

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Riverside Valley of Journey		STREET ADDRESS, CITY, STATE, ZIP CODE 6500 MacCorkle Avenue SW Saint Albans, WV 25177	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation and staff interview the facility failed to follow Physicians orders and maintain standard of nursing care for tube feeding syringe and graduate. This was a random opportunity for discovery. Resident Identifier: # 1 Facility Census: #84 Findings include: a) Resident #1 On 12/18/25 at 3:10 PM observation found the tube feeding syringe and graduate container at bedside used for tube feeding flushes, residual checks and tube feeding administration were not dated. The resident had a current order for: 1) Enteral Feed Order: every day and night shift Check tube placement before initiation of formula, medication administration and flushing tube. 2) Jevity 1.5 237 mls 6 times daily to provide 2139 Kcals, 90gr protein, 720 ml free water. Flush with 60 mls water before and after feeding for a total of 1800 mls six times a day. 3) Change enteral irrigation syringe and graduate every night shift. According to Registered Nurse #35 the syringe/graduate is to be dated every day and discarded after 24 hours. This is a standard of nursing care for tube feeding and a Physicians order. On 12/18/25 at 3:15 PM it was confirmed with the Director of Nursing the syringe or graduate were not dated when they should have been. She agreed at this time.</p>

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, record review and staff interview the facility failed to ensure a Resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This was true for one (1) of three (3) pressures reviewed for care. Resident Identifier: #1 Facility Census: #84 Findings include: 1) Resident #1 On 12/18/25 at 9:50 AM observation found that Resident #1 had the following wound treatments for the left thigh and sacrum ordered by the Physician. Left Thigh a) Cleanse area to left thigh with vashe (wound cleanser) pat dry, apply silvasorb, cover with calcium alginate, and cover with foam dressing. Change daily and as needed (PRN), every day shift for wound care. Sacrum b) Wound to sacrum. Cleanse with in house wound care (IHWC). Pat dry. Lightly pack with iodoform, place calcium alginate with silver and cover with silicone foam border. Change daily and PRN every day shift for wound care. On 12/18/25 at 9:55 AM upon observation of the sacral wound with Unit Manager, Licensed Practical Nurse (LPN) #67 it was found the resident had no dressing in place. The resident had also had a bowel movement which caused the wound to be dirty. LPN #67 stated she would clean the resident and have the Residents' nurse place a dressing. At 3:10 PM when the Surveyor was preparing to recheck wound, the orders and the Treatment Administration Record (TAR) it was noted the wound to the residents left thigh had also been completed. With the assistance of the Director of Nursing (DON) and Registered Nurse (RN) #35 observation found that the left thigh dressing had not been completed but had been checked off on the TAR as being complete. According to RN #35, it was her initials on the TAR indicating the dressing had been completed when it had not. This was confirmed with the DON at this time as well. The Care Plan review revealed the following: FOCUS: The Resident has altered skin integrity related to areas of sacrum, foot and leg with continued risk r/t hemiplegia, and CV disease with end of life services with Hospice. GOAL: The Resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. Resident will not develop further skin impairment through next review. INTERVENTIONS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. If the resident refuses treatment confer with the resident, IDT, and family to determine why and try alternative methods to gain compliance. Document alternative methods. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. On 12/18/25 at 3:45 PM it was confirmed with the DON that the dressings had not been completed as per the Physician's orders at which time she agreed.</p>		