| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465<br><br>Based on observation, policy review and staff interview the facility failed to provide a clean comfortable home like environment. These practices were found in more than a limited area of the facility. residents reviewed for environment during the Long-Term Care Survey Process. Sixteen (16) resident rooms had a black substance on the heating/cooling unit. Windowsills and doorjambs were covered in a black substance. The resident's bathroom was not maintained in a sanitray conditin. Room Numbers: #99, #100, #101, #102, #103, #104, #105, #107, #131, #132, #133, #134, #136, #138, #109, #110. Resident identifiers: #43, #75, #32, and #69. Facility census: 80.<br><br>Facility census: 80.<br><br>Findings included:<br><br>a) Resident #32<br><br>The initial observation, on 07/30/24 at 1:00 PM, of Resident #32's room revealed a double door that went out into the courtyard. The entire door jamb of the door was covered with buildup of a black substance. The black substance was also found to be around the receptacle and the air conditioning unit.<br><br>Further observation revealed dry hard food products and dust webs under the wardrobe.<br><br>During an interview on 08/01/24 at 9:42 AM, The Housekeeping Supervisor (HS), went to the room with the surveyor to look at the substance. HS stated, Oh, yes that is a lot of buildup. We will work on it.<br><br>A policy review on read as follows:<br><br>Subject 5- step daily patient room cleaning<br><br>4. All corners and along all baseboards must be dust mopped to prevent buildup. When water pushes dust into corners, problems occur.<br><br>A review of the Housekeeping cleaning schedule shows that Resident #32's room was to be cleaned daily using the 5-step daily patient room cleaning.<br><br>(continued on next page) |



| 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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b) Resident #69<br><br>During the initial observation on 07/30/24 at 1:00 PM of Resident #69's room revealed three big windows that joined together. The windowsill was covered in a black substance that appeared dry in some spots and wet in others.<br><br>During an interview, on 08/01/24 at 9:42 AM, The Housekeeping Supervisor (HS), went to the room with the surveyor to look at the substance. HS stated, Oh, yes that is a lot of buildup. We will work on it.<br><br>A policy review on 08/01/24 at 10:30 AM reads as follows:<br><br>Subject 5- step daily patient room cleaning<br><br>2. As you enter the room, work clockwise around the room hitting all surfaces.<br><br>Table tops, headboards, window sills, and chairs should all be done.<br><br>A review of the Housekeeping cleaning schedule revealed that Resident #69's room was supposed to be cleaned daily using the 5-step daily patient room cleaning.<br><br>c) Rooms<br><br>Observation during the morning on 07/30/24 of room [ROOM NUMBER], #100, #101, #102, #103, #104, #105, #107, #131, #132, #133, #134, #136, #138, #109, #110 found a black spotted substance on the heating and cooling units (P-Tac)<br><br>On 07/30/24 at around 11:00 AM, the Maintenance Director also confirmed the presence of debris in the heating and cooling unit. He stated that cover / vents would be clear of debris and the black substance today.<br><br>50795<br><br>d) Resident #43<br><br>At approximately 12:22 PM on 07/30/24, an interview was conducted with Resident #43 concerning the care they received at the facility. With the permission of the resident, inspection of the resident's restroom revealed a bed pan in a plastic bag that was suspended from a grab bar in the restroom. The suspended bed pan was dangling in the trash can. The trash can was piled high with trash, and the bedpan was almost covered in trash. Further inspection revealed a band of black grime at the base of the commode, where the commode met the floor.<br><br>Upon being brought to the attention of Registered Nurse (RN) #78, she confirmed that the bed pan wasn't supposed to be in the trash can.<br><br>e) Resident #75<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/03/24 at 1:22 PM, Resident #75 stated that the faucet at her hand-sink did not work well. Turning on the hot water revealed a very low flow into the sink. Maintenance Director (MD) #62 confirmed that the water flow was inadequate and proceeded to work on it and replace the aerator in the faucet. The water flow was strong after the repair.<br><br>Inspection of the resident's restroom revealed a band of black grime at the base of the commode.<br><br>Further inspection also revealed the bucket of the bedside commode in the shower area. The bucket was observed with dried residue coating its base. LPN #40 confirmed that the bucket had not been cleaned and should not be in the shower area. She further stated that she thought the housekeeping staff were responsible for cleaning the restroom. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120<br><br>Based on staff interview and record review the facility failed to complete a comprehensive assessment for mood and behavior. This was true for six (6) of 25 residents reviewed during the Long-Term Survey Process. Resident identifiers: #44, #47, #34, #71, #4 and #54. Facility Census: 80.<br><br>Findings Included:<br><br>a) Resident #44<br><br>On 07/31/24 during record review of Resident #44 MDS review of Quarterly Minimum Data Set (MDS) assessment 06/19/24, Section C, cognitive pattern, was not assessed and section D, Mood, was not assessed.<br><br>During an Interview on 07/31/24 at 1:55 PM the Cooperate Nurse verified the section C and D was not completed for Resident #44s 06/19/24 MDS assessment.<br><br>b) Resident #47<br><br>On 07/31/24 during record review of Resident #47 MDS review of Quarterly Minimum Data Set (MDS) assessment 06/30/24, Section C, cognitive pattern, was not assessed and section D, Mood, was not assessed.<br><br>During an Interview on 07/31/24 at 1:55 PM the Cooperate Nurse verified the section C and D was not completed for Resident #47s 06/30/24 MDS assessment.<br><br>c) Resident # 34<br><br>On 07/31/24 during record review of Resident #34 MDS review of Quarterly Minimum Data Set (MDS) assessment 06/18/24, Section C, cognitive pattern, was not assessed and section D, Mood, was not assessed.<br><br>During an Interview on 07/31/24 at 1:55 PM the Cooperate Nurse verified the section C and D was not completed for Resident #34s 06/18/24 MDS assessment.<br><br>45173<br><br>e) Resident #4<br><br>On 07/31/24 at 2:15 PM, a record review was completed for Resident #4. The review found the MDS dated [DATE] was incomplete. Section C entitled, Cognitive Patterns had no information regarding the BIMS, without this score the status of cognition is unknown.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/31/24 at approximately 3:00 PM, the Corporate Nurse was interviewed regarding section C. The Corporate Nurse stated, the MDS assessments are done remotely and maybe that is why it is incomplete.<br><br>f) Resident #54<br><br>On 07/31/24 at 2:25 PM, a record review was completed for Resident #54. The review found the MDS dated [DATE] was incomplete. Section C entitled, Cognitive Patterns had no information regarding the BIMS, without this score the status of cognition is unknown.<br><br>On 07/31/24 at approximately 3:00 PM, the Corporate Nurse was interviewed regarding Section C. The Corporate Nurse stated, the MDS assessments are done remotely and maybe that is why it is incomplete.<br><br>49465<br><br>d) Resident #71<br><br>A record review on 07/30/24 at 2:35 PM, revealed that Resident #71 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/17/24 section C{cognitive pattern} and Section D {mood} was not filled out for the quarter and had no Brief interview for mental status (BIMS)<br><br>Further record review of Physicians Determination of Capacity shows that Resident #71 had capacity.<br><br>During an interview on 07/31/24 at 1:59 PM, the Corporate Nurse (CN) stated, I don't have an answer. Let me see what I can find out. The CN later confirmed that Resident #71 was not assessed properly. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment.<br><br>49751<br><br>Based on record review and staff interview, the facility failed to transmit residents assessments for a discharge. This failed practice was found true for one (1) of two (2) residents reviewed under the Facility Tasks during the Long Term Care Survey and hat the potential to affect a limited number of residents residing in the facility. Facility census:80. Resident Identifier: #45<br><br>Findings included:<br><br>a) Resident #45<br><br>On 07/31/24 at approximately 11:20 AM record review of Resident #45's The Minimum Data Set (MDS) { standardized assessment tool that measures health status in nursing home residents} reveaeld on 03/27/24 a discharge MDS was completed, and not transmitted/accepted.<br><br>During staff interview on 07/31/24 at approximately 1:00 PM the Director of Nursing confirmed the discharge MDS should have been transmitted within 14 days after a facility completes a resident's assessment. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120<br><br>49751<br><br>Based on record review and staff interviews the facility failed to identify Major Depressive disorder on Preadmission Screening and Resident Review (PASSR). This was found true for two (2) of five(5) residents reviewed during the long term care survey process. Facility Census: 80 Resident identifiers: #22, and #26.<br><br>Findings included:<br><br>a) Resident #22<br><br>Record review on 07/30/24 for Resident #22 found the PASSR completed on 11/04/16 to have coded diagnosis of Cerebral infarction, Hemiplefie, adjustment disorder with disturbance, and cognitive communication deficit and ataxic gate.<br><br>further record review found Resident #22 also has Major depressive disorder that was diagnosed on [DATE].<br><br>On 7/30/24 at 12:30 PM the Director of Nursing (DON) confirmed the diagnoses of Major Depressive disorder should have been identified on the PASSR.<br><br>b) Resident #26<br><br>Record review for resident #26 and found the PASSR completed on 02/13/24 contained diagnosis of Schizophrenic disorder, and affective bipolar disorder.<br><br>further record review found Resident #26 also has Major depressive disorder that was diagnosed on [DATE].<br><br>On 7/30/24 at 12:30 PM the Director of Nursing (DON) confirmed the diagnoses of Major Depressive disorder should have been identified on the PASSR. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465<br><br>Based on staff interview and record review the facility failed to complete a new Preadmission Screening and Resident Review (PASARR) for Resident #20 when the original PASARR had expired. This failed practice was found true for (1) one of (5) five residents reviewed for PASARR during the Long-Term Care Survey Process. Resident identifier: #20. Facility census: 80.<br><br>Findings included:<br><br>a) Resident #20<br><br>A record review on [DATE] at 2:51 PM, revealed that Resident #20 was admitted to the facility on [DATE] and had a PASARR completed on [DATE].<br><br>Further record review showed that Resident #20's PASARR was marked for 3 months or less.<br><br>During an interview on [DATE] at 3:20 PM, The Director of Nursing (DON) stated, We do know we have a problem with PASARR'S. I just started an audit on them. DON confirmed that the PASARR for Resident #20 had expired. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>42120<br><br>Based on record review, and staff interview, the facility failed to ensure a Resident had a person-centered comprehensive care plan developed and implemented to meet his / her other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. This practice affected one (1) of (24) resident's care plans reviewed during the Long-Term Care Survey Process (LTCSP). The failure to ensure the comprehensive care plan was developed for the resident's highest practicable well-being placed the residents at risk of not receiving services that would meet their desires or wants and a decreased quality of life. Resident Identifiers: #44. Facility census: 80.<br><br>Findings included:<br><br>a) Resident #44<br><br>A review of the current Diagnosis List showed the diagnosis of Schizophrenia.<br><br>A continued review revealed the current care plan did not contain a diagnosis of Schizophrenia or monitoring.<br><br>On 07/31/24 at 2:06 PM during an Interview with the Director of Nursing (DON), she confirmed the current care plan did not reflect the resident's need. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173<br><br>Based on record review and staff interview, the facility failed to revise a care plan for one (1) of 24 residents. Resident #53 regarding the cardiopulmonary (CPR) status. Resident Identifiers: #53. Facility Census: 80.<br><br>Findings Include:<br><br>a) Resident #53<br><br>On [DATE] at 11:40 AM, a record review was completed for Resident #53. The review found a focus area of I choose to have CPR. An intervention was listed as I prefer to be left alone with my family.<br><br>On [DATE] at 11:55 AM, the Director of Nursing (DON) was notified. The DON stated, I don't know why this intervention is under this focus area .we will get it corrected.<br><br>50795 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>50795<br><br>Based on investigation, record review and interview, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of all pre and post discharge medications, and develop a post-discharge plan of care, including discharge instructions. Resident identifier #85. Facility Census: 80.<br><br>Findings included:<br><br>a) Resident #85<br><br>Record review, on 07/31/24 at 09:27 AM, revealed no discharge summary, post discharge plan of care, or discharge instructions for Resident #85.<br><br>Further document review revealed a nursing note on 5/1/2024 at 10:31 by RN #69, which stated:<br><br>Resident discharged from facility at this time via public bus. All personal belongings taken with resident upon discharge. Discharge instructions reviewed with resident, and she verbalized understanding. Resident refused to have medication called in to her pharmacy for refill, she states I'm not going to take it.<br><br>Interview with Registered Nurse (RN) #69 on 07/31/24 at 11:57 AM, revealed Resident #85 refused RN's offer to call the pharmacy for a refill, and stated that she would not take the medications.<br><br>Document review also revealed a social services note dated 5/19/24 at 1:55 PM, which stated:<br><br>Psychosocial Assessment completed including MDS interviews and assessment. Resident's overall goal: Discharge to the community.<br><br>Source of goal setting: Resident.<br><br>Is active discharge planning already occurring? No.<br><br>The previous social worker was no longer at the facility and was unavailable for interview.<br><br>An interview with the interim Social Worker #99 on 07/31/24, confirmed the facility had not developed a discharge summary, including a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre and post discharge medications for Resident #85.<br><br>The facility had also failed to a provide a post-discharge plan of care, including discharge instructions to the resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This surveyor interviewed Resident #85 over the phone on 08/01/24 at 8:36 AM. She stated that she was kicked out of the facility. Resident stated, they are terrible people. I was getting better, and my legs were getting stronger, but physical therapy said that it was the best I was going to get. So, the insurance refused to pay for any more therapy, and they kicked me out.<br><br>When questioned about her medications, she stated that the medications she was given were unnecessary and she was not going to take them. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>50795<br><br>Based on observation, U.S. Pharmacopeia, and staff interview, the facility failed to ensure all medical supplies in the medication storage room were stored in accordance with manufacturers recommended standards. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 80<br><br>Findings included:<br><br>a) Inspection of Medication Storage Room East on 07/31/24 at 11:02 AM, accompanied by Registered Nurse (RN) #69. Observation of the medication storage refrigerator log revealed that the PM refrigerator for 07/30/24 had not been recorded. RN # 69 confirmed that the temperature had not been logged.<br><br>b) Inspection of Medication Storage Room West, on 07/31/24 at 11:14 AM, accompanied by Licensed Practical Nurse (LPN) #40. LPN stated that this medication room was not used for storage of anything other than supplies and IV solutions.<br><br>The medication room thermometer revealed a temperature of 80 degrees Fahrenheit. LPN #40 confirmed that the temperature of the room was at 80 degrees Fahrenheit.<br><br>Review of the medication room temperature log revealed that the medication room temperature fluctuated between 80 to 82 degrees Fahrenheit.<br><br>Inspection of the medications stored in the medication cart revealed ten (12) bags of 0.9% Normal Saline (1000) milliliters, and 8 (eight) bags of Metronidazole Injection, USP 500mg/100 mL (5mg/mL). A review of the manufacturers storage temperature recommendation revealed that these IV medications were required to be stored at 20 - 25 degrees Centigrade (60 to 77 degrees Fahrenheit).<br><br>U. S. Pharmacopeia (USP) Chapter 1079 provides guidance concerning storage, distribution, and shipping of pharmacopeial preparations.<br><br>It states that there is great risk associated with medication being compromised by exposure to temperatures beyond the safe temperature range determined by the manufacturer. The loss of efficacy can result in many issues compromising the health of the patient.<br><br>The chapter further explains the temperature ranges for drugs stored at the following requirements:<br><br>Room Temperature Storage: 20 C - 25 C<br><br>Cool Storage: 8 C - 15 C<br><br>Refrigerator Storage: 2 C - 8 C<br><br>Freezer Storage: -25 C - 10 C |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>45173<br><br>Based on record review and staff interview, the facility failed to maintain an accurate and complete record for transfers to an acute care facility for Resident #15. This is true for two (2) of three (3) residents reviewed under the care area of hospitalization s. Resident identifier: #15. Facility Census: 80.<br><br>Findings include:<br><br>a) Resident #15<br><br>A record review was completed on 08/01/24 at 9:45 AM. The review found the resident had been transferred to an acute care facility on 06/12/24. However, the date listed on the transfer form was dated 04/14/24.<br><br>On 08/01/24 at 10:25 AM, the corporate nurse and the Director of Nursing were notified. The Corporate nurse stated, I will check and see why the date is incorrect.<br><br>A record review was completed on 08/01/24 at 9:45 AM.<br><br>The review found the resident had been transferred to an acute care facility on 07/09/24. However, the date listed on the transfer form was dated 06/12/24.<br><br>On 08/01/24 at 10:25 AM, the corporate nurse and the Director of Nursing were notified. The Corporate nurse stated, I will check and see why the date is incorrect. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>45173<br><br>Based on observation, record review and staff interview, the facility failed to maintain an appropriate infection control program during meal service for Resident #15. This was a random opportunity for discovery. Facility Census: 80.<br><br>Findings included:<br><br>a) Resident #15<br><br>On 07/30/24 at 1:13 PM, the resident was observed receiving a lunch tray from Nurse Aide (NA) #30. The resident asked for assistance with setting up the tray. NA #30 was observed touching the hamburger buns with bare hands. NA #30 was asked, Do you normally wear gloves when assisting residents with their meals? NA #30 stated, I sanitize my hands between trays.<br><br>On 07/30/24 at 1:40 PM, the Director of Nursing (DON) was notified of the observation. The DON stated, I'll take care of this right away. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515035 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Valley of Journey | 6500 MacCorkle Avenue SW<br>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) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120<br><br>Based on observation and staff interview the facility failed to incorporate an effective pest control program. One (1) room had gnats. Facility census: 80.<br><br>a) room [ROOM NUMBER] A<br><br>On 07/29/24 12:13 PM during the initial tour there were gnats all over the over bed table including his drinks and pudding.<br><br>On 07/29/24 at 12:15 PM during an interview Nurse Aide #3 verified the gnats and stated that they do have an issue with gnats in this room. She stated that she would get someone to clean the room. |