STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 000	INITIAL COMMENTS 483.25 (F 323) at J Immediate Jeopardy began on 05/22/2015 and the Administrator was notified on 07/22/2015 at 6:50 PM. Immediate Jeopardy was removed on 7/24/2015 at 5:11 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of systems put in place and 100% of employee training. 483.75 (F 490) at J Immediate Jeopardy began on 05/22/2015 and the Administrator was notified on 07/22/2015 at 6:50 PM. Immediate Jeopardy was removed on 07/24/2015 at 5:11 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of systems put in place and 100% of employee training.	F 000		
F 202 SS=D	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i)	F 202		8/12/15

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

Electronically Signed | 08/14/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 202	Continued From page 1 or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews, the facility failed to show documentation to justify why they could not meet the needs of 1 of 4 residents reviewed for discharge (Resident #191). Findings included: Resident #191 was admitted to the facility 4/28/2015 with diagnoses including Parkinson's disease, Alzheimer's disease, muscle weakness, lack of coordination, anxiety, depression and Post Traumatic Stress Disorder. The admission comprehensive Minimum Data Set [MDS] dated 5/5/2015 indicated the resident was severely cognitively impaired but had not exhibited wandering during the assessment period, The MDS also indicated the resident's walking balance was not steady and he required extensive assistance of two staff members for locomotion on and off the unit. The Plan of Care [originally dated 5/11/2015] indicated the resident had short and long term memory problems due to Alzheimer's disease, received medications for anxiety and depression and was at risk for falls. A physician's order dated 5/12/2015 revealed the resident was to receive Physical Therapy three times a week for gait training.	F 202	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of qualify of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings F202 Documentation for Transfer / Discharge It is the policy of this facility to show documentation to justify why the needs of residents could not be met in the facility and an unplanned transfer/discharge is necessary for the resident's welfare and that the resident's needs cannot be met in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 202	Continued From page 2 Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the patio dining room. The nursing documentation note included, "resident stood up and opened patio door and tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair], resident stated he was leaving and very determined to get out any door in facility, will monitor closely, call light within reach." A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that, with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident's bed and wheelchair to alert staff if the resident attempted to rise off of the pad. Resident #191's Plan of Care was updated on 5/14/2015 to indicate a wander guard bracelet was in place to prevent elopement. The facility was unable to provide any evidence of assessments or attempted interventions put in place regarding wandering behavior between 5/14/2015 and 5/25/2015 when the resident was discharged from the facility. Record review revealed a note by the Social Worker (SW) dated 5/21/2015 at 6:58 PM which included, "Resident went out patio door in dayroom, locked his wheelchair breaks, climbed over the short brick wall on the patio, ambulated around the facility and was walking down the 600 hall driveway, when staff were alerted to resident	F 202	the facility. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 was discharged to home on 5/25/15, therefore no other corrective action could be taken. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: The Administrative Team met on 7/29/15 and reviewed the clinical documentation of all current residents identified as "high risk" for elopement to determine if there were any needs for unplanned transfers/discharges because of the facility not being able to meet their needs. No other unplanned transfers or discharges were identified. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: The facility's Transfer or Discharge Notice Policy and Procedure was reviewed and revised to include the following: If an unplanned transfer or discharge becomes necessary for the resident's welfare, and it is determined that the resident's needs cannot be met in the facility, the following steps will be taken: a. The Administrator or designee will review the resident's chart to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 202	Continued From page 3 being outside. Resident redirected back into the facility. RP [Responsible Party] made aware. Assistant Administrator made aware. Decision made that resident must be placed at a locked unit or discharged home by Monday, 5/25/2015, due to this facility being unable to meet his needs/safety concerns." The note indicated the family had been made aware of the decision but did not want the resident moved to another facility. The noted ended with, "(Family member) stated she cannot care for resident at home and expressed understanding of why the facility believes resident needs a locked unit, however she wishes he could stay at (this facility) because everyone has been so good to resident. (A different family member) stated she would like to speak with Assistant Administrator about the decision to place resident elsewhere and SW assured (family member) that SW would pass on her request." The patio dining room door was observed on 7/21/2015 at 11:50 AM and again at 2:22 PM. There was a sign on the door which read, "KEEP THIS DOOR LOCKED AT ALL TIMES" Approximately 24 inches above the doorknob was a deadbolt lock. The door was locked. The door was able to be unlocked by turning the deadbolt to the left and no alarm sounded. The Assistant Administrator was interviewed on 7/22/2015 at 4:24 PM. The Assistant Administrator said a wander guard alarm system was in place and all exit doors were alarmed except this one. There was no electricity to this patio door so it could not be alarmed with the system so they put up a sign that said to keep door locked. The Assistant Administrator said after the investigation on 5/25/2015 of the	F 202	there is sufficient documentation to justify why the needs of the resident cannot be met at the facility. This documentation should include, but not limited to, completed assessments, interventions implemented to address the resident¿s condition/behavior/situation, resident response to the interventions and physician notes. b. The physician will be notified of the necessity for the unplanned transfer/discharge, and, if in agreement, an order will be obtained for the discharge. c. The family and resident will be notified of the discharge decision and a Transfer/Discharge Notice will be implemented indicating the date of the pending discharge. A new form titled "Chart Review for Possible Initiation of Transfer/Discharge Notice" has been implemented that will be utilized when reviewing the clinical documentation to determine if a transfer/discharge is needed to maintain the resident's safety and wellbeing. All licensed nursing staff were in-serviced on 8/11/15 and Administrative and Social Work staff were in-serviced on 8/12/15 by the Nurse Consultant regarding the importance of thorough and complete documentation including assessments completed, attempted interventions, resident outcomes and physician documentation related to the policy revisions stated above.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 202	Continued From page 4 elopement on 5/21/2015, the facility attached a personal body alarm to the patio door. The Assistant Administrator said she had noticed someone had removed the personal body alarm from the patio door so she placed one on the door again just prior to the interview. She did not know how long it had been gone from the door. On 7/23/2015 at 10:31 AM, the Administrator and Assistant Administrator were both interviewed about the attempted elopement on 5/12/2015. Both of them stated they had been made aware of Resident#191's exit-seeking behavior but they were not aware he had attempted to leave by a non-alarmed door. On 7/23/15 at 12:37 PM, the Social Worker was interviewed concerning about her communication with Resident #191's family about the discharge. The SW said, "I told her the Assistant Administrator was made aware and the decision was made that we were not a safe facility for him at this point." She told the family that Resident #191 would need to be placed in a locked unit or discharge home saying, "so that by Monday (5/25/2015) one or the other would occur. I would be working with them to set up placement. It was explained that if it didn't happen they could talk to administration but something had to be in place by 5/25." The SW indicated she had sent information to two facilities but neither were able to accept him and the family thought those facilities were too far away. The SW said, "They [the family] told me they were going to take him home. Their main focus was that he should stay here." When asked if the resident had reached his maximum level of ability with Physical Therapy [PT] the SW she did not think he had	F 202	4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: The clinical documentation of residents who exhibit wandering or other adverse behaviors will be reviewed by the Administrator or designee to ensure proper documentation is present that includes assessments, interventions implemented and resident outcomes, and to ensure the facility procedure related to Transfers/Discharges, as stated in #3 was followed. This will be done weekly for four (4) weeks; and then monthly for four months. Nurse Consultant will also audit this area during routine monthly visits. The Administrator or designee will present results of these reviews in the monthly Quality Assurance Performance improvement Committee meetings. The QAPI Committee will assess and modify the action plan as needed to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 202	Continued From page 5 been discharge from PT before he was discharge from the facility. Resident #191's family member was interviewed on 7/24/15 at 11:06 AM about what she was told about the expectation of discharge on 5/25/2015. The family member indicated she was informed on 5/21/2015 and stated the SW, "came in the room and said he had to be out by Monday. I said, 'You mean to tell me you are going to put a Veteran out on Memorial Day?' and she said the Director made the decision that he (Resident #191) had to be out by Monday, either to a different nursing home or he had to go home." She stated that on Monday, because no placement had been found, she (the family member) went to pick the resident up and the Social Worker "did ask, once we had his things packed up, if we wanted to talk to the Director to see about maybe extending the stay. I said, 'No, I'm taking my (Resident #191) home. I'm not begging nobody to keep my husband.'" On 7/24/2015 at 3:42 PM, the Administrator was interviewed about Resident #191's discharge. The Administrator indicated she was not aware staff had indicated to the family that the resident had to be out by 5/25/2015. She said, "I need to be notified immediately and be involved with any unexpected discharge from this facility. I want the resident to be kept safe, and then we can take time to make a decision."	F 202		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		8/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 6 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair metal edging on smoke prevention doors on 3 of 4 doors (#200 and #300 halls), repair resident doors with broken and splintered laminate and wood for 27 of 80 resident rooms (Resident room #102,#106, #108, #109, #111, #115, #116, #204, #210, #211, #213, #303, #306, #307, #311, #315, #316, #406, #407, #408, #409, #413, #414, #501, #503, #504, #505) and failed to repair a door with broken and splintered laminate and wood on 1 of 2 central bath doors (#400 hall). The findings included: 1. a. Observations of a smoke barrier door on the 200 hall located on the left side of the hall when entering the unit during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. Observations on 07/22/15 at 4:29 PM revealed the smoke barrier door on the 200 hall located on the left side of the hall when entering the unit had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. Observations on 07/23/15 at 11:20 AM revealed the smoke barrier door on the 200 hall located on the left side of the hall when entering the unit had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward.	F 253	F253 Housekeeping / Maintenance Services It is the policy of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1. Corrective actions taken for residents found to have been affected by alleged deficient practice: The metal edging was removed and straightened to repair the #200 and #300 smoke prevention doors on 7/27/15 by the Maintenance Director. The doors to resident rooms #102, #106, #108, #109, #111, #115, #116, #204, #210, #211, #213, #303, #307, #311, #315, #316, #406, #407, #408, #409, #413, #414, #501, #503, #504, #505, and #400 Central Bath; as identified by the surveyor as having broken and / or splintered laminate veneer; were all sanded, wood putty applied, and stained. Repairs were completed to these doors by the Maintenance Director on 7/30/15. 2. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: The Maintenance Director conducted an audit of all interior doors to inspect for bent edging, broken or splintered laminate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 7 Observations on 07/24/15 at 11:30 AM revealed the smoke barrier door on the 200 hall located on the left side of the hall when entering the unit had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. b. Observations of 2 smoke barrier doors on the 300 hall on 07/20/15 at 9:30 AM revealed both doors had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. Observations on 07/22/15 at 4:29 PM of 2 smoke barrier doors on the 300 hall revealed both doors had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. Observations on 07/23/15 at 11:20 AM of 2 smoke barrier doors on the 300 hall revealed both doors had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. Observations on 07/24/15 at 11:30 AM of 2 smoke barrier doors on the 300 hall revealed both doors had a metal edge protector that was bent at the bottom of the door with a sharp pointed edge facing outward. 2. a. Observations of Room 102 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 102 had broken and splintered laminate on the front of the bottom half of the door.	F 253	veneer, or other damage requiring repair on 7/30/15. Repairs were made to all doors identified to be in need of repair, as a result of the audit. Those repairs were completed on 8/11/15 by the Maintenance Director. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: The Assistant Administrator met with the Maintenance Director on 7/27/15 to discuss the findings of the survey. A new "Door Maintenance Audit" tool was initiated. This audit is to ensure doors within the facility in need of repair are identified and repaired timely. The Maintenance Director will conduct a monthly inspection of all doors within the facility. All doors requiring repair will be listed on the Door Maintenance Audit tool which will include the location of the door and the type of repair needed. The maintenance staff will make necessary repairs to each door and indicate the date the repair was completed and who completed the repair. A copy of the monthly audit will be given to the Assistant Administrator when repairs are completed. The Assistant Administrator and the Maintenance Director will then visually inspect all doors listed on that months audit to ensure all necessary repairs have been made. The Environmental Services Housekeeping staff was provided in-service training on 8/6/15. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 8 Observations on 07/23/15 at 11:20 AM revealed the door of resident room 102 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 102 had broken and splintered laminate on the front of the bottom half of the door. b. Observations of Room 106 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 106 had broken and splintered laminate on the front of the bottom half of the door. c. Observations of Room 108 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the door on the right corner of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 108 had broken and splintered laminate on the on the front of the door on the right corner of the bottom half of the door.	F 253	in-service emphasized the need to promptly fill out Maintenance Request forms if they notice any splintering, broken veneer, or other damage to the doors or any other wood work while cleaning. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: This plan was implemented and the corrective action will be evaluated for effectiveness. This plan of correction is integrated into the monthly Quality Assurance Performance Improvement (QAPI) program as follows: The Environmental Subcommittee, of the Quality Assurance Performance Improvement (QAPI) Committee, made up of Maintenance Director, Environmental Supervisor and chaired by the Assistant Administrator, shall review the results of the monthly Door Maintenance Audits. They will review the audits monthly for 3 consecutive months and then quarterly thereafter to ensure that the doors are maintained in compliance with F253. The results of the monthly Door Maintenance Audits will be presented by the Assistant Administrator at the monthly QAPI Committee Meeting. The results will be monitored by QAPI Committee monthly for a period of 3 consecutive months then will continue the monitoring on a quarterly basis for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 9 Observations on 07/23/15 at 11:20 AM revealed the door of resident room 108 had broken and splintered laminate on the front of the door on the right corner of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 108 had broken and splintered laminate on the front of the door on the right corner of the bottom half of the door. d. Observations of Room 109 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 109 had broken and splintered laminate on the front of the bottom half of the door. e. Observations of Room 111 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 111 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed	F 253	The QAPI committee will assess and modify the action plan as needed to ensure continual compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 10 the door of resident room 111 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 111 had broken and splintered laminate on the front of the bottom half of the door. f. Observations of Room 115 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had 2 large areas of broken laminate that were circular and approximately 2 inches in diameter in the center of the front side of the door. Observation on 07/22/15 at 4:29 PM revealed the door of resident room 115 had 2 large areas of broken laminate that were circular and approximately 2 inches in diameter in the center of the front side of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 115 had 2 large areas of broken laminate that were circular and approximately 2 inches in diameter in the center of the front side of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 115 had 2 large areas of broken laminate that were circular and approximately 2 inches in diameter in the center of the front side of the door. g. Observations of Room 116 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door Observations on 07/22/15 at 4:29 PM revealed the door of resident room 116 had broken and	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 11 splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 116 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 116 had broken and splintered laminate on the front of the bottom half of the door. h. Observations of Room 204 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 204 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 204 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 204 had broken and splintered laminate on the front of the bottom half of the door. i. Observations of Room 210 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 210 had broken and splintered laminate on the front of the bottom half	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 12 of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 210 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 210 had broken and splintered laminate on the front of the bottom half of the door. j. Observations of Room 211 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 211 had broken and splintered laminate on the front of the bottom half of the door. k. Observations of Room 213 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had a large area of broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 213 had a large area of broken and splintered laminate on the front of the bottom half of the door.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 13 Observations on 07/23/15 at 11:20 AM revealed the door of resident room 213 had a large area of broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 213 had a large area of broken and splintered laminate on the front of the bottom half of the door and a large splinter of wood broke off when touched. l. Observations of Room 303 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 303 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 303 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 303 had broken and splintered laminate on the front of the bottom half of the door. m. Observations of Room 306 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 306 had broken and splintered laminate on the front of the bottom half of the door.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 14 Observations on 07/23/15 at 11:20 AM revealed the door of resident room 306 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 306 had broken and splintered laminate on the front of the bottom half of the door. n. Observations of Room 307 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 307 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 307 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 307 had broken and splintered laminate on the front of the bottom half of the door. o. Observations of Room 311 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 311 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 15 the door of resident room 311 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 311 had broken and splintered laminate on the front of the bottom half of the door. p. Observations of Room 315 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 315 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 315 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 315 had broken and splintered laminate on the front of the bottom half of the door. q. Observations of Room 316 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 316 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 316 had broken and	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 16 splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 316 had broken and splintered laminate on the front of the bottom half of the door. r. Observations of Room 406 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 406 had broken and splintered laminate on the front of the bottom half of the door. s. Observations of Room 407 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 407 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 407 had broken and splintered laminate on the front of the bottom half	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 17 of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 407 had broken and splintered laminate on the front of the bottom half of the door. t. Observations of Room 408 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 408 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 408 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 408 had broken and splintered laminate on the front of the bottom half of the door. u. Observations of Room 409 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 409 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 409 had broken and splintered laminate on the front of the bottom half of the door.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 18 Observations on 07/24/15 at 11:30 AM revealed the door of resident room 409 had broken and splintered laminate on the front of the bottom half of the door. v. Observations of Room 413 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 413 had broken and splintered laminate of the front on the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 413 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 413 had broken and splintered laminate on the front of the bottom half of the door. w. Observations of Room 414 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 414 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 414 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 19 the door of resident room 414 had broken and splintered laminate on the front of the bottom half of the door. x. Observations of Room 501 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 501 had broken and splintered laminate on the front of the bottom half of the door. y. Observations of Room 503 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 503 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 503 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 503 had broken and	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 20 splintered laminate on the front of the bottom half of the door. z. Observations of Room 504 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 504 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 504 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 504 had broken and splintered laminate on the front of the bottom half of the door. aa. Observations of Room 505 during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the door of resident room 505 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the door of resident room 505 had broken and splintered laminate on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the door of resident room 505 had broken and splintered laminate on the front of the bottom half	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 21 of the door. 3. Observations of a central bath door on the 400 hall during the initial tour of the facility on 07/20/15 at 9:30 AM revealed the door had large areas of broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed the central bath door on 400 hall had large areas of broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed the central bath door on 400 hall had large areas of broken and splintered laminate and wood on the front of the bottom half of the door. Observations on 07/24/15 at 11:30 AM revealed the central bath door on 400 hall had large areas of broken and splintered laminate and wood on the front of the bottom half of the door. During a tour and interview on 07/24/15 at 11:57 AM the Maintenance Director confirmed the laminate on the resident room doors and the central bath door on the 400 hall needed to be sanded, patched and painted. He stated he did not have a defined plan to repair doors but a couple of times a year he tried to put wood putty and stain on the doors but that happened when he had time to do it. He explained he had been painting door frames early in the week but he had not noticed the damaged laminate on the front of the door of Room 115 and thought staff had hit the door with a lift and that broke the laminate. He stated he had worked on the hinge of Room 213 earlier that morning but did not notice the splintered laminate on the door. He explained	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 253	Continued From page 22 staff could report damaged doors by filling out a maintenance request form that was located in each clean linen closet. He further explained he made rounds and checked for maintenance requests several times a day but he had not received any requests to repair broken laminate on doors. He stated the metal edges that were bent outward on the smoke barrier doors on the 200 hall and 300 hall was caused when equipment was bumped into the door and he needed to straighten them so they did not stick outward and cause injury. During an interview on 07/24/15 at 3:15 PM the Assistant Administrator stated it was her expectation for the Maintenance Director to do regular rounds and repair any door that had broken laminate or wood. She further stated she expected the Maintenance Director to repair the metal edges on the smoke barrier doors and he should be monitoring doors to ensure the metal edges did not stick outward. During an interview on 07/24/15 at 5:10 PM the Administrator explained she had 2 full time staff in the maintenance department and they should have repaired the broken laminate and wood on the doors. She stated if the doors could not be repaired then they would have to be replaced. She explained staff were encouraged routinely to fill out maintenance requests when they saw things that needed repair. She further stated she expected for the maintenance staff to make regular rounds on a daily basis and look at doors and repair them when they were damaged.	F 253		
F 272	483.20(b)(1) COMPREHENSIVE	F 272		8/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272 SS=D	Continued From page 23 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors and risk factors for 1 of 27 sampled residents (Resident #149). The findings included: Resident #149 was admitted to the facility on 2/10/2015 with diagnoses including Alzheimer's disease. Record review revealed an evaluation by Speech Therapy on 2/12/2015, and that the resident's diet was subsequently changed from mechanical soft to a pureed diet. The Admission comprehensive Minimum Data Set (MDS) dated 02/17/2015 indicated the resident was severely cognitively impaired. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.	F 272	F272 Comprehensive Assessments It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: The Admission comprehensive Minimum Data Set (MDS) dated 2/17/15 for Resident #149 was modified and transmitted on 8/4/15 by the MDS Nurse. Section L0200 (B) was correctly coded to indicate that the resident is edentulous (no natural teeth or tooth fragments). A Dental Care Area Assessment (CAA) was triggered and completed and a Care Plan initiated with appropriate interventions 8/4/15 by the MDS Nurse. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: All residents in the facility were reassessed on 8/11/15 by the MDS Nurses for oral status to determine if natural teeth or dentures were present. Section L of the most current comprehensive Minimum Data Sets (MDS) for all current residents in the facility was then reviewed and compared	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 25 The undated and unsigned Nutrition Care Area Assessment for the MDS dated 2/17/2015 stated the resident, "was noted to cough with mechanical soft meats. She was evaluated by speech therapy. Diet was changed to puree with thin liquids. No difficulty chewing/swallowing or mouth pain with present diet." There was no indication if the resident had well-fitting dentures at the time of the Speech Therapy evaluation or if the problem with the mechanical diet was related to swallowing or chewing. On 7/21/2015, Resident #149 was in her room. The resident did not have any upper or lower natural teeth and was not wearing dentures. On 7/22/2015 at 12:35 PM, Resident #149 was observed in the dining room for lunch. She was not wearing any dentures. At 8:25 AM on 7/23/15, Medication Aide #1 stated Resident #149 did not have any natural teeth and did not have dentures. MDS Coordinator #1 was interviewed on 7/23/2015 at 3:11 PM. MDS Coordinator #1 stated she had completed Resident #149's Nutrition Care Area Assessment [CAA] and at the time of the assessment the resident had dentures. MDS Coordinator #1 indicated she copied the dietary notes and put them in the CAA summary. The MDS Coordinator did not know if the resident had difficulty with chewing or swallowing or both, but did not believe she needed to say anything in the analysis of	F 272	to the oral status assessment to determine if this section was coded accurately. This task was completed by the MDS Nurses on 8/12/2015. All MDS coding errors related to the resident having dentures or natural teeth were corrected on the most current comprehensive MDS, Dental Care Area Assessments or Nutrition Care Assessments (CAA's) were completed if triggered or as appropriate to address underlying causes, contributing and risk factors related to oral status using RAI process guidelines by the MDS Nurses and this will be completed by the Completion Date listed of 8/23/15. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: MDS Nurses were in-serviced on the proper coding procedure for Section L (Oral/Dental Status) of the MDS and the Care Area Assessment procedure per RAI guidelines on 8/11/15 by the Nurse Consultant. L0200 (B) is now being coded on all residents who are edentulous. Care Area Assessments (Nutrition and/or Dental Care) are now being completed when triggered to address underlying causes, contributing and risk factors related to oral status using RAI process guidelines. The MDS Nurse will implement a care plan when appropriate. 4. How the corrective actions will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 26 Resident #149's nutritional status about dentures, or why the resident switched from mechanical soft to pureed diet during the assessment period. During an interview on 7/24/15 1:40 PM, the Director of Nursing stated the CAA summary should give the reader a total picture of the resident related that area being assessed.	F 272	monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: The DON and or designee will monitor admission comprehensive and annual MDS assessments to determine if Section L (Dental Status) is coded accurately. This will be done weekly for one month, then every other week for one month. This area will also be monitored during routine Nurse Consultant visits for the next 2 months. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QAPI committee will assess and modify the action plan as needed to ensure continual compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		8/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 278	Continued From page 27 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to code the Minimum Data Set accurately to reflect the dental status for 1 of 27 sampled residents (Resident #149). The findings included: Resident #149 was admitted to the facility on 2/10/2015 with diagnoses including Alzheimer's disease. The Admission comprehensive Minimum Data Set (MDS) dated 02/17/2015 indicated the resident was severely cognitively impaired. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further	F 278	F278 Accuracy of MDS It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident¿s functional capacity. 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: The Admission comprehensive Minimum Data set (MDS) dated 2/17/15 for Resident #149 was modified and transmitted on 8/4/15 by the MDS Nurse. Section L0200 (B) was correctly coded to indicate that the resident is edentulous (No natural teeth or tooth fragments). A Dental Care Area Assessment (CAA) was triggered and completed for further assessment on 8/4/15 by the MDS Nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 278	Continued From page 28 assessment. On 7/21/2015, Resident #149 was in her room. The resident did not have any upper or lower natural teeth and was not wearing dentures. On 7/22/2015 at 12:35 PM, Resident #149 was observed in the dining room for lunch. She was not wearing any dentures. During an interview on 7/23/2015 at 8:05 AM, Nursing Assistant [NA] #3 indicated she was not aware that Resident #149 ever had any dentures, but did know the resident had no natural teeth. At 8:25 AM on 7/23/15, Medication Aide #1 stated Resident #149 did not have any natural teeth and did not have dentures. MDS Coordinator #1 was interviewed on 7/23/2015 at 1:57 PM, about why her coding on the MDS indicated Resident #149 had natural teeth. MDS Coordinator #1 said, "She does have upper and lower dentures so if they have dentures I don't code them as having no teeth." After review of the MDS question again, the MDS Coordinator indicated she had misread the question, and said she did not accurately code the MDS for Resident #149 because the resident had.no natural teeth. During an interview on 7/24/2015 at 1:28 PM, the Director of Nursing (DON) indicated it was her	F 278	2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: The dental status of all current residents was assessed by the MDS Nurse on 8/11/15 and then compared to Section L of the most recent comprehensive Minimum Data Sets (MDS) to identify if any coding errors were present related to a resident having no natural teeth or tooth fragments (edentulous). All coding errors were corrected and the MDS modified and transmitted as appropriate. Dental Care Area Assessments or Nutrition Care Assessments (CAA's) were completed as appropriate to address underlying causes, contributing and risk factors. These tasks will be completed by the MDS Nurses on or before the Completion Date of 8/23/15. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: All MDS Nurses were in-serviced by the Nurse Consultant on the accuracy of coding Section L (Oral/Dental Status) using the coding guidelines and definitions listed in the RAI Manual. All L0200 (B) is now being coded on all residents who are edentulous Care Area Assessments (Nutrition and/or Dental Care) are now being completed and addressed when triggered and a care plan implemented when appropriate by the MDS nurses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 278	Continued From page 29 expectation for the MDS to accurately reflect resident information and should be coded correctly before it was transmitted.	F 278	4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: The Director of Nursing or designee will monitor 3 MDS assessments per week for one (1) month, then every other week for one (1) month and taper to monthly for two or more consecutive months to ensure accurate coding of resident's dental status on the MDS assessments. Section L coding accuracy will also be monitored by the Nurse Consultant during routine visits. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA committee will assess and modify the action plan as needed to ensure continual compliance.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		8/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 279	Continued From page 30 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a care plan to address a resident with wandering behaviors and at risk for elopement for 1 of 3 sampled residents at risk for elopement (Resident #21). The findings included: Resident #21 was admitted to the facility on 05/18/15 with dementia and discharged on 06/03/15. Review of Resident #21's nurse's notes revealed that on 05/19/15 the resident was "pacing and wandering" the facility and asking how to get out. Another nurse's note dated 05/20/15 read in part that Resident #21 was trying to exit the facility. A nurse's note dated 05/21/15 read in part that a wander guard bracelet (a security device) was unable to be applied to the resident due to the resident being "uncooperative." The admission Minimum Data Set (MDS) dated 05/25/15 specified the resident had severely impaired cognition, was delusional, had verbal and physical behaviors, rejected care and wandered the facility. The MDS also specified the resident's wandering placed the resident at significant risk of getting to a potentially	F 279	F-279 Comprehensive Care Plans It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #21 was discharged from the facility on 6/3/15 therefore no other corrective actions could be taken. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A 100% chart audit of all residents identified with wandering behaviors was conducted by the MDS Nurse on 7/24/15 to ensure a care plan was in place and to assess the appropriateness of care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 279	Continued From page 31 dangerous place. Review of Resident #21's care plan dated 05/25/15 did not address Resident #21's risk for elopement or wandering behaviors. On 07/23/15 at 12:44 PM MDS Coordinator #2 was interviewed and reported that when developing care plans she tried to individualize each care plan to reflect the resident's needs and concerns. The MDS Coordinator reviewed Resident #21's care plan and note that the resident had wandering behaviors and was at risk for elopement. She stated that the resident should have had a care plan to address the concerns but did not and felt it was an oversight.	F 279	goals and interventions. All other wandering care plans were in place and appropriate. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: The MDS Nurses will review the 24-hour report on a daily basis to identify any residents exhibiting new wandering behaviors and a care plan will be implemented with appropriate interventions. The MDS/Care Plan Nurses were in-serviced on 8/11/15 by the Nurse Consultant regarding care plan development and update, specifically that: (1) care plans should be consistent with resident¿s specific conditions, risks, needs, etc., and current standards of practice (2) the need to include measurable objectives, approximate timetables, specific interventions and/or services needed to address those needs and conditions, and (3) the process for reviewing and revising the care plan periodically and as necessary to reflect changes in resident conditions. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented. The DON or designee will review the nursing documentation of any resident exhibiting increased wandering/exit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 279	Continued From page 32	F 279	seeking behaviors to ensure that a care plan has been implemented with appropriate interventions. This will be done weekly for one month, then every other week for one month. This area will also be monitored during routine Consultant visits for the next two months. Results of the audit will be reviewed and discussed in the monthly Quality Assurance and Performance Improvement Committee meeting. The QA Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to have interventions in place to prevent 1 of 3 cognitively impaired residents with wandering behavior from exiting, unsupervised from the facility. On 5/12/2015 Resident #191 was seen attempting to leave the facility through a non-alarmed door and 5/21/2015 the resident was found outside by a	F 323	F323 Free of Accident Hazards/Supervision/Devices It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	7/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 33 staff member, approximately 300 feet from the same, non-alarmed exit door. Immediate Jeopardy began on 5/21/2015 and the Administrator was notified on 7/22/2015 at 6:50 PM. Immediate Jeopardy was removed on 7/24/2015 at 5:11 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of systems put in place and 100% of employee training. Findings included: The facility Policy Statement, titled Elopements [revised February 2014], included: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. Resident #191 was admitted to the facility 4/28/2015 with diagnoses including Parkinson's disease, Alzheimer's disease, muscle weakness, lack of coordination, anxiety, depression and Post Traumatic Stress Disorder. The admission comprehensive Minimum Data Set [MDS] dated 5/5/2015 indicated the resident was severely cognitively impaired but had not exhibited wandering during the assessment period, The MDS also indicated the resident's walking balance was not steady and he required extensive assistance of two staff members for locomotion on and off the unit.	F 323	1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 no longer resides in facility. Resident #191 exited the facility through the locked patio door, went off the bricked in patio, and was observed ambulating outside crossing the courtyard between the 200 and 600 hall. He was met by staff on the grass beside the end of the 600 hall wing. He was seated in the wheelchair and brought back inside in the presence of his wife and examined for injuries by the DON and his hall Nurse. There were no apparent injuries observed and the resident was in no distress other than he repeatedly stated he wanted to go home. The VA, and the medical provider were notified of the incident. The resident's wife was present in the facility when the incident occurred and therefore was aware of the occurrence. On 5/21/15 it was determined Resident #191 could return to home with his family and VA Home Care services as was the planned goal upon admission to the SNF, or if the family and VA choose, we initiate referral and would seek placement in facility with a locked unit. He was discharged with his wife on 5/25/15. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: A keyed padlock was placed on the door	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 34 The Plan of Care [originally dated 5/11/2015] indicated the resident had short and long term memory problems due to Alzheimer's disease, received medications for anxiety and depression and was at risk for falls. Review of the facility 24 Hour Report Sheet dated 5/12/2015 revealed a note by Resident #191's name which read, "opened patio door on second shift" but did not indicate a time for the incident. Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the patio dining room. The nursing documentation note included, "resident stood up and opened patio door and tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair], resident stated he was leaving and very determined to get out any door in facility, will monitor closely, call light within reach." The note did not indicate the time of the incident. The facility did not provide an incident report for the attempted elopement on 5/12/2015. A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident's bed and wheelchair to alert staff if the resident attempted to rise off of the pad. Resident #191's Plan of Care was updated on 5/14/2015 to indicate a wander guard bracelet was in place to prevent elopement.	F 323	to the bricked in patio, by the maintenance director, on 7/22/15 at 7:40pm. The door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. (Please Note: This door is NOT an emergency exit. This was approved by Life Safety). The lock will be used temporarily until a more permanent solution can be implemented The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the "verify that patio door is locked log that is posted on the unalarmed patio door in the day room. All other facility door alarms and doors with Wander Guard monitors are checked three times weekly for functionality and documented by maintenance staff on the "Wander Guard and Fire Exit Door Alarm Monitoring" log. Wander Guard devices on residents are verified for placement and checked for functionality by nursing and documented each shift on the eMAR. All resident are assessed for wandering in Section E0900 "Wandering- Presence and Frequency" and Section E1000 "Wandering and Impact" on the MDS assessment upon admission and at least quarterly. More frequent assessments are completed if change in behaviors/condition are determined. Interventions to maintain the resident in a safe environment are initiated through the Care Area Assessment (CAA¿s) and plan of care process by the Interdisciplinary Care Plan Team. This information is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 35 A note in the clinical record dated 5/20/2015 at 5:28 PM read, "Resident attempting to leave facility this afternoon. Redirection attempts by staff unsuccessful SW [Social Worker] asked resident why he was trying to leave, resident indicated he was going home." The record also indicated the Nurse Practitioner was informed and the resident was given a one-time dose of Ativan 1 milligram, intramuscularly for agitation. Further review of the clinical record revealed the resident succeeded in exiting the facility without staff knowledge on 5/21/2015. A note by the SW dated 5/21/2015 at 6:58 PM included, "Resident went out patio door in dayroom, locked his wheelchair breaks, climbed over the short brick wall on the patio, ambulated around the facility and was walking down the 600 hall driveway, when staff were alerted to resident being outside. Resident redirected back into the facility." Review of the facility investigation included a description of the incident, written by the Director of Nursing [DON] on 5/25/2015. The description included, "On 5/21/2015, at approximately 4:30 PM, resident was observed by staff through a resident's window outside on the grounds. Resident was walking alongside the building independently. Staff immediately went to resident and resident was cooperative and allowed staff to lead him back inside the building." The patio dining room door was observed on 7/21/2015 at 11:50 AM and again at 2:22 PM. There was a sign on the door which read, "KEEP THIS DOOR LOCKED AT ALL TIMES" Approximately 24 inches above the doorknob was a deadbolt lock. The door was locked. The door was able to be unlocked by turning the deadbolt	F 323	available to all nursing staff and Care Plan team via the electronic charting software. The list of residents identified as having wandering behaviors is sent out to all inside facility email recipients to be printed by department managers and posted within their department and available to all staff. The MDS Nurses are responsible to update the list as changes are made and disseminate information via email and EMR. All staff will be oriented to this process upon hire and annually thereafter. All facility staff educated to policies Wandering-Presence and Frequency prior to beginning their next work shift. On the night of 7/22/15 a 100% audit of all residents identified with wandering behaviors was conducted by the MDS / Care Plan nurses. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. On 7/24/15 all residents were assessed by Nurses using the new Wandering Risk assessment tool implemented. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: A keyed padlock was placed on the door to the bricked in patio, by the maintenance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 36 to the left and no alarm sounded. Outside the door was a 15 foot square patio surrounded by a brick wall that was approximately 26 inches high. A second brick wall surrounded the first wall, separated by a space of approximately 8 inches. The space between the brick walls was filled with dirt which formed a garden where tomato plants were growing. Beyond the patio was a large grassy area with trees and bushes. Beyond the grassy area was a driveway which ran behind the facility and then a chain-link fence and a downward sloping area that was heavily wooded. The driveway behind the facility went around to the side of the building where there was a parking lot and then further around to the front parking lot. Nurse #1 was interviewed on 7/22/2015 at 3:16 PM. She stated she was working on 5/12/2015 (attempted elopement through patio door) and also on 5/21/2015 when Resident #191 was found outside the 600 hall wing. When asked about the incident on 5/12/2015, Nurse #1 said the resident was observed to stand up from his wheelchair, unlock the patio door and was going to step outside when he was stopped by another nurse who brought him back into the building. Nurse #1 indicated that between 5/12/2015 and the time of his discharge on 5/25/2015, the resident would go to all the doors and try to get out. She said after he was admitted, "His meds were decreased and when he started to wake up is when it started. He would go to the 600 door or patio door and try to go out." The nurse added that she had questioned why the patio door was not alarmed and was told the door could not have the wander guard lock on it. The nurse said, "The sign, 'This door must be locked at all times' was already posted at that door but he saw activity staff unlock the door and go out with residents to	F 323	director, on 7/22/15 at 7:40pm. The door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. The key to the patio will be available from the Activity Director, Administration, Maintenance, DON, ADON, and Charge Nurse. (Please Note: This door is NOT an emergency exit.) The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the ¿verify that patio door is locked¿ log that is posted on the unalarmed patio door in the day room. A policy/procedure titled "Bricked in Patio" was developed on 7/23/15 by Administration that describes the steps outlined above. A copy of the policy was distributed to and reviewed with the Maintenance Director, Environmental services, DON, ADON, Life Enrichment Coordinator, and Nurse Managers/Supervisors on 7/23/15 by Administration. A copy of the policy is posted on the patio door and also a list of all staff members who have a key to unlock the door to use the patio. Key will be available to unlock the door 24 hours a day. Nursing Staff including all direct care CNA staff, as well as all other departments within the facility was provided in-service training beginning on 7/22/15, 7/23/15, 7/24/15 by nurse management and administration on emergency "Code E" - missing resident procedures and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 37 do activities on the patio, I guess." Nurse #1 said she made sure the attempted elopement was documented, passed on in report and was on the 24 hour Report Sheet. During the same interview Nurse #1 described the events on 5/21/2015 when the resident was successful in leaving the building unsupervised. Nurse #1 said she had spoken to the resident 10-15 minutes earlier and the resident's family member was looking for him too when Resident #191 was observed through the 100 hall window, moving through the backyard. Nurse #1 sent staff to get him while she went around to the closest door on the 600 hall with a wheelchair to meet them and the resident's family member, "was right behind me." "My question was this an elopement or just an incident because he wasn't off the grounds. The DON said she would take care of the documentation and notifying the appropriate people and I could just go back to what I was doing." Nurse #1 clarified that Nursing Assistant [NA] #2 had told her the resident was outside and the nurse was also aware a NA on 600 hall saw the resident through another resident's window on 600 hall. The Assistant Administrator was interviewed on 7/22/2015 at 4:24 PM. The Assistant Administrator said a wander guard alarm system was in place and all exit doors were alarmed except this one. There was no electricity to this patio door so it could not be alarmed with the system so they put up a sign that said to keep door locked. The Assistant Administrator said after the investigation on 5/25/2015 of the elopement on 5/21/2015, the facility attached a personal body alarm to the patio door. The Assistant Administrator said she had noticed	F 323	"Wandering, Unsafe Resident" Policy. Nurses were also instructed to immediately inform the nurse manager on duty in facility, or to call the nurse manager on call, if a resident demonstrates exit seeking behaviors and interventions currently in place are not effective in maintaining the resident in a safe environment. The nurse manager will be responsible for re-assessing the situation, implement additional interventions and measures to ensure the resident¿s safety is maintained. These interventions may include but are not limited to: redirection, diversional activities (recreation, music, IN2L, talking with family members) intensified visual monitoring, one-on-one with staff, initiation of wander guard, visual barriers (stop signs, ribbons) etc. Effectiveness of the interventions will be monitored and documented by the nurse. The nursing staff will report to the Nurse Manager if the new interventions implemented are not effective who will then notify the DON and Administrative on call person (Administrator or Assistant Administrator). As of 7/28/15 100% of the all current staff; to include Administration, Nurses, CNA, Respiratory Therapy, Life Enrichment, Therapy, Environmental Services, Office Personnel, Medical Records, Dietary, and Maintenance; had received this training. A new assessment Wandering Data Collection Tool was implemented on 7/24/15 by DON to help staff identify residents at risk of wandering, presence of wandering and the impact of wandering	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 38	F 323		

someone had removed the personal body alarm from the patio door so she placed one on the door again just prior to the interview. She did not know how long it had been gone from the door.

NA #1 was working on 600 hall on 5/21/2015 and was interviewed on 7/22/2015 4:46 PM. NA #1 said, "I was assisting a resident in room 621 and went to shut the blind and happened to look up and saw him [Resident #191]. I went running out the door to go get him." NA#1 went on to say, "I didn't have the code for the door nearest (room) 621 so I ran up the hall and went out the door by the 600 hall lobby and ran down the side of the building to get him." NA #1 clarified that Room 621 overlooked the facility's side parking lot and one could not see the backyard from that room.

On 7/23/2015 at 10:31 AM, the Administrator and Assistant Administrator were both interviewed about the attempted elopement on 5/12/2015. Both of them stated they had been made aware of Resident#191's exit-seeking behavior but they were not aware he had attempted to leave by a non-alarmed door.

On 7/23/2015 at 10:48 AM, the Director of Nursing [DON] was interviewed about the attempted elopement on 5/12/2015. She stated she was present at the Clinical Meeting on 5/13/2015 when it was discussed. The DON indicated it was she who had obtained the physician order on 5/14/2015 for the wander guard alarm ankle bracelet and the pad alarm that was in his wheelchair. When asked about the non-alarmed patio door where he had attempted to get out, the DON indicated the resident had

on resident safety/disruption a new. The assessment will be completed upon admission and quarterly thereafter. More frequent assessments may be completed if change in behaviors/condition is determined.

4. How the corrective actions will be monitored to ensure the deficient practice will not
reoccur, i.e. quality assurance measures implemented:

The DON or designee will audit medical records to ensure that clinical documentation of any resident who has been reported as exhibiting exit-seeking behaviors describes that appropriate interventions have been initiated to ensure resident safety. These audits will be done daily for one month, weekly for four weeks and monthly for six months. Nurse Consultant will also audit these areas during routine visits.

The Administrator or designee will review the 24-hour shift reports to ensure they are aware of any unusual occurrences related to wandering residents. The Administrator or designee will also monitor the lock placed on the patio door to ensure it is in place. These audits will be done daily for two weeks, weekly for four weeks and monthly for four months.

Results of the audit will be reviewed and discussed in the month Quality Assurance and Performance Improvement Committee meeting. The QA Committee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 39 also made attempts to exit the facility by alarmed doors. On 7/23/2015 at 11:25 AM, the Director of Maintenance measured the two routes the resident could have taken when he exited by the patio door on 5/21/2015. If he had climbed over the brick wall (approximately 26 inches high) and taken a direct path to the other side of the 600 hall wing, the distance was approximately 249 feet from the patio door. If the resident went over a lower portion of the brick wall that was only 12-14 inches high, which is where he had parked his wheelchair, the distance covered would have been approximately 354 feet. NA #2 was interviewed on 7/23/2015 at 4:30 PM, about where Resident #191's wheelchair was found on 5/1/2015 after the elopement. NA#2 stated that after the resident was returned to the building she went to look for his wheelchair and said, "I walked around (inside) the building and found the patio door was unlocked. " She indicated the wheelchair was parked right beside the patio door and next to the area of the brick wall that was just 12-14 inches high. She said, "the wheels were locked and the alarm was going off. It was a pad alarm it was pretty loud. I remember as soon as I opened the door it was loud." NA#2 approximated the resident had last been seen approximately 10 minutes prior to the elopement. She stated she and another NA had last seen him on the 100 hall near his room. The Administrator was notified of the Immediate Jeopardy on 7/22/2015 at 6:50 PM.	F 323	will assess and modify the action plan as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 40	F 323		

The facility presented a credible allegation of compliance on 7/24/2015 at 5:01 PM which included:

This plan of correction represents Valley Nursing Center's credible Allegation of Compliance. The submission of the following combined plan of correction and allegation of compliance does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to F323 alleged deficient practice with determination of immediate jeopardy. Please accept this corrective action as our credible Allegation of Compliance with F323:
1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 no longer resides in facility. Resident #191 exited the facility through the locked patio door, went off the bricked in patio, and was observed ambulating outside crossing the courtyard between the 200 and 600 hall. He was met by staff on the grass beside the end of the 600 hall wing. He was seated in the wheelchair and brought back inside in the presence of his [family member] and examined for injuries by the DON and his hall Nurse. There were no apparent injuries observed and the resident was in no distress other than he repeatedly stated he wanted to go home. The VA [Veteran's Administration], and the medical provider were notified of the incident. The resident's [family member] was present in the facility when the incident occurred and therefore was aware of the occurrence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 41	F 323		

On 5/21/15 it was determined Resident # 191 could return to home with his family and VA Home Care services as was the planned goal upon admission to the SNF, or if the family and VA choose, we initiate referral and would seek placement in facility with a locked unit. He was discharged with his wife on 5/25/15.

2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice:

A keyed padlock was placed on the door to the bricked in patio, by the maintenance director, on 7/22/15 at 7:40pm. The door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. (Please Note: This door is NOT an emergency exit. This was approved by Life Safety). The lock will be used temporarily until a more permanent solution can be implemented. The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the " verify that patio door is locked" log that is posted on the unalarmed patio door in the day room.

All other facility door alarms and doors with WanderGuard monitors are checked three times weekly for functionality and documented by maintenance staff on the "WanderGuard and Fire Exit Door Alarm Monitoring" log. WanderGuard devices on residents are verified for placement and checked for functionality by nursing and documented each shift on the eMAR [electronic Medication Administration Record.

All resident are assessed for wandering in Section E0900 "Wandering- Presence and Frequency" and Section E1000 - "Wandering and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 42	F 323		

Impact" on the MDS assessment upon admission and at least quarterly. More frequent assessments are completed if change in behaviors/condition are determined. Interventions to maintain the resident in a safe environment are initiated through the Care Area Assessment (CAAs) and plan of care process by the Interdisciplinary Care Plan Team. This information is available to all nursing staff and Care Plan team via the electronic charting software. The list of residents identified as having wandering behaviors is sent out to all inside facility email recipients to be printed by department managers and posted within their department and available to all staff. The MDS Nurses are responsible to update the list as changes are made and disseminate information via email and EMR. All staff will be oriented to this process upon hire and annually thereafter. All facility staff will be educated to policies Wandering-Presence and Frequency by 07/28/15.

On the night of 7/22/15 a 100% audit of all residents identified with wandering behaviors was conducted by the MDS/Care Plan nurses. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety.

Beginning on the morning of 7/24/15 all residents assessed by Nurses using the new " risk assessment tool " implemented. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety.

3. Measures taken and systems changed to prevent repeat of alleged deficient practice:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 43	F 323		

A keyed padlock was placed on the door to the bricked in patio, by the maintenance director, on 7/22/15 at 7:40pm. The door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. The key to the patio will be available from the Activity Director, Administration, Maintenance, DON, ADON, and Charge Nurse. (Please Note: This door is NOT an emergency exit.) The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the " verify that patio door is locked " log that is posted on the unalarmed patio door in the day room.

A policy/procedure titled "Bricked in Patio" was developed on 7/23/15 by Administration that describes the steps outlined above. A copy of the policy was distributed to and reviewed with the Maintenance Director, Environmental services, DON, ADON, Life Enrichment Coordinator, and Nurse Managers/Supervisors on 7/23/15 by Administration. A copy of the policy is posted on the patio door and also a list of all staff members who have a key to unlock the door to use the patio. Key will be available to unlock the door 24 hours a day.

Nursing Staff including all direct care staff, CNA staff, as well as other departments within the facility was provided in-service training beginning on 7/22/15, 7/23/15, 7/24/15 by nurse management and administration on emergency "Code E" - missing resident procedures and the "Wandering, Unsafe Resident" Policy. Nurses were also instructed to immediately inform the nurse manager on duty in facility, or to call the nurse manager on call, if a resident demonstrates exit seeking behaviors and interventions currently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 44	F 323		

in place are not effective in maintaining the resident in a safe environment. The nurse manager will be responsible for re-assessing the situation, implement additional interventions and measures to ensure the resident's safety is maintained. These interventions may include but are not limited to: redirection, diversional activities (recreation, music, IN2L, talking with family members) intensified visual monitoring, one-on-one with staff, initiation of wander guard, visual barriers (stop signs, ribbons) etc. Effectiveness of the interventions will be monitored and documented by the nurse. The nursing staff will report to the Nurse Manager if the new interventions implemented are not effective who will then notify the DON and Administrative on call person (Administrator or Assistant Administrator). As of 7/24/15, 155 employees out of a total of 240 (includes PRN staff) have received re-training described above. Each staff member who has not been trained will be required to receive training prior to beginning their next work shift. At this time 94% of all regular full-time staff has received training.

A new assessment tool was implemented on 7/24/15 by DON to help staff identify residents at risk of wandering, presence of wandering and the impact of wandering on resident safety/disruption a new tool entitled "Risk of Elopement / Wandering Review". The assessment will be completed upon admission and quarterly thereafter. More frequent assessments may be completed if change in behaviors/condition is determined.
Completion Date: 7/24/15

Immediate Jeopardy was removed on 7/24/015 at 5:11 PM. Observations revealed the patio door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 323	Continued From page 45 was equipped with the padlock. Interviews with direct care staff and licensed staff confirmed they had received in-servicing on responding to residents with exit-seeking behavior. Staff were able to define the method of communication to ensure Administrative staff was made aware so appropriate measures could be put in place to ensure safe environment. Staff were also able to describe a new assessment tool entitled "Risk of Elopement / Wandering Review"	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to keep fans clean from dust and debris and the fans were in use blowing air over food preparation areas. The findings included: On 07/20/15 at 9:30 AM an initial tour of the facility's kitchen was made with the Dietary Manager (DM). The dish room was observed and noted to have an oscillating fan in use pointed in the direction of the clean dishware as it	F 371	F371 Food Procure, Store/Prepare/Serve - Sanitary It is the policy of this facility to store, prepare, distribute, and serve food under sanitary conditions. 1. Corrective actions taken for residents found to have been affected by alleged deficient practice: There were no specific residents identified to have been affected by the alleged	7/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 371	Continued From page 46 was removed from the machine. Observations of the fan revealed a thick accumulation of dust and debris covering the back surface of the fan. During the initial tour, a second oscillating fan was observed in use. The fan was noted to be positioned on top of a food preparation counter and it was in use blowing air in the direction of the stove and oven area. During the observation, a dietary staff member was preparing food. Observations of the fan revealed a thick accumulation of dust and debris covering the back surface of the fan. A third oscillating fan was also observed on the initial tour conducted on 07/20/15 at 9:30 AM that was in use blowing air in the direction of a food preparation area. Observations of the fan revealed a thick accumulation of dust and debris covering the back surface of the fan. Review of the kitchen's cleaning schedule specified the fans were cleaned every two weeks. The DM was present for the observations and interviewed at 9:40 AM. The DM reported that the fans were cleaned every two weeks and were last cleaned on 07/08/15. The DM observed the fans and reported that they were dirty and should be cleaned. The DM added that during the summer months when the fans were in use they should be cleaned more often.	F 371	deficient practice. All three fans in the kitchen were cleaned on 7/20/15. 2. Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice: An assessment was completed by the Dietary Manager on 7/20/15 to determine if other fans were in use in the food preparation/storage/dining areas. There were no other fans in use in the kitchen or dining areas. Only those listed and identified as having issues by the surveyor. 3. Measures taken and systemic changes implemented to prevent alleged deficient practice: The Dietary Manager revised the dietary equipment Cleaning Schedule on 7/20/15 to indicate all fans in use in the kitchen shall now be cleaned weekly, instead of every two weeks as previously listed. All Dietary staff was provided in-service training by the Assistant Dietary Manager on the update to cleaning schedule and making sure all fans are cleaned weekly. The in-service training was completed 7/27/15. All fans in the kitchen will be cleaned weekly to prevent dust and debris build up. The staff member assigned to clean the fans will sign the Cleaning Schedule on the day the fans are cleaned. The Assistant Dietary Manager will be responsible to review the cleaning schedule and observe the cleanliness of the fans weekly to ensure that the fans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 371	Continued From page 47	F 371	have been satisfactorily cleaned and there is no dust or debris build up present. After observation of the fans, the Assistant Dietary Manager will then sign the cleaning schedule to confirm timely and adequate cleaning of the fans. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: This plan was implemented and the corrective action will be evaluated for effectiveness. This plan of correction is integrated into the monthly Quality Assurance Performance Improvement (QAPI) program as follows: The Assistant Administrator will be required to audit the kitchen fans for cleanliness weekly and will report the results of those weekly audits to the QAPI Committee monthly for 3 months. If the QAPI Committee determines that the weekly fan inspections are satisfactory during the initial 3 month period, the inspections by the Assistant Administrator may be reduced to monthly for 3 months. The QAPI Committee will monitor to ensure compliance is sustained with F371. The QAPI committee will assess and modify the action plan as needed to ensure continual compliance.	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		7/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 48 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to have interventions in place to prevent 1 of 3 cognitively impaired residents with wandering behavior from exiting, unsupervised from the facility. Administrative staff were not informed that Resident #191 was seen attempting to leave the facility through a non-alarmed door on 5/12/2015. The wander guard ankle bracelet intervention put in place on 5/13/2015 did not prevent the resident from exiting the building unattended on 5/21/2015 through the same, non-alarmed exit door. Immediate Jeopardy began on 05/21/2015 and the Administrator was notified on 7/22/2015 at 6:50 PM. Immediate Jeopardy was removed on 7/24/2015 at 5:11 PM when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of systems put in place and 100% of employee training. Findings included:	F 490	F490 Effective Administration/Resident Well-Being 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 no longer resides in facility. New policies developed and interventions implemented to ensure immediate notification will be made to administration if a resident is attempting to elope. When incidences of wandering and/or attempted elopement are reported, a complete and thorough investigation and inquiry will be immediately initiated by the Administrator and or designee. Due to residents continued efforts to exit the facility to "Go Home", it was determined on 5/21/15 that for his own safety and best interests, he could return to home with family and VA Home Care services as stated as his planned goal upon admission, or be relocated to a locked facility as soon as feasibly possible. The VA, the medical provider, was notified of the unwitnessed exit from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 49 The facility Policy Statement, titled Elopements [revised February 2014], included: 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. Resident #191 was admitted to the facility 4/28/2015 with diagnoses including Parkinson's disease, Alzheimer's disease, muscle weakness, lack of coordination, anxiety, depression and Post Traumatic Stress Disorder. The admission comprehensive Minimum Data Set [MDS] dated 5/5/2015 indicated the resident was severely cognitively impaired but had not exhibited wandering during the assessment period, The MDS also indicated the resident's walking balance was not steady and he required extensive assistance of two staff members for locomotion on and off the unit. The Plan of Care [originally dated 5/11/2015] indicated the resident had short and long term memory problems due to Alzheimer's disease, received medications for anxiety and depression and was at risk for falls. Review of the facility 24 Hour Report Sheet dated 5/12/2015 revealed a note next to Resident #191's name which read, "opened patio door on second shift" but did not indicate a time for the incident. Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the patio dining room. The nursing documentation note included, "resident stood up and opened patio door and	F 490	the locked dayroom door onto the patio and onto facility courtyard located between the 200 hall and the 600 hall. The resident¿s wife was present in the facility when he was observed by staff outside and brought back into the building. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: To ensure other residents were not at similar risk, on the night of 7/22/15 the Administrator instructed the MDS/Care Plan Nurses to complete a 100% audit of all residents identified with wandering behaviors and to review/revise resident Care Plans as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety and to ensure that none of these identified residents had attempted to elope. The results of the audit showed that there were no other noted elopement attempts made by any other resident. The Administrator and Assistant Administrator reviewed the audit results on 7/23/15. On 7/24/15 all residents were assessed by nursing using the newly implemented Wandering Risk Assessment Tool. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. Residents identified with wandering behaviors are available to all nursing staff and Care Plan team via the electronic charting software. The list of residents identified as having	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 50 tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair], resident stated he was leaving and very determined to get out any door in facility, will monitor closely, call light within reach." The note did not indicate the time of the incident. A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident ' s bed and wheelchair to alert staff if the resident attempted to rise off of the pad. Resident #191's Plan of Care was updated on 5/14/2015 to indicate a wander guard bracelet was in place to prevent elopement. A note in the clinical record dated 5/20/2015 at 5:28 PM read, "Resident attempting to leave facility this afternoon. Redirection attempts by staff unsuccessful SW [Social Worker] asked resident why he was trying to leave, resident indicated he was going home." The record also indicated the Nurse Practitioner was informed and the resident was given a one-time dose of Ativan 1 milligram, intramuscularly for agitation. Further review of the clinical record revealed the resident succeeded in exiting the facility without staff knowledge on 5/21/2015. A note by the SW dated 5/21/2015 at 6:58 PM included, "Resident went out patio door in dayroom, locked his wheelchair breaks, climbed over the short brick wall on the patio, ambulated around the facility and was walking down the 600 hall driveway, when staff were alerted to resident being outside.	F 490	wandering behaviors is sent out to all inside facility email recipients to be printed by department managers and posted within their department and available to all staff. The MDS Nurses are responsible to update the list as changes are made and disseminate information via email and EMR. All staff will be oriented to this process upon hire and annually thereafter. 3. Measures taken and systems changed to prevent repeat of alleged deficient practice: A keyed padlock was placed on the door to the bricked in patio, by the maintenance director, on 7/22/15 at 7:40pm. This door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. (Please Note: This door is NOT an emergency exit.) The lock will be used temporarily until a more permanent solution can be implemented. The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the "verify that patio door is locked" log that is posted on the unalarmed patio door in the day room. Administrator and/or Assistant Administrator reviewed the logs on 7/22, 7/23 and 7/24 and will continue to review the logs regularly to assure continued compliance. A policy/procedure titled "Bricked in Patio" was developed on 7/23/15 by Administration that describes the steps outlined above. A copy of the policy was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 51 Resident redirected back into the facility." Review of the facility investigation included a description of the incident, written by the Director of Nursing [DON] on 5/25/2015. The description included, "On 5/21/2015, at approximately 4:30 PM, resident was observed by staff through a resident's window outside on the grounds. Resident was walking alongside the building independently. Staff immediately went to resident and resident was cooperative and allowed staff to lead him back inside the building." The patio dining room door was observed on 7/21/2015 at 11:50 AM and again at 2:22 PM. There was a sign on the door which read, "KEEP THIS DOOR LOCKED AT ALL TIMES" Approximately 24 inches above the doorknob was a deadbolt lock. The door was locked. The door was able to be unlocked by turning the deadbolt to the left and no alarm sounded. Outside the door was a 15 foot square patio surrounded by a brick wall that was approximately 26 inches high. A second brick wall surrounded the first wall, separated by a space of approximately 8 inches. The space between the brick walls was filled with dirt which formed a garden where tomato plants were growing. Beyond the patio was a large grassy area with trees and bushes. Beyond the grassy area was a driveway which ran behind the facility and then a chain-link fence and a downward sloping area that was heavily wooded. The driveway behind the facility went around to the side of the building where there was a parking lot and then further around to the front parking lot. Nurse #1 was interviewed on 7/22/2015 at 3:16 PM. She stated she was working on 5/12/2015 (attempted elopement through patio door) and	F 490	distributed to and reviewed with the Maintenance Director, Environmental services, Life Enrichment coordinator, DON, ADON and Nurse Managers/Supervisors on 7/23/15 by Administration. Keys were distributed to Admin, Nurse Admin, Charge Nurse on Duty, Life Enrichment coordinator, EVS, and Maintenance. All other facility door alarms and doors with Wander Guard monitors are checked three times weekly for functionality and documented by maintenance staff on the "Wander Guard and Fire Exit Door Alarm Monitoring" log. Wander Guard devices on residents are verified for placement and checked for functionality by nursing and documented each shift in the eMAR. Administrator and/or Assistant Administrator reviewed this process and verified compliance on 7/23/15. On the night of 7/22/15 a 100% audit of all residents identified with wandering behaviors was conducted by the MDS / Care Plan nurses. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. The audit results were reviewed by the Administrator and Assistant Administrator on 7/23/15 to assure completion. Nursing Staff including direct care staff was provided in-service training on 7/22/15, 7/23/15 and 7/24/15. Emphasis was placed on the immediate urgency to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 52 also on 5/21/2015 when Resident #191 was found outside the 600 hall wing. When asked about the incident on 5/12/2015, Nurse #1 said the resident was observed to stand up from his wheelchair, unlock the patio door and was going to step outside when he was stopped by another nurse who brought him back into the building. Nurse #1 indicated that between 5/12/2015 and the time of his discharge on 5/25/2015, the resident would go to all the doors and try to get out. She said after he was admitted, "His meds were decreased and when he started to wake up is when it started. He would go to the 600 door or patio door and try to go out." The nurse added that she had questioned why the patio door was not alarmed and was told the door could not have the wander guard lock on it. The nurse said, "The sign, 'This door must be locked at all times' was already posted at that door but he saw activity staff unlock the door and go out with residents to do activities on the patio, I guess." Nurse #1 said she made sure the attempted elopement was documented, passed on in report and was on the 24 hour Report Sheet. During the same interview Nurse #1 described the events on 5/21/2015 when the resident was successful in leaving the building unsupervised. Nurse #1 said she had spoken to the resident 10-15 minutes earlier and the resident ' s family member was looking for him too when Resident #191 was observed through the 100 hall window, moving through the backyard. Nurse #1 sent staff to get him while she went around to the closest door on the 600 hall with a wheelchair to meet them. "My question was this an elopement or just an incident because he wasn't off the grounds. The DON said she would take care of the documentation and notifying the appropriate	F 490	notify Administration if a resident attempts to Elope so that appropriate safeguards can be initiated. The in-services were presented by nurse management and Administration to include emergency "Code E" - missing resident and procedures from policy for Wandering, Unsafe Resident. Nurses were also instructed to immediately inform the nurse manager on duty in facility, or to call the nurse manager on call, if a resident demonstrates exit seeking behaviors and interventions currently in place are not effective in maintaining the resident in a safe environment. The nurse manager will be responsible for re-assessing the situation, implement additional interventions and measures to ensure the resident¿s safety is maintained. These interventions may include but are not limited to: redirection, diversional activities (recreation, music, talking, IN2L, time with family members) intensified visual monitoring, one-on-one with staff, initiation of wander guard, visual barriers (stop signs, ribbons) etc. Effectiveness of the interventions will be monitored and documented by the nurse. The nursing staff will report to the Nurse Manager if the new interventions implemented are not effective who will then immediately notify the DON and Administrator on call person (Administrator or Assistant Administrator). Each staff member employed by the facility is required to receive training prior to beginning their next work shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 53 people and I could just go back to what I was doing." Nurse #1 clarified that Nursing Assistant [NA] #2 had told her the resident was outside and the nurse was also aware a NA on 600 hall saw the resident through another resident's window on 600 hall. The Assistant Administrator was interviewed on 7/22/2015 at 4:24 PM. The Assistant Administrator said a wander guard alarm system was in place and all exit doors were alarmed except this one. There was no electricity to this patio door so it could not be alarmed with the system so they put up a sign that said to keep door locked. The Assistant Administrator said after the investigation on 5/25/2015 of the elopement on 5/21/2015, the facility attached a personal body alarm to the patio door. The Assistant Administrator said she had noticed someone had removed the personal body alarm from the patio door so she placed one on the door again just prior to the interview. She did not know how long it had been gone from the door. NA #1 was working on 600 hall on 5/21/2015 and was interviewed on 7/22/2015 4:46 PM. NA #1 said, "I was assisting a resident in room 621 and went to shut the blind and happened to look up and saw him [Resident #191]. I went running out the door to go get him." NA#1 went on to say, "I didn't have the code for the door nearest (room) 621 so I ran up the hall and went out the door by the 600 hall lobby and ran down the side of the building to get him." NA #1 clarified that Room 621 overlooked the facility's side parking lot and one could not see the backyard from that room. On 7/23/2015 at 10:31 AM, the Administrator and	F 490	A new assessment called Wandering Data Collection Tool was implemented on 7/24/15 by DON to help staff identify residents at risk of wandering, presence of wandering and the impact of wandering on resident safety/disruption. The assessment will be completed upon admission, with an increase in exit-seeking behavior, and then quarterly thereafter. Administrator and Assistant Administrator reviewed the "Wandering, Unsafe Resident Policy" on 7/22/15 and revisions to the policy written on 7/23/15 as follows: #1. Language added to include the use of the new Wander Data Collection Tool, #4 b Language added to notify the Administrator, DON immediately if a resident is suspected as "missing" and # 5 b Language added to contact the Administrator when the resident is returned to the facility and report findings and conditions of the resident. The content of this policy was used with the in-service training beginning 7/22/15. As of 7/28/15 100% of the all current staff; to include Administration, Nurses, CNA, Respiratory Therapy, Life Enrichment, Therapy, Environmental Services, Office Personnel, Medical Records, Dietary, and Maintenance; had received this training. This training added to new hire orientation and added to the required annual in-services for all staff. On 7/22/15 (following the announcement of the IJ situation) the Administrator and Assistant Administrator met with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 54 Assistant Administrator were both interviewed about the attempted elopement on 5/12/2015. Both of them stated they had been made aware of Resident#191's exit-seeking behavior but they were not aware he had attempted to leave by a non-alarmed door. On 7/23/2015 at 10:48 AM, the Director of Nursing [DON] was interviewed about the attempted elopement on 5/12/2015. She stated she and the Assistant Administrator were present at the Clinical Meeting on 5/13/2015 when it was discussed but the emphasis was on the exit-seeking behavior, not on which doors he had been using. The DON indicated it was she who had obtained the physician order on 5/14/2015 for the wander guard alarm ankle bracelet and the pad alarm that was in his wheelchair. On 7/23/2015 at 11:25 AM, the Director of Maintenance measured the two routes the resident could have taken when he exited by the patio door on 5/21/2015. If he had climbed over the brick wall (approximately 26 inches high) and taken a direct path to the other side of the 600 hall wing, the distance was approximately 249 feet from the patio door. If the resident went over a lower portion of the brick wall that was only 12-14 inches high, which is where he had parked his wheelchair, the distance covered would have been approximately 354 feet. On 7/24/2015 at 3:42 PM, the Administrator was interviewed about the attempted elopement on 5/12/2015. The Administrator indicated if she had known he had attempted to leave through a	F 490	facility Management staff and all charge nurses on staff informing them of the need to contact the Administrator and Assistant Administrator when residents are suspected as ¿elopement risks¿ and exhibiting exit seeking behaviors. 7/22/15 Administrator and Assistant Administrator checked each nurses¿ station to assure their contact information (phone numbers) was readily accessible. Compliance was noted. 7/22/15 (2nd shift) Administrator and Assistant Administrator immediately began rounding throughout the facility interviewing staff to assure they were aware of the Code E elopement policy/procedure and inquiring about any untoward incidents/resident behavior. Rounds continued on 3rd shift until 2 a.m. Rounds resumed on 7/23/15 on first shift at 7am. 7/23/15 8:30 Management staff were reminded again of the need to immediately communicate potential elopement risk concerns to Administrator. Administrator and Assistant Administrator continued to round throughout the day until approximately 9:30 pm. 7/24/15 Assistant Administrator conducted rounds at 7am and received report from the DON who had also completed rounds prior to 7am. There were no issues reported. Process was developed to enhance the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 55 non-alarmed door, different measures could have been used. She said, "For any attempt by a resident who is trying to elope, my expectation is that staff call me and we can assess what needs to be done in that particular area. It is my responsibility to keep these residents safe." The Administrator was notified of the Immediate Jeopardy on 7/22/2015 at 6:50 PM. The facility presented a credible allegation of compliance on 7/24/2015 at 5:01 PM which included: This plan of correction represents Valley Nursing Center ' s credible Allegation of Compliance. The submission of the following combined plan of correction and allegation of compliance does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to F490 alleged deficient practice with determination of immediate jeopardy. Please accept this corrective action as our credible Allegation of Compliance with F490: 1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 no longer resides in facility. New policies developed and interventions implemented to ensure immediate notification will be made to administration if a resident is attempting to elope. When incidences of wandering and or attempted elopement are	F 490	communication between the Nursing Staff and Administrator of daily activities that occur in the facility during "off" hours and weekends. "Off" hours are defined as hours outside of the normal work scheduled times (8:00 a.m. ¿ 5:00 p.m.) The process "Facility Pulse Checks" was initiated 7/23/15. Administration will log on the "Facility Pulse Check" form when they call or come to the facility during "Off" hours. 4. How the corrective actions will be monitored to ensure the deficient practice will not reoccur, i.e. quality assurance measures implemented: The DON or designee will audit the medical record to ensure that clinical documentation of any resident who has been reported as exhibiting exit-seeking behaviors describes that appropriate interventions have been initiated to ensure resident safety. These audits will be done daily for one month, weekly for four weeks and monthly for six months. Nurse Consultant will also audit these areas during routine visits. The Administrator or designee will review the 24-hour shift reports to ensure they are aware of any unusual occurrences related to wandering residents. The Administrator or designee will also monitor the lock placed on the patio door to ensure it is in place. This will be done daily for two weeks, weekly for four weeks, and monthly for four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 56 reported, a more thorough investigation and inquiry will be immediately initiated by the Administrator. Resident #191 exited the facility through the locked patio door, went off the bricked in patio, and was observed ambulating outside crossing the courtyard between the 200 and 600 hall. He was met by staff on the grass beside the end of the 600 hall wing. He was seated in the wheelchair and brought back inside in the presence of his [family member] and examined for injuries by the DON and his hall Nurse. There were no apparent injuries observed and the resident in no distress except him repeatedly stating the he " wants to go home " . Due to residents continued efforts to exit the facility to "Go Home", it was determined on 5/21/15 that for his own safety and best interests, he could returned to home with family and VA [Veteran's Administration] Home Care services as stated as his planned goal upon admission, or be relocated to a locked facility as soon as feasibly possible. The VA, the medical provider were notified of the unwitnessed exit from the locked dayroom door onto the patio and onto facility courtyard located between the 200 hall and the 600 hall. The resident ' s wife was present in the facility when he was observed by staff outside and brought back into the building. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: To ensure other residents were not at similar risk, no the night of 7/22/15 the Administrator instructed the MDS/Care Plan Nurses to complete a 100% audit of all residents identified	F 490	Results of these audits will be reviewed and discussed in the monthly Quality Assurance and Performance Improvement Committee meeting. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 57	F 490		

with wandering behaviors and to review/revised resident Care Plans as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety and to ensure that none of these identified residents had attempted to elope. The results of the audit showed that there were no other noted elopement attempts made by any other resident. The Administrator and Assistant Administrator reviewed the audit results on 7/23/15.

On 7/24/15 all residents were assessed by nursing using the new "risk assessment tool" implemented. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. Residents identified with wandering behaviors are available to all nursing staff and Care Plan team via the electronic charting software. The list of residents identified as having wandering behaviors is sent out to all inside facility email recipients to be printed by department managers and posted within their department and available to all staff. The MDS Nurses are responsible to update the list as changes are made and disseminate information via email and EMR. All staff will be oriented to this process upon hire and annually thereafter.

3. Measures taken and systems changed to prevent repeat of alleged deficient practice:

Systematic changes implemented by Administration include:

· A keyed padlock was placed on the door to the bricked in patio, by the maintenance director, on 7/22/15 at 7:40pm. The door will be kept locked at all times unless staff is present to unlock it with a key and supervise residents. (Please Note: This door is NOT an emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 58	F 490		

exit.) The lock will be used temporarily until a more permanent solution can be implemented. The environmental services staff that cleans the day room daily 7 days each week will be responsible to visually check, ensure, and sign off daily on the "verify that patio door is locked" log that is posted on the unalarmed patio door in the day room. Administrator and/or Assistant Administrator reviewed the logs on 7/22, 7/23 and 7/24 and will continue to review the logs regularly to assure continued compliance.

· A policy/procedure titled "Bricked in Patio" was developed on 7/23/15 by Administration that describes the steps outlined above. A copy of the policy was distributed to and reviewed with the Maintenance Director, Environmental services, Life Enrichment coordinator, DON, ADON and Nurse Managers/Supervisors on 7/23/15 by Administration. Keys distributes to Admin, Nurse Admin, Charge Nurse on Duty, Life Enrichment coordinator, EVS, and Maintenance.

· All other facility door alarms and doors with WanderGuard monitors are checked three times weekly for functionality and documented by maintenance staff on the "WanderGuard and Fire Exit Door Alarm Monitoring " log. WanderGuard devices on residents are verified for placement and checked for functionality by nursing and documented each shift on the eMAR [electronic Medication Administration Record]. Administrator and/or Assistant Administrator reviewed this process and verified compliance on 7/23/15.

· On the night of 7/22/15 a 100% audit of all residents identified with wandering behaviors was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 59 conducted by the MDS / Care Plan nurses. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. The audit results were reviewed by the Administrator and Assistant Administrator on 7/23/15 to assure completion. · Nursing Staff including direct care staff was provided in-service training on 7/22/15, 7/23/15 and 7/24/15. Emphasis was placed on the immediate urgency to notify Administration if a resident attempts to Elope so that appropriate safeguards can be initiated. The in-services were presented by nurse management and Administration to include emergency "Code E" - missing resident and procedures from policy for Wandering, Unsafe Resident. Nurses were also instructed to immediately inform the nurse manager on duty in facility, or to call the nurse manager on call, if a resident demonstrates exit seeking behaviors and interventions currently in place are not effective in maintaining the resident in a safe environment. The nurse manager will be responsible for re-assessing the situation, implement additional interventions and measures to ensure the resident ' s safety is maintained. These interventions may include but are not limited to: redirection, diversional activities (recreation, music, talking, IN2L, time with family members) intensified visual monitoring, one-on-one with staff, initiation of wander guard, visual barriers (stop signs, ribbons) etc. Effectiveness of the interventions will be monitored and documented by the nurse. The nursing staff will report to the Nurse Manager if the new interventions implemented are not effective who will then	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 60 immediately notify the DON and Administrator on call person (Administrator or Assistant Administrator). As of 7/24/15, 155 employees out of a total of 240 (includes PRN staff) have received re-training described above. Each staff member employed by the facility who has not been trained will be required to receive training prior to beginning their next work shift. · A new assessment tool was implemented on 7/24/15 by DON to help staff identify residents at risk of wandering, presence of wandering and the impact of wandering on resident safety/disruption (See assessment tool titled "Risk of Elopement / Wandering Review"). The assessment will be completed upon admission and quarterly thereafter. More frequent assessments may be completed if a change in behaviors/condition are determined. · Administrator and Assistant Administrator reviewed the "Wandering, Unsafe Policy" on 7/22/15 and revisions to the policy written on 7/23/15 as follows: #1. - Language added to include the use of the new Wander Data Collection Tool, #4 b - Language added to notify the Administrator, DON immediately if a resident is suspected as " missing" and # 5 b - Language added to contact the Administrator when the resident is returned to the facility and report findings and conditions of the resident. The content of this policy was used with the in-service training beginning 7/22/15 continuing through 7/28/15. As of today, 7/24/15, 155 of 164 full time staff have been trained. The remaining full-time, part-time, and PRN staff will be contacted and trained. Every staff member MUST be trained prior to beginning their next work shift in the facility. This training will be added to new hire	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 490	Continued From page 61	F 490		

orientation and added to the required annual in-services for all staff.

· 7/22/15 (following the announcement of the IJ situation) the Administrator and Assistant Administrator met with the facility Management staff and all charge nurses on staff informing them of the need to contact Administrator and Assistant Administrator when residents are suspected as "elopement risks".

· 7/22/15 Administrator and Assistant Administrator checked each nurses station to assure their contact information (phone numbers) was readily accessible. Compliance was noted.

· 7/22/15 (2nd shift) Administrator and Assistant Administrator immediately began rounding throughout the facility interviewing staff to assure they were aware of the Code E policy/procedure and inquiring about any untoward incidents/resident behavior. Rounds continued on 3rd shift until 2 a.m. Rounds resumed on 7/23/15 on first shift at 7am.

· 7/23/15 8:30 - Management staff were reminded again of the need to immediately communicate potential elopement risk concerns to Administrator. Administrator and Assistant Administrator continued to round throughout the day until approximately 9:30 pm.

· 7/24/15 - Assistant Administrator conducted rounds at 7am and received report from the DON who had also completed rounds prior to 7am. There were no issues reported.

· Process was developed to enhance the communication between the Nursing Staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	**581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681**

(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 490	Continued From page 62 Administrator of daily activities that occur in the facility during "off " hours and weekends. "Off" hours are defined as hours outside of the normal work scheduled times (8:00 a.m.-5:00 p.m.) The process "Facility Pulse Checks" was initiated 7/23/15. Completion Date: 7/24/15 Immediate Jeopardy was removed on 7/24/015 at 5:11 PM. Observations revealed the patio door was equipped with the padlock. Interviews with direct care staff and licensed staff confirmed they had received in-servicing on responding to residents with exit-seeking behavior. Staff were able to define the method of communication to ensure Administrative staff was made aware so appropriate measures could be put in place to ensure safe environment. Staff were also able to describe a new assessment tool entitled "Risk of Elopement/Wandering Review"	F 490		