STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 168 SS=C	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the phone number for the State Complaint Intake Unit, failed to list the current Division name, and failed to list the current Division phone number. Findings included: On 08/17/15 an observation during initial tour at 10:00 AM revealed the State Complaint Intake Unit phone number was not found posted anywhere in the facility. On 08/19/15 an interview with the Administrator at 9:33 AM revealed he thought the State Complaint Intake Unit Information was the "Your Rights" disability poster which was posted on the bulletin board by the nurse's station. The telephone number that was listed on the poster read 1-877-235-4210. This number was called by surveyor and a message was heard stating "Thanks for calling Disability Rights North Carolina." He revealed he had not known where the State Complaint Intake Unit telephone number was, but he would find someone who did know where it was located. An interview with the Regional Director of Clinical Services on 08/19/15 at 9:40 AM revealed she	F 168	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. No residents were injured related to this citation. 2. All residents have the potential to be affected by this citation. On 08/17/2015 the Executive Director printed and posted the State of North Carolina Complaint Intake Unit phone number in four (4) conspicuous locations. 3. The Executive Director was in serviced by the Regional Director of Clinical Services on 08/17/2015 on the posting of the State of North Carolina Complaint Intake unit phone number. The Executive Director will perform Quality Improvement Monitoring one time a week for 6 months and/or until substantial compliance is obtained. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of the audits will	9/14/15

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

Electronically Signed | 09/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 168	Continued From page 1 had located the State Complaint intake phone number in a booklet hanging by the bulletin board. The booklet was titled Resident/Grievance/Complaint Procedures. She pointed out a telephone number which was located on the back of the first page in the booklet. The name and number read State Licensing Agency NC State, 932 Old Hwy 70 E, Black Mountain, NC 28711. The telephone number listed was: 828-669-3388 and 919-855-3400. She stated it would have been hard for residents to access the information in the location it had been in. On 08/19/15 at 10:00 AM a telephone call was placed by surveyor to the telephone number that was listed in the booklet that read 919-855-3400 and a recording was heard that stated: "You have reached the office of aging and adult services." An interview with the Administrator on 08/19/15 at 4:00 PM verified the State Complaint Intake Unit telephone number had not been posted nor had it been accessible for all residents.	F 168	be reported to the Quality Assurance Performance Improvement Committee Meeting for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to cover an indwelling urinary catheter drainage bag for privacy for 1 of	F 241	1. Resident #58 was not injured related to this citation. 2. Residents with Foley Catheter's have	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 241	Continued From page 2 2 residents who had a urinary drainage bag. (Resident #58). The findings included: A record review of the admission assessment Minimum Data Set (MDS) dated 08/05/15 revealed Resident #58 was admitted to the facility on 07/29/2015 with diagnoses of renal insufficiency, benign prostatic hypertrophy, and non-Alzheimer's dementia. Resident #58 was not cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #58 was coded as having an indwelling catheter. A record review of Resident #58's care plan dated 08/05/15 revealed problem of urinary catheter related to urinary retention. Interventions to address urinary catheter included as follows: · Catheter care was to be provided daily to prevent urinary tract infection. · Privacy bag was to cover catheter drainage bag at all times. Observations were conducted of Resident #58 and revealed the following: · 08/17/2015 at 12:39 PM Resident #58 was resting in bed and indwelling catheter bag was observed hanging on the side of the bed and was not covered by privacy bag. · 08/17/2015 at 3:29 PM Resident #58 was resting in bed and indwelling catheter bag was observed hanging on the side of the bed and was not covered by privacy bag. · 08/18/20 at 9:51 AM Resident #58 was observed receiving physical therapy services in	F 241	the potential to be affected by this citation. Observations of privacy bags for foley catheters were made on 08/17/2015 by the Director of Clinical Services. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced Licensed Nurses and Certified Nursing Assistants on providing foley drainage bag covers to promote dignity 09/01/2015 - 09/10/2015. The Director of Clinical Services and/or Nursing Manager will perform Quality Improvement Monitoring of placement of privacy bags for foley catheter's five times a week for one month, three times a week for one month, two times a week for two months, and one time a week for two months and/or until substantial compliance is obtained. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of this audit will be reported to the Quality Assurance Improvement Committee members for 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 241	Continued From page 3	F 241		

his bed. Indwelling catheter bag was observed hanging on the side of the bed and indwelling catheter bag was not covered by privacy bag.

A review of facility policy dated 11/30/15 and entitled Catheterization, Male and Female revealed (in part) catheter (foley) bag must be covered by a privacy bag at all times to preserve dignity of the resident.

On 08/18/15 at 10:08 AM an interview was conducted with Nurse Aide (NA) #1 who stated she made sure Resident #58's urinary drainage bag was not touching the floor. NA #1 stated Resident # 58's urinary drainage bag was not covered with privacy bag. NA #1 stated she knew the urinary drainage bag needed to be covered for Resident #58 but thought the urinary drainage bag needed to be covered only when Resident #58 was out of bed. NA #1 thought the procedure at the facility was to cover urinary drainage bag only when resident was out of bed. NA #1 stated she had not received any facility training regarding covering resident's urinary drainage bag with privacy bag to provide dignity for the resident.

On 08/18/15 at 10:24 AM an interview was conducted with Nurse #1 who stated she was aware that resident #58's urinary drainage bag was not covered with privacy bag on 08/17/2015 and 08/18/15. Nurse #1 stated she would not have covered Resident # 58's urinary drainage bag with privacy bag or delegated NA to place urinary drainage bag in privacy bag. Nurse #1 stated she was unaware of a facility policy that indicated urinary drainage bag was required to be covered with privacy bag. Nurse #1 stated she had not received any facility training regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 241	Continued From page 4 covering resident's urinary drainage bag with privacy bag to provide dignity for the resident. On 08/18/2015 at 10:35 AM an interview was conducted with the Director of Clinical Services (DCS) who stated when a resident was admitted to the facility with an indwelling catheter with urinary drainage bag then nursing staff was required to cover the urinary drainage bag with privacy cover. The DCS stated her expectations were that nursing staff would have covered Resident #58's urinary drainage bag with privacy bag on admission to the facility. DCS stated it was an oversight that nursing staff had not covered Resident #58's urinary drainage bag with privacy bag. DCS stated she would address covering urinary drainage bag with privacy bag with the nursing staff.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accomodate a resident's needs by placing a resident at a table which was not at the correct height for the resident to eat comfortably for 1 of 11 residents observed during dining. (Resident #51).	F 246	1. Resident # 51 was not injured related to this citation. Resident #51 was moved to a table of appropriate height immediately by the Director of Clinical Services on 08/20/2015. 2. Residents that choose to dine in the	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 246	Continued From page 5 The findings included: Resident #51 was admitted to the facility on 08/11/12 with diagnoses including Alzheimer's disease, hypertension, dysphagia and muscle weakness. An annual Minimum Data Set (MDS) assessment completed on 05/06/15 indicated Resident #51 had severe cognitive impairment of skills for daily decision making. The MDS also indicated Resident #51 required extensive assistance with all Activities of Daily Living (ADL) except eating for which she required limited assistance. Resident #51's care plan was reviewed and it was appropriate to address her needs. The care plan indicated Resident #51 needed staff support with eating and staff were to keep needed items in easy reach. Resident #51 was observed on 08/20/15 at 1:25 PM eating lunch in the main dining room and seated at a table with 3 other residents. Resident #51 was eating without any assistance from staff. The top edge of the table was at chin level with the resident. Resident #51 was observed reaching up at an awkward angle to scoop her food off the plate. A nurse aide was seated across the table from Resident #51 feeding another resident. On 08/20/15 at 1:35 PM the Director of Clinical Services and Administrator were asked to observe Resident #51 in the dining room with surveyor. The Administrator acknowledged that the table was too high for the resident. On 08/20/15 at 1:37 PM Resident #51 was moved to another table which was lower and slightly above waist level for resident. Resident	F 246	dining room have the potential to be affected by this citation. On 08/20/2015 observations of residents dining in the dining room was performed to ensure that residents were seated at tables of appropriate height by the Director of Clinical Services and/or Nursing Supervisor. Seating chart was developed and posted for staff to have access to by the Director of Clinical Services. 3. Licensed Nurses, certified nursing assistants, and the interdisciplinary team were in serviced by the Director of Clinical Services on placing residents during meal times at a table that is an appropriate height using the table assignment sheet 09/09/2015. the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Executive Director, Activities, Medical Records) will perform Quality Improvement monitoring of 5 residents during each meal in the dining room for proper table height five times a week for one month, three times a week for one months, two times a week for two months, one time a week for two months and/or substantial compliance obtained. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 246	Continued From page 6 #51 continued eating without any assistance from staff and appeared to be able to reach the food more easily. An interview with the Administrator on 08/20/15 at 4:10 PM revealed he expected residents to be seated at a table that was the proper height for them to eat and for the residents to be positioned in a dignified manner.	F 246	members consist of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to keep residents' rooms in good repair for 1 of 26 bathrooms and 2 of 26 resident rooms that were inspected (bathroom shared by residents in Room 132 and Room 134 and resident rooms 129 and 133). The findings included: 1. Observation of the bathroom shared by Residents #16, #92 and #119 on 08/18/15 at 9:07 AM revealed the pull cord for the emergency call bell was missing. Additional observations on 08/19/15 at 3:00 PM and 08/20/15 at 1:05 PM revealed the pull cord for the emergency call bell was still missing. An interview on 08/20/15 at 1:02 PM with the Maintenance supervisor about how he did	F 253	1. Resident #16 was not injured related to this citation. The emergency call bell cored was replaced on 08/20/2015 by the Maintenance Director. Resident #92 was not injured related to this citation. The emergency call bell cored by was replaced on 08/20/2015 by the Maintenance Director. Resident#119 was not injured related to this citation. The emergency call bell cord was replaced on 08/20/2015 by the Maintenance Director. Resident #86 was not injured related to this citation. The outlet cover was replaced on 08/20/2015 by the Maintenance Director. Resident#9 was not injured related to this citation. The baseboard and plaster were repaired on 08/20/2015 by the	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 preventative maintenance in the facility revealed he did spot checks of residents' rooms and housekeeping and nursing staff notified him verbally or by a work order when something needed repaired. He stated staff completed a work order form and placed it in his mailbox or placed it on the door to his office. During observation with the Maintenance supervisor on 08/20/15 at 1:05 PM, he stated he was not aware the cord for the emergency call bell was missing and would replace it right away. 2. Observation of Residents #86's room on 08/17/15 at 3:52 PM revealed the cover was missing from the electrical outlet on the wall between Resident #86's bed and his roommate's bed. Additional observations on 08/19/15 at 11:20 AM and 08/20/15 at 1:05 PM revealed the cover was still missing from the electrical outlet on the wall. An interview on 08/20/15 at 1:02 PM with the Maintenance supervisor about how he did preventative maintenance in the facility revealed he did spot checks of residents' rooms and housekeeping and nursing staff notified him verbally or by a work order when something needed repaired. He stated staff completed a work order form and placed it in his mailbox or placed it on the door to his office. During observation with the Maintenance supervisor on 08/20/15 at 1:05 PM, he stated he was not aware the electrical outlet did not have a cover on it. 3. Observation of the room shared by Residents #9 and #30 on 08/18/15 at 12:09 PM revealed a	F 253	Maintenance Director. Resident#30 was not injured related to this citation. The baseboard and plaster were repaired on 08/20/2015 by the Maintenance Director. 2. All residents have the potential to be affected by this citation. Observations of residents rooms and bathrooms for presence of call bell cord, baseboards, outlet covers, and intact plaster was completed on 09/08/2015 by the Maintenance Director. 3. The Maintenance Director was in serviced by the Executive Director on maintaining call cords, baseboards, plaster and electrical covers on 09/08/2015. The Maintenance Director along with the Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Executive Director, Activities, Medical Records,) will perform Quality Improvement monitoring of 5 residents rooms for call bell cords, intact and secured baseboards, outlet covers, and walls in need of repair five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or substantial compliance obtained. 4. The Maintenance Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until substantial compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 loose piece of baseboard on the wall between the 2 beds adjacent to the bathroom door. There was also a 2 inch wide, deep gash in the plaster on the wall to the right of the bathroom door and in the wood on the outside of the bathroom door and the door to the room. Additional observations on 08/19/15 at 11:29 AM and 08/20/15 at 10:57 AM revealed the baseboard remained loose and the deep gash remained in the wall plaster and the doors. An interview with Resident #9 on 08/19/15 at 11:29 AM revealed he thought the gashes in the wall and doors were caused by his wheelchair scraping against them. An interview on 08/20/15 at 1:02 PM with the Maintenance supervisor about how he did preventative maintenance in the facility revealed he did spot checks of residents' rooms and housekeeping and nursing staff notified him verbally or by a work order when something needed repaired. He stated staff completed a work order form and placed it in his mailbox or placed it on the door to his office. During observation with the Maintenance supervisor on 08/20/15 at 1:05 PM he revealed he depended on housekeeping and nursing staff to notify him of repairs that were needed. He stated he had repaired the gashes on the door several times in the past but Resident #9 continued to scrape the door with his wheelchair when going in and out of the room. An interview with the Administrator on 08/20/15 at 4:10 PM revealed department managers did observations of residents' rooms every day and reported any concerns during the daily meetings.	F 253	The Quality Assurance Performance Committee members consist of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 The Administrator stated he expected staff to identify and report any maintenance concerns so they could be corrected.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff and family, the facility failed to provide nail care to 1 of 2 residents reviewed for assistance with activities of daily living (ADL). (Resident #119). The findings included: Resident #119 was admitted to the facility on 08/05/15 with diagnoses including open wound abdominal wall, malignant neoplasm of colon and secondary thrombocytopenia. Her admission Minimum Data Set (MDS) assessment indicated Resident #119 had moderately impaired cognitive skills for daily decision making and required extensive assistance from staff with all ADL including personal hygiene and bathing. The MDS indicated Resident #119 had no behavioral symptoms or rejection of care. The comprehensive care plan had not been completed but the initial care plan indicated Resident #119 needed assistance from staff with	F 312	1. Resident#119 no longer resides at the facility. 2. All residents have the potential to be affected by this citation. Director of Clinical Services and/or Nursing Supervisor performed Quality Improvement Monitoring of resident nails on 09/08/2015. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses and certified nursing assistants on providing nail care to residents when showers given and as needed 09/01/2015 - 09/10/2015. Interdisciplinary team (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Executive Director, Activities, Medical Records,) will perform Quality Improvement monitoring of 10 residents nails five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 312	Continued From page 10 all ADL. Review of the shower schedule, which was located at the nurses station and identified by the nurse aides as what they used to know when residents received their showers, revealed Resident #119 was scheduled for a shower on Tuesdays, Fridays and Sundays. Observations of Resident #119 on 08/17/15 at 5:46 PM, 08/18/15 at 9:00 AM and 1:36 PM, on 08/19/15 at 11:18 AM and 4:55 PM and on 08/20/15 at 12:50 PM revealed the fingernails on resident's right hand extended approximately 1/4 inch over the end of her finger and curved down slightly on the end. There was brown debris visible under all of the fingernails on the right hand. An interview with the Resident's family member on 08/20/15 at 12:50 PM revealed Resident #119's fingernails tended to curve down when they got too long. The family member indicated the nails needed trimmed. An interview on 08/20/15 at 11:09 AM with Nurse Aide (NA) #2, who was on the shower team, revealed she didn't give resident a shower on Tuesday, 08/18/15 because resident didn't feel like getting a shower. When asked what personal care was provided on Tuesday for Resident #119, NA #2 stated she gave the resident a bedbath. A subsequent interview with NA #2 on 08/20/15 at 2:55 PM revealed she had just finished giving Resident #119 a bed bath. Observation of Resident #119's fingernails with NA #2 at that time revealed they remained untrimmed and the fingernails on the right hand had brown debris underneath them.	F 312	substantial compliance obtained. 4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Improvement Committee on 09/11/2015. The results of the audit will be reported to the Quality Assurance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Improvement Committee members consists of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 312	Continued From page 11 An interview with the Administrator on 08/20/15 at 4:10 PM revealed he expected cleanliness of the resident's body, mouth, nails and perineal area after baths and showers were given. He stated a staff member was assigned to check every resident every day for any concerns with care that needed provided and for any complaints from the resident. The Administrator stated he expected the Director of Clinical Services (DCS) to also be checking residents. He further stated he expected the DCS to follow up on any care issues that were identified and shared during the daily meeting with department managers.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 329	Continued From page 12	F 329		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and interviews with staff the facility failed to monitor for side effects and effectiveness of antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #86).

The findings included:

Resident #86 was admitted to the facility on 09/30/14 with diagnoses including dementia, obsessive compulsive disorder, depression, anxiety and psychosis with auditory hallucinations.

An admission Minimum Data Set (MDS) assessment dated 10/09/14 indicated Resident #86 had mild cognitive impairment and had no delirium, psychosis or behavioral symptoms. The MDS indicated he received antidepressant medication for 7 days of the observation period.

The Care Area Assessment (CAA) summary for Psychotropic Drug Use indicated Resident #86 had a history of psychosis and needed antidepressant medication and monitoring for side effects and effectiveness of medications.

A quarterly MDS dated 06/01/15 indicated Resident #86 had moderate cognitive impairment and no delirium or psychosis. The MDS indicated he had physical behavioral symptoms directed toward others and he received antipsychotic

1. Resident #86 was not injured related to this citation. The behavior monitoring sheet was completed by the Director of Clinical Services on 08/20/2015.
2. Residents with behaviors have the potential to be affected by this citation. Quality Improvement Monitoring was completed on 08/21/2015 to identify any further behavior sheets not filled out completely by the Director of Clinical Services.
3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on filling out Behavior Monitoring form completely for residents with behaviors on 09/01/2015 - 09/10/2015. The Director of Clinical Services and/or Nursing Manager will perform Quality Improvement monitoring of the completeness of Behavior Monitoring forms five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or until substantial compliance is obtained.
4. The Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee members for 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 329	Continued From page 13 medication for 6 out of 7 days of the observation period. The MDS indicated he received antidepressant medication for 7 days of the observation period. Resident #86's most recent Care Plan addressed his need for psychotropic medications and the interventions were appropriate to address his needs. The interventions included observe for effectiveness and side effects of psychotropic medications. Review of Resident #86's medical record revealed a physician's order dated 04/23/14 for Seroquel 25 milligrams (mg) every night. Further review of Resident #86's medical record revealed documents titled "Behavior Symptom Monitoring Sheet" dated May 2015 and June 2015 which were blank and filed with the Medication Administration Records (MARs). There was not a July 2015 Behavior Symptom Monitoring Sheet on the chart. An interview on 08/20/15 at 10:48 with the Director of Clinical Services (DCS) revealed the sheets should have been completed with the behavior or symptom the medication was being used to treat, causes or triggers of the behavior, non-pharmacological and pharmacological interventions located at the top of the form. The DCS explained that the section at the bottom of the form was for documentation of monitoring of any behaviors or symptoms, possible causes for the behavior and interventions that were used. When the DCS was asked why the forms were blank, she stated she thought the staff who completed the MARs must have overlooked completing the form.	F 329	months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 329	Continued From page 14 Review of August MARs on 08/20/15 at 11:21 AM with Nurse #2 revealed there was no Behavior Monitoring Sheet for August 2015 for Resident #86. An interview on 08/20/15 at 11:22 AM with Nurse #2 revealed Behavior Monitoring Sheets were usually kept on the MAR and she didn't know why there wasn't one for Resident #86. An interview on 08/20/15 at 4:10 PM with the Administrator revealed he expected nursing staff to document interventions being done to address the resident's behaviors as well as any side effects and the effectiveness of medications. The Administrator stated Resident #86 had obsessive compulsive behavior and he personally provided one on one interventions every day with the resident. The Administrator stated he expected residents to be treated as clinically sound as they could be. He further stated that use of psychotropic medications was discussed at the monthly Quality Assurance meetings and Resident #86 must have been overlooked.	F 329		
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	F 371		9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 15 This REQUIREMENT is not met as evidenced by: Based on observations, review of the dish machine log book and interviews, the facility failed to ensure the final rinse temperature of the dish machine reached a minimum of 180 degrees Fahrenheit (F), food in the refrigerator was dated and labeled and out of date food was removed from the refrigerator. The findings included: 1. On 08/17/15 at 9:55 AM the Dietary Manager (DM) was observed processing dishes through the dish machine. Two racks of dishes including cups, glasses and bowls were observed processed through the dish machine. These dishes were placed in clean storage. Observation of the dish machine temperature while 2 more racks of dishes were processed through the dish machine revealed the highest temperature reached during the final rinse cycle was 161 degrees F. An interview with the DM at that time revealed the service technician had checked the machine a couple weeks prior and had told her the dish machine wasn't registering the accurate temperature because of low water pressure. On 08/17/15 at 10:05 AM a dietary aide was observed filling the recently stored glasses with water for use on the lunch meal trays. The DM was advised at that time that the dishes including cups, glasses, plates, bowls and cutlery must be sanitized before use since the dish machine temperature didn't reach 180 degrees F. Review of a service detail report dated 08/05/15 by the service technician revealed the thermostat	F 371	1. No residents was injured related to this citation. The dish machine was taken out of service and further meals were served on disposable dishware on 08/17/2015. Eco Lab service technician was immediately notified for service and the dish machine was repaired on 08/20/2015. Out of date food was discarded on 08/17/2015 by the dietary manager. 2. All residents have the potential to be affected by this citation. 3. Dietary Manager was in serviced by Registered Dietician on water temperatures and proper storage and disposal of food items on 08/17/2015. On 08/20/20105 - 09/10/2015 in servicing began of all dietary cooks and dietary aides on proper acceptable temperature ranges for the dish machine, what to do in the event temperatures are not within acceptable range and the storage and disposal of food items by the District Dietary Manager and/or Dietary Manager. The Dietary Manager and/or Executive Director will do Quality Improvement monitoring of the recording of the dish machine temperatures each meal 5 times a week for 8 weeks, three times a week for 8 weeks, 2 times a week for 8 weeks and/or until substantial compliance is obtained. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of the audit will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 16 for the final rinse was not functioning properly and he replaced the thermostat. The report also indicated the water pressure was too low on the final rinse and it was adjusted. An interview with the service technician on 08/17/15 at 2:34 PM revealed he thought the problem had been resolved by the end of his visit on 08/05/15 even though the temperature on the final rinse cycle only reached 175 degrees F. He stated he thought that was because the hot water temperature in the facility's main hot water heater had not reached the proper level because of the recent water outage. He stated he had not been contacted about any further problems until he was notified earlier in the day on 08/17/15 of the low level found by the surveyor. The service technician stated he had checked the dish machine and determined the problem on 08/17/15 was an electrical issue and would need to be repaired by an electrician. Review of the facility's dish machine temperature log revealed the following final rinse temperatures that were below 180 degrees F: 08/07/15 - 170 degrees F 08/10/15 - 176 degrees F 08/12/15 - 175 degrees F 08/14/15 - 179 degrees F 08/15/15 - 176 degrees F. An interview on 08/17/15 at 2:50 PM with the DM revealed staff were trained to use chemical sanitization if the temperature on the final rinse cycle didn't reach 180 degrees F. The DM stated the dish machine had been taken out of service on 08/17/15 until an electrician could make the necessary repairs.	F 371	reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee members consists of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 17	F 371		

An interview on 08/19/15 at 10:10 AM with the Administrator and Maintenance Director revealed an electrician checked the dish machine on 08/18/15 and determined there was an element in the dish machine that wasn't functioning properly. The Maintenance Director stated the service technician for the dish machine expected to have the part and be at the facility on 08/20/15 to repair the machine.

An interview on 08/19/15 at 2:10 PM with the DM revealed she had not notified the service technician of the temperatures on the final rinse cycle that were less that 180 degrees F after his service visit on 08/05/15. The DM stated she misunderstood the service technician and thought the dish machine was incorrectly reading low until she read back over his notes.

On 08/20/15 at 11:10 AM the Maintenance Director notified the surveyor that the dish machine was repaired and dietary staff were processing breakfast dishes through the machine.

On 08/20/15 at 11:25 AM observation with the DM of the dish machine processing dishes revealed the wash cycle reached 165 degrees F and the final rinse cycle reached 184 degrees F.

2. During the initial tour of the facility kitchen on 08/17/15 at 10:14 AM 3 bowls of fruit and 1 cheese sandwich, which were not labeled or dated, were observed stored in the 2 compartment refrigerator . The cheese sandwich was in a plastic bag that wasn't sealed and the edges of the bread were dry and crusty. A plastic container with approximately 1 quart was labeled pork BBQ (barbecue) and a plastic container with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 18	F 371		

approximately 4 quarts was labeled pork and beans; both containers had the dates 08/13/15 and 08/16/15. The DM stated 08/13/15 was the date the food was placed in the refrigerator and 08/16/15 was the date the food should have been discarded. Posted on the outside of the refrigerator door were 2 handwritten notes - one read "Please, date and label all food items;" the other note read "Discard after 3 days."

An interview on 08/19/15 at 1:48 PM Interview with a Dietary Aide about the expectation for labeling of food items revealed food should be labeled with the name of the food and the date it was put in storage and should be discarded after 3 days.

An interview on 08/19/15 at 2:10 PM with the DM revealed the facility policy for storing leftover food had changed from 3 days to 7 days as of 08/17/15. When asked how staff were educated on the policy change, she stated she had told staff individually and an inservice was scheduled for 08/21/15.

An interview with the Administrator on 08/20/15 at 4:10 PM about his expectations for monitoring of the dish machine temperatures revealed he expected the DM to notify either himself or the Maintenance Supervisor if the temperature was lower than required for the wash or final rinse cycle. He further stated he expected the DM to take the machine out of service when the temperatures were too low until it could be repaired. When the Administrator was asked about his expectations for food dating, labeling and storage, he stated he expected leftover food to be dated and labeled when it was put into storage. He also stated he expected the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 19 refrigerator to be checked for out of date items and discarded according to facility policy. The Administrator stated he did a tour of the kitchen every day and checked for out of date items. He stated he had not completed a tour of the kitchen on Monday, 08/17/15, and expected the DM to check for out of date items whenever he didn't.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 441	Continued From page 20 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to use proper infection control practices by failing to remove personal protective equipment and wash hands prior to exiting a room that was identified as having contact precaution isolation for 1 of 2 residents on contact isolation (Resident # 117). Findings included: Review of the facility's policy and procedure for Preventing Spread of Multi Drug Resistant Organisms dated 11/30/14 revealed gloves and gowns shall be removed before leaving the resident's room and placed in a plastic bag, and wash hands immediately with an antimicrobial soap. Observation of a housekeeping staff member on 08/17/15 at 10:00 AM revealed he had been in a contact isolation room wearing an isolation gown and gloves. There was a sign posted on the door of Resident # 117's room that read "Contact Isolation." He was emptying the garbage. He exited the contact isolation room with the isolation gown and gloves on. He went to the medication cart and removed his gloves and dropped them in the garbage attached to the medication cart. He	F 441	1. No resident was injured related to this citation. Staff #1 was in serviced by the housekeeping supervisor on 08/20/2015. 2. All residents have the potential to be affected by this citation. 3. the District Housekeeping Supervisor and/or nursing supervisor in serviced housekeeping on proper isolation procedures with removing gloves and gowns and hand hygiene 08/20/2015 - 09/10/2015. The Director of Clinical Services and Executive Director will perform Quality Improvement monitoring of housekeeping staff using proper isolation procedures with removing of gloves, gowns, and hand hygiene five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or substantial compliance obtained. 4. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 441	Continued From page 21 went down the hall to where the housekeeping cart was located and removed the isolation gown and dropped it in the cart garbage. He then went into another resident's room without washing his hands. An interview with housekeeping staff # 1 on 08/20/15 at 5:50 PM revealed he had been working on 8/17/15 in an isolation room. He stated he had been wearing an isolation gown and gloves. He had pulled the garbage out of the garbage can and double bagged it. He stated he had walked out of the isolation room with the gown and gloves on. He stated he had gone to the medication cart, removed his gloves and put them into the medication cart garbage. He then walked down the hall with the gown still on and put the garbage into the housekeeping cart. He then removed the gown and put it into the garbage in the housekeeping cart, and had gone into another resident's room. He stated after he thought about it he realized he had not followed the isolation precaution procedures, and could have caused cross contamination. He stated he had received training in isolation precautions when he had started working with the company. An interview with the housekeeping supervisor on 08/20/15 at 5:10 PM revealed his company had trained their employees in isolation precautions, and expected the staff to follow the policy. An interview with the Director of Nursing on 8/20/15 at 5:55 PM revealed her expectations of all staff would be to follow isolation precaution protocol, and if they had any questions they would be expected to ask the nurse.	F 441	compliance is obtained. The Quality Assurance Performance Improvement Committee members consists of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 441	Continued From page 22	F 441		
F 514 SS=D	I 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain complete medical records for 16 of 35 current residents and 1 discharged resident by not recording weights on	F 514	1. No resident was injured related to this citation. Resident #9 weights were added to the medical record on 08/18/2015 by the	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 514	Continued From page 23	F 514		

the clinical record. (Residents #9, #10, #12, #16, #27, #30, #35, #47, #49, #50, #62, #64, #65, #67, #86, #92 and #115).

The findings included:

Review of residents' medical records during Stage I of the survey revealed weights were not available on the medical record for long term stay residents, other than admission weights and occasional weights in the progress notes by the Registered Dietician. Residents #9, #10, #12, #16, #27, #30, #35, #47, #49, #50, #62, #64, #65, #67, #86, #92 did not have any other weights recorded on the medical record. Residents newly admitted for short term rehabilitative services had weights recorded in their medical record

Review of the closed medical record for Resident #115 revealed there was only 1 weight recorded, which was on the admission nursing assessment. No other weights were available on the chart.

An interview on 08/18/15 at 8:15 AM with the Director of Clinical Services (DCS) revealed she kept a list of residents' weights in her office after they were obtained each month. The DCS confirmed the weights were not recorded on the permanent medical record for each individual resident.

An interview on 08/20/15 at 4:10 PM with the Administrator revealed he expected residents' weights to be recorded on their individual medical records because weights were considered a vital sign and should be readily available.

Director of Clinical Services.
Resident #10 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #12 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #16 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #27 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #30 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #35 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #47 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #49 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #50 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #62 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #64 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #65 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services.
Resident #67 weights were added to the medical record on 08/18/2015 by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 514	Continued From page 24	F 514	Director of Clinical Services. Resident #86 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services. Resident #92 weights were added to the medical record on 08/18/2015 by the Director of Clinical Services. 2. All residents have the potential to be affected by this citation. An audit of all residents charts was initiated on 08/18/2015 to ensure weights were documented in the medical record by the Director of Clinical Services. 3. The Director of Clinical Services in serviced the unit clerk on recording the residents weights in the medical record on 09/08/2015. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of weights being recorded in the medical records two times a week for four months then one time a week for two months and/or substantial compliance is obtained. 4. the Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee members consists of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 514	Continued From page 25	F 514	Coordinator.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to four recited	F 520	1. No residents were injured related to this citation. 2. All residents have the potential to be affected by this citation. The Executive Director and Director of Clinical Services have been re-educated on the regulation	9/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 520	Continued From page 26 deficiencies which were originally cited during the facility's 06/12/2014 recertification survey and were recited during the facility's current recertification survey. The recited deficiencies were in the areas of food procurement and storage, activities of daily living, drug regimen free of unnecessary medication, and infection control. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during two consecutive federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is crossed referenced to: 1. F 371: Food Procurement and Storage: Based on observations, review of the dish machine log book, and interviews, the facility failed to ensure the final rinse temperature of the dish machine reached minimum of 180 degrees Fahrenheit (F), food was dated and labeled in the refrigerator and out of date food was removed from the refrigerator. During the recertification survey of 08/20/2015 the facility was cited for failure to ensure the final rinse temperature of the dish machine reached minimum of 180 degrees (F) and failure to date and label food in the refrigerator and discard outdated food. During the recertification survey of 06/12/2014 the facility was cited for failure to discard expired food and failure to clean the beverage dispensing nozzles. 2. F 312: Activities of Daily Living: Based on observations, record review, and interviews with	F 520	F520 and the facility's policy and procedures for quality assurance and performance improvement by the Regional Director of Clinical Services on 09/11/2015. The Regional Director of Clinical Services has re-educated the interdisciplinary team members on regulation F520 and the facility's policy and procedures for Quality Assurance Performance Improvement on 09/11/2015. Director of Clinical Services and/or Nursing Supervisor performed Quality Improvement monitoring of residents nails on 09/08/2015. 3. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses and certified nursing assistants on providing nail care to residents when showers given and as needed 09/01/2015 - 09/10/2015. Interdisciplinary team, (Director of Clinical Services and/or Nursing Supervisor, Business Office Manager, Social Services, Executive Director, Activities, Medical Records,) will perform Quality Improvement monitoring of 10 residents nails five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or substantial compliance obtained. The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on filling out the Behavior Monitoring Form completely for residents with behaviors 09/01/2015 - 09/10/2015. The Director of Clinical Services and/or Nursing Manager will perform Quality Improvement monitoring of the completeness of Behavior Monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 520	Continued From page 27 staff and family, the facility failed to provide nail care to 1 of 2 residents reviewed for assistance with activities of daily living. (Resident #119). During the recertification survey of 08/20/2015 the facility was cited for failure to provide nail care to Resident #119. During the recertification survey of 06/12/2014 the facility was cited for failure to provide correct perineal care for a resident who was incontinent and dependent on staff. (Resident #87). 3. F 329: Drug Regimen Free of Unnecessary Medication: Based on observations, record review, and interviews with staff, the facility failed to monitor for side effects and effectiveness of antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #86). During the recertification survey of 08/20/2015 the facility was cited for failure to monitor for side effects and effectiveness of antipsychotic medication for Resident #86. During the recertification survey of 06/12/2014 the facility was cited for failure to monitor residents for adverse reactions (tardive dyskinesia) for 3 of 3 sampled residents who were prescribed antipsychotic medications. (Resident #70, #55, and #78). 4. F 441: Infection Control Practices: Based on observation, record review, and staff interviews, staff member failed to use proper infection control practices by failing to remove personal protective equipment and washing hands prior to exiting a room that was identified as having contact precaution isolation for 1of 2 residents on contact isolation (Resident #117).	F 520	Forms five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two months and/or until substantial compliance is obtained. Dietary Manager was in serviced by Registered Dietician on water temperatures and proper storage and disposal of food items on 08/17/2015. On 08/20/2015 - 09/10/2015 in servicing began of all dietary cooks and dietary aides on proper acceptable temperature ranges for the dish machine, what to do in the event temperatures are not within acceptable range and the storage and disposal of food items by the District Dietary Manager and/or Dietary Manager. The Dietary Manager and/or Executive Director will do Quality Improvement Monitoring of the recording of the dish machine temperatures each meal five times a week for 8 weeks, three times a week for 8 weeks, two times a week for 8 weeks and/or until substantial compliance is obtained. The District Housekeeping Supervisor and/or Nursing Supervisor in serviced housekeeping on proper isolation procedures with removing gloves and gowns and hand hygiene 08/20/2015 - 09/10/2015. The Director of Clinical Services and/or Executive Director will perform Quality Improvement monitoring of housekeeping staff using proper isolation procedures with removing of gloves, gowns and hand hygiene five times a week for one month, three times a week for one month, two times a week for two months, one time a week for two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 520	Continued From page 28 . During the recertification survey of 08/20/2015 the facility was cited for failure to follow proper infection control practices by not removing personal protective equipment and washing hands prior to exiting a room that was identified as having contact precaution isolation for 1 of 2 residents on contact isolation (Resident #117). During the recertification survey of 06/12/2014 the facility was cited for failure to use proper infection control practices including hand washing, glove usage, and handling of soiled linens to prevent cross contamination and soiling of environmental surfaces during 1 of 4 observations of care. An interview was conducted with the administrator on 08/20/2015 at 4:10 PM who confirmed the facility had a Quality Assessment and Assurance (QA&A) Program that met monthly rather than quarterly. The Administrator stated that all administrative staff members, medical director, and the pharmacist consultant attended the QA&A monthly meeting. The administrator stated due to deficient practice identified on the last survey the QA&A committee decided that the facility's administrative team would conduct a daily mock survey. The administrator stated the results of the daily mock survey were shared in morning meeting. The administrator stated there must have been a break down in the daily mock survey process. The administrator stated his explanation for continued deficient practice in food procurement and storage, activities of daily living, drug regimen free of unnecessary medication, and infection control were as follows: · Food Procurement and Storage: The	F 520	months and/or substantial compliance obtained. the RVPO and/or RDCS will conduct Quality Improvement monitoring of the facility's QAPI process by attending, to ensure that issues identified are handled appropriately using the action plan one time a month for three months. 4. The Executive Director and Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/11/2015. The results of this audit will be reported to the Quality Assurance Performance Improvement Committee members for 6 months and/or until compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but is not limited to the Executive Director, Director of Clinical Services, Unit Manager, Staff Development, Activities, Medical Director, Social Services, Maintenance Director, Dietary Manager, and Minimum Data Set Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

(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 520	Continued From page 29	F 520		

administrator stated it was the responsibility of the dietary manager to check daily the dates on food stored in the kitchen and discard outdated or undated food. The administrator stated it was the responsibility of the dietary manager to notify him of any equipment concerns in the kitchen. The administrator stated the process broke down when the food in the kitchen was not checked daily by the dietary manager for outdate and undated food. The administrator stated the dietary manager had not notified him of a problem with the rinse temperature on the dish machine.

· Activities of Daily Living (ADL): The administrator stated it was his expectation that the Director of Clinical Services (DCS) was to follow up daily on nursing staff's administration of ADL care to residents such as condition of grooming, hair, nails, cleanliness of body, oral, and perineal care. The administrator stated the break down in the process was that the DCS did not assure that all residents in the facility had ADL care completed.

· Drug Regimen Free of Unnecessary Medication: The administrator stated the process broke down because drug monitoring for psychotropic drug use fell through the cracks. The administrator stated he was sorry and did not know how monitoring of psychotropic drug use was missed.

· Infection Control (IC): The administrator stated the DCS was non-compliant in her responsibility to assure that (IC) practices in the facility were in place. The administrator stated (IC) practices in the facility broke down because the DCS should have assured that all staff in the facility knew about the facility's (IC) practices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	**551 KENT STREET ANDREWS, NC 28901**

(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