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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 05/13/24 through 05/15/24. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000	This plan of correction is our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 5/13/24 through 5/15/24. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three (3) complaints were investigated during the survey: 1. VA00057885 - Compliant with Regulations 2. VA00058502 - Compliant with Regulations 3. VA00059917 - Compliant with Regulations The Life Safety Code survey/report will follow. The census in this 112 certified bed facility was 108 at the time of the survey. The survey sample consisted of 23 current resident reviews and 6 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550	**F550** **Corrective action(s)** Resident #89's call bell times for the remainder of the stated day were reviewed with others being in normal range. A facility Incident Report was completed for failure to adequately respond to Resident #89's request for toileting assistance. **Identification of Deficient Practice(s) and Corrective Action(s)** This practice could potentially affect all patients on the unit on that day. Those patients' call bell times were reviewed with nothing out of the ordinary found. All other residents residing on	June 26, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 5/31/24

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.

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, facility staff failed to ensure the resident was treated with dignity related to toileting for 1 of 23 current residents in the survey sample (Resident #89).	F 550	Resident #89's unit on stated day may have potentially been affected. The DON and/or designee will conduct an audit of these residents' call bell records to ensure that call bells were responded to within expected and acceptable timeframes. Any/all negative findings will result in the completion of an Incident Report and notification to the attending physician. **Systemic Change(s)** Facility policy and procedures have been reviewed with no revisions warranted at this time. The DON and/or designee will in-service all licensed staff on Resident Rights with special importance on treating residents with dignity in responding to call bells timely and appropriately. **Monitoring** The DON is responsible for maintaining compliance. Call bell times will be reviewed each morning in morning meeting (with Mondays to include a review of the weekend) daily for four weeks to ensure proper response times have been achieved. After the initial four-week review, call bell response times will be reviewed weekly between the DON and Administrator for an additional four weeks. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reporting to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 550	Continued From page 2	F 550		

Resident #89 was admitted to the facility with diagnoses which included aftercare joint replacement, anemia, hypertension, anticoagulants, abnormal gait, and a history of pulmonary embolism. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behavior affecting care.

During initial tour on 5/13/2024, Resident #89 complained that she was left on the toilet for 2 1/2 hours on 5/12/24.

On 5/14/24, the surveyor received the call Alarm History for the resident's room from 5/12/24 at 12:00 AM through 5/13/24 at 12 AM. The log documented a call from the bed active from 10:21:01 through 12:21:41 (duration 120 minutes). The log documented 7 calls from the bathroom starting at 12:41:27 and ending 14:44:48 (duration in minutes 7.55, 9.33, 2.78, 18.52, 38.28, 39.07, and 6.68) indicating the resident had been in the bathroom for 122 minutes.

The surveyor discussed the Alarm History with the director of nursing (DON), stating that it appeared the resident had been left in the bathroom for a significant amount of time.

Nursing staff working on 5/13 reported that neither of the nurses or aids working that day had worked on 5/12. The surveyor reported the concern to the director of nursing (DON) and asked to contact the nurse responsible for the resident's care on 5/12/24. On 5/14, the DON supplied the nurse's contact information, however, the nurse was unable to make contact

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 550	Continued From page 3 with the nurse for an interview. Activity of daily living notes documented the resident used the toilet 1 time during the day shift on 5/12/24. The administrator and DON were notified of the ongoing concern during a summary meeting on 5/14/2024.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580	**F580** **Corrective action(s)** Resident #69's provider was notified of resident #69's weight loss. No orders were changed. An Incident & Accident form was completed for the failure to properly notify the physician of the noted weight loss. **Identification of Deficient Practice(s) and Corrective Action(s)** This practice could potentially affect all current patients who had experienced a significant weight loss. Those patients who had experienced a significant weight loss within the last 30 days will be audited. Negative findings will result in a proper notification to the provider and completion of an Incident & Accident form. **Systemic Change(s)** Facility policies and procedures have been reviewed. Going forward, the dietitian will notify the provider and responsible party when a patient experiences significant weight loss. Dietitian was in-serviced on the need to properly notify the provider and responsible party in the event of a significant weight loss. **Monitoring** The DON is responsible for maintaining compliance. The DON or designee will work with the dietitian to audit this process weekly for four weeks (during the risk management meeting) to ensure proper notifications have	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 580	Continued From page 4 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify and consult with the medical provider following a significant weight loss for 1 of 23 current sampled residents, Resident #69. The findings included: For Resident #69, the facility staff failed to notify and consult with the medical provider following a significant weight loss identified on 3/11/24. Resident #69's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Convulsions, Parkinson's Disease, Lymphedema, Essential Hypertension, and	F 580	occurred. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. This will continue monthly for two months. Following this, the results will be reviewed at QAPI for review, analysis, and recommendations for change in facility policy, procedure, or practice.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 580	Continued From page 5 Second-Degree Atrioventricular Block. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #69 was coded as having had a significant weight loss without a physician-prescribed weight loss regimen. A review of Resident #69's weights revealed a weight of 160.6 on 3/01/24 and a weight of 148.6 on 3/11/24 revealing a 12-pound/7.47% loss in 10 days. The resident's most recent weight of 137.8 was obtained on 5/13/24. Surveyor reviewed Resident #69's clinical record and was unable to locate evidence of medical provider notification of the significant and sustained weight loss. Surveyor spoke with the Director of Nursing (DON) on 5/15/24 at 11:10 AM regarding Resident #69's significant weight loss. The DON was unable to provide evidence of medical provider notification of the weight loss. Surveyor requested and received the facility policy titled "Weight Assessment and Intervention" dated 10/2023 which read in part " ...3. Any significant weight changes since last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the dietician and the physician/practitioner ..." On 5/15/24 at 3:15 PM, the survey team met with the Administrator and DON and discussed the	F 580		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 580	Continued From page 6 concern of staff failing to notify the medical provider of Resident #69's significant weight loss. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582	**Corrective action(s)** Resident 69's Responsible Party was made aware of the facility's failure to properly provide a SNF ABN when the resident was discharged from Medicare Part A services with skilled benefit days remaining. **Identification of Deficient Practice(s) and Corrective Action(s)** All other residents for whom an ABN should have been issued could have been affected. An audit of these patients over the last 30 days will be completed with any negative findings corrected at the time of discovery and responsible party notified. **Systemic Change(s)** Facility policy and procedures have been reviewed with no changes warranted at this time. The Social Services team has been in-serviced on the regulation to provide a SNF ABN to residents when they are discharged from Medicare Part A services with skilled benefit days remaining. **Monitoring** The Social Services Director is responsible for maintaining compliance. The Social Services Director will provide a copy of all ABN's to the Administrator for review weekly for four weeks. A monthly review will continue for another two months after that. Negative findings will be corrected at the time of discovery with disciplinary action taken, as necessary. Aggregate findings of these reviews will be reported to the Quality Assurance Committee for	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 582	Continued From page 7 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (ABN) notification for 1 of 3 residents selected for SNF Beneficiary Notification Review (BNR), Resident #69. The findings included: For Resident #69, the facility staff failed to provide a SNF ABN notification when the resident was discharged from Medicare Part A services with skilled benefit days remaining while continuing to reside in the facility.	F 582	review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Results will be reviewed in our next QAPI meeting, with any potential misses corrected as soon as identified.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 582	Continued From page 8	F 582		

Resident #69's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Convulsions, Parkinson's Disease, Lymphedema, Essential Hypertension, and Second-Degree Atrioventricular Block.

The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/11/24 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems.

Resident #69's clinical record included a social services progress note dated 3/18/24 10:36 AM which read in part, "SW [social worker] spoke with [name omitted]/POA [power of attorney] via phone. Explained Notice of Non-coverage and appeal rights. Made aware of effective date of 3-20-24 as date of skilled services ending and date financial liability to begin on 3-21-24. Informed that a request for an immediate appeal should be made as soon as possible, but no later than noon on the day before the effective date. Provided QIO [Quality Improvement Organization] Contact # [number omitted]. Confirmed that the representative understood all information explained. Last skilled day will be 3-20-24 and will be discharged on 3-21-24. A copy of the NOMNC [Notice of Medicare Non-Coverage] was mailed to [name omitted]."

Surveyor requested to view notices that were provided to the resident's POA when discharged from Medicare Part A services. On 5/14/24 at 2:54 PM, the Administrator provided a copy of a NOMNC dated 3/18/24 and stated they could not locate an ABN notice for Resident #69.

On 5/15/24 at 3:15 PM, the survey team met with

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 582	Continued From page 9 the Administrator and Director of Nursing and discussed the concern of staff failing to issue Resident #69 a SNF ABN. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to accurately complete a minimum data set (MDS) assessment for 2 of 23 residents, Resident #65 and #102. The findings included: 1. The facility staff failed to accurately complete a quarterly MDS assessment. The facility staff failed to mark the resident self-catheterization (intermittent catheterization). Resident #65's diagnoses included, obstructive and reflux uropathy, chronic kidney disease, and diabetes. Section C (cognitive patterns) of Resident #65's quarterly MDS assessment with an assessment reference date (ARD) of 04/10/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded always continent of urine. The	F 641	**Corrective action(s)** Resident #65 had a modification assessment completed to appropriately capture the intermittent catherization. Resident #102's discharge assessment was modified to accurately reflect the discharge destination. **Identification of Deficient Practice(s) and Corrective Action(s)** All residents who are receiving assistance with foley catheters and self-catheterization could have potentially been affected by the issue impacting Resident #65. A review of all these patients' assessments will be completed to discover any discrepancies in self-performance of the tasks and the assessment. All residents who discharged home in February 2024 could have potentially been affected by the issue impacting Resident #102. A review of these patients' assessments will be completed to discover any discrepancies in discharge destination. Any/all negative findings will be corrected at the time of discovery with a modification assessment completed and an Incident Report completed for each occurrence. **Systemic Change(s)** Facility policy & procedure have been reviewed with no changes warranted at this time. The IDT has been in-serviced on correctly coding their respective sections of the resident assessment to ensure accuracy	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	**3719 KNOLLRIDGE ROAD 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 641	Continued From page 10 box beside of intermittent catheterization was left blank (unchecked). On 05/13/24 during initial tour Resident #65 stated they did their own catheterization and had been doing so for a while. Resident #65's clinical record included a provider order dated 05/25/23 that read "Resident to self cath 4 times a day." On 05/14/24 at 8:45 a.m., during an interview with MDS Coordinator/Registered Nurse #1 this staff reviewed the MDS and confirmed catheterization was not marked on the MDS. On 05/14/24 at 4:00 p.m., during an end of the day meeting with the Administrator and Director of Nursing (DON) the inaccurate MDS was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 641	**Monitoring** The Director of Clinical Reimbursement will be responsible for maintaining compliance. Assessments are run through a scrubber to ensure completion and similarly identified residents will have their assessments reviewed to ensure accuracy in coding of urinary assistive devices and discharge destinations. Assessments will be tracked weekly for eight weeks in conjunction with the weekly risk meeting, with negative findings corrected at the time of discovery and disciplinary action taken as warranted. Aggregate findings will be taken to the Quality Assurance Meeting for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 641	Continued From page 11 2. For Resident #102, the facility staff coded the resident as being discharged to a hospital when in fact the resident had been discharged home. Resident #102's diagnosis list indicated diagnoses, which included, but not limited to Wedge Compression Fracture of T11-T12 Vertebra, Syndrome of Inappropriate Secretion of Antidiuretic Hormone, Protein-Calorie Malnutrition, Cirrhosis of Liver, and Type 2 Diabetes Mellitus. The discharge minimum data set (MDS) with an assessment reference date (ARD) of 2/29/24 coded the resident as being discharged to a short-term general hospital. However, a 2/29/24 12:25 PM nursing progress note read in part "Patient discharged home ..." Resident #102's clinical record also included a medical provider order dated 2/29/24 stating "D/C [discontinue] all meds [medications] and tx [treatment] pt [patient] discharged home". On 5/15/24 at 10:19 AM, surveyor spoke with the MDS Nurse and requested they review the MDS coding related to the resident's discharge location. The MDS Nurse returned at 1:34 PM and provided documentation indicating the 2/29/24 discharge MDS had been corrected to indicate Resident #102 was discharged home. On 5/15/24 at 3:15 PM, the survey team met with the Administrator and Director of Nursing and discussed the concern of the inaccurate MDS coding for Resident #102. No further information regarding this concern was	F 641		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 641	Continued From page 12 presented to the survey team prior to the exit conference on 5/15/24.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 whether the resident's desire to return to the	F 656	**Corrective action(s)** Activity care plans were implemented for Residents #34 and #26 and the provider was notified. A facility Incident & Accident form was completed for both occurrences. **Identification of Deficient Practice(s) and Corrective Action(s)** All residents who have had been identified as benefitting from one-to-one activities in their room could have potentially been affected. The activities records of these patients will be audited to ensure that the comprehensive care plan developed for these patients has been followed. Negative findings will be corrected at the time of discovery with an Incident & Accident form completed and the provider notified. **Systemic Change(s)** Facility policy and procedure have been reviewed with no changes warranted at this time. The Director of Activities has been in-serviced on the need to follow-through on resident specific plans of care for patients who are determined to benefit from one-to-one activities. **Monitoring** The Director of Activities is responsible for maintaining compliance. An audit of the similarly identified patients' activities records will be audited weekly for four weeks, and then monthly thereafter for two months. Aggregate findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 13 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to implement a comprehensive person-centered activity care plan to provide one-to-one activity programming for two (2) of 23 sampled residents (Resident #34 and Resident #26). The findings include: 1. For Resident #34 (R34) the facility staff failed to implement a comprehensive person-centered activity care plan to provide one-to-one activities in her room two times per week. R34's diagnosis list indicated diagnoses that included, but were not limited to, Dementia, Abnormal Posture, Hemiplegia and Hemiparesis, Aphasia following Cerebral Infarction (stroke), Cognitive Communication Deficit, Depression and Epilepsy. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 02/17/24, coded the resident as having modified independence in cognitive skills for daily decision making with short and long-term memory problems.	F 656		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 14 On 05/14/24 at 10:42 AM, surveyor interviewed R34 about activities and she conveyed activity staff do not do anything in her room with her. A review of the most recent comprehensive activity care plan dated 2/15/24, revealed, "...enjoys independent activities in her room and does not prefer to get out of bed very often...will be encouraged to accept social and active one on one visits at least twice a week...Ensure frequent 1:1 visits to encourage participation in independent activities...Offer social one on one visits such...to help build rapport..." The care plan revealed an initiated date of, "11/25/2015" and a revision date of, "9/5/2023" and no changes were identified for this Focus, Goal, or Interventions during these revisions. On 5/14/24 at 11:05 AM, surveyor interviewed Activity Director (AD) and asked what types of activities are provided for R34. AD stated R34 used to come to bingo, and he has been told she hasn't been feeling well and has not been attending bingo. AD stated she turns down supplies and he holds music twice a month, but she doesn't want to come to bingo now. Surveyor requested to see activity participation records for R34, and AD stated he has no documentation for any activities that he does, and he does not do activity participation records. AD was unable to provide evidence of one-on-one visits with R34. Surveyor requested and received a facility policy for care planning with no title, that revealed, "The facility will develop a comprehensive care plan...which will include measurable objectives and timetables to meet the resident's...mental, and psychosocial needs...PROCEDURE: 1. The	F 656		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 15 comprehensive plan of care...will be designed to: A. Address the needs, risks, strengths, and preferences of the resident..." Surveyor also requested and received a facility policy titled, "...Activities Program", that revealed, "4...Activities are offered in several settings to include: (a) one-to-one programming...for residents who will not or cannot plan their own activity pursuits or residents needing specialized programming to enhance their overall quality of life...6...staff must be assigned to assist with activity programming..." This concern was discussed with the Administrator and DON (director of nursing) at the end of day meeting on 5/14/24 and at pre-exit meeting on 5/15/24. No further information was provided to the survey team prior to exit. 2. For resident #26 (R26) facility staff failed to implement a comprehensive person-centered activity care plan to ensure frequent one-to-one staff visits to encourage socialization. R26's diagnosis list indicated diagnoses that included, but were not limited to, Alzheimer's Disease, Vascular Dementia, Depression, Chronic Pain Syndrome, History of Falling, and Insomnia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 04/14/24, coded the resident as being severely cognitively impaired for making decisions with short and long-term memory problems. A review of the most recent comprehensive activity care plan dated 4/12/24, revealed, "...At	F 656		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 16	F 656		

risk for activity participation related to: cognitive deficit...Will attend/participate in 1 activity a week...Ensure frequent 1:1 staff visits to encourage socialization..." The care plan revealed an initiated date of, "8/16/2022" and a revision date of, "7/14/2023" and no changes were identified for this Focus, Goal, or Interventions during these revisions.

On 5/14/24 at 11:05 AM, surveyor interviewed the Activity Director (AD) and asked what types of activities he provides for R26. AD stated due to her condition he usually tries to involve her in food-related programs. Surveyor asked what he does for one-to-one programming and lower-functioning programming/sensory programming and AD stated he does the best he can. Surveyor requested to see activity participation records for R26, and AD stated he has no documentation for any activities that he does, and he does not do activity participation records. AD was unable to provide evidence of one-on-one staff visits with R26.

Surveyor requested and received a facility policy for care planning with no title, that revealed, "The facility will develop a comprehensive care plan...which will include measurable objectives and timetables to meet the resident's...mental, and psychosocial needs...PROCEDURE: 1. The comprehensive plan of care...will be designed to: A. Address the needs, risks, strengths, and preferences of the resident..."

Surveyor also requested and received a facility policy titled, "...Activities Program", that revealed, "4...Activities are offered in several settings to include: (a) one-to-one programming...for residents who will not or cannot plan their own

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 17 activity pursuits or residents needing specialized programming to enhance their overall quality of life...6...staff must be assigned to assist with activity programming..." This concern was discussed with the Administrator and DON at the end of day meeting on 5/14/24 and at the pre-exit meeting on 5/15/24. No further information was provided to the survey team prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657	**Corrective action(s)** Resident #65's comprehensive care plan was revised during the survey to accurately reflect for self-catheterization and prophylactic antibiotics. A copy was provided to the survey team. Resident #65's attending physician was notified of the facility's failure to update the care plan appropriately. **Identification of Deficient Practice(s) and Corrective Action(s)** All residents receiving urinary assistance devices could have potentially been affected by this practice. All identified residents will have their comprehensive care plan reviewed to ensure that the care plan developed is person-centered and accurate based upon their needs. Any negative findings will be corrected at the time of discovery with the attending physician notified as necessary. **Systemic Change(s)** The facility policy and procedures have been reviewed and no changes are warranted at this time. At the weekly risk meeting, MDS will verify with the unit managers whether there are any new orders for self-catheterization or prophylactic antibiotics and revise care plans accordingly. MDS will also track new admissions for these orders. The IDT team has	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 657	Continued From page 18 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to review and revise the residents comprehensive care plan (CCP) for 1 of 23 current residents, Resident #65. The findings included: The facility staff failed to review and revise the residents CCP to include their prophylactic antibiotic and their self-catheterization. Resident #65's diagnoses included, obstructive and reflux uropathy, chronic kidney disease, and diabetes. Section C (cognitive patterns) of Resident #65's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/10/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate this resident was always continent of urine. The box beside of intermittent catheterization was left blank (unchecked). On 05/13/24 during initial tour Resident #65 stated they did their own catheterization and had been doing so for a while. Resident #65's clinical record included provider orders to self-cath 4 times a day (05/25/23) and for the prophylactic antibiotic Macrobid 100 mg 1	F 657	been in-serviced on accurately developing and revising comprehensive care plans. **Monitoring** The Director of Clinical Reimbursement is be responsible for maintaining compliance. Similarly identified residents will have their comprehensive care plans reviewed weekly for eight weeks, and then monthly thereafter, for two months to ensure accuracy. Negative findings will be corrected at the time of discovery and disciplinary action taken, as necessary. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 657	Continued From page 19 capsule one time a day every Monday, Wednesday, and Friday (06/23/23). During the clinical record review, the surveyor was unable to locate a care plan that included either of these areas. On 05/14/24 at 8:45 a.m., during an interview with MDS Coordinator/Registered Nurse #1 this staff reviewed the clinical record and confirmed there was not a care plan in place for these areas. During and end of the day meeting with the Administrator and Director of Nursing (DON) on 05/14/24 at 4:00 p.m. the issue with Resident #65's CCP was reviewed. On 05/15/24 at 9:00 a.m., the Administrator and DON provided the surveyor with a copy of a revised care plan that included the focus areas alteration in bladder elimination has an order that they may self-cath up to 4 times a day. Receives a prophylactic antibiotic for urinary tract infections. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
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	F 684	**Corrective Action(s)** Resident #93's provider was notified that the facility failed to follow orders for tramadol and gabapentin. No new orders were given in response. A medication error form was completed. Resident #312's provider was notified that the facility failed to follow orders for diazepam and oxycodone. No new orders were given in response. A medication error form was completed.	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 20 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to follow physician's orders for the administration of medications for 2 of 23 residents, Resident #93 and Resident #312. The findings included: 1. For Resident #93 the facility staff failed to administer the medications tramadol and gabapentin per the physician's order. Resident #93's face sheet listed diagnoses which included but not limited to pain in left hip and unspecified dementia. Resident #93's most recent minimum data set with an assessment reference date of 02/17/24 coded the resident as having both long- and short-term memory loss with severely impaired cognitive skills for daily decision making. Resident #93's comprehensive care plan was reviewed and contained care plans for " ... is at risk for altered levels of pain r/t (related to) a dx (diagnosis) of left hip and vertebrae fx (fracture). She has scheduled and prn (as needed) ordered". Resident #93's clinical record was reviewed and contained a physician's order summary which read in part, "tramadol HCl Oral Tablet 50 mg (Tramadol HCl). Give 1 tablet by mouth four times a day for pain" and "Gabapentin capsule 100 mg. Give 1 capsule by mouth every 8 hours for	F 684	**Identification of Deficient Practices/Corrective Action(s)** All other residents may have been potentially affected. The DON and Unit Managers will conduct a 100% audit of all residents' physician orders and MARs over the past 30 days to identify residents at risk. Residents identified at risk will be corrected at the time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s)** The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed Nurses were in-serviced by the DON and/or designee on what medications were available in the CUBEX and the process for gaining access to and administering both controlled and non-controlled medications. **Monitoring** The DON will be responsible for maintaining compliance. Nursing management will perform daily audits for anything missing in the MAR/TAR for two weeks, then weekly for another two weeks, and monthly for two months. Any negative findings will be corrected at the time of discovery with disciplinary actions taken, as necessary. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy or procedure.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 21	F 684		

neuropathy." Resident's clinical record also contained a physician's order which read in part, "tramadol HCl 50 mg. Give 0.5 tablet by mouth two times a day for pain.

Resident #93's electronic medication administration record (eMAR) for the months of March, April, and May 2024 were reviewed and contained entries as above. On 03/18/24, the entry for tramadol was coded "9" at 2 pm and blank at 8 pm. On 03/19/24, the tramadol was coded "MU" at 8 pm. On 04/05/24 the gabapentin was coded "5" at 2 pm. On 04/15/24 and 04/30/24 the tramadol was coded "MU" at 8 pm. On 05/04/24 the gabapentin was coded "MU" at 10 pm. On 05/05/24 the gabapentin was coded "MU" at 6 am and "9" at 10 pm. Chart coded "5" is equivalent to "Hold/See Progress Note." Chart code "9" is equivalent to "Other/See Nurses Notes Effective". Surveyor spoke with the director of nursing (DON) on 05/15/24 at 9:15 am, and asked DON what "MU" on the eMAR meant. DON stated, "Medication unavailable."

Resident #93's nurse's progress notes were reviewed and contained notes which read in part, "3/19/2024 21:32 tramadol HCl Oral Tablet 50 mg. Give 0.5 tablet by mouth two times a day for pain med on order", "4/5/2024 13:23 Gabapentin capsule 100 mg. Give 1 capsule by mouth every 8 hours for Neuropathy. On hold until arrival from pharmacy. MD notified", "4/15/2024 22:30 tramadol HCl Oral Tablet 50 mg. Give 1 tablet by mouth three times a day for pain no tramadol in narc box per nurse that report was taken from she reordered no pain noted at this time and MD was made aware", and "5/52024 21:50 Gabapentin capsule 100 mg. give 1 capsule by mouth every 8 hours for Neuropathy. Medication

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 22 unavailable at this time." There was no note for 05/04/24. Surveyor spoke with registered nurse (RN) #3 on 05/14/24 at 11:30 am regarding unavailability of medications. RN #3 stated that if a medication is unavailable, they check the medication cart, then check to see if the medication is available in the facility Cubex (emergency medication supply). If not available in the Cubex, notify the pharmacy and call the physician. Surveyor requested a list of medications available in the facility Cubex. The medications tramadol 50 mg and gabapentin 100 mg were both listed as available. Surveyor requested and was provided with a facility policy entitled "Ordering and Procuring Extra Doses (XD) of Medication" which read in part, "Policy: A nurse may be required to request an extra dose (XD) of medication for the following reasons: b. Missing dose. Procedure: 1. If a medication is not available in the 24 hour unit dose supply, the nurse will check the next day's bag (same resident and time pass) and remove the unit dose medication from the bag to administer. Document on the outside of the bag that medication was removed and by whom. Also document on the bag that an XD was ordered. 2. The nurse will fax the pharmacy indicating that an extra dose (XD) is required using the 'Extra Dose Request Order Form.'" The concern of not following physician's orders for Resident #93 was discussed with the DON and administrator on 05/15/24 at 3:15 pm No further information was provided prior to exit.	F 684		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 23	F 684		

2. For Resident #312 the facility staff failed to administer the medications diazepam and oxycodone per the physician's orders.

Resident #312's face sheet listed diagnoses which included but not limited to anxiety disorder, long-term (current) use of opiate analgesic and chronic pain syndrome.

Resident #312's most recent minimum data set with an assessment refer date of 05/07/24 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.

Resident #312 is a new admission; therefore, the comprehensive care plan has not been completed.
Resident #312's clinical record was reviewed and contained a physician's order summary which read in part, "diazepam Oral Tablet 5 mg (Diazepam). Give 2.5 mg every morning and at bedtime for anxiety" and "oxycodone HCl Oral Tablet 5 mg (Oxycodone HCl). Give 1 tablet by mouth every morning and at bedtime for pain management."

Resident #312's electronic medication administration record (eMAR) for the month of May 2024 was reviewed and contained entries as above. The entry for diazepam was coded "MU" on 05/10/24 at 9 am and the entry for oxycodone was coded "9" on 05/11/24. Chart code "9" is the equivalent of "Hold/See Nurses Note Effective." Surveyor spoke with the 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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 24	F 684		

(DON) on 05/15/24 at 9:15 am, and asked DON what "MU" on the eMAR meant. DON stated, "Medication unavailable."

Resident #312's nurse's progress notes were reviewed and contained notes which read in part, "5/10/2014 11:36 diazepam Oral Tablet 5 mg. Give 2.5 mg every morning and at bedtime for anxiety. Medication unavailable in stat box. This nurse does not have access to the Omnicell (emergency medication supply). New prescriptions requested by this nurse to be sent in by ... (name omitted) NP (nurse practitioner)" and "5/11/2024 12:27 oxycodone HCl Oral Tablet 5mg. Give 2.5 mg every morning and at bedtime for pain management. Medication is not available, MD is aware."

Surveyor spoke with registered nurse (RN) #3 on 05/14/24 at 11:30 am regarding unavailability of medications. RN #3 stated that if a medication is unavailable, they check the medication cart, then check to see if the medication is available in the facility Cubex (emergency medication supply). If not available in the Cubex, notify the pharmacy and call the physician.

Surveyor requested a list of medications available in the facility Cubex. The medications diazepam 5 mg and oxycodone mg were both listed as available.

Surveyor requested and was provided with a facility policy entitled "Ordering and Procuring Extra Doses (XD) of Medication" which read in part, "Policy: A nurse may be required to request an extra dose (XD) of medication for the following reasons: b. Missing dose. Procedure: 1. If a medication is not available in the 24-hour unit

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 25 dose supply, the nurse will check the next day's bag (same resident and time pass) and remove the unit dose medication from the bag to administer. Document on the outside of the bag that medication was removed and by whom. Also document on the bag that an XD was ordered. 2. The nurse will fax the pharmacy indicating that an extra dose (XD) is required using the 'Extra Dose Request Order Form.'" The concern of not following physician's orders for Resident #312 was discussed with the DON and administrator on 05/15/24 at 3:15 pm No further information was provided prior to exit.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756	**Corrective Action(s):** Residents #7's provider was notified of the pharmacy recommendation from 3/20/24 on 5/2/24 and has since also been notified of the deficient practice of not responding to the recommendation in a more timely manner. Resident #26's provider was notified of the pharmacy recommendations from 1/25/24 and 3/19/24 and has been notified of the deficient practice of not responding to the pharmacy recommendations. **Identification of Deficient Practices/Corrective Action(s)** All other residents receiving pharmacy recommendations may have been potentially affected. The DON and Unit Managers will audit all pharmacy recommendations over the past 30 days to identify any others that had not been reviewed with the provider. Any identified will be corrected when discovered, to include provider notification and care plan update, if needed. **Systemic Change(s):** The facility policy and procedures have been	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 756	Continued From page 26 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow up on pharmacy recommendations for 2 of 5 residents chosen for the unnecessary medication task, Residents #7 and #26. The findings included: 1. For Resident #7, the facility staff did not follow up on a pharmacy recommendation dated 03/20/24 until 05/02/24. Resident #7's diagnoses included, but were not limited to, insomnia and major depressive disorder. Section C (cognitive patterns) of Resident #7's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/15/24 included a brief interview for mental	F 756	reviewed and no changes are warranted at this time. The DON and/or designee will in-service unit managers and household coordinators/unit support on the process of promptly communicating pharmacy recommendations and documenting that notification/any change coming from that notification. **Monitoring:** The DON will be responsible for maintaining compliance. The DON/designee will audit the pharmacy recommendations monthly for the next two months. Negative findings will be corrected at the time of discovery with disciplinary action taken, as necessary. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes to facility policy and procedure.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	**3719 KNOLLRIDGE ROAD 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 756	Continued From page 27 status summary score of 13 out of a possible 15 points. On 03/20/24 the pharmacist documented "Monthly medication regimen and chart review. Please see pharmacist report for recommendation." The surveyor was unable to find this recommendation in the clinical record. On 05/14/24 at 4:00 p.m., during an end of the day meeting with the Administrator and Director of Nursing (DON) the missing pharmacy recommendation was reviewed. On 05/15/24, the DON provided the surveyor with a copy of a pharmacy recommendation dated 03/20/24 requesting the provider to consider a gradual dose reduction (GDR) of the medications Ramelteon and Buspar. This recommendation was unsigned and the boxes that read agree, disagree, or other were all unchecked. The clinical record included the following provider orders Ramelteon 8 mg 1 tablet by mouth at bedtime for insomnia date of order 08/17/23 and Buspirone (Buspar) 15 mg 1 tablet by mouth three times a day for depression date of order 07/16/23. The clinical record also included a progress note documented by the Nurse Practitioner on 05/02/24 that read "GDR for ramelteon and buspar not recommended at this time. Current regimen is necessary to maintain the residents function." Indicating the recommendation was not followed up on from 03/20/24 until 05/02/24. The medication Ramelteon was discontinued by the provider on 05/15/24.	F 756		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 756	Continued From page 28 No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #26, the facility staff failed to provide evidence of the 1/25/24 and 3/19/24 drug regimen reviews being reported to and acted upon by the medical provider. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Vascular Dementia, CHF (congestive heart failure), Depression, History of Falling and CKD (chronic kidney disease) Stage 2 (two) Mild. Section C (cognitive patterns) of Resident #26's most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/14/24, coded the resident as being rarely/never understood with short/long-term memory problems and indicated the resident was severely cognitively impaired and never/rarely making decisions. A review of the Resident #26's clinical record revealed progress notes which indicated drug regimen reviews were completed on 1/25/24 and 3/19/24, each with recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record. On 5/15/24, surveyor requested and received the drug regimen review recommendation reports completed by the pharmacist on 1/25/24 and 3/19/24 from the Director of Nursing (DON).	F 756		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 756	Continued From page 29 The 1/25/24 "Note to Attending Physician/Prescriber" read in part "...Resident has an order for Abilify 2 (two) mg (milligrams) BID (two times per day). This medication is intended to be dosed QD (once a day). Please evaluate for possible QD dosing..." The 1/25/24 "Note to Attending Physician/Prescriber" report had not been signed by the medical provider indicating review and the boxes that read "...agree, disagree, or other..." were all unchecked. A review of the physician's orders included the following order dated 1/16/24, "Abilify Oral Tablet 2 mg (Aripiprazole) Give 1 (one) tablet by mouth two times a day for mood disorder..." A new physician's order dated 5/2/24, revealed, "Abilify Oral Tablet 2 mg (Aripiprazole) Give 2 tablet by mouth one time a day for mood disorder..." The pharmacy recommendation dated 03/19/24 requesting the provider to consider a gradual dose reduction (GDR) of the medications Sertraline and Mirtazapine, had not been signed by the medical provider indicating review and the boxes that read "...agree, disagree, or other..." were all unchecked. On 5/15/24 at 10:58 AM, the survey team met with the Administrator and DON, and discussed the concern of staff failing to address Resident #26's January and March drug regimen reviews. Surveyor requested but did not receive the facility policy for Medication Drug Regimen Review, as the DON stated she was not sure if there was a policy, and if there was, she was unable to locate it.	F 756		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 756	Continued From page 30 No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.	F 756		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842	**Corrective Action(s):** Residents #93's provider was notified that the facility failed to ensure that house supplement, Pro-Stat, and Tylenol were given on 3/3/24. Additionally, the provider was notified that the facility failed to ensure that geri sleeves, heel protectors, a wound vac, and a mattress check were done on 5/5/24. Medication error forms were completed for these incidents **Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON and/or designee will complete a MAR/TAR audit of all residents to ensure that there were no similar blank entries noted in the records. Any negative findings will be corrected at the time of discovery and that patient's provider will be notified of any such errors found and a medication error form will be completed. **Systemic Change(s):** The facility policy has been reviewed with no changes warranted at this time. The DON and/or designee will in-service all nurses on the procedure for completing and documenting all medication and treatment orders. **Monitoring:** The DON will be responsible for maintaining compliance. Nursing management will perform daily audits for anything missing in the MAR/TAR for two weeks, then weekly for another two weeks, and monthly for two months. Any negative findings will be corrected at the time of discovery with disciplinary actions taken, as necessary. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 842	Continued From page 31 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure a complete and accurate clinical record for 1 of 23 residents, Resident #93. The findings included:	F 842	facility policy or procedure.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 842	Continued From page 32 1. For Resident #93 the facility staff failed to ensure the electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) were complete. Resident #93's face sheet listed diagnoses which included but not limited to pain in left hip and unspecified dementia. Resident #93's most recent minimum data set with an assessment reference date of 02/17/24 coded the resident as having both long- and short-term memory loss with severely impaired cognitive skills for daily decision making. Resident #93's comprehensive care plan was reviewed and contained care plans for " ... is at risk for altered levels of pain r/t (related to) a dx (diagnosis) of left hip and vertebrae fx (fracture). She has scheduled and prn (as needed) ordered", "... has the potential for/impaired skin integrity r/t recent hip fx with limited mobility, dementia and overall weakness. Stage 3- POA- wound vac in place- see MAR/TAR", and "... is at risk for nutritional decline 2' (secondary to) hx (history) dysphagia, needs modified diet. She has increased nutrient needs 2' wounds/wound healing. Hx hip fx, dementia, CKD (chronic kidney disease). She has had significant wt (weight) loss and wt gain." Resident #93's clinical record was reviewed and contained a physician's order summary which read in part, "Geri sleeves as tolerated to BUE (bilateral upper extremities)", "heel protectors on while in bed", "group 2 mattress check for function", "wound vac to sacrum continuously @ 125mmhg every shift for wound care", "House	F 842		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 842	Continued From page 33 Supplement 2 ounces three times a day for supplement", "Pro-Stat Oral Liquid (Amino Acids-Protein Hydrolysate). Give 30 ml by mouth two times a day for wound healing", and "Tylenol Oral Tablet 325 mg (Acetaminophen). Give 2 tablet by mouth four times a day for pain." Resident #93's eMAR for the month of March 2024 was reviewed and contained entries for House Supplement, Pro-Stat, and Tylenol. These entries were blank on 03/03/24 at 5 pm. Resident #93's eTAR for the month of May 2024 was reviewed and contained entries for geri sleeves, check mattress, heel protectors, and wound vac. These entries were blank on 05/05/24 on evening shift. Surveyor requested and was provided with a facility policy entitled "Nursing Documentation" which read in part, "Purpose: 1. To substantiate daily care, communicate the resident's needs and care received. Procedure: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records." The concern of leaving blanks on the resident's eMAR/eTAR was discussed with the administrator and director of nursing on 05/15/24 at 3:15 pm. No further information was provided prior to exit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883	**Corrective Action(s):** A pneumococcal vaccine was offered to resident #99's son (responsible party). **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been affected. The DON and/or designee will audit all current	June 26, 2024

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 883	Continued From page 34 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883	residents to ensure that all residents have been offered the pneumococcal vaccine and that documentation is present proving that said vaccine was offered. All negative findings will be corrected at the time of discovery and the residents' physician and responsible party will be notified. **Systemic Change(s):** The facility policy has been reviewed and no changes are warranted at this time. All Unit Managers have been in-serviced on the requirement to offer a pneumococcal vaccine following admission to the facility. **Monitoring:** The DON will be responsible for maintaining compliance. Nursing management will perform daily audits on new admissions for two weeks, then weekly for another two weeks. Negative findings will be corrected at the time of discovery with disciplinary action taken, as necessary. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and revisions to facility policy and procedures.	

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER - SALEM	3719 KNOLLRIDGE ROAD 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 883	Continued From page 35 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for 1 of 5 sampled residents reviewed for immunizations, Resident #99. The findings included: For Resident #99, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 15 (PCV15) or a pneumococcal conjugate vaccine 20 (PCV20) following admission to the facility. A review of the Centers for Disease Control and Prevention (CDC) guideline titled, "Pneumococcal Vaccination: Summary of Who and When to Vaccinate" last reviewed 9/22/23 read in part that adults 65 years or older that have never received any pneumococcal vaccine should receive one dose of PCV15 or PCV20. Resident #99's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Traumatic Subdural	F 883		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 883	Continued From page 36 Hemorrhage, Dementia, Acute Kidney Failure, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/14/24 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 indicating the resident was severely cognitively impaired. Resident #99 was over the age of 65 years when admitted to the facility. Resident #99's clinical record included their Virginia Immunization Information System (VIIS) Record dated 4/20/24. According to this record, Resident #99 had not received a pneumococcal vaccine prior to admission to the facility. Surveyor reviewed the resident's clinical record and was unable to locate evidence of Resident #99 being offered a PCV15 or a PCV20 following admission to the facility. On 5/15/24 at 1:00 PM, surveyor spoke with the Director of Nursing/Infection Preventionist (DON) regarding Resident #99's pneumococcal vaccine history. DON was unable to provide evidence of the resident being offered a pneumococcal vaccine following admission to the facility. Surveyor requested and received the facility policy titled, "Influenza/Pneumococcal/COVID-19 Immunization and Education" which read in part, "Purpose: To provide a means for the facility to track ...pneumococcal immunization administration and education ensuring all eligible residents receive immunization as recommended by the Center for Disease Control....1. Upon admission the resident or their responsible party	F 883		

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 _____	C 05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD HEALTH CENTER – SALEM	3719 KNOLLRIDGE ROAD 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 883	Continued From page 37 will be provided the option for the resident to receive the ...pneumococcal ...immunization ...10. Persons sixty-five (65) years of age and older who have not received the pneumococcal vaccine is [sic] the past five (5) years should receive another dose of vaccine ..." On 5/15/24 at 3:15 PM, the survey team met with the Administrator and DON and discussed the concern of the facility staff failing to offer Resident #99 a pneumococcal vaccine following admission. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/15/24.	F 883		