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	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richfield Health Center - Salem	3719 Knollridge Road Salem, VA 24153

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews, clinical record review, and facility document review, the facility staff failed to follow professional standards of practice related to assessing a resident's change in condition for one (1) of five (5) sampled residents (Resident #1). The findings include: The facility staff failed to ensure Resident #1 had assessments, including reassessments, completed and/or documented according to professional standards of practice. Resident #1's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/8/24, was signed as completed on 5/15/24. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1 had a change in condition which resulted in the need to obtain medical provider orders for oxygen via a nasal cannula for oxygen saturation levels less than 90% on 6/12/24 at 7:48 p.m. Resident #1's condition also resulted in the nurse obtaining an order for a chest x-ray on 6/12/24 at 10:15 p.m. (The chest x-ray order included the following wording: . x-ray (related to) increased (shortness of breath) and increased fluid .) The nurse failed to complete and/or document an assessment to address the resident's condition resulting in the need for these orders. The nurse failed to document contacting the medical provider to obtain the orders. On 12/4/24 at 11:25, the Director of Nursing (DON) reported the nurse should have documented a progress note when receiving medical provider orders. Resident #1's clinical record included a note documented by Respiratory Therapist (RT) #1, dated 6/13/24 at 12:04 p.m., which stated the resident's oxygen saturation level dropped to 80's [sic] during therapy. Assessed (the resident) while at rest, SPO2 81%. Placed on 3 lpm (three liter per minute) O2 (oxygen) and alerted nursing. No documentation was found to detail the resident's vital signs and/or lung sounds. No documentation was found to identify which nursing staff member had been notified. No documentation was found of a reassessment of the resident's condition after the application of the oxygen. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER: Richfield Health Center - Salem		STREET ADDRESS, CITY, STATE, ZIP CODE: 3719 Knollridge Road Salem, VA 24153	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 4:16 p.m., the surveyor interviewed RT #1 about Resident #1's care on 6/13/24. RT #1 reported they were unable to remember Resident #1. RT #1 stated they did not recall which nursing staff member was notified in the aforementioned note; RT #1 reported they had not been told to document the name of the individual to whom they provide information about resident changes. RT #1 reported respiratory assessment includes: oxygen saturation level, heart rate, use of accessory muscles, lung sounds, and work of breathing. The following information was found in a facility policy titled NURSING DOCUMENTATION (dated 3/2016): - All observations, medications administered, services performed, etc., must be documented in the resident's clinical records. - Documentation should include the status of the identified problems until they are resolved. - WHAT TO CHART: . All injuries, illnesses and unusual health situations until they are resolved . - WHAT TO CHART: . Response to a medication or treatment . - WHAT TO CHART: . New symptoms or change in condition . The following information was found in a facility policy titled Change in Resident Condition or Status (dated 8/2008): All changes in the resident's medical condition must be properly recorded in the resident's medical record . On 12/5/24 at 11:46 a.m., the surveyor met with the facility's Administrator and Director of Nursing (DON). During this meeting, the surveyor discussed the failure of facility staff to follow professional standards of practice related to assessing and reassessing Resident #1's respiratory status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews, clinical record review, and facility document review, the facility staff failed to prevent significant medication errors for one (1) of five (5) sampled residents (Resident #1). The findings included: The facility staff failed to administer Resident #1's diabetic medication according to the medical provider's orders. This resulted in the need to administer an injectable medication to increase Resident #1's blood sugar on the morning of 5/16/24, with a subsequent transfer to a local emergency department. Resident #1's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/8/24, was signed as completed on 5/15/24. Resident #1 was assessed as being able to be understood, and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1's diagnoses included Type 2 Diabetes Mellitus, and Congestive Heart Failure. Resident #1's clinical record included an order, for the dates 5/7/24 - 5/16/24, for Tresiba 30 units to be administered at bedtime, with instructions to hold this medication if the resident's finger stick blood sugar (FSBS) is less than 200. (Tresiba is a long-acting insulin used to manage blood sugar levels.) The Director of Nursing confirmed that Tresiba 30 units were administered on 5/12/24, 5/14/24, and 5/15/24 when it should have been held due to the resident's FSBS being less than 200. Resident #1's clinical record included the following information: - The 5/12/24 bedtime dose of Tresiba was documented as being administered at 9:12 p.m.; Resident #1's blood sugar was documented as 141 on 5/12/24 at 9:12 p.m. - The 5/14/24 bedtime dose of Tresiba was documented as being administered at 11:35 p.m.; Resident #1's blood sugar was documented as 129 on 5/14/24 at 11:34 p.m. - The 5/15/24 bedtime dose of Tresiba was documented as being administered at 9:00 p.m.; Resident #1's blood sugar was documented as 111 on 5/15/24 at 9:06 p.m. (The Director of Nursing confirmed the 9:06 p. m. FSBS results would have been used to guide administration of the 9:00 p.m. administration of Tresiba.) A nurse's note, dated 5/16/24 at 8:25 a.m., indicated Resident #1 was discovered in bed unresponsive with minimal amounts of blood coming out of (the resident's) mouth. Resident #1 was assessed as having a finger stick blood sugar of 39. This note indicated that injectable Glucagon was administered. Resident #1 was sent to a local emergency department. (Glucagon is an injectable medication used to treat low blood sugar levels.) Resident #1's clinical record included an Emergency Provider Report dated 5/16/24. This document indicated Resident #1 was sent to the emergency department on the morning of 5/16/24 due to a low blood sugar level. Upon Resident #1's arrival at the emergency department, the resident was alert and oriented with a blood sugar level of 71 gm/dL. Resident #1 was discharged from the emergency department with orders to decrease the medication (Tresiba) from 30 units at bedtime to 15 units at bedtime. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident #1's clinical record included an order, for the dates 5/16/24 - 6/4/24, for Tresiba 15 units to be administered at bedtime with instructions to hold this medication if the resident's finger stick blood sugar (FSBS) is less than 200. The Director of Nursing confirmed the Tresiba 15 units was administered on 5/31/24 when it should have been held due to the resident's FSBS being less than 200. Resident #1's clinical record included the following information: - The 5/31/24 bedtime dose of Tresiba was documented as being administered at 8:03 p.m.; Resident #1's blood sugar was documented as 121 on 5/31/24 at 8:01 p.m. This medication was administered when it should have been held. The following information was found in a facility policy titled Medication and Treatment Administration (dated 11/2015): - PURPOSE: To ensure all medications and treatments are administered to each resident according to the correct dose, route and times as ordered by the provider. - All medications and treatments are prepared and administered by a Registered Nurse or Licensed Practical Nurse per their practice acts. - The licensed nurse is responsible for preparing, administering and recording all medications and treatments. The licensed nurse must assume total responsibility for preparing, administering, and documenting the medications/treatments which he/she gives. On 12/5/24 at 11:46 a.m., the surveyor met with the facility's Administrator and Director of Nursing (DON). During this meeting, the surveyor discussed the facility staff members incorrectly administering Resident #1's Tresiba (on 5/12/24, 5/14/24, 5/15/24, and 5/31/24) when it should have been held due to the resident's blood sugar level at the time of administration.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interviews, clinical record review, and facility document review, the facility staff failed to obtain medical provider ordered laboratory tests for one (1) of five (5) sampled residents (Resident #1). The findings include: The facility staff failed to obtain Resident #1's medical provider ordered laboratory blood test. Resident #1's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/8/24, was signed as completed on 5/15/24. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. The following information was found in a facility policy titled Telephone Orders (dated 11/2020): Verbal telephone orders must be documented by the nurse receiving the order. The documentation occurs in two locations in the order entry field and in the resident's medical record under progress notes. Resident #1's clinical documentation included the following information, in a nursing progress note dated 5/13/24 at 5:53 p.m.: N.O. (new order) one-time dose of Bumex 2 mg now (5:00 p.m.). Bumex 2 mg daily (due to) (bilateral) edema in legs and arms. Obtain cbc and cmp [sic] on 5/24/24. Lymphatic drainage massage suggested COTA (certified occupational therapist assistant) made aware. Compression socks on during the day and off at night. (A complete blood count (CBC) and comprehensive metabolic panel (CMP) are laboratory blood tests.) The results of the 5/24/24 CBC and CMP test results were not found in Resident #1's clinical record. On 12/4/24 at 9:02 a.m., the Director of Nursing (DON) confirmed results for Resident #1's medical provider ordered CBC and CMP, for 5/24/24, was not found. On 12/5/24 at 11:46 a.m., the surveyor met with the facility's Administrator and Director of Nursing (DON). During this meeting, the failure of the facility staff to obtain Resident #1's laboratory blood tests ordered for 5/24/24 was discussed for a final time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure prompt implementation of a medical provider order for rehabilitative services for one (1) of five (5) sampled residents (Resident #1). The findings include: The facility staff failed to promptly implement a medical provider order for Resident #1 to be assessed for and/or receive lymphatic drainage massage. Resident #1's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/8/24, was signed as completed on 5/15/24. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. The following information was found in a facility policy titled Telephone Orders (dated 11/2020): Verbal telephone orders must be documented by the nurse receiving the order. The documentation occurs in two locations in the order entry field and in the resident's medical record under progress notes. Resident #1's clinical documentation included the following information, in a nursing progress note dated 5/13/24 at 5:53 p.m.: N.O. (new order) one-time dose of bumex 2 mg now (5:00 p.m.). Bumex 2 mg daily (due to) (bilateral) edema in legs and arms. Obtain cbc and cmp [sic] on 5/24/24. Lymphatic drainage massage suggested COTA (certified occupational therapist assistant) made aware. Compression socks on during the day and off at night. On 12/4/24 at 10:16 a.m., the Director of Therapy reported they could not find where therapy staff was notified of Resident #1's medical provider order related to lymphatic drainage massage. The Director of Therapy reported therapy staff became aware of the lymphatic drainage massage order during a care plan meeting on 5/23/24. On 12/4/24, the Director of Therapy provided the surveyor with: (a) documentation to show Resident #1 was assessed for lymphatic drainage massage on 5/24/24 and (b) documentation to show the first lymphatic drainage massage occurred on 5/29/24. On 12/5/24 at 11:46 a.m., the surveyor met with the facility's Administrator and Director of Nursing (DON). During this meeting, the delay in implementing Resident #1's medical provider ordered lymphatic drainage massage was discussed.