reported Incident was submitted on 7/7/21 and resident #54 longer resides in the facility as of 6/11 The facility provided education to CN/B, LPNA, LPNB and RNA on providing emergency care (CPR) on unrespons residents on 6/11/2021.</li> <li>Residents and staff will be intervious residents.</li> </ol>	//21. As A, g ive

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(XX	3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	0110012021	
DIVEDOID	E CONVAL CENTER M	ATLIEVA/		603 MAIN STREET			
KIVEKSID	E CONVAL CENTER-M	AIREW		MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 610	Continued From pag	ge 27	F 6	610			
F 610	On 6/11/21, Resider was found unrespor (CNAA, CNAB, LPI CPR certified, negle emergency medical staff response was runusual occurence; conduct an investigation of the findings included Resident #54, diagnostimited to: CAD (core (hypertension), old rediabetes, and anxiet Resident #54's mosset) (an assessment referer as a quarterly assessored as having harmoderately impaired decision making. He required extensive a member for activities on 7/7/21, during a determined that Resident #54, had a Resident #54, had a Resident #54, had a	at #54, who was a full code isive. Four staff members, NA, RNA), all of which were cted to provide any type of care, to include CPR. The neglegnt, as well as an and the facility staff failed to ation of the event.  d:  osis included but were not conary artery disease), HTN myocardial infarction, by disorder.  trecent MDS (minimum data at tool) with an ARD need ate) of 4/8/21 was coded isment. Resident #54 was discognitive impairment and discognitive skills for daily are was also coded as having issistance of one staff is of daily living.  clinical record review it was also coded to be a control of the event of rest.	F6	to determine if there a neglect or unusual oc they were investigated residents have require 6/11/21.  3. The leadership we the Director of Educated 8/2/21 on the process with medical director, and Clinical Quality the unusual occurrence to investigation and report of the director of th	currence to ensure d and reported. No ed CPR since will be educated by tion/designee on a for collaborating administrator, DON eam after any censure all required orting is completed. by the ocedure to follow if it is found and unusual occurrences ion. eglect and unusual occurrences at the facility will be at they were fully writed in accordance evention and weekly for 8 weeks lit all residents found a code status to edical care was for 8 weeks and of the audits will be committee by the aluation of ing monitoring for ent analysis ions will be	s e	
		Employee H, entered a ne clinical record on 1/19/21					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STAT 603 MAIN STREET MATHEWS, VA 23109	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 610	Continued From pag at 16:14, that read, "CODE".  Review of the careplan entry that read, "Frepresentative] desir associated goal for the "Resident's FULL CODE honored, through Review of the nursing AM, an entry read, "reshivering stated was discomfort or pain give to observe". The next expired 0930, no head upon auscultation, no painful stimuli" that we 6/11/21, by RN A. The clinical record of CPF called, or any emergibeing provided to Refound unresponsive at Throughout the entire no evidence to suggestions.	e 28Resident is a FULL an for Resident #54 revealed Resident and RR [responsible e FULL CODE status", the nis careplan read, DDE status designation, will				
	CPR was attempted On 7/7/21 at 3:19 PN conducted with CNA the events involving CNA A stated, she ha she attempted to deli #54 in the common a CNA A then stated, " name redacted] whe wasn't feeling well so	or initiated on Resident #54.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	MULTIPLE CONSTRUCTION  ILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, 3 603 MAIN STREET MATHEWS, VA 23109	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 610	new and had never eso I went and got [CN (CNAB) went in, chewake him, she said "cand went to get [LPN go back, until I helped clean him up afterwards and hasn't been talked about the conducted with CNAD (CNAB) and conducted with CNAD (CNAB) name redacted] asketake his breakfast trayme and said "I'm tryin wake up", so I went in deceased so I went to name redacted] can looked him over, she A name redacted] can said he wasn't alive, I verified they were doredacted] and I clean and changed him. I can wasn't a DNR [do not he was a full code I was about 3-4 extra prograte and they can code and we had to so CPR until after I had been laying there and the breakdown was, a should have started was atted was atted was atted we had to so code and we started was about have started was about have started was about have started was should have started was atted was att	aldn't answer, I'm still fairly experienced anything like that IA B name redacted]. She cked his pulse and tried to oh my God, I think he's gone A name redacted], I didn't de [CNA B name redacted] rds". CNA A confirmed that late CPR despite being CPR on to state, "they did a desked questions but it out since that day".  I, an interview was B. CNA B stated, "[CNA A de where he was and went to be you to him, then she came to long to wake him and he won't he. I could tell he was a get the nurse. [LPN A de into the room and she was checking him and [RN me to check for a pulse, they he's gone, that was it, so I	F	510			
		w was conducted with LPN					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER	IATHEW	603	REET ADDRESS, CITY, STATE, ZIP CODE  MAIN STREET  THEWS, VA 23109	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 610	A. LPN A confirmed code and CPR should LPN A further acknows staff who were CPR Resident #54 CPR and RN A pronounce on 7/7/21, during the conducted with the Corporate Clinical Edasked if this event of #54 was considered Administrator said "(facility reported incomposite of the Corporate Clinical Edasked if this event of #54 was considered Administrator said "(facility reported incomposite of the Corporate Clinical Edasked if this event of #54 was considered Administrator said "(facility reported incomposite of the Corporate Clinical Edasked in the Corporate Corporate Clinical Edasked in the Corporate Corporat	that Resident #54 was a full all have been performed. Swledged that despite several accrified responding to check was not immediately initiated sed the Resident deceased.  The afternoon, an interview was facility Administrator and Director/Employee D. When so 6/11/21, involving Resident d an unusual occurrence, the yes". When asked if a FRI ident) report had been sorate Clinical Director stated, do a FRI after we talked to our identified as Corporate Office and Employee F].  The y Administrator provided the FRI that had been submitted of Licensure and Certification), we Services), and the findings: After investigation, it at CPR was not initiated to the ctions: All corrective actions	F 610		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From page	e 31	F 6	510		
	talk about the situation	ted to see how she was and n". The Administrator further e facility staff was still tions" as of 7/7/21.				
	Employee H, the socias, "not being tended needed". Employee is a full code and is for do not perform CPR, H said, "yeah". She whappened and she imcalled the name of Rerecall the events on 6 Resident #54. She simorning some said [Fredacted] had died, m God, did they do CPF CPR, he's a full code said it to, but I think of	byee H, the Social Worker. al worker defined neglect to, not providing what is H was asked, "if a Resident bund unresponsive and staff is that neglect"? Employee was asked if this has mediately said "yes" and esident #54. When asked to 6/11/21, with regards to tated, "when I came in that Resident #54 name ny first thought was, Oh my R. I said, I hope they did thers were realizing it at the				
	people were scattering confusion".  On 7/9/21 1:28 PM, a with the survey team During this conversate stated that CPR had immediately as it sho confirmed that Reside staff had not perform treatment measures after realizing he was Director went on to stouch an event "should health department and staff had not perform treatment measures of the staff had not perform the staff had not	uld have been. He ent #54 was a full code and ed any emergency medical until at least 30 minutes later a full code. The Medical ate that he fully anticipated d have been reported to the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		[`		SURVEY LETED
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	603 I	EET ADDRESS, CITY, STATE, ZIP CODE MAIN STREET 'HEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	a FRI be submitted, the when needed and he submitted following the in-depth investigation. Director did confirm the Hoc QA meeting on 7 was discussed but was a full investigation or conducted.  The facility policy title Management Policy 2/19/21, read, "negled its employees or services to necessary to avoid phanguish, or emotional Designated staff will investigate all allegation abuse. a.) The results be communicated to the designated represofficals in accordance the State Survey Age the incidentsb) The analysis for trends an incidentsc) Outside as the local police will the administrator or he Quality Assurance/Pec Committee will monitored.	the doesn't have to ask that hey automatically send them expected a FRI to be his incident as well as an conducted. The Medical hat he had attended an Ad (79/21, where the incident as not aware of the details of root cause analysis being d, "Abuse Prevention and with a review date of ct is the failure of the facility, ice providers to provide a resident that are hysical harm, pain, mental distress 4. Investigation. Immediately review and hons or observations of so of all investigations are to the administrator or his or sentative and to other with State law, including to ncy, within 5 working days of organizaiton will conduct he patterns related to investigative bodies, such the contacted as directed by its or her designeed) The enformance Improvement or trends and patterns for acility policy, practice or	F	510			
	140 Iditalor Illiorniauor	i was provided.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _		07/09/202 <sup>2</sup>	1
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	-
				603 MAIN STREET		
RIVERSID	E CONVAL CENTER-	MATHEW		MATHEWS, VA 23109		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION (X5	5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLI	ETION
F 641	Continued From pa	age 33	F 6	41		
F 641	Accuracy of Asses	- <del>-</del>	F 6	41	8/18/2	1 I
SS=D					0/10/2	
		cy of Assessments.				
		nust accurately reflect the				
	resident's status.					
		NT is not met as evidenced				
	by:	diam internieus feathir.		42)/AC E 274 250/A)/4)/C) an		
		ation, interview, facility  d clinical record review the		12VAC 5-371-250(A)(1)(6) an 12VAC5-371-250(D)	J	
		o accurately reflect status of		1. Resident #42 documentat	ion and	
		sments for 1 Resident (#42) in		assessment was corrected to		
	a survey sample or	• •		resident's condition by the DO		
	a carvey cample c	101 Rosidonio.		on 7/31/21. Resident #42's ME	· ·	
				assessment was completed ar		
	The findings include	led:		submitted to reflect current find		
				before 8/18/21.		
	For Resident #42 t	the facility documentation and		2. Skin observations were c	ompleted on	
	assessments do no	ot accurately reflect the		all residents on or before 8/3/2	1. MDS	
	Resident's condition	on.		assessments will be completed	d to reflect	
				new pressure injuries on/or be	fore	
		year old man admitted to the		8/18/2021.		
		with diagnoses of but not				
		ompression fracture 5th lumbar		3. LPN B and DON were pro	vided	
	· ·	equard Syndrome, autonomic		education by the Director of		
		e spasm, fracture of neck,		Education/designee on ¬¬¬¬8		
	•	ture of 5th cervical vertebra,		regarding the requirement for I		
		cal spinal cord. Resident #42's		findings to be reviewed by RN		
		( minimum data set) with an		Provider. MDS Coordinator wa		
	,	reference date) of 6/16/21, a		on ensuring MDSs are current	anu	
		coded the Resident as having a ew of Mental Status) score of		consistent with wound status documentation by the Director	of Clinical	
	,	ognitive impairment. The MDS		Reimbursement/designee on 7		
		sident as requiring extensive		Treimbursement designee on 7	10012021.	
		off physical assistance and the		4. Two resident charts will be	e audited	
		all transfers, and extensive		weekly for 8 weeks to validate		
		off for all aspects of ADL care.		and completion of wound asse	-	
		elf can bear some weight with		the RN or provider. Two reside	-	
		however he is unable to stand		will be audited weekly for 8 we		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/	09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		6	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	tour of the facility, Re sitting in his room in a transported by mechalt was noted that the heel with blood on it. an interview was conductor comes in with talks about his electric minutes but doesn't h	mately 1:00 PM during initial sident #42 was observed a shower chair about to be anical lift to his wheelchair. resident had a towel at his After his being transferred ducted with #42 who stated, if here are great but the his Hollywood attitude and c car outside my door for 30 have time to look at my	F	641	accurate MDS wound coding by the Director of Clinical Reimbursement/designee. The results the audits will be reported to the QAPI committee by the DON/designee for evaluation of compliance and ongoing monitoring for continuous improvemen analysis  5. All corrective actions will be completed by 8/18/21.			
	the other day and said came back over an ho would see me next we here if he couldn't see explained that he has March and has develor and left foot and his of parts of his body at di "Right now I have 3 a my right calf and my fo	not right. He came in here d he would be right back and our later and told me he eek. I told him to get out of e me now." The Resident s been at the facility since oped wounds on his right calf and blisters on different different times. He said direas I'm concerned about feet. The one wound on my one point the smell was ag better now."						
	the following: MDS on admission da "Section M - 0210 - D	loes the resident have any cers stage 1 or higher - 0.						
		umber of unstageable						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING	B. WING		07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	suspected deep tissu "M 1030 - Total numb ulcers - 0"  The information on al	e 35 of unstageable wounds with e injury in evolution -1" er of venous and arterial I skin and wound issues for mitted by the facility as a	F	641			
	time line. They also s assessment sheets" t wound.	submitted the "Wound o coincide with each listed					
	Per the document end developed wounds as	titled Wounds, Resident #42 s follows:					
	blisters to right wrist ( Assessment # 47978 Blister to right outer a Assessment # 47978 blisters to right elbow Assessment # 47978 -Blisters to left groin	458 - 3/27/21 at 12:38 PM - nterior wrist 470 - 3/27/21 at 12:41 PM-					
	Assessment # 48035 Deep Tissue Injury to Assessment # 48035 Deep Tissue Injury to Assessment # 48122 DTI left Heel - (found Assessment # 48196 Blister right upper this partial thickness 0.9 of Assessment # 41896 Blister unstageable Assessment # 48196	084 - 3/31/21 at 3:38 PM- Sacrum area 818 - 4/7/21 at 12:35 PM - at DTI 7 cm x 6 cm) 729 - 4/12/21 at 9:59 AM - gh (recorded as Stage II					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49E215	B. WING		07/	09/2021
	ROVIDER OR SUPPLIER	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 641	open area in DTI undepth recorded to the Assessment # 4860 -DTI to Right Heel (*Assessment # 4860 DTI to 5th toe (1.0 c Assessment # 4860 Blister stage II to left Assessment # 4860 DTI's and blister Assessment # 4865 Blister due to cathet II partial thickness 1 recorded) Assessment # 4867 Blister upper left thig Assessment # 4867 Blister to lateral left partial thickness 7 crecorded) A review of the "Word page 2 of each would wounds listed above assessments for wo assessments were conducted with the I stated that skin asses weekly. She was as doing the wound assessment as word they did. She stated to the stated that skin asses weekly. She was as doing the wound as she stated LPN B is she "advises the oth the facility has a word they did. She stated	stageable calf (2.5 x .5) [no is open area] 1073 - 5/12/21 at 1:47 PM 1 cm x 1 cm) 1161 - 5/12/21 at 1:52 PM - 1204 - 5/12/21 at 1:57 PM - 1204 - 5/12/21 at 1:57 PM - 1204 - 5/12/21 at 2:06 PM - 1204 - 5/12/21 at 2:06 PM - 1204 - 5/12/21 at 2:29 PM - 1204 - 5/16/21 at 2:29 PM - 1205 - 5/16/21 at 2:59 PM - 1206 - 5/17/21 at 2:59 PM - 1207 - 5/17/21 at 2:59 PM - 1208 - 5/17/21 at 2:59 PM - 1209 - 5/16/21 at 2:59 PM - 1209 - 5/17/21 at 2:59 PM - 120	F 64			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMF	PLETED
		49E215	B. WING		07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 641	wound does not get to provider (MD or NP) or	further stated that if the better or if it worsens the will come and look at it.  Inately 10:30 an interview the Clinical Services Director ated that we have a "Wound ated LPN B was that person. The expectation that LPN B and off on the initial ging of the wounds she are an expectation.  Inately 11:00 AM an interview mpion" LPN B who stated the developed blisters the probably vascular, which is arron the wound when asked if she was the itial assessments and at she was.  India were observed by and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel wound is dry and the left foot has heavy the right heel."	F 64	.1		
F 656 SS=G		Comprehensive Care Plan	F 65	6		8/2/21

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		6	TREET ADDRESS, CITY, STATE, ZIP CODE  03 MAIN STREET  MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	implement a compreh care plan for each respectives and timefra medical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483.2 provided due to the reunder §483.10, including treatment under §483.3 (iii) Any specialized screhabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation with resident's representation (A) The resident's good desired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's community was assessible call contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate,	cility must develop and densive person-centered sident, consistent with the sth at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial died in the comprehensive exprehensive care plan must great to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6).  Between the furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6).  Between the furnished to attain ent's medical record in the resident and the tive(s)-als for admission and efference and potential for desire to return to the essed and any referrals to se and/or other appropriate	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		07/09/2021		
	ROVIDER OR SUPPLIER  DE CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION		
F 656	section. This REQUIREMEN by: Based on staff inter and facility documer failed to implement the for 1 resident (Resident of 31 residents.) For Resident #54, the implement resuscitation his comprehensive found unresponsive in harm at past non-The findings include Resident #54 was at 1/19/21 for long term confusion and declir function. Resident #which indicated result provided if the heart stopped.  Review of Resident an Admission Note of "Resident is a FULL order which read, "FReview of the Compeffective date 1/24/2" "Advance Directives from page 13 of the and RR [Resident Resident R	T is not met as evidenced  view, clinical record review, ntation review, the facility staff he comprehensive care plan ent #54) in a survey sample  de facility staff failed to tion interventions as indicated we care plan when he was and not breathing, resulting compliance.  dmitted to the facility on a care due to increasing the in cognitive and physical secitation efforts would be stopped beating or breathing  #54's clinical record revealed dated 1/19/21 which read, CODE", and a physician's full CODE".  rehensive Care Plan, 1-Present [6/11/21], page 1, ", read "Full Code". Excerpts Care Plan read, "Resident epresentative] desire FULL US: Active (Current),	F 656	Past noncompliance: no plan of correction required.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	1, ,	E SURVEY PLETED
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	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE  603 MAIN STREET  MATHEWS, VA 23109	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	to carry out his/her of cardiopulmonary arr CPR per his/her req (Current)".  Review of the nursing AM, an entry read, "shivering stated was discomfort or pain got to observe". The neexpired 0930, no he upon auscultation, repainful stimuli" that of 6/11/21, by RN A. To clinical record of CP called, or any emergibeing provided to Refound unresponsive.  Throughout the entire no evidence to sugge medical treatment, to CPR was attempted.  On 7/7/21 at approximate was conducted with take care of Resider stated, "When I came that [name redacted feeling well earlier than the manner of the was sleeping on his he wasn't feeling well earlier than the care of the came than the came that sleep a little bit more redacted, CNA B] casomething was not considered.	make all reasonable efforts vishes" and "In the event of est, resident WILL receive uest, STATUS: Active  and notes dated 6/11/21 at 5:30 resident was noted to be cold temp 99.0 rectal denied iven blanket and will continue ext entry read, "resident art nor lung sounds heard to response to verbal or was entered at 9:48 AM, on there was no evidence in the R being initiated, 911 being gency medical treatment esident #54 when he was and without vital signs.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated on Resident #54.  The clinical record, there was test that any emergency or include but not limited to, or initiated to have assigned to the first that any emergency or include but not limited to, or initiated on Resident #54.	F 65			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		OATE SURVEY OMPLETED
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F 656	side and looked discomplished and checked my status, he was full concerning and checked my status, he was full concerning and checked my status, he was full concerning and checked my status, he was full conducted the doctor, [M [Resident #54] was a CPRI know now the CPR first".  On 7/7/21 at 3:19 Proceeded with CNA the events involving CNA a stated, she has he attempted to de #54 in the common and CNA at then stated, name redacted] where wasn't feeling wells in proceeded to state is the room and "he wo new and had never so I went and got [C (CNA B) went in, checked him, she said and went to get [LPP] go back, until I helpe clean him up afterwashe neglected to initicertified.  On 7/7/21 at 3:22 Proceeded with CNA name redacted] asket take his breakfast trame and said "I'm tryiwake up", so I went	colored, I hollered out for [RN clipboard to check his code ode but [RN A] said he was Manager, [LPN B] and she D, name redacted] said already deceased, not to do nat we should have started  M, an interview was A. CNA A was asked about Resident #54 on 6/11/21. and his meal tray and when liver it she didn't find Resident areas, where he normally sits. If went and asked [CNA B are he was, she said he on he was still in bed. CNA A are went to take the tray into buildn't answer, I'm still fairly experienced anything like that NA B name redacted]. She ecked his pulse and tried to only his pulse and tried to are considered. CNA A confirmed that interview was AB. CNA B stated, "[CNA A end where he was and went to any to him, then she came to ng to wake him and he won't in. I could tell he was	F	656		
	conducted with CNA name redacted] ask take his breakfast tra me and said "I'm tryi wake up", so I went deceased so I went name redacted] cam	B. CNA B stated, "[CNA A ed where he was and went to ay to him, then she came to ng to wake him and he won't				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			7/09/2021	
	ROVIDER OR SUPPLIER  DE CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP COI 603 MAIN STREET MATHEWS, VA 23109	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	A name redacted] casaid he wasn't alive, verified they were do redacted] and I clear and changed him. I wasn't a DNR [do not he was a full code I was about 3-4 extra corporate and they code and we had to CPR until after I had been laying there and the breakdown was, should have started not responding, but  On 7/7/21, a group in the Facility Administ Educator, and the Cowhom all concurred resuscitation) should Resident #54 was for and not stopped until or the MD ordered COn 7/8/21 at approximately of events for Reside 6/11/21 which read a Approx 6:30am: per resident not feeling was Approx 0700: [CNA approximately 0700 that [name redacted]	here to check for a pulse, they he's gone, that was it, so I one and [CNA A name ned him up, gave him a bath didn't even think to check he of resuscitate], had I known would have started CPR. It people here that day from came and said he was a full start CPR. Nobody started cleaned him and he had a hour". When asked where CNA B stated, "initially it with the CNA that found him I also dropped the ball".  Interview was conducted with rator, the DON, the Staff linical Services Director that CPR (cardiopulmonary if have been initiated when bund unresponsive by CNA A if either EMT's took over care conducted a timeline in the staff linical services of the stop.  Interview was conducted with rator, the DON, the Staff linical Services Director that CPR (cardiopulmonary if have been initiated when bund unresponsive by CNA A if either EMT's took over care conducted a timeline in the staff linical note, nurse states well, rectal temp 99.0	F 65	6			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	, ,	E SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From pag	e 43	F 6	556		
	1	Resident [54] noted by [CNA mself over in bed on right				
	Approx 0800: [LPN A on right side	ɪ] reports seeing him laying				
	breakfast and found unresponsive, she st wake him, she imme went into the residen A] who contacted [LF	ates that she was unable to diately got [CNA B] and they t's room, then notified [LPN PN B], [LPN A] also reports ing partially on right side,				
	notified provider, em	pronounced and [LPN B] ergency contact for resident ssage was left to call the				
	onsite were alerted the team immediately was initiated by [Empeducator], [MD name [LPN B], who was on	redacted] was called by the phone with provider in ider gave a verbal order via				
	staff on advanced dir and code blue proced found without vital signeeds to occur, Socio of all code statuses in	Director of Education to debrief and educated the rectives, color coded dots dures and if a resident is gns, the process of what al Worker pulled current list in the facility and those listed eviewed with team members				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	at the huddle, time we questions, and individe followed up with by me Social Worker comples code status and no decode status and status and resident not breathing able to provide sufficionable to provide sufficional Review of employee of the responding status and RN A) held currecertification, which indetermining when to determining when to read, "Purpose:the resident's unique patients."	as allowed for staff to ask dual team members were nembers of leadership, eted 100% audit of resident iscrepancies were noted.  The team conducted domly sampled clinical staff their response to the dyou do if you found a graph of the team to the ent answers.  The staff members were ent answers.  The cords revealed that all four ff (CNAA, CNAB, LPNA) and active CPR cluded training for initiate CPR.  The spolicy entitled, "Resident evision date 12/15/2020, care plan becomes each	F 6	56		
F 657 SS=D	it was evidenced thro staff interview that the deficient practice on ( Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comple-	I Revision (i)-(iii) ensive Care Plans orehensive care plan must 7 days after completion of	F 6	57		8/18/21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		49E215	B. WING		0	7/09/2021	
	NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-MATHEW			STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	includes but is not lir (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent prather resident and the An explanation must medical record if the and their resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and revite am after each assecomprehensive and assessments. This REQUIREMENT by: Based on observation documentation and of facility staff failed to comprehensive care with measurable goal Resident (#42) in a serior Resident #42 the and implement a correct and implement a correct resident.	nterdisciplinary team, that mited to ysician.  se with responsibility for the or resident's representative(s). The participation of the resident or resident or professionals in the resident or professionals in the resident. The resident or resident or resident or resident or resident or resident.  The resident or professionals in the resident or resident or resident or resident. The resident or resident. The resident or resident.  The resident or resident's needs or resident or res	F 65	) 12VAC5-371-250(F)  1. Care plan for Resident #42 reviewed and updated to accura resident's skin status with reside centered focused interventions a measurable goals and objective 7/16/21.  2. 100% audit of all residents who have pressure injuries will he resident centered care plans wit measurable goals and objective 3. The Director of Clinical Reimbursement/designee will ed Interdisciplinary Team including Coordinator. Director of Nursing	ately reflect ent and s on in facility have h s. ducate the MDS		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		60	TREET ADDRESS, CITY, STATE, ZIP CODE D3 MAIN STREET IATHEWS, VA 23109	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	assessments do not a Resident's condition.  Resident #42, a 69 ye facility on 3/12/21 wit limited to wedge comvertebra, Brown-Sequence particular and injury of cervical most recent MDS (mark)	facility documentation and accurately reflect the  ear old man admitted to the h diagnoses of but not pression fracture 5th lumbar uard Syndrome, autonomic spasm, fracture of neck, e of 5th cervical vertebra, spinal cord. Resident #42's inimum data set) with an ference date) of 6/16/21, a ded the Resident as having a of Mental Status) score of itive impairment. The MDS ent as requiring extensive ohysical assistance and the transfers, and extensive for all aspects of ADL care. can bear some weight with wever he is unable to stand	F 6	957	Services Director, Activities Director, a Director of Rehabilitation on developing comprehensive care plans that are resident centered with measurable goal 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 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.	g als 3 d I be	
	talks about his electri minutes but doesn't h wounds? That's just r the other day and sai	c car outside my door for 30 lave time to look at my not right. He came in here d he would be right back and our later and told me he					

	/IDER/SUPPLIER/CLIA FIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION		E SURVEY PLETED
	49E215	B. WING _			07.	/09/2021
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-MATHEW			603 MA	ADDRESS, CITY, STATE, ZIP CODE IN STREET EWS, VA 23109		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657 Continued From page 47 would see me next week. I tol here if he couldn't see me now explained that he has been at March and has developed wou and left foot and his calf and b parts of his body at different tir "Right now I have 3 areas I'm my right calf and my feet. The leg was really bad at one point horrible, but it's getting better r  On 7/7/21 at approximately 1:1 was conducted with LPN B wh purpose of the care plan was t the patient. To address each o inform the staff of how  A review of the care plan revea objectives were not specific an all aspects of care often the dis to perform the care) was left b frequency of the interventions excerpts are as follows:  "Use preventive measures for pressure relief in accordance w STATUS: Active (Current) EFF 3/19/2021 - Present CREATED 3:27:24 PM [RN name redacte "Frequency" Column left blank "Discipline" Column left blank "Encourage resident to re-posi assistance with turning and rep needed STATUS: Active (Curre 3/19/2021 - Present CREATED 3:27:24 PM [RN name redacte "Frequency" Column left blank "Discipline" Column left blank "Discipline" Column left blank "Discipline" Column left blank "Discipline" Column left blank	the facility since and so his right listers on different mes. He said concerned about one wound on my the smell was now."  If PM an interview of stated the office direct the care off of his needs and to alled the care planted did not address scipline (who was also left blank, positioning and with facility policy. ECTIVE: D: 3/22/2021 ad]"  Ition or provide positioning as sent) EFFECTIVE: D: 3/22/2021 ad]"	F6	657			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		6	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET NATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	assistance with turning needed STATUS: Active (Curt 3/19/2021 - Present C 3:27:24 PM (RN name "Frequency" Column "Discipline" Column Research Research Column	to re-position or provide g and repositioning as rent) EFFECTIVE: CREATED: 3/22/2021 e redacted)" left blank eft blank.  earn per order/protocol rent) EFFECTIVE: I 3:27:24 PM (RN, name left blank eft blank.  erning he is to be of his Power chair using the US: Active (Current) I - Present CREATED: [RN name redacted] left blank REATED: 4/5/2021 4:59"  ess, skin tears, swelling, or or any signs of skin Active (Current) 21 - Present CREATED: //" (RN name redacted) left blank eft blank eft blank.	F	657	DEFICIENCY)		
	to edema STATUS: A	nal changes frequently due ctive (Current) EFFECTIVE: CREATED: 3/24/2021					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658 SS=D	pressure reduction. SEFFECTIVE: 6/9/202 6/10/2021 11:45:14 A "Frequency" Column Discipline" Column Discipline" Column In A review of the physicany boots for heel proreflect an order on 6/2 pillow to right lower ewas after the wound and no further informations. Services Provided McCFR(s): 483.21(b)(3) S483.21(b)(3) Composition CFR(s): 483.21(b)(3) S483.21(b)(3) Composition CFR(s): 483.21(b)(3) CFR(s): 483.21(b)(3) CFR(s): 483.21(b)(3) CFR(s): 483.21(b)(3) CFR(s): 483.21(b)(3) CFR(s): 483.21(	left blank.  attress to bed to assist with ETATUS: Active (Current) 1 - Present CREATED: M" (RN name redacted) left blank.  cians orders do not show of tection however it does 22/21 for circular foot lift extremity as tolerated this appeared.  end of day meeting the ade aware of the concerns ation was provided.  eet Professional Standards (i)  ehensive Care Plans dor arranged by the facility, mprehensive care plan,  standards of quality.  standards of quality.  is not met as evidenced  iew, facility documentation cord review, the facility staff in accordance with is of practice for 4 Residents ent #42, Resident #7,	F 6		n the eived erse d y in 23 th	8/18/21

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		49E215	B. WING _			07	/09/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
DI (500)				6	03 MAIN STREET		
RIVERSID	E CONVAL CENTER-MA	IHEW		N	MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	∍ 50	F 6	558			
		orovide any emergency cluding CPR, when he was			aware of the delay in medications administered. On 8/2/21 the DON/designee provided education to the LPN B on wound observation and sta		
	2. For Resident #7, t administer narcotic pa ordered by a physicia	ain medication timely as			related to her scope of practice.  2. No residents who are a full code has required any emergency medical treatment, including CPR since 6/11/2	nave	
		the facility failed to ons, including a narcotic y as ordered by a physician.			100% of all residents will have an aud medication pass times to ensure for appropriate scheduling/timing by pharmacist, nursing and/or provider.		
	care according to pro by having an LPN per	ging, which is out of the			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 unresponsive resident found by team	g	
	The findings included:  1. For Resident #54, who was a full code, the facility staff failed to provide any emergency				members. Licensed nurses will be educated by DON/designee on requirement for orded medications to be administered timely ordered by physician, including narcot pain medication.	as	
	medical treatment, in				Licensed nurses will be educated by DON/designee on professional standa of care including tasks such as wound observation and staging.		
		-			4. Will audit all residents found unresponsive and have full code statu ensure emergency medical care was provided as indicated for 8 weeks and ongoing.	s to	
	set) (an assessment of (assessment reference as a quarterly assess coded as having had	recent MDS (minimum data tool) with an ARD ce date) of 4/8/21 was coded ment. Resident #54 was cognitive impairment and cognitive skills for daily			Will audit 10% of Resident Medication Administration Records weekly to valid that medications/narcotics were administered timely as ordered by physician. Will audit pressure injury documentation	late	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	гнеw		603	REET ADDRESS, CITY, STATE, ZIP CODE  MAIN STREET  THEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	decision making. He required extensive as member for activities  On 7/7/21, during a cl determined that Reside Full Code, wishing to cardio pulmonary arrest Resident #54, had a phis electronic clinical of admission that read of admission that read. The Social Worker, E progress note into the at 16:14, that read, " CODE".  Review of the carepla an entry that read, "R representative] desire associated goal for th "Resident's FULL CO be honored, through resident's FULL CO be honored, through resident's FULL CO be honored, through resident's read, "resident's FULL CO be honored, through resident's FULL CO be honored, through resident was discomfort or pain give to observe". The next expired 0930, no head upon auscultation, no painful stimuli" that we 6/11/21, by RN A. The clinical record of CPR called, or any emerger	was also coded as having sistance of one staff of daily living.  inical record review it was dent #54 had elected to be a have CPR in the event of est.  Ohysician order entered into record on 1/19/21, the day d, "Full Code".  Imployee H, entered a eclinical record on 1/19/21Resident is a FULL  In for Resident #54 revealed esident and RR [responsible effull CODE status", the is careplan read, DE status designation, will next review".  In notes dated 6/11/21 at 6:30 esident was noted to be cold temp 99.0 rectal denied en blanket and will continue tentry read, "resident rt nor lung sounds heard response to verbal or as entered at 9:48 AM, on ere was no evidence in the dening initiated, 911 being ency medical treatment sident #54 when he was	F 6		weekly to validate that that wound observation, including staging were completed by an RN and/or Provider. It results of the audits will be reported to QAPI committee by the DON/designee evaluation of compliance and ongoing monitoring for continuous improvement analysis.  5. All corrective actions will be completed by 8/18/21.	the for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING	<del></del>	07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 658	Throughout the entir no evidence to sugg medical treatment, to CPR was attempted  On 7/7/21 at 3:19 PN conducted with CNA the events involving CNA A stated, she has the attempted to del #54 in the common at CNA A then stated, "name redacted] whe wasn't feeling well so proceeded to state so the room and "he wonew and had never so I went and got [C (CNA B) went in, che wake him, she said and went to get [LPN go back, until I helpe clean him up afterwashe neglected to initic certified. CNA A wenhuddle afterwards an hasn't been talked at On 7/7/21 at 3:22 PN conducted with CNA name redacted] aske take his breakfast trame and said "I'm tryi wake up", so I went	e clinical record, there was est that any emergency of include but not limited to, or initiated on Resident #54.  M, an interview was A. CNA A was asked about Resident #54 on 6/11/21.  and his meal tray and when iver it she didn't find Resident areas, where he normally sits. I went and asked [CNA B are he was, she said he of he was still in bed. CNA A he went to take the tray into outdn't answer, I'm still fairly experienced anything like that NA B name redacted]. She ecked his pulse and tried to both my God, I think he's gone of I A name redacted, I didn't are CPR despite being CPR to no to state, "they did a and asked questions but it bout since that day".  M, an interview was B. CNA B stated, "[CNA A end where he was and went to any to him, then she came to no go to wake him and he won't in. I could tell he was	F 65	58	
	name redacted] cam looked him over, she A name redacted] ca	to get the nurse. [LPN A e into the room and she was checking him and [RN ame to check for a pulse, they he's gone, that was it, so I			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP COE 603 MAIN STREET MATHEWS, VA 23109		7770372021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	redacted] and I clear and changed him. I wasn't a DNR [do no he was a full code I was about 3-4 extra corporate and they code and we had to code and we had to come the breakdown was, should have started not responding, but I on 7/7/21 an interviet A. LPN A confirmed to code and CPR shoul LPN A further acknowstaff who were CPR Resident #54 CPR wand RN A pronounce of the responding stand RN A) held currecertification from the which included training this conversa stated that CPR had immediately as it should that Resid staff had not perform treatment measures after realizing he was stated that staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Resid staff had not perform treatment measures after realizing he was stated that confirmed that Residual that confirmed that Residual that confirmed that Residual that confirmed that confirmed that Residual that the confirmed that	ne and [CNA A name and indicated him up, gave him a bath didn't even think to check he tresuscitate], had I known would have started CPR. It people here that day from ame and said he was a full start CPR. No body started cleaned him and he had hour". When asked where CNA B stated, "initially it with the CNA that found him also dropped the ball".  We was conducted with LPN that Resident #54 was a full d have been performed. Wedged that despite several certified responding to check was not immediately initiated d the Resident deceased.  Trecords revealed that all four aff (CNA A, CNA B, LPN A tent and active CPR.  American Heart Association, and in when to initiate CPR.  The initiated and the Medical Director. It is not the Medical Director and the Medical Director not been initiated and thave been. He ent #54 was a full code and ed any emergency medical until at least 30 minutes later	F 65			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY 603 MAIN STREET MATHEWS, VA 2310			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	(Office of Licensure a Protective Services), 7/7/21. This report re and Final Facility Rej 2021. Findings: Afte determined that CPR Resident timely".  The facility policy title Resuscitation (CPR) 1/2/20, read "Prior to medical services (ENCPR when cardiac a respirations and/or punless: A Resident h Resident presents with A POS Attempt Resuscitate Orde presents with a POS Attempt Resuscitation with approved jewelr Resuscitate, or A phyresident shows Amer of clinical death as defor CPR and Emerge 2015. Obvious signs mortis, dependent livit transection, or decomphysician can pronoun Not an RN, NP or PAC On 7/8/21, the facility team with the training Association that is us their staff. The Amer defines the following Life Support training,	RI (Facility Reported en submitted to the OLC and Certification), APS (Adult and the Ombudaman on ad, "July 7, 2021 re: First ported Incident of June 11, r investigation, it was a was not initiated to the ed, "Cardio-Pulmonary with a revision date of the arrival of emergency (AS), the staff must initiate rrest (cessation of ulse) occurs for residents as a valid DNR order, or A (A) in a completed, Durable Doer form, or A resident T form indicating Do not an, or A Resident presents by indicating Do Not a visician orders otherwise, A condican Heart Association signs befined in the AHA Guidelines and Cardiovascular Care and of clinical death, e.g., rigoridity, decapitation, and position. *** Only a condition of the American Heart Association "Critical Skills" in their Basic "Critical Skills" in their Basic	F	658			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE COMF	SURVEY
		49E215	B. WING _		07/	/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 658	starting compression determining the sce responsiveness by the form help/directs som AED/defibrillator, chonormal breathing, chormal breathing, chormal breathing, chormal breathing, chormal breaths by using a breath breaths by using a breath by using a brea	victim and activates e system (this must precede ns) within 30 seconds. After ne is safe: checks for apping and shouting, shouts eone to call for help and get ecks for no breathing or no necks carotid pulse. 2. ry chest compressions ons immediately after nc arrest). 3. Provides 2 parrier device. 4. Performs pressions and breaths for a. 6. Resumes compressions".  and DON (Director of Nursing) a facility staff's negligence to medical treatment to include a being considered failure to standards on 7/8/21 at 12 day debriefing. During this ate Clinical Director asked if this incident could be non-compliance. However, non-compliance is not able the facility was still estigation during the survey, heir plan of correction prior to ey, and the QA (Quality ee had not meet until 7/9/21.  on was provided.	F 6	58		
	documentation revie	on, staff interview, facility ew, and clinical record review, d to maintain professional e for medication				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		49E215	B. WING _			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		60	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET IATHEWS, VA 23109		
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F 658	Continued From page	e 56	F	558			
		ng two Residents (Residents vey sample of 31 Residents.					
		ne facility failed to administer tion timely as ordered by a					
		the facility failed to ions, including a narcotic y as ordered by a physician.					
	The findings included	l:					
	12-18-12. Diagnoses disease, and right sh	admitted to the facility on sincluded; Parkinson's oulder dislocation with pain, d, osteoarthritis, and chronic					
	set) with an ARD (ass 4-14-21 was coded a Resident #7 was cod interview of mental st possible 15, or, no c Resident #7 was also extensive to total ass activities of daily livin						
	conducted with Licen A. Resident #7 recei The Resident receive	pass observations were sed Practical Nurse (LPN) ved medications at 1:40 p.m. d tramadol, a narcotic pain ated "these are the morning					
	Review of the "Medic	ation Administration Record"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW	60	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET ATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 658	to the exact time the administered, theref nurse could administered nurse could administered nurse could administered nurse could administered nurse could experience of the c	in no time was documented as emedication was fore, the oncoming evening ster the narcotic pain a soon as 3:00 p.m., and the erience over sedation.  #7's clinical record revealed sters for the pain medication er was as follows:  ams one tablet by mouth three  ay to give the medication, a range of time, and are as a to 10:00 a.m., (2) 4:00 p.m.  by 9:00 p.m. to 10:00 p.m.  y's policy entitled, "Medication saled that all medications are go to the prescriber's order ocumented by the dual as soon as the  ed "Mosby's" as their clinical reference. The reference following excerpt;  a Administration  e on the order and the patient.  dentify himself/herself.  to use technology (for example,	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		49E215	B. WING	<del> </del>	07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 658	current drug referen  If necessary, ca another nurse calcu A. Right route Again, check th of the route ordered Confirm that the the medication by th S. Right time Check the frequ medication. Double-check th dose at the correct t Confirm when th Again, check the S. Right time Check the frequ medication. Double-check th dose at the correct t Confirm when th Charles the time, information as neces of an injection or any that needed to be ch Right reason Confirm the rati medication. What is he/she taking this m	r. riateness of the dose using a ce. liculate the dose and have late the dose as well. e order and appropriateness e patient can take or receive e ordered route. liency of the ordered late you are giving the ordered lime. he last dose was given. ion linistration AFTER giving the route, and any other specific essary. For example, the site y laboratory value or vital sign necked before giving the drug. onale for the ordered of the patient's history? Why is	F 65		
	" Make sure that effect. If an antihypo his/her blood pressurpatient verbalize impon an antidepressar" Be sure to documents.	the drug led to the desired ertensive was given, has are improved? Does the provement in depression while at? Imment your monitoring of the er nursing interventions that			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		DATE SURVEY COMPLETED
		49E215	B. WING			07/09/2021
	ROVIDER OR SUPPLIER	ATHEW	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	are applicable.  When interviewed of DON (director of nurstated that the range and the medications which could cause of closely together, and pain for the Residen DON stated her expadminister medication physician's orders at The administrator ar failure of the staff to medications were according to the staff to t	n 7-6-21 at 4:00 p.m., the sing), and Corporate Liason was going to be changed, were administered late, ver sedation if given too discould allow break through tif spaced too far apart. The ectation was for staff to ons and treatments per and to administer them timely.	F 65	58		
	1-28-20. Diagnoses failure with hypoxia, deficiency, diabetes, Resident #23's most set) with an ARD (as 5-12-21 was coded assessment. Reside a BIMS (brief intervie "unable to complete impairment. Reside requiring extensive to perform activities of mobility, transferring toileting.	as admitted to the facility on included; Acute respiatory sacral pressure ulcer, protein and cardiac/heart disease.  Trecent MDS (minimum data seessment reference date) of as a significant change ent #23 was coded as having ew of mental status) score of ', or, severe cognitive nt #23 was also coded as to total assistance of staff to daily living, such as bed , hygiene, locomotion, and				
	On 7-6-21 from 1:00	p.m., until 2:00 p.m.,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		60	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET IATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	conducted with Licen A. Resident #23 recorp.m. The Resident remedications which wadministered more that to be given during a refollows;  1. Albuterol metered three times per day at 12:00 p.m. to 2:00 p. p.m.  2. Flonase nasal ster twice per day at 8:00 p.m. to 8:00 p.m.  3. Liquicell protein 30 8:00 a.m. to 10:00 a. p.m.  4. Metoprolol heart matwice per day at 8:00 p.m. to 8:00 p.m.  5. Hydrocodone naro milligrams/325 milligrams/325 milligram. to 10:00 a.m., at the conduction of the medications was time, however, they wadministered once per added to the deficient "these are the morning them finished."	pass observations were used Practical Nurse (LPN) elived medications at 1:30 eccived the following 5 ere ordered to be man once per day, and were range of time. They are as dose inhaler one to two puffs at 8:00 a.m. to 10:00 a.m., m., and 6:00 p.m. to 8:00 eccived the following 5 ere ordered to be man once per day, and were range of time. They are as dose inhaler one to two puffs at 8:00 a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 eccive the following states a.m. to 10:00 a.m., and 6:00 p.m. to 8:00 eccive the following states a.m. to 10:00 a.m., and 6:00 eccive the following states a.m. to 10:00 a.m., and 6:00 eccive the following states a.m. to 10:00 a.m., and 6:00 eccive the following states a.m. to 10:00 a.m., and 6:00 eccive the following states are also as a fo	F	658			

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	49E215	B. WING _			07/	09/2021
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		F6	658			
administered, therefo nurse could administe late, and the Residen respiratory, and cardi	re, the oncoming evening er the medications early or it could experience poor ac results, over sedation,					
valid physician's orde	ers for the multiple significant					
Administration" reveato be given according timely, and signed/do	aled that all medications are to the prescriber's order ocumented by the					
standard of practice r	reference. The reference					
1. Right patient  " Check the name  " Use 2 identifiers."  " Ask patient to ide  " When available, bar-code system).  2. Right medication  " Check the medic  " Check the order.  3. Right dose  " Check the order.  " Confirm appropricurrent drug reference  " If necessary, calcanother nurse calculated.	on the order and the patient. entify himself/herself. use technology (for example, eation label. diateness of the dose using a e. culate the dose and have					
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA  SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page to the exact time the administered, therefo nurse could administe late, and the Residen respiratory, and cardi and or lack of pain co Review of Resident # valid physician's orde medications given lat  Review of the facility' Administration" revea to be given according timely, and signed/do administering individu medication is given.  The facility staff state standard of practice r review revealed the for Rights of Medication 1. Right patient " Check the name " Use 2 identifiers " Ask patient to ide " When available, bar-code system). 2. Right medication " Check the medic " Check the order. 3. Right dose " Check the order. " Confirm appropri current drug reference " If necessary, cali	A9E215  ROVIDER OR SUPPLIER  E CONVAL CENTER-MATHEW  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 61 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.	ROVIDER OR SUPPLIER  E CONVAL CENTER-MATHEW  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 61  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 medication label.  " Check the order.  3. Right dose  " Check the order.  " Confirm appropriateness of the dose using a current drug reference."  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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 658	of the route ordered " Confirm that the the medication by the 5. Right time " Check the frequenced and the medication. " Double-check the dose at the correct and the correct and the time, information as neces of an injection or an that needed to be correct and the time, information as neces of an injection or an that needed to be correct and the reason " Confirm the rate and the reason " Confirm the rate and the sure that effect. If an antihyphis/her blood presson " Make sure that effect. If an antihyphis/her blood presson patient verbalize im on an antidepressan " Be sure to door patient and any other applicable.  When interviewed corrected and the medications which could cause in the co	the order and appropriateness l.  the patient can take or receive the ordered route.  The patient can take or receive the ordered route.  The last of the ordered the last dose was given. The last dose was given. The last dose was given to the last dose was given. The last dose was given the site of last last last last last last last last	F 658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 658	spaced too far apart. expectation was for some dications and treat orders and to adminite the administrator and failure of the staff to medications were administrators.	rough pain for the Resident if The DON stated her staff to administer atments per physician's ster them timely.  d DON were informed of the	F 65	8	
	care according to pro by having an LPN pe	aging, which is out of the			
	1	e facility documentation and accurately reflect the			
	facility on 3/12/21 will limited to wedge convertebra, Brown-Sequeuropathy, muscle non-displaced fractuand injury of cervical most recent MDS (nach and Compart of the comp	rear old man admitted to the th diagnoses of but not appression fracture 5th lumbar uard Syndrome, autonomic spasm, fracture of neck, re of 5th cervical vertebra, spinal cord. Resident #42's minimum data set) with an afference date) of 6/16/21, a ded the Resident as having a wof Mental Status) score of intive impairment. The MDS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP COD 603 MAIN STREET MATHEWS, VA 23109	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag		F6	58			
	assistance of 2 staff mechanical lift for all assistance of 2 staff He can feed himself the sit to stand lift ho or walk, and has an emobility.  On 7/6/21 at approxitour of the facility, Resitting in his room in transported by mechalt was noted that the heel with blood on it. an interview was consumed to the sit wounds? That's just the other day and sa came back over an hould see me next where if he couldn't see explained that he has March and has devel and left foot and his oparts of his body at disparts of his body at disparts of his body at the result of the sit of the see that have a sit of the sit of the see that have a sit of the see that he have a sit of the see that he have a sit of the see that have a sit	f the clinical record revealed					
		Does the resident have any Icers stage 1 or higher - 0.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTR A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 658	wounds due to sloug "M 0300 G - Number suspected deep tisse "M 1030 - Total num ulcers - 0"  The information on a this resident was sul time line. They also assessment sheets" wound.  Per the document er developed wounds a Assessment # 4793; blisters to right wrist	ed 6/16/21 read: Number of unstageable th or eschar - 4" of unstageable wounds with the injury in evolution -1" ther of venous and arterial all skin and wound issues for comitted by the facility as a submitted the "Wound to coincide with each listed attitled Wounds, Resident #42 as follows:  7912 - 3/24/21 at 11:48 AM - (1.5 cm x .5 cm)	F 65	58	
	Blister to right outer Assessment # 47978 blisters to right elbow Assessment # 47978 -Blisters to left groin Assessment # 48038 -DTI Sacrum Assessment # 48038 Deep Tissue Injury to Assessment # 48128 DTI left Heel - (found Assessment # 48198	3470 - 3/27/21 at 12:41 PM- v (2 cm x 1.5 cm) 3479 - 3/3:27 PM/21 at 12:44 5076 - 3 /31/21 at 3:32 PM 5080 - 3/31/21 at 3:35 PM - c R Sacrum 5084 - 3/31/21 at 3:38 PM- c Sacrum area 2818 - 4/7/21 at 12:35 PM - d at DTI 7 cm x 6 cm) 5729 - 4/12/21 at 9:59 AM - igh (recorded as Stage II			

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER	NATHEW	6	STREET ADDRESS, CITY, STATE, ZIP CODE 103 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 658	Blister unstageable Assessment # 4819 DTI right upper positive to the light of the	96745 - 4/12/21 at 10:03 AM - 96760 - 4/12/21 at 10:08 AM - 98406 - 4/19/21 at 3:25 PM - 98406 - 4/19/21 at 3:25 PM - 98406 - 4/19/21 at 1:47 PM 901073 - 5/12/21 at 1:47 PM 901161 - 5/12/21 at 1:52 PM - 901204 - 5/12/21 at 1:57 PM - 901204 - 5/12/21 at 1:57 PM - 901204 - 5/12/21 at 2:06 PM - 901204 - 5/16/21 at 2:29 PM -	F 658			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш	•	STREET ADDRESS, CITY, STATE, ZIP COD 603 MAIN STREET MATHEWS, VA 23109	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 658	she stated LPN B is of she "advises the other the facility has a wou they did. She stated initial assessment and for wound care. She wound does not get be	be 67 bur Wound Champion and ber nurses." When asked if and protocol she stated yes that LPN B would do the did that she has credentials further stated that if the better or if it worsens the will come and look at it.	F6	658		
	with the "Wound Cha that when the Reside doctor told her it was why she wrote vascu assessment sheets.	When asked if she was the itial assessments and				
	are as follows: "Practical nursing or performed under the licensed medical prac nurse, registered nur nurse or other license authorized by regulat According to the Virg	inia Department of Health				
	"Assessments: RN vs "LPN - focused assess contribute to assessr findings/results to RN "RN - comprehensive synthesizes the information."	esment -gathers data to nent and reports I." e, initial & ongoing -				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	49E215	B. WING _		07/	09/2021
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-I	MATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658 Continued From pa	age 68	F 6	58		
was conducted wit (employee D) who Champion" and inc When asked if it was would have an RN assessments and stated that it would The facility submitt for LPN B they are Certificate of Partic "Nursing insight Pr Comprehensive loc Certificate of Comp "Pressure Ulcers a Pressure Areas: M Certificate of comp Wound Dressing C Certificate of Comp and Pressure Injur Certificate of Comp "Wound dressing C Certificate of Comp "Wound dressing C Certificate of Comp "Certificate o	cipation dated 10/27/2011 - essure Ulcers Taking a bk"  Deletion dated 7/27/2015 - nd Differentiation of Non- easuring and Documenting"  Deletion dated 4/29/2020 - onsideration and Categories"  Deletion 11/17/2020 - The Skin es (1.0 Training hours)  Deletion dated 5/23/2021 - Consideration and Categories  The end of day conference the made aware of the concerns mation was provided.  Resuscitation (CPR)	F 6	78		8/2/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW	6	STREET ADDRESS, CITY, STATE, ZIP CODE 503 MAIN STREET MATHEWS, VA 23109	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 678	Continued From pag	e 69	F 678		
	by: Based on staff intervand facility documen failed to provide resu	T is not met as evidenced view, clinical record review, tation review, the facility staff ascitation interventions for 1 54) in a survey sample of 31		Past noncompliance: no plan of correction required.	
	staff failed to provide when he was found or	ho was a full code, the facility resuscitation interventions unresponsive and not ted in harm cited at past			
	The findings include:				
	1/19/21 for long term confusion and declin function. Resident #8 which indicated resu	dmitted to the facility on a care due to increasing e in cognitive and physical 54 was a "full code" status scitation efforts would be stopped beating or breathing			
	an Admission Note d	#54's clinical record revealed lated 1/19/21 which read, CODE", and a physician's ULL CODE".			
	effective date 1/24/2 "Advance Directives' from page 13 of the and RR [Resident Recode status, STATI GoalsResident's Flatesignation will be here."	,			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	1	STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 678	preferences and will to carry out his/her w cardiopulmonary arred CPR per his/her required (Current)".  Review of the nursing AM, an entry read, "reshivering stated was discomfort or pain give to observe". The next expired 0930, no head upon auscultation, no painful stimuli" that w 6/11/21, by RN A. The clinical record of CPE called, or any emerge being provided to Refound unresponsive at Throughout the entire no evidence to suggest medical treatment, to CPR was attempted of CPE was attempted of CPE was attempted of the care of Resident stated, "When I came that [name redacted, feeling well earlier that on him around 8 o'cloud didn't appear to be at was sleeping on his she wasn't feeling well sleep a little bit more, redacted, CNA B] car something was not questions.	make all reasonable efforts ishes" and "In the event of st, resident WILL receive	F 6	578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E215	B. WING		,	07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 678	A] and checked my of status, he was full corgone, I got my Unit No called the doctor, [M [Resident #54] was a CPRI know now the CPR first".  On 7/7/21 at 3:19 PN conducted with CNA the events involving CNA A stated, she has the attempted to del #54 in the common a CNA A then stated, "name redacted] whe wasn't feeling well so proceeded to state so the room and "he wonew and had never so I went and got [C (CNA B) went in, che wake him, she said "and went to get [LPN go back, until I helpe clean him up afterwashe neglected to initic certified.  On 7/7/21 at 3:22 PN conducted with CNA name redacted] asket take his breakfast trame and said "I'm tryi wake up", so I went in deceased so I went in name redacted] came reda	colored, I hollered out for [RN clipboard to check his code ode but [RN A] said he was Manager, [LPN B] and she D, name redacted] said already deceased, not to do nat we should have started  M, an interview was A. CNA A was asked about Resident #54 on 6/11/21. and his meal tray and when iver it she didn't find Resident areas, where he normally sits. I went and asked [CNA B are he was, she said he of he was still in bed. CNA A he went to take the tray into couldn't answer, I'm still fairly experienced anything like that NA B name redacted]. She ecked his pulse and tried to oh my God, I think he's gone of I A name redacted], I didn't and [CNA B name redacted] ards". CNA A confirmed that ate CPR despite being CPR	F 67			

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			07/09/2021	
	ROVIDER OR SUPPLIER	THEW		STREET ADDRESS, CITY, STATE, ZIP COI 603 MAIN STREET MATHEWS, VA 23109	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 678	said he wasn't alive, verified they were do redacted] and I clear and changed him. I wasn't a DNR [do no he was a full code I was about 3-4 extra corporate and they code and we had to CPR until after I had been laying there an the breakdown was, should have started not responding, but I On 7/7/21, a group in the Facility Administr Educator, and the Cl whom all concurred resuscitation) should Resident #54 was fo and not stopped untio or the MD ordered C Review of employee of the responding stand RN A) held curre certification, which in determining when to The facility policy title Resuscitation (CPR) 1/2/20, read, "Prior to medical services (EM CPR when cardiac a respirations and/or punless: A Resident h	me to check for a pulse, they he's gone, that was it, so I ne and [CNA A name led him up, gave him a bath didn't even think to check he tresuscitate], had I known would have started CPR. It people here that day from ame and said he was a full start CPR. Nobody started cleaned him and he had hour". When asked where CNA B stated, "initially it with the CNA that found him also dropped the ball".  Interview was conducted with lator, the DON, the Staff inical Services Director hat CPR (cardiopulmonary have been initiated when lund unresponsive by CNA A leither EMT's took over care PR to stop.  Trecords revealed that all four lift (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A leither EMT's took over care left (CNA A, CNA B, LPN A left (CNA A, CN	F 67	78			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	` ,	DATE SURVEY OMPLETED
		49E215	B. WING _			07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	STREET ADDRESS, CITY, STATE 603 MAIN STREET MATHEWS, VA 23109	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTI' CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 678	Not Resuscitate Order presents with a POST Attempt Resuscitation with approved jewelry Resuscitate, or A phyresident shows Ameriof clinical death as defor CPR and Emerger 2015. Obvious signs mortis, dependent livit transection, or decomphysician can pronou Not an RN, NP or PA'  On 7/7/21, at the end Administrator, DON, SC Clinical Services Direcurrent findings for Reconsidered at a level On 7/8/21 at approxim Administrator stated to investigation on 7/7/2 of events for Residen 6/11/21 which read as Approx 6:30am: per coresident not feeling we Approx 0700: [CNA Beapproximately 0700 at that [name redacted, grade fever overnight and had been snoring Approx 0715-0720: Resident 0715	r form, or A resident form indicating Do not n, or A Resident presents r indicating Do Not sician orders otherwise, or A can Heart Association signs fined in the AHA Guidelines ncy Cardiovascular Care of clinical death, e.g., rigor dity, decapitation, position. *** Only a nce if unanticipated death.  of day meeting, the Facility Staff Educator, and the ctor were notified that esident #54 were being 3 severity.  nately 8:45 AM, the Facility hat she had begun an 1 and submitted a timeline t #54 that occurred on s follows:  linical note, nurse states ell, rectal temp 99.0  ] arrived at work at nd was told in shift change Resident #54] had a low and was not feeling well	F	678		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 678	Approx 0800: [LPN A on right side  Approx 0900-0915: [Coreakfast and found hunresponsive, she stawake him, she immedwent into the resident A] who contacted [LP that resident was layi with discoloration to so approx 0930: [RN A] notified provider, emewas notified, and mestacility  Approx 0930-1000: Tonsite were alerted the team immediately was initiated by [Empeducator], [MD name [LPN B], who was on the hallway and provispeaker phone to sto approx 1030-1100: Doconducted a huddle to staff on advanced dinand code blue proceed found without vital signeeds to occur, Social of all code statuses in as a full code were reat the huddle, time was questions, and individed followed up with by mesocial Worker complete.	CNA A] went in to give him him lying in the bed lates that she was unable to diately got [CNA B] and they let's room, then notified [LPN let B], [LPN A] also reports and partially on right side, skin noted  pronounced and [LPN B] let gency contact for resident let sage was left to call the let clinical support team the resident was a full code, went to his room and CPR loyee J, RN clinical redacted] was called by the phone with provider in der gave a verbal order via p CPR	F 67	8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE COMPLETION
F 678	Continued From page	e 75	F 67	8	
	interviews to assess question, "What woul resident not breathing able to provide suffice."  On 7/9/21 1:28 PM, a with the survey team During this conversal stated that CPR had immediately as it should confirmed that Residestaff had not perform treatment measures.	adomly sampled clinical staff their response to the ld you do if you found a g"? The staff members were ient answers.  In interview was conducted and the Medical Director. Ition the Medical Director not been initiated ould have been. He ent #54 was a full code and ed any emergency medical until at least 30 minutes later is a full code. No further			
F 686 SS=G	it was evidenced throstaff interview that the deficient practice on Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ§483.25(b)(1) Pressu Based on the compreresident, the facility n (i) A resident received professional standard pressure ulcers and oulcers unless the indidemonstrates that the (ii) A resident with president with with president with with president with with with with with with with wit	grity	F 68	6	8/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	1, ,	X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page promote healing, promote healing, promote healing, promote with the protection both the protection boots to a until after he developilateral heels, and in Resident with the protection boots to a until after he developilateral heels, and in Resident #42 a 69 y facility on 3/12/21 w limited to wedge convertebra, Brown-Seconeuropathy, muscle non-displaced fractuand injury of cervical MDS (minimum dat (assessment referer	ge 76 event infection and prevent reloping. T is not met as evidenced on, interview, facility clinical record review the adequately prevent and treat I Resident (#42) in a survey  d: e facility failed to provide heel a non-ambulatory resident ped pressure areas to right calf.  ear old man admitted to the ith diagnoses of but not impression fracture 5th lumbar quard Syndrome, autonomic spasm, fracture of neck, ire of 5th cervical vertebra, I spinal cord. Resident #42's	F 6	DEFICIENCY)	sialty air as as as of sking size bat heels ure ccare l 21. sidents to includes ent care l own kly IDT to are gnee will on essure		
	14 indicating no cog also coded the Resi assistance of 2 staff mechanical lift for al assistance of 2 staff He can feed himself wheelchair for mobil			non-ambulatory residents.  4. Will audit 10% of non-ambu residents weekly for 8 weeks to pressure injury prevention and trinterventions are in place and documented. The results of the abe reported to the QAPI committ DON/designee for evaluation of compliance and ongoing monitor continuous improvement analysis	ensure reatment audits will ree by the		
		esident #42 was observed		5. All corrective actions will be			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		,	07/09/2021
	ROVIDER OR SUPPLIER  DE CONVAL CENTER-MA	ATHEW	STREET ADDRESS, CITY, STATE, ZIP CODE  603 MAIN STREET  MATHEWS, VA 23109			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	sitting in his room in transported by mech It was noted that the heel with blood on it an interview was con "The nurses and sta Doctor comes in with talks about his elect minutes but doesn't wounds? That's just the other day and sa came back over an I would see me next where if he couldn't see explained that he had March and has dever and left foot and his parts of his body at a "Right now I have 3 my right calf and my leg was really bad a horrible, but it's getting."  On 7/7/21 a review of the following:  MDS on admission of "Section M - 0210 - unhealed pressure to NO"  MDS (Quarterly) dat "Section M 0300 F. I wounds due to sloug "M 0300 G - Numbe suspected deep tiss	a shower chair about to be nanical lift to his wheelchair. It resident had a towel at his a feresident had a towel at his and a towel at his hollywood attitude and a tric car outside my door for 30 have time to look at my not right. He came in here had he would be right back and thour later and told me he week. I told him to get out of the me now." The Resident has been at the facility since beloped wounds on his right calf and blisters on different different times. He said areas I'm concerned about a feet. The one wound on my to one point the smell was and better now."  The clinical record revealed dated 3/19/21  Does the resident have any alcers stage 1 or higher - 0.  The clinical read:  Number of unstageable	F 68	completed by 8/18/21.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	STREET ADDRESS, CITY, STATE, ZIP COD 603 MAIN STREET MATHEWS, VA 23109		DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 686	this resident was subtime line. They also assessment sheets" wound.  Per the document endeveloped wounds at Assessment # 47978 blisters to right wrist Assessment # 47978 blisters to right outer at Assessment # 47978 blisters to right elbow Assessment # 47978 blisters to left groin Assessment # 48035 beep Tissue Injury to Assessment # 48035 beep Tissue Injury to Assessment # 48035 beep Tissue Injury to Assessment # 48122 btl left Heel - (found Assessment # 48196 blister right upper this partial thickness 0.9 Assessment # 48196 blister unstageable Assessment # 48196 btl right upper postex 2 cm)	Il skin and wound issues for mitted by the facility as a submitted the "Wound to coincide with each listed wittled Wounds, Resident #42 is follows:  1912 - 3/24/21 at 11:48 AM - (1.5 cm x .5 cm) (1.5 cm x .1.5 cm) (1.5 c	F 68	6		
	open area in DTI uns depth recorded to thi	stageable calf (2.5 x .5) [no s open area] 073 - 5/12/21 at 1:47 PM				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	E SURVEY IPLETED				
		49E215	B. WING		0:	7/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	Assessment # 48601 DTI to 5th toe (1.0 cn Assessment # 48601 Blister stage II to left Assessment # 48601 DTI's and blister Assessment # 48650 Blister due to cathete II partial thickness 1 crecorded) Assessment # 48670 Blister upper left thigh Assessment # 48670 Blister upper left thigh Assessment # 48670 Blister to lateral left th partial thickness 7 cm recorded)  A review of the "Wou page 2 of each woun wounds listed above assessments for wou assessments were co LPN B.  On 7/8/21 at 10:13 A conducted with the D stated that skin asses weekly. She was ask doing the wound asses she stated LPN B is of she "advises the other the facility has a wou they did. She stated initial assessment an for wound care. She wound does not get to provider (MD or NP)	161 - 5/12/21 at 1:52 PM - n x 0.5 cm) 204 -5/12/21 at 1:57 PM - upper thigh (3.0 x 0.5 cm) 263 - 5/12/21 at 2:06 PM - 949 - 5/16/21 at 2:29 PM - or tubing (recorded as Stage cm x 2 cm no depth  103 - 5/17/21 at 2:45 PM _ n 743 - 5/17/21 at 2:59 PM - nigh (recorded as Stage II) n x 0.5 cm no depth  and Assessment Sheets" on depth  depth sheet labeled all of the as "Vascular" in nature. All ands to include the initial onducted and signed off by	F 64	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		49E215	B. WING			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		6	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET IATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	(employee D) who sta Champion" and indicated Champion" and indicated Champion" and indicated Champion" and indicated Champion and indicat	the Clinical Services Director ated that we have a "Wound ated LPN B was that person."  Inately 11:00 AM an interview impion" LPN B who stated int developed blisters the probably vascular, which is ar on the wound when asked if she was the itial assessments and at she was.  If the physician notes in the property of the physician notes in the property of the physician notes in the physici	F	686			

AND DUAN OF CORRECTION		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 686	erythema continue S non-adherent dressi Keflex 500 mg po TI antibiotic 500 mg giv "5/12/21 Resident n right heel measuring right 5th toe 1 cm x 0 upper right from cath x 0.5 cm and a mole irritated and bleeding	g increased drainage and cantyl to areas with slough, and to lower wound.  D x 7 days." [Keflex e 3 times a day for 7 days]  oted to have a DTI to his 1 cm x 1 cm; a DTI to his 2.5 cm; a blister to his left eter tubing measuring 3 cm to left mid back that is 3."	F 68	36	
	cm x 1 cm; DTI to his a blister to his left up measuring 3 cm x 0. "Resident is a total of indwelling Foley cath bowel with episodes currently has 3 new and air mattress and times to help reduce Patient is alert and of	are for all ADL's. He has an neter and is continent of of incontinence. He wounds see above. He uses had has heel boots on at all risk of pressure areas.			
	open wounds to righ orders left heel Sant and foam boarder dr DTI, right upper post calf lower posterior of dressing over each of and wrap with Kling	eschar to left heel. He has t leg. Current treatment yl covered with moist 2 x 2 essing, skin prep right heel erior calf, right mid posterior ealf treat with damp 22 of the wounds with ABD pad bid. [Twice daily] Patient was e and orders placed earlier			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			07/09/2021	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 686	interview was cond who stated that on Resident who was #42 he would come back to the room the because he told hin he had to get to. Hupset and he left the was not having a "stated he did not rethe hallway but the lot of trauma and histaff. When asked that "He has had a etiologies." When Vascular in nature sure of the thigh blimust have "made to venous ulcers" becedema could creat He indicated that the vascular wounds.  A review of the cardid not address prepressure reduction excerpts from the compressure relief in a STATUS: Active (C 3/19/2021 - Preser 3:27:24 PM [RN nate of the column of the colu	ximately 12:45 PM an lucted with the Medical Director Monday he had another very ill and he told Resident e back to him. When he came he Resident was upset in he had another appointment de said the Resident became he room because the Resident good interaction with him." He emember the conversation in Resident has "Gone through a le becomes frustrated with about the wounds he stated lot of wounds of various in asked if they were all the stated that they weren't lister etiology and the LPN he leap to vascular and leause I said the swelling and leause I said the swelling and leause I said the care plan reventative measures for were measurable or specific care plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:  The plan revealed the care plan eventative measures for large plan read:	F6	86			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	TE SURVEY MPLETED			
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	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	STREET ADDRESS, CITY, STATE, ZIP CODE  603 MAIN STREET  MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	assistance with turnir needed STATUS: Act 3/19/2021 - Present 0/3:27:24 PM [RN nam "Frequency" Column "Discipline" Column lo "Encourage resident assistance with turnir needed STATUS: Active (Cur 3/19/2021 - Present 0/3:27:24 PM (RN nam "Frequency" Column "Discipline" Column lo "Apply skin barrier crostatus: Active (Cur 3/19/2021 - Present CREATED: 3/22/2027 redacted)" "Frequency" Column "Discipline" Column lo "Staff education concernsferred in and out mechanical lift. STAT EFFECTIVE: 4/2/2024/5/2021 4:59:55 PM "Frequency -" column "Discipline Nursing Colu	ive (Current) EFFECTIVE: CREATED: 3/22/2021 e redacted]" left blank eft blank.  to re-position or provide ig and repositioning as rent) EFFECTIVE: CREATED: 3/22/2021 e redacted)" left blank eft blank erning he is to be c of his Power chair using the US: Active (Current) 1 - Present CREATED: [RN name redacted] c left blank REATED: 4/5/2021 4:59"  ess, skin tears, swelling, or ort any signs of skin c Active (Current) 21 - Present CREATED: //" (RN name redacted)	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _		07/0	09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	Continued From page "Discipline" Column le		F 6	86			
		left blank					
	pressure reduction. S EFFECTIVE: 6/9/202	attress to bed to assist with TATUS: Active (Current) 1 - Present I 11:45:14 AM" (RN name					
	orders for heel protect reflect an order on 6/2 pillow to right lower ex						
	Administrator was ma with the development wounds. No further in	end of day meeting the ade aware of the concerns and care of the pressure nformation was provided. f Significant Med Errors	F 7	60		8/18/21	
	medication errors. This REQUIREMENT by: Based on Observation	ore that its- its are free of any significant is not met as evidenced on, staff interview, facility y, and clinical record review,		12VAC5-371-220 (B) 1. Resident #7 received the medica	tion		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 503 MAIN STREET MATHEWS, VA 23109	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 760	were free from signific (Residents #7, and #2 Residents.  1. For Resident #7, the administer narcotic particle ordered by a physicial series of the properties of the particle	to ensure two Residents cant medication errors 23) in a survey sample of 31 the facility failed to ain medication timely as n.  the facility failed to ons, including a narcotic y as ordered by a physician.  : admitted to the facility on sincluded; Parkinson's pulder dislocation with pain, d, osteoarthritis, and chronic ecent MDS (minimum data	F 760	on 7/6/21 with no adverse effect. The resident representative and provider wade aware of the delayed time of the medication on 7/27/21.  Resident #23 received the medication 7/6/21 with no adverse effect. The resident representative and provider wade 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 ensifor appropriate scheduling/timing by pharmacist, nursing and/or provider.  3. Licensed nurses will be educated DON/designee on requirement for ord medications to be administered timely ordered by physician, including narcot pain medication.  4. Will audit 10% weekly of Residen Medication Administration Records to validate that medications/narcotics we administered timely as ordered by the	s on vere e ure by ered as ic t	
	4-14-21 was coded a Resident #7 was code interview of mental st possible 15, or, no co Resident #7 was also extensive to total ass activities of daily living transferring, hygiene, On 7-6-21 from 1:00 p medication pour and conducted with Licen A. Resident #7 receive	ocoded as requiring istance of staff to perform g, such as bed mobility, locomotion, and toileting.  o.m., until 2:00 p.m., pass observations were sed Practical Nurse (LPN) wed medications at 1:40 p.m. d tramadol, a narcotic pain ated "these are the morning		physician. The results of the audits wi 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.	e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	(>	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING _			07/09/2021		
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP 603 MAIN STREET MATHEWS, VA 23109	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE		
F 760	Continued From page		F7	760				
	(MAR) revealed that it to the exact time the administered, therefor nurse could administed medication again as a Resident could expersive the resident could expersive the resident for the resid	re, the oncoming evening er the narcotic pain soon as 3:00 p.m., and the ience over sedation.  7's clinical record revealed rs for the pain medication						
	timely, and signed/do administering individual medication is given.  When interviewed on DON (director of nurs stated that the range and the medications which could cause over closely together, and pain for the Resident DON stated her expended in the medication of the respended in the respendence of the respendence	cumented by the sal as soon as the  7-6-21 at 4:00 p.m., the singly, and Corporate Liason was going to be changed, were administered late, er sedation if given too could allow break through if spaced too far apart. The ctation was for staff to						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
F 760	failure of the staff to medications were ad at 4:00 p.m. No furth by the facility.	d DON were informed of the ensure significant ministered timely, on 7-6-21 ner information was provided	F 76	0		
	1-28-20. Diagnoses failure with hypoxia, deficiency, diabetes, Resident #23's most set) with an ARD (as 5-12-21 was coded a assessment. Resider a BIMS (brief intervie "unable to complete" impairment. Resider requiring extensive to perform activities of mobility, transferring toileting.  On 7-6-21 from 1:00 medication pour and conducted with Licer A. Resident #23 rec p.m. The Resident redications which wadministered more the	pass observations were used Practical Nurse (LPN) eived medications at 1:30 eceived the following 5				
	three times per day a	dose inhaler one to two puffs at 8:00 a.m. to 10:00 a.m., m., and 6:00 p.m. to 8:00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER	ATHEW	60	TREET ADDRESS, CITY, STATE, ZIP CODE D3 MAIN STREET IATHEWS, VA 23109	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 760	Continued From pag	ge 88	F 760		
	I .	roid one spray in each nare ) a.m. to 10:00 a.m., and 6:00			
		0 milliliters twice per day at .m., and 6:00 p.m. to 8:00			
		medication 50 milligrams 0 a.m. to 10:00 a.m., and 6:00			
	_	cotic pain reliever 5 rams twice per day at 8:00 and 6:00 p.m. to 8:00 p.m.			
	time, however, they administered once p added to the deficien	vere also administered at the were only ordered to be ser day, and so were not nt practice. LPN A stated ing meds, I am just getting			
	(MAR) revealed that to the exact time the administered, theref- nurse could adminis late, and the Reside	ore, the oncoming evening ter the medications early or nt could experience poor diac results, over sedation,			
		#23's clinical record revealed ers for the multiple significant tte.			
		r's policy entitled, "Medication aled that all medications are			

	TEMENT OF DEFICIENCIES O PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		49E215	B. WING			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE 603 MAIN STREET MATHEWS, VA 23109	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIA <sup>*</sup> ICIENCY)		(X5) COMPLETION DATE
F 760	to be given according timely, and signed/do administering individual medication is given.  When interviewed on DON (director of nurs stated that the range and the medications which could cause no over sedation if given could allow break throspaced too far apart. expectation was for smedications and treat orders and to administrator and failure of the staff to emedications were adrat 4:00 p.m. No furth by the facility.  COVID-19 Immunizatt CFR(s): 483.80(d)(3) COVID-19 Immunization is medication is medication is medication in the covid-individual confered the coviding and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID-immunization is medication of the coviding conference of the co	to the prescriber's order cumented by the call as soon as the  7-6-21 at 4:00 p.m., the sing), and Corporate Liason was going to be changed, were administered late, on-therapeutic side effects, too closely together, and ough pain for the Resident if The DON stated her taff to administer them timely.  d DON were informed of the ensure significant ministered timely, on 7-6-21 er information was provided cion  (i)-(vii)  D-19 immunizations. The elop and implement policies sure all the following: accine is available to the and staff member -19 vaccine unless the cally contraindicated or the ber has already been  DVID-19 vaccine, all staff d with education is and risks and potential side		387			8/18/21

		IDENTIFICATION NI IMBED:		PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _		,	07/09/2021	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш		STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 887	resident or the resider receives education rerisks and potential since the COVID-19 vaccin (iv) In situations whe requires multiple dos resident representati provided with current additional doses, includes at a minimu (A) That staff were provided educated with the resident or covided with the covided educated benefits and potential covided educated educated benefits and potential covided educated educ	OVID-19 vaccine, each ent representative egarding the benefits and de effects associated with ne; re COVID-19 vaccination es, the resident, ve, or staff member is information regarding those luding any changes in the potential side effects COVID-19 vaccine, before or administration of any dent representative, or staff ortunity to accept or refuse a and change their decision; edical record includes andicates, at a minimum, or resident representative ion regarding the all risks associated with and VID-19 vaccine administered all not receive the COVID-19 call refusal; and tains documentation related coination that m, the following: rovided education regarding ential risks	F8	87			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			7/09/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	'		
DIVEDOID	NE CONVAL CENTER I	AATHEM.		603 MAIN STREET			
RIVERSIL	DE CONVAL CENTER-N	MATHEW		MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 887	Continued From pa	nge 91	F 8	87			
	related information Disease Control an Healthcare Safety This REQUIREMED by:	as indicated by the Centers for deleters for					
	Based on staff intereview and clinical failed to offer the Control Residents (Residents), #43) in a survice The facility staff fail they offered the Control Residents when the facility having vaccontrol The findings included On 7/7/21 at approach with the facility who is also serving Preventionist. Duri	ximately 11:00 AM, Surveyor A Director of Nursing (DON) as the facility's Infection ing this review Surveyor A the immunization logs for staff		1. Resident #3 no longer refacility as of 7/4/21. Resident longer resides in the facility Resident #22 refused COVII 7/8/21. Resident #27's RR von 7/8/21 and expressed was discuss further with extende Resident #28 received the volume 7/9/21. Resident #31 refused the Con 7/8/21. Resident #38 received the volume 7/9/21. 2. 100% of all new resident residents at facility, who have previously received all doses vaccine, will be audited to elevate of the volume for the vol	at #21 no as of 7/11/21. D vaccine on vas contacted anting to d family. vaccine on  OVID vaccine raccine on  at and current ve not s of COVID nsure vaccine d. ceive gnee on residents the		
	performed to find e include the COVID having difficulty find the facility staff for The facility staff we day meeting on 7/7 evidence of the vac administered or de	or of the clinical records were vidence of immunizations, to vaccine. Surveyor A was ding the information and asked assistance.  For reminded at the end of the 1/21 and again on 7/8/21, that becine being offered, clined was needed for 1/22, 1/27, 1/28, 1/32, 1/38, 1/43.		COVID vaccine on admission the COVID vaccine to all residuate have not previously received the COVID vaccine at least 4. All newly admitted residuarrent residents, who have vaccinated, will be audited to vaccine was offered and distresults of the audits will be recommended in the medical results of the audits will be recommended in the audits of the audits will be recommended in the audits of the audits will be recommended in the audits of the audits will be recommended in the audits of the	sidents who d all doses of quarterly. dents and not been fully o ensure cussion was record. The reported to the N/designee for d ongoing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE COI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE COI A. BUILDING		(X3) DATE SURVEY COMPLETED	
<b>49E215</b> B. WING		07/09/2021	
RIVERSIDE CONVAL CENTER-MATHEW 603 M	EET ADDRESS, CITY, STATE, ZIP CODE  MAIN STREET  HEWS, VA 23109		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
the survey team with the following data: 5	analysis.  5. All corrective action will be completed by 8/18/21.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		07/09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW	60	TREET ADDRESS, CITY, STATE, ZIP CODE 13 MAIN STREET ATHEWS, VA 23109	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 887	Continued From page	ge 93	F 887		
	conducted with the that the documents the above reference offered the vaccine stated that [Resider eligible for the vacci their vaccine clinic, COVID positive in Easked for evidence recovery she was o stated that she didn information. She sa on admission and vit". The DON further are offered that she documented in the CON 7/9/21, during the was made aware of lack of evidence of offered on the 8 ReCON 7/9/21 at 12:22 confirmed, "COVID centrally at one of of doses weekly, which we have had no differenced."	aid "I know they are offered it erbally declined but I can't find er stated that when vaccines does expect this to be			
	Vaccine Documenta Vaccinations will be residents/represent and residents/repre	y policy titled "COVID- ation" it read, "COVID-19 offered to atives and staff and all staff sentatives will be educated on ine they are offered in a			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			07/	09/2021
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	60	TREET ADDRESS, CITY, STATE, ZIP CODE 03 MAIN STREET IATHEWS, VA 23109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	with the CDC and/or and residents/represe opportunity to refuse their decision about v Residents: 1. All curre the COVID-19 vaccin fact sheets to the spereceive. 2. During the assessment, resident on the COVID-19 vac will be offered at the fis maintained in the record or in the paper vaccination information the [Company name of Vaccine Record. B. CEducation, Consent/E reviewed with the Reserepresentative as approximation of the paper vaccine and the paper vaccine Record. B. CEDUCATION CONSENT/E	erstand including nefits and risks consistent FDA information Staff entatives will be provided the the vaccine and/or change faccination at any time. The entered ations well as corresponding for entered ations well as corresponding for entered ations will be provided education as will be provided education for exident's electronic medical for chart. A. Resident for will be documented on finitials redacted] COVID-19 COVID-19 Vaccine Declination Form will be sident and/or Resident	F	887			