STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/27/2021 through 07/29/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/27/21 through 7/29/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 280 certified bed facility was 135 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		9/10/21

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

Electronically Signed | 09/02/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the right to formulate an advanced directive as evidence by the advanced directive in the resident record not completed accurately for one of 30 residents, Resident #93. The findings included: For Resident #93 the facility staff failed ensure a Virginia Department of Health DDNR (durable do not resuscitate) form was complete.	F 578	1. Corrective Action Resident #93□s DDNR was completed on August 27, 2021. 2. Identification of Deficient Practice Residents with DDNR on file have the potential to be affected. 3. Systemic Changes A) All DDNR□s on file were audited to ensure the forms were filled out correctly. B) Social Workers, Household Coordinators and Clinical Coordinators were educated on proper procedure for completing DDNR forms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2 Resident #93's face sheet listed diagnoses which included but not limited to chronic kidney disease, dementia, type II diabetes mellitus, dysphagia, depression, hypertension, and hypothyroidism. Resident #93's most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 07/08/2021 assigned the resident a BIMS (brief interview for mental status) score of 3 out 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #93's clinical record was reviewed on 07/28/21. It contained a physician's order summary for the month of July 2021 which read in part, "DNR (do not resuscitate)". The clinical record also contained a Virginia Department of Health DDNR form dated10/22/2020, which read as follows: I further certify (must check 1 or 2): [] 1. The Patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required) [X] 2. The Patient is INCAPABLE of making an informed decision about provided, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision , or to make a rational evaluation of the risks and benefits of alternatives to that decision. If you checked 2 above, check A, B, or C below: [] A. While capable of making an informed decision, the Patient has executed a written	F 578	4. Monitoring Social Worker / designee will audit the DDNR during care plan meetings to ensure completion weekly x 4 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Director of Social Services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 3 advanced directive which directs that life-prolonging procedures be withheld or withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.) [] C. The Patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required) Section II of the DDNR form had not been checked as directed. The concern of the incomplete DDNR form was discussed with the administrative team (administrator, DON [director of nursing], ADON [assistant director of nursing],) during a meeting on at approximately 7:00 pm. No further information was provided prior to exit.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility staff failed to ensure a homelike environment on 1 of 7 units, 3 East. The findings included:	F 584	1. Corrective Action Facility stopped using Styrofoam plates and cardboard trays on July 28, 2021 and switched back to normal plates and trays. 2. Identification of Deficient Practice All Residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 The facility staff were using styrofoam plates and cardboard trays on 3 East. 07/27/21 dinner observation on 3 East. The residents on this unit were observed to be using styrofoam plates and cardboard trays. 07/27/21 5:36 p.m., dietary employee #3 stated they were using styrofoam plates and cardboard trays due to a leak in the kitchen in the building. Dietary employee #3 stated the kitchen in this building was no longer in use. 07/28/21 8:05 a.m., dietary employee #4 stated they were using the styrofoam plates and cardboard trays due to COVID-19 precautions and stated a staff person had tested positive that worked this unit. 07/28/21 8:10 a.m., Resident #72 stated they had been using styrofoam for a little while. 07/28/21 8:18 a.m. Resident #68 stated they were not sure how long they had been using styrofoam, they had not been given a reason for using it, but it hadn't been too long. 07/28/21 8:29 a.m., Resident #107 stated the disposable items made them feel "not important." 07/28/21 9:43 a.m., during a meeting with the administrator and (DON) director of nursing the administrator stated they did not know why they were using styrofoam and cardboard on 3 East, did not know who made that decision, and confirmed the kitchen in the building was closed. The facility had other kitchen on site in other buildings.	F 584	affected when using Styrofoam plates and cardboard trays. 3. Systemic Changes A) Facility switched from Styrofoam plates and cardboard trays back to normal plates, bowls and trays. B) Morrison staff that works for RRCC were in serviced on the importance of Homelike Environment for residents. Styrofoam plates / cardboard trays were not to be used unless in emergency situations that would be approved by Administration. 4. Monitoring Morrison□s Dietary Manager /designee will complete an audit on trays, plates and bowls used during meals to ensure Styrofoam / cardboard plates are not used unless during an Emergency with Administration approval. This will be audited weekly x 4 weeks, every other week x 4 weeks and every month x 4 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Director of Dietary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 No further information regarding this issue was provided to the survey team prior to the exit conference.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of documents, it was determined the facility staff failed to develop and implement a person centered care plan to address the hospice needs for one (1) of 30 sampled residents (Resident #10). The findings include: The facility staff failed to develop a hospice care plan for Resident #10. Resident #10's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 7/16/21, was signed as completed on 7/26/2021. The resident was assessed as sometimes being able to make self understood and as sometimes being able to understand others. The resident's Brief Interview for Mental Status (BIMS) summary score was three (3) out of 15. The resident was assessed as requiring extensive assistance with bed mobility, transfers, dressing, eating, and personal hygiene. The resident was assessed as being dependent on others for toilet use and bathing. Resident #10's diagnoses included, but were not limited to: high blood pressure, dementia, anxiety, and depression. Resident #10 had a provider order dated	F 656	1. Corrective Action Resident #10□s care plan was updated on 7/28/21 to include the resident□s hospice plan. 2. Identification of Deficient Practice Residents who receive hospice services have the potential to be affected. 3. Systemic Changes Nursing staff have been re-educated regarding the requirements for hospice plan of services to be on the resident□s care plan. Clinical Coordinator/designee will complete an audit on all hospice residents to ensure their care plan includes hospice□s plan of care. 4. Monitoring Clinical Coordinator/designee will complete an audit on all residents who receive hospice services to ensure accurate care plan is in place weekly x 4 weeks, every other week x 4 weeks and every month x 4 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 11/19/2020 at 1:57 p.m. for hospice. Review of Resident #10's care plan failed to reveal a focus addressing the resident's hospice needs. The facility's nursing policy and procedure with the subject of "Care Plans; Goals and Objectives" (with an effective date of 10/2020) included the following information: - "Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence." - "Care plan goals and objectives are defined as the desired outcome for a specific resident problem." - "Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether the desired outcomes are being achieved." The following information was found in the "HOSPICE SERVICES AGREEMENT" between the facility and the hospice (dated 11/4/20): "Facility will develop and/or maintain a Facility Plan of Care for Hospice Patient in accordance with any federal, state or local laws and regulations ... Facility will furnish Facility Services to each Hospice Patient in accordance with the Hospice Patient's Facility Plan of Care." During an interview on 7/29/21 at 10:10 a.m., the director of nursing (DON) and the Clinical Coordinator reported they were unable to find a hospice care plan in Resident #10's chart; they offered to contact the hospice to see if the hospice staff had a care plan that could be sent to the facility.	F 656	Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the residents receive treatment and care in accordance with the comprehensive person-centered care plan for 1 of 30 residents in the survey sample, Resident #117. The findings included: For Resident #117, the facility staff failed to follow physician's orders for blood sugar monitoring. Resident #117's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified, Hypothyroidism Unspecified, Spinal Stenosis Lumbar Region without Neurogenic Claudication, and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 7/02/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. In section I, Active Diagnoses, Resident #117 was coded for	F 684	1. Corrective Action Physician for Resident #117 was notified that blood sugar monitoring was not performed on 5/26/21. 2. Identification of Deficient Practice Residents with physician ordered blood sugar monitoring have the potential to be affected. 3. Systemic Changes Clinical Coordinator/designee will complete 100% audit of their residents to ensure physician□s orders were followed for blood sugar monitoring. Nursing Staff have been re-educated regarding monitoring residents□ blood sugars per physician order. 4. Monitoring Clinical Coordinator/Designee will audit physician orders for blood sugar monitoring every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10,	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 the diagnosis of Diabetes Mellitus. Resident #117's clinical record included a medication regimen review dated 5/20/21 entitled "Recommendation for Provider" stating in part, "Consider re-initiating at least daily fingersticks as PCC (Point Click Care) data is limited at this time, and (he/she) is on DM2 (Type 2 Diabetes Mellitus) medications". The provider's response dated 5/25/21 stated in part, "accucheck am and pm x 14 days". A physician's order stating "Accuchecks in AM and PM for 14 days" was transcribed in the resident's clinical record on 5/25/21 at 2204 (10:04 pm). The surveyor reviewed Resident #117's May 2021 MARs (medication administration record), TARs (treatment administration record) and clinical record documentation and was unable to locate blood sugar documentation following the 5/25/21 order. Resident #117's care plan included a discontinued intervention originally dated 5/26/21 which stated "observe resident's blood sugars and medication per MD order as directed". On 7/29/21 at approximately 11:00 am, surveyor spoke with the Director of Nursing and notified them of the above findings. On 7/29/21 at 5:30 pm, surveyor spoke with the Clinical Coordinator who stated Resident #117's blood sugars were not checked due to the order not being entered for documentation. No further information regarding this issue was presented to the survey team prior to the exit conference on 7/29/21.	F 684	2021 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure 2 of 7 units were free of accident hazards, 3 East and Honeysuckle Cottage. The findings included: 1. The surveyor observed three unsecured bottles of the spray disinfectant Avistat-D in the shower room on 3 East. 07/28/21 9:25 a.m., the surveyor observed three opened bottles of the spray disinfectant Avistat-D on a wooden shelf in the shower room on 3 East. The manufacturer label read "...KEEP OUT OF REACH OF CHILDREN CAUTION..." The shower door was unlocked and the surveyor was able to push open the door and enter. There was no residents observed in the immediate area. 07/28/21 11:51 a.m., rechecked shower room on 3 East. Two bottles of Avistat-D remained on the wooden shelf one bottle was sitting on a stretcher. The door to this shower room was not completely shut. There were no staff or residents in the immediate area.	F 689	Section 1 1. Corrective Action Avistat-D chemicals were removed from the shower room on 7/29/21. 2. Identification of Deficient Practice All residents have the potential to be affected. 3. Systemic Changes A) Environmental staff Members were educated on not leaving chemicals in an unlocked area. B) Housekeeping Manager/Designee will conduct audits of proper storage of chemicals by members every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. 4. Monitoring Housekeeping Manager/Designee will monitor proper storage of chemicals every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations.	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 07/29/21 8:50 a.m., the administrator provided the surveyor with the (MSDS) material safety data sheet for the Avistat-D disinfectant spray. This document read in part, "...Health Hazards Serious eye damage/eye irritation..." 07/28/21 5:02 p.m., the administrator and (DON) director of nursing were made aware of the unsecured spray disinfectant on 3 East. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure water temperatures were maintained in acceptable parameters to decrease the risk of resident injury. On the afternoon of 7/27/21, it was noted that water temperatures were uncomfortably hot in two (2) residents' kitchen-area sinks. The water temperatures, of the two (2) kitchen area sinks were check by a facility Clinical Coordinator (Employee #24). The water temperature, from the kitchen-area sink for rooms 116A and 116B, was 129.1 degrees Fahrenheit on 7/27/21 at 3:18 p.m. The water temperature, from the kitchen-area sink for room 125, was 132.5 degrees Fahrenheit on 7/27/21 at 3:26 p.m. The facility's administrator was notified of the aforementioned water temperatures on 7/27/21 at 3:30 p.m. (The facility design had resident rooms that included a personal bathroom sink and a personal sink in a small kitchen area; these sinks were either dedicated to one (1) resident or shared by two (2) residents.) On the afternoon of 7/27/21, Resident #7 was interviewed about the water temperatures of the kitchen-area sinks. Resident #7 reported when	F 689	5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Administrator. Section 2 1. Corrective Action Maintenance staff and a contractor called in and fixed the issue with the hot water on 7/27/21. 2. Identification of Deficient Practice All Residents have the potential to be affected by the water temperature. 3. Systemic Changes A) Maintenance staff and contractor fixed issue with hot water. B) Maintenance staff monitored daily with random checks of water temperatures until issue was confirmed to be resolved. Maintenance staff randomly check water temperatures weekly and sign off completion via Worxhub. 4. Monitoring Maintenance Director/designee will complete an audit on water temperatures randomly throughout The Health Center to ensure there are safe hot water temperatures for our residents. Monitoring weekly x 4 weeks, every other week x 4 weeks and every month x 4 months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 staff would need warmer water to provide resident care the staff members would get the water from the kitchen-area sinks because it was hotter than the water from the bathroom sinks. On 7/27/21 at 3:33 p.m., Employee #22 was interviewed about the water temperatures in residents' rooms. Employee #22 confirmed the water from the kitchen-area sinks was hotter than the water from the resident bathroom sinks. On 7/27/21 at 3:35 p.m., Employee #23 was interviewed about the water temperatures in residents' rooms. Employee #23 confirmed the water from the kitchen-area sinks was hotter than the water from the resident bathroom sinks. The following information was found in a facility policy with the subject of "Water Temperature Monitoring" (with a revised date of January 2021): "PURPOSE: To provide residents and team member with safe hot water. POLICY: 1. Hot water from taps throughout the facility will be maintained at temperatures between 105 degrees and 120 degrees (Fahrenheit) ..." On 7/28/21 at 3:05 p.m., the facility's Administrator provided the survey team evidence of having a contractor start working on the water distribution system on 7/27/21. On 7/28/21 at 4:59 p.m., the aforementioned hot water temperatures was discussed, during a survey team meeting, with the facility's Administrator and DON; it was reported the scheduled weekly water temperature monitoring had been increased to daily monitoring.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 14 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 690	1. Corrective Action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 15 interview, and facility document review, the facility staff failed to ensure a resident with a catheter received the apppropriate services in regards to anchoring the foley catheter for 1 of 30 residents, Resident #19. The findings included: The facility staff failed to anchor Resident #19's foley catheter. Resident #19's face sheet included the diagnoses, benign prostatic hyperplasia, cyst of kidney, and calculus of kidney. The resident was listed as their own responsible party on the face sheet. Section C (cognitive patterns) of the Residents admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 05/03/2021 included a (BIMS) brief interview for mental status summary score of 3 out of a possible 15 points. Section G (functional status) was coded to indicate the resident required extensive assistance of two people for personal hygiene. Section H (bladder and bowel) was coded to indicate the resident had a catheter in place. The residents (CCP) comprehensive care plan included the focus area altered elimination status related to use of foley catheter. Interventions included, but were not limited to, catheter care per policy. 07/27/21 4:22 p.m., Resident #19 observed on bed family member in room. When asked if their foley catheter was strapped or secured to their leg Resident #19 stated no and it had never been.	F 690	Resident #19□s catheter was correctly anchored on 7/28/21. Nursing staff obtained an order to change foley catheter anchor every month with foley catheter change 2. Identification of Deficient Practice Residents with indwelling urinary catheters have the potential to be affected. 3. Systemic Changes Nursing staff were educated on the indwelling urinary catheter order requirements, including proper anchor placement. 4. Monitoring Clinical Coordinator/Designee will conduct an audit of current residents with indwelling urinary catheters to ensure catheter is correctly anchored and a physician order is accurately placed. The Clinical Coordinator/Designee will audit all residents with indwelling urinary catheters to ensure proper orders are obtained and the catheter is correctly anchored every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 16 The family member stated the resident had a history of (UTIs) urinary tract infections. 07/28/21 9:12 a.m., checked foley catheter with unit coordinator. No anchor in place the unit coordinator stated they would anchor the foley catheter and that the resident has pulled the foley catheter out. 07/28/21 10:39 a.m., the (DON) director of nursing was made aware that the resident's foley catheter was not anchored. 07/28/21, the DON provided the surveyor with a copy of policy titled, "Catheter Care, Urinary." This policy read in part, "...The catheter will be anchored to reduce friction and movement at the insertion site..." The (EHR) electronic health record included an order-dated 07/26/21 for the antibiotic ceftriaxone 1-gram (IM) intramuscularly everyday X 7 days for a UTI. 07/28/21 the facility obtained an order to change foley catheter anchor every month with foley catheter change. 07/28/21 5:15 p.m., the issue with the residents foley catheter not being anchored was reviewed with the administrator and DON. 07/28/21 the residents CCP was updated to include the focus area "At risk for altered behavior related to dementia/confusion: rsd has HX (history) of pulling foley catheter out, removing anchor..." No further information regarding this issue was	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 17 provided to the survey team prior to the exit conference.	F 690		
F 772 SS=D	Lab Services Not Provided On-Site CFR(s): 483.50(a)(1)(iv) §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 2 of 30 residents, Resident #19 and #42. The findings included: 1. For Resident #19, the facility staff failed to obtain the laboratory test PT/INR. A prothrombin time (PT) test measures how long it takes for a clot to form in a blood sample. An INR (international normalized ratio) is a type of calculation based on PT test results. Resident #19's face sheet included the diagnoses, atrial fibrillation and atherosclerotic heart disease. The resident was listed as their own responsible party on the face sheet. Section C (cognitive patterns) of Resident #19 admission (MDS) minimum data set assessment	F 772	Section 1 1. Corrective Action Resident #19 PT/INR was completed. Physician contacted once completed for direction on treatment. 2. Identification of Deficient Practice Residents with orders to obtain PT/INR level have the potential to be affected. 3. Systemic Changes PT/INR order was completed. Nursing staff were educated on the PT/INR order requirements, including protocol if PT/INR strips are unavailable. 4. Monitoring Clinical Coordinator/Designee will audit residents with physician ordered PT/INR level every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations.	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 772	Continued From page 18 with an (ARD) assessment reference date of 05/03/2021 included a (BIMS) brief interview for mental status summary score of 3 out of a possible 15 points. On 07/27/21 (LPN) licensed practical nurse #1 documented the following in a progress note in Resident #19's (EHR) electronic health record "...NP (nurse practitioner) contacted in regards to not being able to complete PT/INR via PT/INR machine d/t (due to) no test strips...NP gave order to DC (discontinue) PT/INR for today and schedule it with ___ lab to be collected on the morning run 07/28/2021 and report results to...NP." 07/28/21 10:39 a.m., the (DON) director of nursing stated the facility had run out of the PT/INR test strips, central supply was aware, they had a delivery date of today (07/28/21) for the test strips, and they obtained an order from the physician to obtain via lab draw. Central supply is now going to keep an extra box. The DON identified one other resident that missed having their PT/INR obtained on this same unit. The EHR included two-progress note dated 07/28/2021. 1. "Rsd is his own RP and aware of PT/INR order change." 2. "Specimen obtained for PT/INR today via phlebotomist from ___. Awaiting results." 07/28/21 5:00 p.m., during an end of the day meeting with the administrator and DON the missing PT/INR was reviewed. The DON stated the results of Resident #19's PT/INR was received the physician was notified and the PT/INR would be repeated on 07/31/21.	F 772	5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Director of Nursing. Section 2 1. Corrective Action Resident #42 PT/INR was completed. Physician contacted once completed for direction on treatment. 2. Identification of Deficient Practice Residents with orders to obtain PT/INR level have the potential to be affected. 3. Systemic Changes PT/INR order was completed. Nursing staff were educated on the PT/INR order requirements, including protocol if PT/INR strips are unavailable. 4. Monitoring Clinical Coordinator/Designee will audit residents with physician ordered PT/INR level every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 772	Continued From page 19 No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #42, the facility staff failed to obtain the laboratory test PT/INR. A prothrombin time (PT) test measures how long it takes for a clot to form in a blood sample. An INR (international normalized ratio) is a type of calculation based on PT test results. Resident #42's face sheet included the diagnoses, end stage renal disease, acquired coagulation factor deficiency, myocardial infarction type 2, and presence of prosthetic heart valve. Section C (cognitive patterns) of Resident #42's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 05/28/21 included a (BIMS) brief interview for mental status summary score of 15 out of a possible 15 points. The (EHR) electronic health record includes a progress note dated 07/27/2021 documented by (LPN) licensed practical nurse #1 that read in part, "...NP (nurse practitioner) contacted in regards to not being able to complete PT/INR via PT/INR machine d/t (due to) no test strips...NP gave orders to DC (discontinue) PT/INR for today and schedule it with ____ lab to be collected on the morning run by 07/28/2021 and report results to _____ NP." On 07/28/21, the clinical coordinator documented "Specimen obtained for PT/INR today via	F 772		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 772	Continued From page 20 phlebotomist from _____. Awaiting results." 07/28/21 5:00 p.m., during an end of the day meeting with the administrator and DON the missing PT/INR was reviewed. The DON stated Resident #42's PT/INR results came back today and the physician had been notified. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 772		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be	F 803		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 21 construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review the facility staff failed follow the menu on 1 of 7 units, 3 East. The findings included: The facility staff failed to follow the menu. 07/27/21 5:30 p.m., evening meal observed on 3 East. Resident #107 stated they were supposed to get peanut butter cookies. The surveyor observed peaches on this resident's dinner tray. The tray ticket that accompanied this meal read peanut butter cookies. 07/27/21 5:36 p.m., dietary employee #3 was asked about the missing peanut butter cookies and stated the baker had left early. 07/27/21 (Tuesday) outside of the dining area on 3 East the surveyor observed the menus for Monday 07/26/21 were still posted. There were no menus posted for Tuesday 07/27/21. A review of the menu revealed the regular diet consistency food trays should have contained peanut butter cookies. 07/29/21 11:17 a.m., the (RD) registered dietician stated there was a miscommunication between staff members and management was not notified there was an issue and a need for a substitution. The employee will be receiving a write up. The RD provided the surveyor with a copy of the	F 803	1. Corrective Action Employee was given counseling for not following proper protocol following resident menu. 2. Identification of Deficient Practice All residents have the potential to be affected who have a regular diet. 3. Systemic Changes A) Counseled team member that did not follow the correct menu. B) In-serviced all dietary team members regarding proper protocol when substituting any food with a regular menu item. 4. Monitoring Dietary Manager/designee will conduct kitchen audits to include monitoring of substitutions for regular diets that the company policy must be followed to contact RD and sign off on substitution log when requesting a change every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 22 "ASSOCIATE COUNSELING REPORT" this report read in part, "...On 7/27/21 the employee chose to substitute peaches in place of peanut butter cookies for the dinner dessert. The employee did not notify appropriate management staff of the need for dessert substitution. Per policy and procedures, menu item substitutions must be approved by RD and signed off on substitution log; employee did not follow company policies..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 Based on observation, staff interview, and facility document review, the facility staff failed to prepare, distribute and serve food in a manner that would prevent foodborne illnesses. The findings included: 1. During initial tour of the facility, the surveyor observed food in the active food supply that was opened and exposed. The dry storage room contained honey that had a best by date of March 2021. 07/27/2021 1:33 p.m., the surveyor entered the dietary kitchen on (TRC) the rehab center. The freezer was observed to have one box of chicken fritters and one box of hamburger patties that had been opened, the plastic bag had been ripped open exposing the items inside. The dry storage was observed to contain one jug of honey dated December 2020 and a best by date of March 2021. Dietary personnel #1 stated the honey was crystallized and removed it from the food supply. 07/28/2021 5:15 p.m., the administrator and DON (director of nursing) were made aware of the issues in the dietary kitchen. 07/29/21 6:47 p.m., the administrator provided the survey team with a copy of a policy titled "FOOD AND SUPPLY STORAGE." This policy is read in part, "All food...used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption...foods past the use by...date should be discarded...Cover, label and date unused	F 812	Section 1 1. Corrective Action Honey, chicken fritters and hamburger patties were thrown away due to expiration date and not sealed properly on 7/28/21. 2. Identification of Deficient Practice All residents that receive food from TRC kitchen have the potential to be affected. 3. Systemic Changes A) Dietary team members will be re-educated regarding the importance of monitoring food expiration dates and properly sealing plus correctly labeling food that has been opened. 4. Monitoring Dietary Manager /Designee will audit food storage areas to ensure that all food is within expiration dates and stored properly once opened every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Administrator. Section 2 1. Corrective Action All food not labeled properly was discarded on 7/29/21. 2. Identification of Deficient Practice All residents that receive food that is stored in a common refrigerator have the potential to be affected. 3. Systemic Changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24 portions and open packages...Discard food past the use-by or expiration date..." No further information regarding this issue was provided to the survey team prior the exit conference. 2. The facility staff failed to ensure refrigerated food was appropriately stored/labeled. The following information was found in a facility policy with the subject "FOOD AND SUPPLY STORAGE" (with a revised date of May 2021): - "All food, non-food items and supplies used in food preparations shall be stored in a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption." - "Cover, label and date unused portions and open packages. Complete all sections on a (name omitted) orange label, or use the (name omitted) or other approved labeling system ... Refer to the Food Storage Chart in this policy to determine the discard date for food items." On 7/29/21 at 9:40 a.m., a food storage refrigerator located in the nurses station on one (1) of the facility's households/units was observed with CNA (certified nursing assistant)/Household Coordinator (Employee #21). Employee #21 confirmed the refrigerator in question held resident food items. Multiple food items, included a sandwich from a restaurant, was observed to not be labeled with a date indicating when the item would need to be discarded. Employee #21 discarded the sandwich. On 7/29/21 at 9:45 a.m., the aforementioned refrigerator was observed with the Administrator	F 812	A) Discarded all food that was not properly labeled in common refrigerator for resident food storage. B) Nursing team members will be re-educated regarding the importance of labeling open food properly per Food and Supply storage policy. 4. Monitoring Clinical Coordinator /Designee will audit food storage areas to ensure that all food is labeled properly per policy every week for 4 weeks, every other week for 4 weeks and every month for four months. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 and Director of Nursing (DON). No dated labels were found on the following opened items: one (1) container of ice cream; two (2) containers of whipped topping; one (1) container of strawberries; one (1) bottle of water; one (1) container of minced garlic; and one (1) container of caramel sauce. These items were discarded by the facility's administrative team members who were present during the observation.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to maintain essential equipment in the residents bathroom for 1 of 30 residents, Resident #107. The findings included: For Resident #107, the bathroom sink was inoperable. There was a plastic bag placed over the sink in the bathroom and the sink in the nurses station. The face sheet in Resident #107's clinical record included the diagnoses, multiple sclerosis, chronic obstructive pulmonary disease, and type 2 diabetes. Section C (cognitive patterns) Resident #107's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 06/30/21 included a (BIMS) brief interview for	F 908	1. Corrective Action Resident #107□s bathroom sink was repaired and the plastic bag was removed on 7/28/21. 2. Identification of Deficient Practice All residents have the potential to be affected. 3. Systemic Changes Nursing staff have been re-educated regarding the use of Worxhub to put in a maintenance request instead of just putting a plastic bag over a leaking sink. Maintenance /designee will complete an audit on all residents sinks to ensure they work properly and not covered with a plastic bag. 4. Monitoring Maintenance /Designee will audit resident sinks to ensure they are working properly	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 26 mental status summary score of 15 out of a possible 15 points. Section H (bladder/bowel) had been coded to indicate the resident had a catheter (suprapubic foley catheter). 07/28/21 8:30 a.m., observation in Resident #107's bathroom. A black trash bag was observed to be placed over the bathroom sink. Resident #107 stated the sink did not work and the staff would go to another room to get hot water. 07/28/21 8:52 a.m., surveyor observed a black trash back over the sink in the nurses office on three East. Three (CNAs) certified nursing assistants were observed in the hallway and stated they go where they can to find water. 07/28/21 9:07 a.m., clinical coordinator stated the staff were using the sink in the pantry to wash their hands and they were not aware the sink in Resident #107's bathroom was inoperable. 07/28/21 9:13 a.m., maintenance technician stated they were not aware the office sink did not work but were aware that Resident #107's sink was not working and there was an ongoing plumbing problem in the building. This building was slated to be closed and the residents moved. 07/28/21 9:19 a.m., clinical coordinator stated they would put a work order in for the sink. 07/28/21 9:43 a.m., administrator, maintenance director and the (DON) director of nursing were made aware of the issues regarding the sinks on 3 East. The maintenance director stated they did not have a work order for the inoperable sink for Resident #107 bathroom.	F 908	every week for 4 weeks, every other week for 4 weeks and every month for four months to ensure compliance. Results of the observations will be reported to the QAPI Committee for review, analysis and recommendations. 5. Dates of Completion: September 10, 2021 6. Title of Person Responsible for Implementation: Maintenance Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495013	A. BUILDING _____ B. WING _____	07/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 27 07/28/21 11:23 a.m., Resident #107's sink was observed to be working. 07/28/21 5:15 p.m., the issue with the inoperable sink was again reviewed with the administrator and DON. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 908		