PRINTED: 04/27/2022 FORM APPROVED OMB NO. 0938-0391

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 _			09	/11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		603 N	ET 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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		EC	00			
F 000 F 576 SS=E	survey was conducted 09/11/19. The facility compliance with 42 C Requirement for Long emergency preparedr investigated during th INITIAL COMMENTS  An unannounced Me conducted 09/10/19 to Corrections are requirements. The Li survey/report will follow investigated during the The census in this 60 at the time of the survey consisted of 35 reside Right to Forms of Corrections of Corrections of Corrections in the survey consisted of 35 reside Right to Forms of Corrections	was in substantial FR Part 483.73, g-Term Care Facilities. No ness complaints were e survey.  dicaid standard survey was through 09/11/19. red for compliance with 42 Il Long Term Care fe Safety Code low. No complaints were e survey.  certified bed facility was 57 rey. The survey sample ent reviews. mmunication w/ Privacy r(9)	F 5				10/18/19
	including TTY and TD the facility where calls	the use of a telephone, D services, and a place in s can be made without being des the right to retain and at the resident's own					
	individuals and entitie facility, including reas (i) A telephone, include	's right to communicate with s within and external to the					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	•		TITLE		(X6) DATE

Electronically Signed 10/03/2019

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 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.

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F 576	the ability to send may \$483.10(g)(8) The reand receive mail, and and other materials or resident through a magnetic service, including the (i) Privacy of such cowith this section; and (ii) Access to statione implements at the residence of the service selectronic communication (i) If the access to the resident (ii) At the resident's expense is incurred the access to the resident (iii) Such use must collaw.  This REQUIREMENT by:  Based on Resident if the facility staff failed with regard to the rig Residents (Resident #19, #41, #46, #42, #Resident #20) in a sure Residents.  The findings included	ge, writing implements and ail.  sident has the right to send do to receive letters, packages delivered to the facility for the eans other than a postal eright to: communications consistent  ery, postage, and writing sident's own expense.  sident has the right to have of and privacy in their use of ations such as email and as and for internet research.  ailable to the facility expense, if any additional by the facility to provide such ant.  comply with State and Federal  T is not met as evidenced  Interview and staff interview of to uphold Resident Rights to receive mail for 15  #45, #56, #2, #49, #51, #25, #24, #40, #16, #18, and urvey sample of 35	F 57	1. A facility staff member was designated by the Administrator/desig on 9/11/19 to obtain the mail for all residents at the nursing facility on Saturdays. The mail will be distributed the residents upon return. Residents #56, #2 #49, #51, #25, #19, #41, #46, #42, #24, #40, #16, #18 and #20 have had delivery of all mail received on Saturday since 9/11/19.  2. All residents who reside at the ce	I to #45,	
	held at 3 PM, all of th	Resident Council meeting ne Residents in attendance, eceive any mail on Saturdays,		have the potential to be affected. All current residents who receive mail will		

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KIVEKSIDI	E CONVAL CENTER-IV	MINEW		MATHEWS, VA 23109			
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F 576	Saturdays prior to de During the Resident Residents identified the post office to pic Employee F gets the Residents.  Following the Resident Residents.  Following the Resident Residents.  Following the Resident	stomed to receiving mail on coming to the facility.  It Council meeting the I that the receptionist goes to ck up the mail, in her absence, e mail and delivers it to  Ident Council meeting an ucted with Employee F. When all delivery for Residents, "to my knowledge no, they aturdays".  PM an interview was facility Administrator. The advised that during the eeting the 15 Residents in ey do not receive mail on ministrator stated, "the post stant to delivering mail here". eene goes to the post office to Saturdays and distribute it to inistrator stated, "no, we have  If AM, the facility Administrator didn't meet the requirements. cost master this morning to that delivery for us [referring to	F 5	have it delivered on Saturd 3. Facility staff and leaded been re-educated on the coregarding Resident Rights Communication with private Administrator/designee on resident council meeting of Activity Director will review the new process for Saturd delivery. A letter will be provened and RR solution to notific thange.  4. The Administrator/designee on the results of the audit will the QAPI meeting by the Administrator/designee for compliance and on-going recontinuous improvement and the provened	ership have senters policy to Forms of cy by the 10/4/19. At 110/16/19 the with residents day mail rovided to all fy them of this signee will audit weeks ensuring the weekend. If the provided to all forms of the weekend at revaluation of monitoring for		

				SURVEY PLETED		
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F 600 SS=D	facility we would delive the facility currently remaster stated "they hand someone comes pick it up". When askable to pick up mail of master stated "sure". any restrictions to whe post master stated "the determine, anyone with determine, anyone with determine, anyone with determine and box] can commaster went on to satisfactory about the mail deliver have told them where heard back from them the Administrator calls move forward with the No further information Free from Abuse and CFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation  The resident has the neglect, misappropriation and exploitation as desincludes but is not limic corporal punishment, any physical or chemit treat the resident's metals.	[mail receptacle] at the ver there". When asked how eceives mail, the post ave a post office box here, about every day or two, to ked if facility staff would be in Saturdays, the post. When asked if there are or can pick up the mail, the mat is for the facility to lith the key to the box [post ome in and get it." The post by, "they approached me ry, about 3 months ago. I lead to put the box. I haven't in until this morning, when lead me stating he wanted to be process."  In was provided.  Neglect  Mabuse, Neglect, and  right to be free from abuse, ation of resident property, lefined in this subpart. This littled to freedom from involuntary seclusion and ical restraint not required to ledical symptoms.  By must-  e verbal, mental, sexual, or		576		10/18/19
	§483.12(a)(1) Not use physical abuse, corpo involuntary seclusion	oral punishment, or				

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F 600	by: Based on observation	Γ is not met as evidenced on, staff interview, facility	F 60	A facility reported incident			
	the facility staff negle services to prevent a Resident (Resident #	w, and clinical record review, ected to provide goods and n elopement for one 436), who had been identified ement, in a survey sample of		and an investigation was initial regarding the elopement involved resident #36 on 9/25/19. At the incident a wander guard wand determined to be function by an elopement reassessment plan was updated for wander guard was updated for wander guard regarder.	ving ne time of /as placed al followed nt. The care	<b>3</b>	
	The findings included	<b>!</b> :		placement on 6/29/19. No elop resident #36 have occurred sin	pements for		
	3/4/16. Her diagnosi	dmitted to the facility on s included but were not hallucinations, dementia, betes.		2. All residents will remain fr abuse and neglect and failure goods. Elopement risk assess all residents will be reviewed a by the DON/designee by 10/14	main free from failure to provide assessments for ewed and updated		
	set) (an assessment (assessment references as a quarterly assess coded as having a Bi Memory Status) scor severe cognitive impalso coded as requiristaff for her activities included: transfers, ke unit, dressing, toilet unit assessment of References as a quarterly assessment as a quarterly	ce date) of 8/7/19 was coded sment. Resident #36 was IMS (Brief Interview for e of 7, which indicated airment. Resident #36 was ng extensive assistance of of daily living which ocomotion on and off of the use, and personal hygiene.		doors were checked for prope and locking by the Director of Environmental Services on 9/2 alarms and wanderguard device checked using a scanning/test to ensure they were working p 3. The DON/designee will reclinical, including Rehab, non-and licensed staff on neglect to goods and services to prevent elopement by 10/8/19. All resireviewed weekly at the At Risk the IDT team to ensure eloper	r closure  23/19. Doo ces were ting device properly. e-educate the clinical state o provide t an dents will be k Meeting b ment	ne ff	
	Place on her wrist. \ However, a review of revealed that on 2/21 was discontinued.  Resident #36's clinical	d a wander guard bracelet in  f Resident #36's careplan  1/19 the wander guard alarm  al record also revealed an vandering evaluation"		prevention devices are in place appropriate.  4. The DON/designee will at residents at risk for elopement per MDS schedule and or any condition as indicated for 4 we for 8 weeks to ensure that all if are appropriate. The results of will be reported at the QAPI me	udit 2 t per week change in eeks then 1 intervention f the audit	s	

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F 600	#36 was assessed to at risk for unsafe war Review of Resident # an entry on 4/4/19 at "redirected from atter this shift. Noted to be was unable to propel into the lobby. Stated redirect without difficing roll about facility in he bed by staff at appropage Another nursing note [9:27pm] that read, "raround building in he 1930 [7:30pm] this nuapproach exit door by redirected from door. [7:45pm] Resident watthe building right outs staff questioned Resident stated "waitin her face. A wander gresident's right wrist, be a good idea to plate Review of the clinical revealed that on 6/29 placed on the Reside and the careplan was 6/30/19 to reflect the wander guard braceled. On 9/11/19 at approx was conducted with the Director of Clinical Section 1.	that indicated, Resident be at risk for elopement and ordering.  #36's nursing notes revealed 22:45 [10:45pm] that read, mpts to exit door to lobby x 2 et able to push door open but her wheelchair thought [sic] de "I'm leaving". Able to cult [sic]. Noted to continue to ear wheelchair until placed in priate time."  #4 entry on 6/29/19 at 21:27 resident noted wandering or wheelchair. Approximately curse seen [sic] resident at approximately 1945 as found outside, in front of side the double doors. When ident on what she was doing, and for you" with a smile on unard was placed on family agreed that this would lice wander guard again."  #4 record for Resident #36 bif19 a wander guard was ent following the elopement is reviewed and revised on implementation of the	F 600	the Director of Nursing/design evaluation of compliance and monitoring for continuous impranalysis.	on-going	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 600	interventions had bee identification of the ware elopement which occa Review of the facility Prevention and Mana page 2, "neglect is the employees or service and services to a resi avoid physical harm, emotional distress".	reed that no revisions or in implemented following the andering risk to prevent the urred.  policy titled, "Abuse gement Policy" read on e failure of the facility ,its providers to provide goods dent that are necessary to pain, mental anguish, or	F 600		10/18/19	
SS=D	CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on Resident a documentation and cl facility staff failed to in	y must develop and icies and procedures that:  It and prevent abuse, ion of residents and esident property,  Is h policies and procedures the allegations, and  It training as required at  It is not met as evidenced  Ind staff interview, facility inical record review the mplement abuse policies for #4) in a survey sample of 35		1. The facility reported the injury of unknown origin involving resident #3 of 9/24/19 and resident #4 on 9/25/19. A investigation was initiated on resident and #4. No injuries of unknown origin have been noted with resident #3 and since 9/11/19.	on .n s #3	

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F 607	Continued From pag  1. For Resident #3 timplement abuse poorigin.  The findings included Resident #3 an 85 yethe facility on 4/26/16 limited to chronic kid gait and movement, dysfunction, aphasia muscle weakness, depilepsy, and history recent MDS (Minimu as having a BIMS (B Status) score of 11 ir impairment. Resider assistance of 2 persobed mobility, transfer assistance of 1 persoother ADL's.  On 9/11/19 during clifound that Resident is origin.	e 7 he facility staff failed to licy for injury of unknown	F 6	2. All residents who reside a have the potential to be affect current residents with skin tea bruising occurring since 9/11/ reviewed by the DON/Designe any injury of unknown origin v reported.  3. Facility staff in all departr leadership have been re-educenters policy titled abuse premanagement, mandated repoinvestigating injuries of unknown the Administrator/designee or 4. The DON/designee will rehour report at Morning Meetin documentation of impaired sk monitor for injuries of unknown the need to complete a Facilit Incident (FRI). DON/designee impaired skin integrity concern for 4 weeks and then 2 concern weeks to ensure immediate in was completed and for timely of a facility reported incident (injuries of unknown origin The these findings will be reported meeting by the Director of Nursing/designee for evaluation.	at the center ted. All ars and 19 will be ee to ensure were ments and cated on the evention and orting, and on own origin by a 10/4/19. Eview the 24 ag for all cin integrity to an origin and cy Reportable e will audit 4 as per week erns for 8 anvestigation completion (FRI) for e results of d at the QAPI on of	DATE
	purple bruise on r [rig (cheek) measuring 1 any harm done, or he nurse that she may hedrail, or possibly la night. Will continue of	M - CNA reports finding ght] side of resident's face .5 cm X 3 cm, denies pain, ow it got there verbalized to have been too close to the aying on her hands during the observe MD and RR aware."		compliance and ongoing mon continuous improvement anal		

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 607	regarding bruising to Denied anyone harm anyone, and express she can go to in case what had happened resident shrugged he asleep" She then puindicating she might scratched her face on ight which may hav not in need of trimmi padded to prevent further and the management of the manag	I - Resident was interviewed the right side of her face. Sing her, denied fear of sed understanding of who se of concern. When asked to cause the bruising er shoulders and said " I was at her hands to her face, have laid on her hands, ar hit the side rail during the se caused the bruising. Nails and and side rails have been ture occurrence."  I facility abuse policy read:  I immediately review and tions or observations of the sadministrator or his or her tative and to other officials in the law, including to the State in 5 working days of the days for incidents in Assisted ged violation is verified the action must be taken. Will conduct analysis for related to incidents (i.e. falls, for injury of unknown origin, for reportable incidents, etc.) in the law including to the original state, and local law.	F 60			

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F 607	Continued From pag	ge 9	F 60	07		
		uittee will monitor trends and changes in facility policy or				
	"Page 5 - Reporting					
	ensure that all allegeneglect exploitation injuries of unknown of resident property no later than 2 hours if the events that catabuse or result in set than 24 hours if the allegation do not invin serious bodily injuto the administrator designee, and to oth State Survey Agenciservices where state in long-term care face	will maintain systems to ed violations involving abuse or mistreatment including source, and misappropriation are reported Immediately, but a after the allegation is made, use the allegation involve vious bodily injury: porno later events that cause the olve abuse and do not result ary. The reports will be made of the facility, or his or her her officials (including to the y and adult protective e law provides for jurisdiction cilities) in accordance with stablished procedures."				
	DON she stated that unknown origin we of then we investigate happened." When State first before the stated "Well we investigate abuse we will report produce any documnotification of OLC.  9/11/2019 at 5: 20 P	PM In an interview with the t " When we find an injury of do a full body assessment and what we think could have asked if they notified the investigation was done she stigate and if we think its it." The DON could not ents of investigation or				
	the surveyors about	rence room to discuss with why the facility staff did not known origin for Resident #3.				

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Continued From pag	e 10	F 60	7		
understanding of the assessment of the si requirement of being.  He also stated that F verbalize due to her no one had harmed anyone. They had onot suspicious and of that Resident could bumped against the  On 9/11/19 at 5:45 F meeting the Adminis	regulation and our tuation, it did not meet the a reportable incident."  Resident #3 was not able to aphasia but she agreed that her and she was not afraid of determined the bruises were ould be explained by the fact have lain on her hands or side rail.  PM during the end of day trator was made aware of				
operationalize the about of bruises and a skind bruises in June 2019.  Resident # 4 was a stoth the facility on 10/3 diagnoses included by Vascular Dementia, and Psychosis.  The most recent MD a Quarterly Assessm Reference Date of 6. Resident #4 as having Mental Status) Score	tear in April 2019 and be tear in April 2019				
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA  SUMMARY S' (EACH DEFICIENC REGULATORY OR  Continued From page The Administrator standerstanding of the assessment of the si requirement of being He also stated that F verbalize due to her no one had harmed anyone. They had onot suspicious and of that Resident could be bumped against the  On 9/11/19 at 5:45 F meeting the Administrator and no furth the facility on 10/3 diagnoses in June 2019  Resident # 4 was a state to the facility on 10/3 diagnoses included by Vascular Dementia, and Psychosis.  The most recent MD a Quarterly Assessman Reference Date of 6 Resident #4 as having Mental Status) Score cognitive impairments.	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 10  The Administrator stated "Based on the understanding of the regulation and our assessment of the situation, it did not meet the requirement of being a reportable incident."  He also stated that Resident #3 was not able to verbalize due to her aphasia but she agreed that no one had harmed her and she was not afraid of anyone. They had determined the bruises were not suspicious and could be explained by the fact that Resident could have lain on her hands or bumped against the side rail.  On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided  2. For Resident # 4, the facility staff failed to operationalize the abuse policies after discovery of bruises and a skin tear in April 2019 and bruises in June 2019.  Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder	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 10  The Administrator stated "Based on the understanding of the regulation and our assessment of the situation, it did not meet the requirement of being a reportable incident."  He also stated that Resident #3 was not able to verbalize due to her aphasia but she agreed that no one had harmed her and she was not afraid of anyone. They had determined the bruises were not suspicious and could be explained by the fact that Resident could have lain on her hands or bumped against the side rail.  On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided  2. For Resident # 4, the facility staff failed to operationalize the abuse policies after discovery of bruises and a skin tear in April 2019 and bruises in June 2019.  Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder and Psychosis.  The most recent MDS (Minimum Data Set), was a Quarterly Assessment with an Assessment Reference Date of 6/26/2019. The MDS coded Resident #4 as having a BIMS (Brief Interview of Mental Status) Score of 12, indicating moderate cognitive impairment. Resident # 4 was coded as	ROWIDER OR SUPPLIER  E CONVAL CENTER-MATHEW  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 10  The Administrator stated "Based on the understanding of the regulation and our assessment of the situation, it did not meet the requirement of being a reportable incident."  He also stated that Resident #3 was not able to verbalize due to her aphasia but she agreed that no one had harmed her and she was not afraid of anyone. They had determined the bruises were not suspicious and could be explained by the fact that Resident could have lain on her hands or bumped against the side rail.  On 9/11/19 at 5:45 PM during the end of day meeting the Administrator was made aware of concerns and no further information as provided  2. For Resident # 4, the facility staff failed to operationalize the abuse policies after discovery of bruises and a skin tear in April 2019 and bruises in June 2019.  Resident # 4 was a 71 year old who was admitted to the facility on 10/3/17. Resident # 4's diagnoses included but were not limited to Vascular Dementia, Major Depressive Disorder and Psychosis.  The most recent MDS (Minimum Data Set), was a Quarterly Assessment with an Assessment Reference Date of 6/26/2019. The MDS coded Resident #4 as having a BIMS (Brief Interview of Mental Status) Socre of 12, indicating moderate cognitive impairment. Resident #4 was coded as	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONST	TRUCTION	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING _			09	/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		603 MAIN	ADDRESS, CITY, STATE, ZIP CODE N STREET WS, 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 607	Continued From pag	e 11	F 6	607				
		of Daily Living (ADLs) total assistance of one staff						
		I record was conducted on f the Nurses Notes revealed						
	summoned me to rest to her left upper arm measuring at 2 cm x where the bruise can don't know." Asked i denied. Resident prothe facility MD Medic	4/28/19 at 3:52 a.m"CNA sidents room to see a bruise bark (sic) blue in color 2 cm. Asked if she knew ne from. Resident stated "I f anyone hurt her which she opels herself all throughout al Doctor) and RR sentative) made						
	skin tear just above to noted, 0/1 x 0.4 cm, not what happened, Assistant) reports the scratching at the bruimplemented, MD/RF	mResident noted to have a pruise to left arm, previously resident states that she does but CNA (Certified Nursing at she not (sic) the resident use on 4/29/19. Protocol R (Medical Representative) aware.						
	documentation on 6/2 bruises noted to top of measuring 8.6 x 4.5 to right upper arm ne 2.5 cm. Resident de	nurse's notes revealed 30/19 of "several small of residents right hand cm. And two bruises noted ear elbow measuring 6.0 X nies pain. Does not recall urred. Denies anyone harmed ) needed."						
		p.m., an interview was proctor of Nursing (DON)						

* *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	MULTIPLE CONSTRUCTION  LIDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/1	1/2019	
	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 607	bruises or skin tear to investigated it and de were probably caused walls or rails. The DC stated that she was nhad hurt her. The DC witness statements on Resident # 4's BIMS Status) Score, the DC the clinical record to DON replied that Resident responsible party. The did have a diagnosis diagnoses.  Review of the Facility and Management Poleofology will be main identification and reposuspicious bruising of patterns and trends the and to determine the investigation.  4. Investigation  Designated staff will investigate all allegationses.  a) The results of all incommunicated to the designated represent accordance with State Survey Agency, within incident	staff did not report the State Agency because they termined that the bruises d by her bumping into the N stated Resident # 4 ot afraid and that nobody N stated there were no btained. When asked about (Brief Interview for Memory N stated she would check determine the score. The sident # 4 was not her own he DON stated Resident # 4 of Dementia and Psychiatric policy on Abuse Prevention licy Last Revision Date of Review: 08/15/2019:  Staff are encouraged and stained to promote timely borting of events, such as fresidents, occurrences, that may constitute abuse;	F 607				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			09/11/2019
	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 DEFICIEN	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 607	Continued From pag		F 60	07		
	skin tears, bruising o	related to incidents [i.e. falls, or injury of unknown origin, s, reportable incidents, etc]				
	ensure that all allegeneglect, exploitation injuries of unknown of resident property, but not later than 2 hade, if the events to involve abuse or resonot later than 24 houthe allegation do not result in serious body made to the administance to the administance of the State Survey Agreevices where state in long-term care facts State law through estimated in the state of the state	will maintain systems to ed violations involving abuse, or mistreatment, including source and misappropriation are reported immediately, nours after the allegations is that cause the allegation ult in serious bodily injury; or are if the events that cause involve abuse and do not ally injury. The reports will be trator of the facility, or his or oother official (including to ency and adult protective alaw provides for jurisdiction collities) in accordance with stablished procedures.  The organization will alleged violations involving ading injuries of unknown				
	investigation and no ever conducted and agency by the facility	led no initial report, no 5 day follow up report, were submitted to the state y, as per regulation. There tements obtained for either				
	4:50 p.m., the facility	y debriefing on 9/11/2019 at Administrator, Corporate ad Director of Nursing were				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _		09	/11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 607	the DON came into the discuss with the survestaff did not report brown Resident # 4 to the S Administrator stated, understanding of the assessment of the sit requirement of being Administrator also state origin of the bruises origin been harmed determined it was not administrator stresses regulation was where no need to report the determined the bruise could be explained by propelled herself throwseen bumping into the stated Resident # 4 do	gs.  D.P.M., the Administrator and the conference room to beyors about why the facility uses of unknown origin for tate Agency. The "Based on the regulation and our uation, it did not meet the a reportable incident." The pated they agreed that the was not known but because amped into walls and denied by anyone, the facility staff at reportable. The did that the second part of the entry determined there was bruises. They had the ses were not suspicious and by the fact that Resident # 4 to the fact that Resident # 5 to the fact that Resident	F6	07		
F 609 SS=D	Reporting of Alleged CFR(s): 483.12(c)(1)(s) §483.12(c) In responsing to the properties of the propert	Violations	F 6	09		10/18/19
	involving abuse, negl					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109	00/11/2010
(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 COMPLETION
F 609	are reported immedia hours after the allegal that cause the allegal serious bodily injury, the events that cause abuse and do not rest the administrator of	priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ault in serious bodily injury, to me facility and to other the State Survey Agency and ces where state law provides aterm care facilities) in the law through established the results of all administrator or his or her tative and to other officials in the law, including to the State and 5 working days of the leged violation is verified to action must be taken. The is not met as evidenced and staff interview, facility linical record review the eport allegations of abuse and #4) in a survey sample of	F 60'	1. The facility reported the injury of unknown origin involving resident #3 of 24-19 and resident #4 on 9/25/19. No injuries of unknown origin have been noted with residents #3 or #4 since 9/11/19.  2. All residents who reside at the cent have the potential to be affected. All current residents with skin tears and bruising occurring since 9/11/19 will be reviewed by the DON/Designee to ensany injury of unknown origin were reported.  3. Facility staff in all departments are leadership have been re-educated on centers policy titled abuse prevention.	nter e sure nd the

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 _			09/	11/2019	
	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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 609	epilepsy, and history most recent MDS (Mi Resident as having a Mental Status) score cognitive impairment. extensive assistance assistance for bed mand extensive assistance for other A On 9/11/19 during clir found that Resident # source.  An excerpt from page read:  "Page 5 - Reporting 6) The organization wensure that all allegeneglect exploitation of injuries of unknown sof resident property and later than 2 hours if the events that causabuse or result in ser than 24 hours if the eallegation do not invoin serious bodily injure to the administrator of designee, and to othe State Survey Agency services where state in long-term care faci State law through estimated.	ementia, vascular dementia, of left femur fracture. The nimum Data Set) codes BIMS (Brief Interview of of 11 indicating moderate Resident was coded as of 2 person physical obility, transfers and bathing ince of 1 person physical ADL's.  Inical record review it was and an injury of unknown at 4 of the facility abuse policy will maintain systems to diviolations involving abuse of mistreatment including ource, and misappropriation re reported Immediately, but after the allegation is made, see the allegation involve ious bodily injury: porno later vents that cause the live abuse and do not result y. The reports will be made of the facility, or his or her er officials (including to the	F 6	management, investigating unknown origin, and manda by the Administrator/designe 4. The DON/designee will hour report at Morning Meet documentation of impaired smonitor for injuries of unknoneed to complete a Facility Incident (FRI). DON/designe impaired skin integrity conce for 4 weeks and then 2 conce weeks to ensure immediate was completed and for time of facility reported incidents unknown origin The results findings will be reported at the meeting by the Director of Nursing/designee for evaluate compliance and ongoing motontinuous improvement and the state of the st	ated reporting the ee on 10/4/ I review the ting for all skin integrity own origin a Reportable ee will auditerns per we cerns for 8 investigation of these the QAPI action of conitoring for	19. 24 y to nd 4 ek on on of		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		TE SURVEY
		49E215	B. WING _			09/11/2019
	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	TATEMENT OF DEFICIENCIES BY 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 609	unknown origin we d then we investigate we happened." When a State first before the stated "Well we invest abuse we will report produce any docume notification that the in reported to the state On 9/11/19 at 5:45 P meeting the Administ	"When we find an injury of o a full body assessment and what we think could have asked if they notified the investigation was done she stigate and if we think its it." The DON could not ents of investigation or njury of unknown source was	F 6	09		
	report the discovery April 2019 and bruise Resident # 4 was a 7 to the facility on 10/3 diagnoses included by Vascular Dementia, I and Psychosis.  The most recent MD a Quarterly Assessm Reference Date of 6/Resident #4 as havin Mental Status) Score cognitive impairment requiring extensive a persons for Activities	1 year old who was admitted				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			9/11/2019	
	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 CY 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 E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From pag	ne 18	F 60	9			
	Review of the clinica 9/11/2019.	ıl record was conducted on					
	Review of the Nurse	s Notes revealed:					
	summoned me to re- to her left upper arm measuring at 2 cm x where the bruise car don't know." Asked denied. Resident pr the facility MD Medic	4/28/19 at 3:52 a.m"CNA sidents room to see a bruise bark (sic) blue in color 2 cm. Asked if she knew me from. Resident stated "I if anyone hurt her which she opels herself all throughout cal Doctor) and RR sentative) made					
	have a skin tear just	19 at 9:14 -Resident noted to above bruise to left arm, x 0.4 cm, resident states					
	Review of the clinica documentation of the of the bruises and sk	e State Agency being notified					
	documentation on 6/bruises noted to top measuring 8.6 x 4.5 to right upper arm no 2.5 cm. Resident de how the bruises occiher. No TX (treatmet On 9/11/219 at 3:15 conducted with the E the facility staff did not top to the staff did not top top top top top top top top top t	e nurse's notes revealed (30/19 of "several small of residents right hand cm. And two bruises noted ear elbow measuring 6.0 X enies pain. Does not recall eurred. Denies anyone harmed int) needed."  p.m., an interview was Director of Nursing who stated ot report the bruises or skin ency because " I feel that the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/11/2019
	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 610 SS=D	resident propels hers and bumps into thing: Interview for Mental Sus if she was afraid on When asked about the policies about reportioning, the DON state report, investigate and the investigations. The felt the bruises are explained since Residumping into things.  Thorough review of the clinical record reveals investigation and not ever conducted and sugency by the facility. During the end of day 4:50 p.m., the facility Nurse Consultant and informed of the finding.  No further information Investigate/Prevent/CCFR(s): 483.12(c)(2)-\$483.12(c) In responsing the end of the finding investigate/Prevent/CCFR(s): 483.12(c)(2)-\$483.12(c) In responsing the end of the finding investigate/Prevent/CCFR(s): 483.12(c)(2)-\$483.12(c)(2) Have exploitations are thorough \$483.12(c)(3) Preventions and the property of the pr	elf throughout the facility is and with her BIMS (Brief Status) score, she could tell in if something happened." e facility's expectations and ing injuries of unknown did the facility staff would did then report the results of the DON again stated that and skin tear could be dent # 4 was observed often the facility documentation and the did no initial report, no to day follow up report, were submitted to the state of debriefing on 9/11/2019 at Administrator, Corporate did Director of Nursing were ges.  In was provided.  Correct Alleged Violation of abuse, or mistreatment, the facility evidence that all alleged ghly investigated.  It further potential abuse, or mistreatment while the	F 609		10/18/19

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		09/11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 503 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 610	designated represer accordance with Sta Survey Agency, with incident, and if the a appropriate corrective. This REQUIREMENT by:  Based on Resident documentation and a facility staff failed to Residents (#3 and #8 Residents.)  The findings include  1. For Resident #3 investigate injury of Resident #3 an 85 years the facility on 4/26/1 limited to chronic king gait and movement, dysfunction, aphasia muscle weakness, depilepsy, and history recent MDS (Minimus)	t the results of all administrator or his or her attative and to other officials in the law, including to the State in 5 working days of the lleged violation is verified to action must be taken.  T is not met as evidenced and staff interview, facility clinical record review the investigate abuse for 2 4) in a survey sample of 35 d:  the facility staff failed to unknown source.  ear old woman admitted to 6 with diagnoses of but not liney disease, abnormalities of memory loss, cognitive a following cerebral infarction, tementia, vascular dementia, of left femur fracture. Most im Data Set) codes Resident	F 610	1. The facility reported and investigathe injury of unknown origin involving resident #3 on 9/24/19 and resident #4 9-25-19. No injuries of unknown origin have been noted with resident #1, resident # 3 and #4 since 9/11/19.  2. All residents who reside at the cert have the potential to be affected. All current residents with skin tears and bruises occurring since 9/11/19 will be reviewed by the DON/Designee to ensall injuries of unknown origin were investigated and reported as appropria 3. Administrator/designee will re-educlinical, including rehab and licensed s non-clinical and leadership on the cent policy titled abuse prevention, investigating injuries of unknown origin and mandated reporting by 10/14/19.	ure ute. ucate taff, ters
	Status) score of 11 i impairment. Reside assistance of 2 pers bed mobility, transfe assistance of 1 pers other ADL's.  On 9/11/19 during cl	rief Interview of Mental ndicating moderate cognitive nt was coded as extensive on physical assistance for rs and bathing and extensive on physical assistance for inical record review it was #3 had an injury of unknown		facility will investigate and immediately report all impaired skin integrity concer and will report all injuries of unknown origin.  4. The DON/designee will review the hour morning report at Morning Meetin for all documentation of impaired skin integrity for investigation and etiology. Events involving impaired skin integrity that occur on the weekend and off hour	ns 24 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 503 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 610	source.  On 9/11/19 at approfor FRI (Facility Rep Investigation docum regards to the bruise made known.  Approximately 2:45 conference room an FRI's for this resider investigation docum none.  On 9/11/19 at 5:45 Fineeting the Administration for the second secon	ximately 2:00 PM, a request	F 610	will be communicated to the On-cal Manager or Administrator. All injuri unknown origin will have a Facility Reported Incident (FRI) completed. DON/designee will audit 4 impaired integrity concerns per week for 4 wand then 2 impaired skin integrity concerns weekly for 8 weeks to ensimmediate investigation was compleand for timely completion of a facilit reported incident (FRI) for injuries ounknown origin. The results of the awill be reported by the DON/designethe QAPI meetings for evaluation of compliance, ongoing monitoring for continuous improvement analysis.	The skin eeks sure eted by of audits ee at f
	thoroughly investiga and a skin tear in Ap 2019.  Resident # 4 was a to the facility on 10/3 diagnoses included Vascular Dementia, and Psychosis.  The most recent ME a Quarterly Assessin Reference Date of 6 Resident #4 as havi Mental Status) Scor cognitive impairment requiring extensive a	the facility staff failed to te the discovery of bruises oril 2019 and bruises in June 71 year old who was admitted 8/17. Resident # 4's but were not limited to Major Depressive Disorder 0S (Minimum Data Set), was ment with an Assessment 1/26/2019. The MDS coded ing a BIMS (Brief Interview of e of 12, indicating moderate t. Resident # 4 was coded as assistance of one to two staff is of Daily Living (ADLs)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING	·····	09/11/2019
	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 610	Continued From pag	e 22	F 61	0	
	except she required person for bathing.	total assistance of one staff			
	Review of the clinica 9/11/2019.	I record was conducted on			
		s Notes revealed injuries of 4/25/19, 5/1/19, and 6/30/19.			
	conducted with the D who stated the facility bruises or skin tear to "investigated it and d were probably cause walls or rails." The D stated that she was r had hurt her. The Do witness statements of Resident # 4's BIMS Status) Score, the Do the clinical record to DON replied that Res responsible party. T	op.m., an interview was birector of Nursing (DON) by staff did not report the constant State Agency because they determined that the bruises and by her bumping into the ON stated Resident # 4 not afraid and that nobody ON stated there were no obtained. When asked about (Brief Interview for Memory ON stated she would check determine the score. The sident # 4 was not her own the DON stated Resident # 4 of Dementia and Psychiatric			
	clinical record reveal day follow up report, submitted to the state per regulation. There statements obtained During the end of day 4:50 p.m., the facility	for either incident.  y debriefing on 9/11/2019 at Administrator, Corporate d Director of Nursing were			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49E215	B. WING		09/11/2019
	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 BY 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 COMPLETION
F 610	Continued From page	e 23	F 610		
F 657 SS=D	No further information Care Plan Timing and CFR(s): 483.21(b)(2)	d Revision	F 65	7	10/18/19
	be- (i) Developed within a the comprehensive a (ii) Prepared by an in includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive the resident and the resident and their and their resident reprot practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii)Reviewed and reviteam after each assecomprehensive and cassessments. This REQUIREMENT by: Based on observation documentation review the facility staff failed	orehensive care plan must  of days after completion of seessment.  terdisciplinary team, that nited to ysician.  e with responsibility for the  d and nutrition services staff.  cticable, the participation of resident's representative(s).  be included in a resident's participation of the resident oresentative is determined to development of the  e staff or professionals in ined by the resident's needs the resident.  ised by the interdisciplinary sement, including both the quarterly review  of is not met as evidenced  on, staff interview, facility we, and clinical record review, to review and revise the ident (Resident #36) in a		1. On 2/27/19 resident # 36 was assessed as an elopement risk by the MDS Coordinator. On 6/29/19 the car plan was updated to include wanderin behavior and elopement risk.	re l

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 _			09/11/2019	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	00.120.10	
				603 MAIN STREET			
RIVERSID	DE CONVAL CENTER-I	MATHEW		MATHEWS, VA 23109			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 657	Continued From particles of the findings included For Resident #36 the care wandering behavior elopement risk.  Resident #36, was 3/4/16. Her diagnor limited to: psychos hypertension and continued for the finding and the f	age 24  led:  the facility staff failed to review eplan following identification of or and identification of an admitted to the facility on osis included but were not is, hallucinations, dementia,	F6	DEFIC	t risk for elopement. I complete an audit to have had a elopement since ired care planning omplete and  nical ucate the MDS ag comprehensive randering and IDS will educate the IDT nsive care plans to elopement risk by e will audit 2 and then 1 per risk and the use of wander ive care plans. The I be reported at the iON/designee for ce and ongoing		
	bed by staff at app  Another nursing no [9:27pm] that read, around building in	her wheelchair until placed in ropriate time."  ote entry on 6/29/19 at 21:27 , "resident noted wandering her wheelchair. Approximately nurse seen [sic] resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		09	/11/2019
	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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	[7:45pm] Resident was the building right outs staff questioned Resident stated "waiting her face. A wander guresident's right wrist, be a good idea to plan Resident #36's clinical "elopement/unsafe was completed on 2/27/19 #36 was assessed to at risk for unsafe wandering of the careplation revisions or interversions or interversions or interversions and atternal type and the state of the careplation of the careplation of being identified on 2/27/19 * wandering and atternal type wandering on 6/29/20 On 9/11/19 at approximate was conducted with the Director of Clinical Seand Employee E reviewed to the state of	At approximately 1945 as found outside, in front of ide the double doors. When dent on what she was doing, ag for you" with a smile on uard was placed on family agreed that this would be wander guard again."  It record also revealed an andering evaluation" that indicated, Resident be at risk for elopement and dering.  In for Resident #36 revealed entions in response to the gran elopement risk as anpt to exit into the lobby on the DON and Employee E, ervices. The 2 of them, DON ewed the careplan for reed that no revisions or in implemented following the andering risk to prevent the urred.	F 65	57		
F 658 SS=D	Services Provided Me	eet Professional Standards	F 65	58		10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER:  A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP CODE 503 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 658	Continued From pag §483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professiona This REQUIREMEN by: Based on observatic clinical record review provide care and se professional standar resident (Resident # residents.  The findings include For Resident #43, L guards were adminiguards had not beer Resident #43, an 89 admitted to the facili included but not limit Resident #43 also h hands.  Resident #43's mos	ge 26 prehensive Care Plans ed or arranged by the facility, comprehensive care plan,  I standards of quality. T is not met as evidenced  ons, staff interview, and w, the facility staff failed to rvices in accordance with rds of practice for one e43) in a sample size of 35  EPN A signed off that palm estered when in fact the palm in administered. E-year old female, was ty on 08/31/2016. Diagnoses ted to Alzheimer's disease. as contractures of both  t recent Minimum Data Set	F 658	1. Resident #43 had the palm protect re-applied by the unit nurse on 9/11/19. The Director of Nursing provided 1:1 education to LPN A and LPN B on 9/11 who failed to comply with the order on 9/11/19. Resident #43 has had no negative outcome from the palm protect not being in place.  2. On 9/11/19 rounds were made by DON on all other residents to ensure placement of ordered adaptic/orthotic devices. Any adaptive/orthotic devices in place were immediately addressed. adaptive/orthotic equipment since 9/11 will be audited for application of compliance by DON/designee by 10/8/ All omissions will have 1:1 education provided to nursing staff by DON/designee.  3. Clinical Educator/Designee will	tor . /19 ctor the not All /19	
	Brief Interview for M Cognitive skills for d coded as severely in bed mobility and dra requiring extensive a toileting, and persor total dependence or	led as a quarterly review. The ental Status was not coded. aily decision-making was impaired. Functional status for essing was coded as assistance from staff. Eating, all hygiene were coded as a staff.		educate the licensed and clinical staff of the process of providing care and servin accordance to provider orders by 10/4/19.  4. The DON/Designee will audit for placement of adaptive orthotic equipme on 2 residents per week for 4 weeks the 1 resident weekly for 8 weeks. The resident of the audit will be reported at the QAP meeting by the Director of	ent en ults	
		oproximately 12:00 PM, bserved sitting in her		Nursing/designee for evaluation of compliance and on-going monitoring for	or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			09/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-M	ATHEW		STREET ADDRESS, CITY, STATE, ZIP 6 603 MAIN STREET MATHEWS, VA 23109	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	that she had contract there were no palm observations at 1:30 #43 was observed a guards applied.  On 09/10/2019 at applied.  On 09/10/2019 at applied.  On 09/10/2017 docume protectors on at all to to contractures of the contracture of the	air watching TV. It was noted stures to both hands and guards applied. Subsequent PM and 3:06 PM, Resident nd there were no palm  proximately 4:30 PM, the eviewed. with a start date of inted, "Bilateral palm mes except bathing D/T [due in hands."  dministration Record for treatment initiated on "Bilateral palm protectors on athing D/T contractures of the of as administered each shift. In Paragraphic PM A) signed off the palm red.  1:30 AM, LPN B was asked if the stated that she was caring do she was also precepting or shared concern with LPN B has observed yesterday applied and asked if she that. She stated she did see Resident #43 did not have herday but did not know why may have been dirty and laundry. When asked about placement palm guards are end they have extras in the fain stated she didn't know	F 6	continuous improvement a	ınalysis.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/	/11/2019	
	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 DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 658	Continued From pag		F 658	3			
F 688 SS=D	audit of the Treatme 09/10/19 to include the facility provided a consistory. LPN A signer administered on 11:1 was just before there observations of Resignards on by this surph, 1:30 PM, and 3 addressing if the pall some reason.  On 09/11/2019 at apadministrator and the information or docurrease/Prevent Dec CFR(s): 483.25(c)(1) The faresident who enters range of motion doer range of motion unlecondition demonstrator of motion is unavoid \$483.25(c)(2) A resimption receives appropriate assistance to maintathe maximum practice.	ecrease in ROM/Mobility )-(3) acility must ensure that a the facility without limited s not experience reduction in ess the resident's clinical tes that a reduction in range	F 688			10/18/19	

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		09/11	1/2019		
NAME OF PROVIDER OR SUPPLIER  RIVERSIDE CONVAL CENTER-MAT	THEW		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109				
PREFIX (EACH DEFICIENCY			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRION DEFICIENCY)	BE	(X5) COMPLETION DATE
by: Based on observation clinical record review, provide assistance to resident (Resident #43; residents.  The findings include:  1. For Resident #43, t apply palm guards as  Resident #43, an 89-y admitted to the facility included but not limite Resident #43 also has hands.  Resident #43's most r with an Assessment R 08/14/2019 was coded Brief Interview for Mer Cognitive skills for dai coded as severely impled mobility and dress extensive assistance fand personal hygiene dependence on staff.  On 09/10/2019 at app Resident #43 was obs specialized wheelchai that she had contract, there were no palm gu	is not met as evidenced as, staff interview, and the facility staff failed to maintain mobility for one 3) in a sample size of 35  the facility staff failed to ordered by the physician.  The rear old female, was on 08/31/2016. Diagnoses d to Alzheimer's disease. The contractures of both  The recent Minimum Data Set the ference Date of d as a quarterly review. The notal Status was not coded. Ity decision-making was poaired. Functional status for sing was coded as requiring from staff. Eating, toileting, were coded as total  The revertise of the recent was noted are sto both hands and pards applied. Subsequent and 3:06 PM, Resident	F 688	1. Resident #43 had the palm protect re-applied by the unit nurse on 9/11/15. The Director of Nursing provided 1:1 education to LPN A and LPN B on 9/17 who failed to comply with the order on 9/11/19. Resident #43 has had no negative outcome from the palm prote not being in place.  2. On 9/11/19 rounds were made on other residents by the DON to ensure placement of ordered Adaptec/orthotic devices. Any adaptive/orthotic devices in place were immediately addressed. adaptive/orthotic equipment since 9/17 will be audited for application of compliance by DON/designee by 10/8 All omissions will have 1:1 education provided to nursing staff by DON/designee.  3. Clinical Educator/ Designee will educate the licensed and clinical staff the process of providing care and serv in accordance to provider orders by 10/4/19.  4. The DON/designee will audit for placement of adaptive orthotic equipm on 2 residents per week for 4 weeks the 1 resident weekly for 8 weeks. The resident weekly for 8 weeks the QAF meeting by the Director of Nursing/designee for evaluation of compliance and on-going monitoring for continuous improvement analysis.	ector all s not All 1/19 /19.  on vices			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			09/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш	,	STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109	DDE		
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F 688	clinical record was re A Physician's Order of 10/19/2017 document protectors on at all tirto] contractures of the On the Care Plan, a poly01/2016 document compromise D/T skin associated with this poly03/24/2017 document protectors to hands a bathing."  On the Treatment Ad September 2019, a treatment and september 2019, a treatment and september 2019, a treatment and september 2019 for the Practical Nurse A (LF guards as administer On 09/10/2019 for the Practical Nurse A (LF guards as administer On 09/11/2019 at 8:00 observed lying in her on both hands.  On 09/11/19 at approximate with LPN B confirmed she was cast and this surveyor et to perform a skin ass LPN B removed the put that there was a left if the left hand and the	proximately 4:30 PM, the viewed. with a start date of sted, "Bilateral palm mes except bathing D/T [due e hands."  problem area initiated on sted, "At risk for skin integrity fragility". An intervention problem initiated on sted, "Bilat [bilateral] palm st all times except for  ministration Record for reatment initiated on shill the state on shill the state of the of as administered each shift. The start of the of as administered each shift. The start of the palm of the palm of the start of the palm of the palm of the start of the palm	F 68	38			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49E215	B. WING			)9/11/2019	
	ROVIDER OR SUPPLIER	ATHEW		STREET ADDRESS, CITY, STATE, ZIP COI 603 MAIN STREET MATHEWS, VA 23109	•	35711/2010	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 688	observed with the cohand. This surveyor caring for Resident #LPN B stated that sh #43 and she was als surveyor shared con Resident #43 was obpalm guards applied anything about that. in her shift that Resident guards on yesterday added that they may to go to the laundry. process when replace needed, LPN B state supply room and agawhy the palm guards. On 09/11/2019 at 1:3 of findings. The DON palm guards were not yesterday and when they stated that the palm guards. When laundry or (Resident the palm guards were not yesterday and when they stated that the palm guards. When asked that the palm guards as toler when asked what we pertaining to the palm guards as toler when asked to observed the order. The locate the order. The	asked LPN B if she was asked LPN B. This cern with LPN B that asked if she knew and asked if she knew She stated she did see later dent #43 did not have palm but did not know why and have been dirty and needed When asked about the asked about the asked she didn't know as were not applied.  B5 PM, the DON was notified asked she saw that the att on (Resident #43) she asked the staff about it, and guards were either in asked about the asked a	F 68	38			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING		09/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш		STREET ADDRESS, CITY, STATE, ZIP CODE 603 MAIN STREET MATHEWS, VA 23109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 688	"OT [occupational the protectors." When as important for (Reside	erapy] requested for palm ked why palm guards were nt #43), the DON stated	F 68	8		
F 689 SS=D	"keep her from gettin moisture."  On 09/11/2019 at appaudit of the Treatmer 09/10/19 to include ti facility provided a cophistory. LPN A signed administered on 11:0 was just before there observations of Resid guards on by this sur PM, 1:30 PM, and 3:0 On 09/11/2019 at appadministrator and the information or docum Free of Accident Haz CFR(s): 483.25(d)(1)  §483.25(d) Accidents The facility must ensight \$483.25(d)(1) The reas free of accident has \$483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on observation	dent #43 without palm veyor on 09/10/19 at 12:00 06 PM.  proximately 5:45 PM, the proximately 5:	F 68	The unit nurse applied a	10/18/19	
	documentation review the facility staff failed	w, and clinical record review,		wander-guard to resident #36 on 6-29- and then the completion of the elopem- risk assessment was completed on 9-2	ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			TE SURVEY MPLETED
		49E215	B. WING _			9/11/2019
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP	•	
				603 MAIN STREET		
RIVERSID	E CONVAL CENTER-M	ATHEW		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	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 689	Continued From pa	ge 33	F 6	689		
	Resident (Resident to be at risk for elop 35 Residents.	#36), who had been identified ement, in a survey sample of		19 by the DON. The care updated on 6-29-19. Ther further elopements of resi 9/11/19.	re have been no ident # 36 since	
	3/4/16. Her diagnost limited to: psychosist hypertension and discrete hypertension assessment reference as a quarterly as	admitted to the facility on sis included but were not s, hallucinations, dementia, abetes.  It recent MDS (minimum data t tool) with an ARD nce date) of 8/7/19 was coded asment. Resident #36 was BIMS (Brief Interview for ore of 7, which indicated pairment. Resident #36 was ring extensive assistance of s of daily living which locomotion on and off of the		2. All residents at risk for be audited by the DON/De accuracy of the elopement assessments and wander placement by 10/8/19 and will be corrected.  3. Clinical Educator/desteducate the licensed and staff on adequate supervisor notification to leadership to the elopement on those identification to the elopement on the elopement on the elopement reviewed in morning meet IDT At Risk Meeting week 10/7/19  4. DON/designee will reall elopement assessment	esignee for at risk riguard d any variances signee will clinical nursing sion and to prevent iffied at risk with ars by 10/4/19. All at risks will be ting and at the dy starting eview and update ts per MDS	
	included: transfers, locomotion on and off of the unit, dressing, toilet use, and personal hygiene.  Observation of Resident #36 on 9/11/19 revealed that she did have a wanderguard bracelet in place on her wrist.  Review of Resident #36's nursing notes revealed an entry on 4/4/19 at 22:45 [10:45pm] that read, "redirected from attempts to exit door to lobby x 2 this shift. Noted to be able to push door open but was unable to propel her wheelchair thought [sic] into the lobby. Stated "I'm leaving". Able to redirect without difficult [sic]. Noted to continue to roll about facility in her wheelchair until placed in bed by staff at appropriate time."			schedule and any change indicated followed by audi at risk for elopement per wweeks, then 1 for 8 weeks interventions are appropri of the audit will be reporte meeting by the Director of Nursing/Designee for eval compliance and on-going continuous improvement a	iting 2 residents week for 4 s to ensure all tate. The results at at the QAPI f luation of monitoring for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		49E215	B. WING _			09/11/2019	
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	тнеш		STREET ADDRESS, CITY, STATE, ZIP CO 603 MAIN STREET MATHEWS, VA 23109	ODE		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	1930 [7:30pm] this mapproach exit door by redirected from door. [7:45pm] Resident where building right outs staff questioned Resident stated "waiting her face. A wander gresident's right wrist, be a good idea to plate the state of the stat	r wheelchair. Approximately urse seen [sic] resident y dd's salon, resident At approximately 1945 as found outside, in front of side the double doors. When ident on what she was doing, ing for you" with a smile on uard was placed on family agreed that this would ince wander guard again."  #36's careplan revealed that erguard alarm was ent #36's clinical record also ent/unsafe wandering in a contract of the following: an revealed no revisions or onse to the following: an elopement risk as mpt to exit into the lobby on 19 at 19:30.  M, an interview was on an interview was on an eceptionist on duty in the following of the door". The DON by had a receptionist on duty	F	589			

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			09/	11/2019
	ROVIDER OR SUPPLIER  E CONVAL CENTER-MA	THEW	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 303 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	asked if this process #36, the DON stated, assessment on her".  On 9/11/19 at 1:48 Pl conducted with Emploirector of Operation would expect to see of the facility unsupervision would get statements occurred, when the reassess the resident, to prevent reoccurrer.  No further information Food Procurement, Since CFR(s): 483.60(i)(1)(1)(1)(1)(2)(1)(2)(2)(3)(3)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	rd on". The DON was was followed for Resident "yes, we did a full body  M, an interview was oyee C, the (RDO) Regional s. When asked what she done when a resident exits sed, the RDO stated, "we from staff regarding what esident was last seen, out an intervention in place nce."  In was provided. tore/Prepare/Serve-Sanitary 2)  ty requirements.		812			10/18/19
	(i) This may include for from local producers, and local laws or regulii) This provision does facilities from using planders, subject to consafe growing and fool (iii) This provision does from consuming food §483.60(i)(2) - Store,	subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not procured by the facility.  prepare, distribute and ance with professional					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) ML IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49E215	B. WING _			09/11/2019	
	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	(EACH CORRECTI CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
F 812	This REQUIREMENT by: Based on observation documentation review the facility staff failed with professional stars safety for 3 Residents #18, and Resident #2 Residents.  The findings included Resident #14 was ad 3/22/19. Resident #1 on 2/1/19. Resident #1 on 2/1/19. Resident #1 on 2/1/19. Resident #1 on 2/1/19, at 12:28 setting up the meal trigrasped the top of the hand and cut the correlipped the ear of correlipped the plate of Resident with the correlipped the top of the hand and cut the correlipped the top of the hand and cut the correlipped the ear of correlipped t	is not met as evidenced  n, staff interview, facility y, and clinical record review, to serve food in accordance adards for food service s (Resident #14, Resident 9) in a survey sample of 35  :  mitted to the facility on 8 was admitted to the facility #29 was admitted to the  8 PM CNA B was observed ay for Resident #14. CNA B be corn cob with her bare n off of the cob. CNA B then n over, and cut off the corn uching with her bare hands, dent #14.  6 PM CNA B was observed ay for Resident #29. CNA B be corn cob with her bare n off of the cob. CNA B then n over, and cut off the corn uching with her bare n off of the cob. CNA B then n over, and cut off the corn uching with her bare hands, dent #29. CNA B was also be dinner roll with her bare	F8	1. The Director of N provided 1:1 education B regarding the proper preparation of food food safety requirement #18 and #29 on 9/10/2. All residents are serve food in accordate professional standard safety. Director of Four Services/designee with for food service safet variances will have in education provided.  3. The Director of Four Services/designee with licensed, clinical, inclinical staff of residents prepared manner by 10/8/19.  4. The Director of Four Services/designee with service 3 times per well service 3 times per well times per week for compliance of food safety the QAPI meeting by Nursing/designee for compliance and on-grontinuous improvement.	on to CNA A and C er handling and or the compliance of ents for resident #1/19.  at risk for failure to ance with ds for food service od ill observe all 3 me by by 10/8/19. All nmediate 1:1  Food ill re-educate the luding Rehab staff, on proper handling a food in a safe food ill audit meal delive reek for 4 weeks the 8 weeks to ensure afety requirements dit will be reported the Director of evaluation of oing monitoring for	NA  of 114,  o eals  ery nen  c. at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		49E215	B. WING		09/1	1/2019	
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 DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETION  DATE		
F 812	off the corn that she bare hands, onto the Dare hands, onto the On 09/11/19, at 01:3 conducted with CNA she and CNA A were Resident's food with asked if it is routine serving residents. Obut it was an ear of else to do."  On 09/11/19, at 03:0 conducted in the co D, the Dietary Mana expects facility staff their bare, un-gloved dietary manager stanegative, yesterday the resident's shuck season they wanted event." When asked to cut the corn off of stated "use a fork to asked if staff are peneeded while prepanded while prepanded while prepanded in the dietary manager of facility staff touch hands, the dietary manager of facility staff touch hands of the facility st	the ear of corn over, and cut had been touching with her e plate of Resident #18.  34 PM, an interview was AB. CNAB was advised that e observed to touch their bare hands and was for them to touch food when CNAB stated, "they say not to, corn and I didn't know what  35 PM, an interview was inference room with Employee inger. When asked if he to touch Resident's food with it hands when serving, the sted: "that would be a would be a special occasion, ed the corn. Since it is in the lit and it is not an every day in the did hands when serving and they would expect staff if the cob, the dietary manager is hold and cut it." He was infirm Resident food he stated they have access to gloves. It was asked what the risk are ing food with their bare manager stated, everything."  They policy titled "Handling wing)" read, "staff should not the hands. To the extent	F 8 <sup>-</sup>	12			
	Resident Food (Ser handle food with ba possible, food is had	ving)" read, "staff should not re hands. To the extent ndled with utensils; when this es may be used and changed					

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 _			09/11/2019	
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	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	According to the "20" the U.S. Public Healt Drug Administration of page 69 stated: "3-30 Contamination from I may not contact exportant forms of the page 69 stated and the page 69 stated and the page 69 stated and the page 60 sta	In Food Code" published by the Service, FDA U.S. Food & chapter 3, section 3-301.11, 201.11 Preventing Hands. FOOD EMPLOYEES aboved, READY-TO-EAT the hands and shall use such as deli tissue, spatulas, eves, or dispensing the failure of facility staff to ance with professional ervice safety during an end of 19 at 4:54 PM.	F8	12			