PRINTED: 08/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C <b>29/2016</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		011	23/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 224 SS=D	MISTREATMENT/NE The facility must deve policies and procedur mistreatment, neglect and misappropriation  This REQUIREMENT by:	t, and abuse of residents of resident property.  is not met as evidenced	F:	224			8/19/16
LABORATORY	resident and staff interprovide incontinence 1 of 1 resident (Resident of personal care assist The findings included Resident #165 was a 01/26/16 with diagnor respiratory failure, higanxiety. The admissi (MDS) dated 02/02/10 was alert and orienter impairment. The MD #165 required extens mobility, toileting, hygquarterly MDS dated cognitive impairment #165 had no short or problems. During an observation 07/28/16 at 1:54 PM, was awakened that me the Nurse (N #1) who Resident #165 stated wet and asked if she #165 stated that N #1	dmitted to the facility on ses including lung disease, in blood pressure, and on Minimum Data Set indicated Resident #165 d with mild cognitive S also indicated Resident ive assistance with bed piene, and dressing. The 04/21/16 indicated the was resolved and Resident long term memory  n of Resident #165 on Resident #165 stated she norning around 2:30 AM by			Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to extent that the summary of findings is factually correct and in order to maintai 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 ref any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal apper procedure and/or administrative or legal proceedings.  F224 483.13(c) Prohibit Mistreatment/Neglect/Misappropriation It is the policy of this facility to prohibit	the n s. a e	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/19/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

**Electronically Signed** 

program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING						(X3) DATE SURVEY COMPLETED	
			7 5 6 5	_		، ا	С
		345247	B. WING				29/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				58	B1 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			T	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE COMP		
	Resident #165 stated was awakened by Nu AM. Resident #165 sher breakfast tray. R asked to be changed the sensation of having feed the dampness of back of her shirt. Restated she could not be they were passing our roommate had alread #165 stated she was changed or to wait or was changed, but have brief.  An interview with NA revealed NA #1 was a be changed before she stated she had alread the roommate of Restated she had alread the roommate of Restated she had laread the roommate of Restated she had been told by was in the room they anyone.  An interview with NA revealed NA #2 assist care for Resident #165 stated NA #2 a	she fell back to sleep and arse Aide (NA#1) at 7:45 stated NA#1 had brought in esident #165 stated she before breakfast as she had ag a wet brief and could also in the lower edges of the sident #165 stated NA#1 be changed then because it breakfast trays and her by received hers. Resident not given the option to be in breakfast until after she id to eat breakfast in a wet wet with a breakfast in a breakfast in a breakfast in a breakfast in a bre	TAG	2224	mistreatment, neglect, and abuse of resident and misappropriation of reside property.  1. Corrective Action taken for residents affected by alleged deficient practice:  Resident #165 was provided incontiner care by NA#1 and NA#2 and both NA# and NA #2 were told by the DON that is expected to provide timely incontiner care to every resident as soon as posseven if meals were being served.  2. Corrective action for residents having the potential to be affected by alleged deficient practice:  A) Administrative Nurses made rounds on each hall on 7/29/16 to ensure that resident who requested or needed incontinence care.  B) On 08/01/16, the Social Workers interviewed each interviewable residents who requires incontinence care, to determine if there were other residents with similar issues of receiving timely continence.	ent  cet fince ible g any t,	DATE
	been wet for a while a wet brief. NA #2 state first started working a	#165 told her that she had and had to eat breakfast in a ed she was told when she to the facility, they were not			after requesting the care, even if it was during a meal. No other resident expressed a problem with this issue.		
	on the halls or trays in it was unsanitary to d During an interview w 07/29/16 at 8:32 AM,				Measures put in place or systemic changes made to ensure deficient practice will not occur:      In-Service training for all staff was initial by the DON on 7/29/16 to ensure that a		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(	C
		345247	B. WING			07/	29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  581 NC HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	crying and stated that care of as well since inventilator unit. Review of completed of 07/28/16 indicated incontinent episode at #165. A second interview with 1:08 PM revealed NA what had actually hap the 4 hours before shis stated NA #3 reported 3:00 AM that morning concerns or tasks near Resident #165. NA #Resident #165 was in actually provide incorbreakfast that mornin During an interview with (DON) on 07/29/16 at acknowledged it was resident that was soil asked to be changed During a phone intervant 1:55 PM, NA #3 incention that Resident #165 with changed before she in the care of th	Resident # 165 started t she just wasn't being taken she had been moved off the  care tasks for the morning NA #2 had documented an t 3:49 AM for Resident  ith NA #2 on 07/29/16 at a #2 stated she didn't know opened with Resident #165 the came into work. NA #2 d off to her before leaving at g and had not expressed any eded to be completed for the stated she signed off incontinent, but did not intinence care until after g. ith the Director of Nursing t 1:19 PM, the DON her expectation for a ed to be changed when they	F	224	staff are aware to provide timely incontinence care to all residents in ever circumstance when they are made award of the need for such care, including whemeal trays are being served.  This in-service training was completed 100% of full-time and part-time Nurses and CNAs by the Quality Improvement Staff Development Nurse on 8/19/16.  4. Indicate how facility plans to monitor performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integral into QA system:  Beginning 08/15/16 the Quality Improvement/Staff Development Nurse will conduct audits / interviews of residents to ensure timely incontinence care is being provided to residents at a times.  These audits are being conducted on 1 random residents each week X 4 week then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters.  The Quality Improvement/Staff Development Nurse will report the result of these audits to the Director of Nursin for review. Any issues or concerns will addressed at the time of occurrence.  Results of the monitor/audits will be reported by the Quality Improvement/S Development Nurse in the monthly Quality Improvement Sulpays and Parformance Improvement.	for / its e ted os,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345247	B. WING		C 07/29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 224	Continued From pag	e 3	F 2	meetings. The results will be rev and discussed and the QAPI com will assess and modify the action needed to ensure continued com with F224.	nmittee plan as
F 241 SS=D	manner and in an en	mote care for residents in a vironment that maintains or lent's dignity and respect in	F 2-	41	8/19/16
	by: Based on observation resident and staff into maintain the dignity of allowing a resident to (Resident #165) and while staff was stand #56). The findings included 1. Resident #165 was 01/26/16 with diagnod disease, respiratory and anxiety. The add (MDS) dated 02/02/16 was alert and oriented impairment. The ME #165 required extensionability, toileting, hy MDS further indicated urinary catheter and The quarterly MDS of	as admitted to the facility on oses including stroke, lung failure, high blood pressure, mission Minimum Data Set 16 indicated Resident #165 ed with mild cognitive DS also indicated Resident sive assistance with bed giene, and dressing. The d she had an indwelling was incontinent of bowel. lated 04/21/16 indicated the it was resolved and Resident		F241 483.15(a) Dignity and Respondividuality  It is the policy of this facility to caresidents in a manner that maintagenhances dignity and respect in frecognition of his/her individuality  1. Corrective Action taken for respondividuality  1. Corrective Action taken for respondividuality  1. Resident #165 was provided incontinence care by NA#1 and Namediately after she attained by immediately after she attained to timely incontinence care to every as needed, even if meals were be served.  2.) Resident #56 was fed her meal on 7/29/16 with the CNA sechair beside her. The DON reministrations.	re for our ains or full /. idents stice: ed NA#2 eakfast. rmed by provide resident eing next eated in a

STATEMENT OF DEFICIENCIES NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER  VALLEY NURSI	OLIVILIV	OT OIT MEDIO/ ITE G	MEDIO/ ND CEITTIOEC				<del>UND I</del>	10.0000 0001
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER    (XI) ID   SUMMARY STATEMENT OF DEFIDIENCIES   SIN IN MIGHWAY 16 SOUTH   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY OR LSC IDENTIFYING INFORMATION)   PREETY   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY OR LSC IDENTIFYING INFORMATION)   PREETY   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY OR LSC IDENTIFYING INFORMATION)   PREETY   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY OR LSC IDENTIFYING INFORMATION)   PREETY   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY OR LSC IDENTIFYING INFORMATION)   PREETY   TAYLORSVILLE, NC 28681    (XI) ID   FREETY   REQUIATORY CORES   TAYLORSVILLE, NC 28681    (XI) ID   FROWDER'S PLAN OF CORRECTION   REQUIATORY CORES   TAYLORSVILLE, NC 28681    (XI) ID   FROWDER'S PLAN OF CORRECTION   REACH CORRECTION   REACH CORRECTIVE ACTION ISROULD BE   CARLOR TO REACH CROSS ARE TRANSPORTANT   CARLOR TO REACH THE TAYLOR TO			I DENTIFICATION NUMBED:				` '	
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES SET NO HIGHWAY 16 SOUTH TAYLORSVILLE, NO 28681 TAY				A. BOILD	_			С
VALLEY NURSING CENTER  VALLEY NURSING CENTER  SI NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  DISTRETT ADDRESS, CITY, STATE, ZIP CODE \$1 NOT HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  PROVIDERS PLANGE CORRECTION DATE  DISTRITE ADDRESS CITY, STATE, ZIP CODE \$1 NOT HIGH AND CORRECTION DATE  CACHOLOGY  (CACHOLOGY CORRECTION DATE  DO COMPLETION TO CORRECTION DATE  DO NOT AT 18 APPROPERATE  DO NOT A #1 AND NA #1 and NA #2 to be seated when feeding residents in the chairs provided.  2. Corrective action for residents having the potential to be affected by alleged deficient practice.  1.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals on			345247	B. WING			0.	
TAYLORSVILLE, NC 28681   TAYLORSVILLE, NC 28681   TAYLORSVILLE, NC 28681   TAYLORSVILLE, NC 28681   PRODUBERS PLAN OF CORRECTION (CAT) PRODUBERS PLAN OF CORRECTION SHOULD BE GROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)   PRODUBERS PLAN OF CORRECTION SHOULD BE GROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)   TAGE   PRODUBERS PLAN OF CORRECTION SHOULD BE GROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)   DEFICIENCY   COMMENTED TO THE APPROPRIATE DEFICIENCY	NAME OF PI	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY))  F 241 Continued From page 4 problems.  Review of nurse's notes indicate Resident #165 was admitted to the facility with an indwelling catheter. An attempt to remove the catheter was successful in May 2016, although Resident #165 on 07/28/16 at 1:54 PM, Resident #165 stated NA #1 had brought in her breakfast tray. Resident #165 stated NA #1 had brought in her breakfast tray. Resident #165 stated Na #1 had brought in her breakfast tray. Resident #165 stated NA #1 stated she asked to be changed before breakfast trays and her roommate had already received hers. Resident #165 stated NA #1 stated she could not be changed then because they were passing out breakfast trays and her roommate had already received hers. Resident #165 stated NA #1 stated she out on the death of the potent to be changed or to wait on breakfast until after she was changed, but had to eat breakfast in a wet brief.  An interview with NA #1 on 07/28/16 at 2:33 PM revealed NA #1 was asked by Resident #165 to be changed before she ate her breakfast. NA #1 stated she had already given a breakfast tray to the roommate of Resident #165 when Resident #165 to be changed on the wash of the problems. No observations of staff standing while feeding were made.  1.) Staff are required to provided.  2.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested on heritage with the potential to be affected by alleged deficient practice:  1.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested on heritage with the potential to be affected by alleged deficient practice:  2.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested on continence care to chains while feeding were	VALLEYN	HIDSING CENTED			58	81 NC HIGHWAY 16 SOUTH		
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 4 problems.  Review of nurse's notes indicate Resident #165 was admitted to the facility with an indwelling catheter. An attempt to remove the catheter was successful in May 2016, although Resident #165 remained frequently incontinent of urine.  During an observation of Resident #165 on 07/28/16 at 1:54 PM. Resident #165 stated she was awakened that morning by Nurse Aide (NA #1) at 7:45 AM. Resident #165 stated NA #1 stated she was awakened the dampness on the lower edges of the back of her shirt. Resident #165 stated She asked to be changed before breakfast trays and her roommate had already received hers. Resident #165 stated she was not given the option to be changed or to wait on breakfast trays and her roommate had already given a breakfast tray is and her roommate for the probability of the potent of the back of her shirt. Resident #165 to be changed before she ate her breakfast. NA #1 stated she was not given the option to be changed or to wait on breakfast until after she was changed, but had to eat breakfast in a wet brief.  An interview with NA #1 on 07/28/16 at 2:33 PM revealed NA #1 was asked by Resident #165 to be changed before she ate her breakfast. NA #1 stated she had already given a breakfast tray to the roommate of Resident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident #165 when Resident #165 to be changed before she ate her breakfast tray to the roommate of Desident	VALLETIN	UKSING CENTER			T.	AYLORSVILLE, NC 28681		
problems. Review of nurse's notes indicate Resident #165 was admitted to the facility with an indwelling catheter. An attempt to remove the catheter was successful in May 2016, although Resident #165 remained frequently incontinent of urine. During an observation of Resident #165 on 07/28/16 at 1:54 PM. Resident #165 stated she was awakened that morning by Nurse Aide (NA #1) at 7:45 AM. Resident #165 stated NA #1 had brought in her breakfast tray. Resident #165 stated she asked to be changed before breakfast as she had the sensation of having a wet brief and could also feed the dampness on the lower edges of the back of her shirt. Resident #165 stated NA #1 stated she could not be changed then because they were passing out breakfast turtil after she was changed, but had to eat breakfast in a wet brief. An interview with NA #1 on 07/28/16 at 2:33 PM revealed NA #1 was asked by Resident #165 to be changed before she at he her breakfast N. W #1 stated she had already given a breakfast tray to the roommate of Resident #165 when Resident #165 asked to be changed. AN #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 asked to be changed. NA #1 stated she told Resident #165 when Resident #165 aske	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
revealed NA #2 assisted NA #1 with incontinence care for Resident #165 after breakfast. NA #2 stated that Resident #165 told her that she had been wet for a while and had to eat breakfast in a wet brief. NA #2 stated she was told when she  provided and to obtain a folding chair from the day room or from the break room in the event the in room chair is unavailable.  This in-service was completed for 100%	F 241	problems. Review of nurse's not was admitted to the facatheter. An attempt successful in May 20 remained frequently in During an observation 07/28/16 at 1:54 PM, was awakened that must awakened the sense and could also feed the deges of the back of stated NA #1 stated with the option to be channed that must after she was choreacted that must awakened NA #1 was awakened that awakened NA #1 was awakened that awakened NA #1 was awakened NA #2 assis she had been told by was in the room they anyone.  An interview with NA revealed NA #2 assis care for Resident #16 stated that R	tes indicate Resident #165 acility with an indwelling to remove the catheter was 16, although Resident #165 ncontinent of urine. In of Resident #165 on Resident #165 stated she norning by Nurse Aide (NA ident #165 stated NA #1 had ast tray. Resident #165 be changed before breakfast ation of having a wet brief the dampness on the lower ther shirt. Resident #165 she could not be changed tere passing out breakfast ate had already received stated she was not given ged or to wait on breakfast langed, but had to eat tef. #1 on 07/28/16 at 2:33 PM asked by Resident #165 to the ate her breakfast. NA #1 dy given a breakfast tray to ident #165 when Resident anged. NA #1 stated she the would need to wait until ted out. NA #1 acknowledged upper management if a tray were not allowed to change #2 on 07/28/16 at 2:54 PM steed NA #1 with incontinence 65 after breakfast. NA #2 #165 told her that she had and had to eat breakfast in a	F	241	both NA #1 and NA #2 to be seated wh feeding residents in the chairs provide 2. Corrective action for residents having the potential to be affected by alleged deficient practice:  1.) Administrative Nurses made rounds on each hall during all meals on 7/29/16 to ensure that any resident who requested or needed incontinence care prior to or during meals, received timel incontinence care.  2.) Administrative Nurses made round on each hall during meals on 7/29/16 to ensure that staff was seated on chairs while feeding all residents. No observations of staff standing while feeding were made.  3. Measures put in place or systemic changes made to ensure deficient practice will not occur:  In-Service training for all staff was initially the DON on 7/29/16. The in-service topics included:  1.) Staff are required to provide time incontinence care to all residents in evolutionine care to all residents in evolutionine care, including who meal trays are being served.  2.) Staff are to be seated beside residents when feeding in the chairs provided and to obtain a folding chair of the day room or from the break room in the event the in room chair is unavailal.	d.  ng  nooeelyy  unds  oo  elely  ery  are  nen  from  n  ble.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _				C / <b>29/2016</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			1 071	23/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	allowed to change a on the halls or trays i it was unsanitary to continuous distribution of the halls or trays in it was unsanitary to continuous distribution of the hall so that the hall so the hall so that the hall so the hall so the hall so that the hall so that the hall so that the hall so	at the facility, they were not resident if there were trays in resident's rooms because to that. With Resident #165 on 165 was asked about how changed before breakfast # 165 started crying and wasn't being taken care of as een moved off the ventilator with the Director of Nursing to 1:19 PM, the DON her expectation for a led to be changed when they	F2	241	of full-time and part-time Nurses and CNAs by the Quality Improvement/Staf Development Nurse on 8/19/16.  4. Indicate how facility plans to monitor performance to make sure solutions ar sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integra into QA system:  The Quality Improvement/Staff Development Nurse began conducting audits / interviews of randomly chosen residents on 07/29/16.  These audits / interviews are to ensure 1.) The staff is providing timely incontinence care and toileting to residents at all times to include during meals if needed.  2.) The staff is seated in a chair when feeding residents to promote a pleasar dining experience.	its e ted	
	02/27/09 with diagno hypertension, Alzheir cerebrovascular dise Review of the most redata set (MDS) dated Resident # 56 was seand required total as with eating. The MD were present and no present.  Observation and inte (NA) #1 on 07/26/16	mer's disease, anxiety, and			These audits are being conducted on 1 random residents each week X 4 week then 10 residents each month X 3 months, then 10 residents each quarte for 2 consecutive quarters.  The Quality Improvement / Staff Development Nurse will report the resu of these audits / interviews to the Direct of Nursing for review. Any issues or concerns will be noted and addressed the time of occurrence.  Results of the monitor/audits will be reported by the Quality Improvement/S	s, r ilts tor at	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345247	B. WING _		07	C // <b>29/2016</b>	
	ROVIDER OR SUPPLIER  URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 241	residents mouth. NA# Resident # 56 most of frequently. There was noted in the corner of Observation of NA #1 standing beside the be with the spoon going residents mouth. The chair noted in the cor Observation of NA #2 standing beside the be with the spoon going residents mouth. The chair noted in the cor Interview with NA #1 revealed that she had years and routinely fo NA #1 stated that the were supposed to fee beside the resident. In a chair available she or table to feed the re that if there was no cl stand up next to the re stated that there was when she fed Reside Interview with Directo 07/29/16 at 10:06 AM the staff to obtain eith or a folding chair to s resident to make the possible. Interview with the Ass 07/29/16 at 10:42 AM	in a downward motion to the stated she worked with lays and fed her meals quite is a high back winged chair of the room.  I on 07/27/16 at 12:51 PM sed feeding Resident #56 in a downward motion to the re was a high back winged ner of the room.  I on 07/28/16 at 8:14 AM sed feeding Resident # 56 in a downward motion to the re was high back winged ner of the room.  I on 07/28/16 at 2:51 PM sed feeding Resident # 56 in a downward motion to the re was high back winged ner of the room.  I on 07/28/16 at 2:51 PM sed Resident # 56 her meals. We have been told that they sed residents while sitting NA #1 stated that if there was would slide it up to the bed sesident, NA#1 also stated thair available she would just sesident to feed them. NA#1 no chair available to sit in not #56.  In of Nursing (DON) on revealed that she expected ner a high back winged chair it down in while feeding a meal as pleasant as	F 2	Development Nurse in the massurance Performance Impreedings. The results will be and discussed and the QAP will assess and modify the aneded to ensure continued with F241.	orovement e reviewed Il committee action plan as		
F 318	•	SE/PREVENT DECREASE	F 3	18		8/19/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 0772372010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 318 SS=D	resident, the facility with a limited range appropriate treatmer	ehensive assessment of a must ensure that a resident of motion receives nt and services to increase //or to prevent further	F 31	8	
	by: Based on observation and staff interviews is sling and hand brace contractures for 1 of range of motion. (Ref. The findings include Resident #108 was a 07/06/12 and readm 05/06/16 with diagnor cerebrovascular account and osteoporosis. Review of the most in minimum data set (Norevealed that Reside intact and required emembers for bed most and toileting. The MIR Resident #108 required to impairment to one up MDS also revealed to forcare was noted. Review of a physicial "sling to stroke affect document refusal."	d: admitted to the facility on itted to the facility on oses that included ident, hemiplegia, arthritis, recent comprehensive MDS) dated 05/13/16 ent #108 was cognitively extensive assistance of 2 staff obility, transfers, dressing, DS further revealed that red extensive assistance of		F318 483.25(e)(2) Increase/Prevent Decrease in Range of Motion  It is the policy of this facility to provappropriate treatment and service increase range of motion and/or to prevent further decline in range of  1. Corrective Action taken for residented by alleged deficient practical RA #1 applied sling and brace to refuse the potential to be affected by alleged deficient practical.  2. Corrective action for residents the potential to be affected by alleged deficient practice:  Administrative Nurses made round halls on 07/29/16 to ensure that all residents who □s plan of care includevices to prevent decline in/or im range of motion, had them in place it was documented that the reside refused such application for the data.	vide s to o f motion.  dents ice: resident s plan of  daying ged  ds on all ll uded aprove e unless nt had

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				CIVID IN	<u>J. 0936-0391</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
							c	
		345247	B. WING				/29/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				58	B1 NC HIGHWAY 16 SOUTH			
VALLEY N	IURSING CENTER			T/	AYLORSVILLE, NC 28681			
()(4) ID	CHMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
					DEFICIENCY)			
E 040								
F 318			F;	318				
		dition to left hand shoulder			All other residents had their devices in			
	due to daily brace and sling use."				place.			
		ve nursing referral dated						
	07/07/16 read, in par				3. Measures put in place or systemic			
		and brace and sling to left			changes made to ensure deficient			
		of care was initiated.			practice will not occur:			
		administration record			la Osadas advastian nasidad fantla			
		6 through 07/31/16 read			In-Service education provided for the	N.I.		
		ed side when out of bed and ls. It was initialed by nursing			Restorative Nursing Aides by the ADO on 08/01/16. This training was on	IN		
	staff daily from 07/01	, ,			ensuring proper application and			
	indicating that the slir	_			documentation of orthotic devices as p	or		
	_	d 07/01/16 through 07/31/16			the plan of care, and to report any mis-			
		condition to left hand and			or ill-fitting devices to the ADON in ord			
		brace and sling use. It was			to facilitate timely and proper	01		
	_	taff daily from 07/01/16			interventions.			
	through 07/30/16.	•						
		ocument titled "Restorative			The Therapy Director ordered addition			
		Roster" dated 07/01/16			orthotic devices to have available on h	and		
	_	icated that on 07/26/16			if needed while others are being			
	_	minutes each day had been #108 for splint or brace			laundered.			
	assistance.				In-Service training initiated by the DON	√ on		
	Observation of Resid	ent #108 on 07/26/16 at			07/29/16 for all Nurses and CNAs on the			
	1:29 PM revealed she	e was up in geri-chair at			importance of following the residents p	lan		
	bedside. Resident #1	08's left hand was			of care for all orthotic devices in order	to		
	contracted into a ball	and she was unable to open			increase range of motion and/or to			
	it. There was no sling	or brace to Resident #108's			prevent further decline in range of mot	ion		
	left upper extremity.				and to immediately report any missing	or		
	Observation of Resid	ent #108 on 07/27/16 at			ill-fitting devices to the ADON for			
		ne was up in geri-chair in the			intervention.			
	dining room. Resident #108's left hand was contracted into a ball and she was unable to open it. There was no sling or brace to Resident #108's							
					This in-service was concluded for 100°			
					full-time and part-time Nurses, CNAs,	and		
	left upper extremity.				Restorative CNAs, by the Quality			
		ent #108 on 07/28/16 at			Improvement/Staff Development Nurse	e on		
		e was up in geri-chair at			8/19/16.			
	bedside. Resident #1							
	contracted into a ball	and she was unable to open			<ol><li>Indicate how facility plans to monito</li></ol>	r its		

CENTER	3 FOR WEDICARE &	MEDICAID SERVICES				OIVID IV	<del>7. 0930-0391</del>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						(	c l	
		345247	B. WING			07/	/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEYA	IUDONO CENTED			58	B1 NC HIGHWAY 16 SOUTH			
VALLETIN	IURSING CENTER			T/	AYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
					DEFICIENCY)			
F 318	Continued From page	a 0		318				
			'	310	performance to make ours colutions as	•		
	left upper extremity.	or brace to Resident #108's			performance to make sure solutions ar sustained and how the plan will be	е		
		ent #108 on 07/28/16 at			implemented and corrective actions			
		he was in geri-chair at			evaluated for effectiveness and integra	tad		
	bedside. Resident #1	_			into QA system:	icu		
		and she was unable to open			into Q/(3y3tcm.			
		or brace to Resident #108's			The Quality Improvement/Staff			
	left upper extremity.	, or prace to recording in root			Development Nurse began conducting			
		g Assistant (NA) #2 on			audits of residents who s plan of care			
		revealed that Resident #108			includes the use of devices to			
	required total assistar	nce all aspects of ADLs due			Increase/Prevent Decrease in Range of	f		
		ected her left side. NA#2			Motion on 08/01/2016.			
	stated that when they	dressed Resident #108			These audits are to ensure that resider	nts		
	they stretched her lef	t arm out as much as			have devices in place, per their			
	possible but other that	an that they did not do			individualized plan of care, to			
	anything with her left	arm or hand because she			increase/prevent decrease in Range of	:		
	,	2 stated that Resident #108			Motion.			
		y therapy that she was aware						
	of.				These audits are being conducted on 1			
		sistant Director of Nursing			random residents each week X 4 week	S,		
	, ,	at 3:30 PM revealed that			then 10 residents each month X 3			
		n restorative caseload and			months, then 10 residents each quarte	r		
	, ,	and hand brace to her left			for 2 consecutive quarters.			
		out of bed as much as stated that if the resident			The Quality Improvement/Staff			
	refused the sling or b				, , ,	ulto		
	_	ectronic medical record,			Development Nurse will report the result of these audits to the Director of Nursin			
		ocumentation confirmed that			for review. Any issues or concerns will	•		
	_	ot refused either the sling or			noted and addressed at the time of	DC		
		so stated that she met with			occurrence.			
		s on a regular basis and						
		they had never mentioned			Beginning 8/5/16, the Therapy departn	nent		
	•	#108 had refused her sling or			is auditing all residents who uses ortho			
	brace.	3 3 3			devices to ensure the devices are			
	Observation and Interview with Resident #108 on 07/29/16 at 9:36 AM revealed she was up in				available and in good repair. These			
					audits will be completed weekly X 8			
		Resident #108's left hand			weeks, then every other week X 8 wee	ks,		
	-	a ball and she was unable to			and then continue on a quarterly basis			
	open it. There was no	sling or brace to Resident			thereafter. The Therapy Director will			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C <b>29/2016</b>
NAME OF PE	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	29/2016
					81 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER				AYLORSVILLE, NC 28681		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES	<u> </u>		PROVIDER'S PLAN OF CORRECTION		0.170
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE	
F 318	#108's left upper extra that sometimes the state of tarm, she could not had applied the sling extremity. Resident # not tell if the sling help when the staff came it she did not refuse, shar left upper extremithat when they would holler in pain but as applying it, the pain was order for upper extremity then place and worn as order for upper extremity then be followed through was on her caseload sling and brace to her stated that Resident # been in the laundry you had not had them on earlier today and got and brace for her left were in place. RA #1 Resident #108 did no	emity. Resident #108 stated aff would put a sling on her of recall the last time they or brace to her left 108 stated that she could ped or not but stated that to put the sling and brace on the would let them put it on ty. Resident #108 stated apply the sling she would oon as they were done would subside.  The ector of Nursing (DON) on the revealed that if Resident as a sling and brace to her left she would expect it to be in dered.  The sistant Administrator (AA) on the revealed that if Resident as a sling and brace to her left she expected the order to with and applied as ordered.  The strength of the sident #108 for range of motion and the left upper extremity. RA #1 the strength of the she went RA #1 stated she went Resident #108 a new sling upper extremity and they	F	318	address any issues identified during thi audit.  Results of the audits will be reported by the Quality Improvement/Staff Development Nurse in the monthly Quates Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committed will assess and modify the action plantaneeded to ensure continued compliance with F318.	/ ality e as	
F 329 SS=D		SIMEN IS FREE FROM UGS	F:	329			8/19/16

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C <b>7/29/2016</b>	
	ROVIDER OR SUPPLIER	0.02.11		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		7/29/2016	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE			
F 329	unnecessary drugs. drug when used in exit duplicate therapy); or without adequate more indications for its use adverse consequences should be reduced or combinations of the resident, the facility rewho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention	regimen must be free from An unnecessary drug is any accessive dose (including or for excessive duration; or anitoring; or without adequate as; or in the presence of the es which indicate the dose or discontinued; or any accessive assessment of a must ensure that residents antipsychotic drugs are not alless antipsychotic drug to treat a specific condition accumented in the clinical as who use antipsychotic all dose reductions, and	F 3.	29			
	by: Based on record rev Practitioner interview the physician's order for 1 of 6 of sampled for unnecessary med unnecessary continu antipsychotic to Resi The findings included Resident #125 was a 01/25/2016 with diag	ts, the facility failed to follow to discontinue a medication residents (#125) reviewed lications. This resulted in an ed administration of an dent #125 for 1 day.		F329 483.25(I) Drug regimen from Unnecessary Drugs  It is the policy of this facility for residents to be free from unnedrugs.  1. Corrective Action taken for raffected by alleged deficient processions.	rall cessary residents ractice:		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		UCTION	(X	3) DATE SURVEY COMPLETED		
		345247	B. WING _				C <b>07/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER				581 NC HIC	DDRESS, CITY, STATE, ZIP CODE GHWAY 16 SOUTH SVILLE, NC 28681		0172072010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				ULD BE	(X5) COMPLETION DATE	
F 329	#125 was discharged. The most recent Min 02/01/16 coded Resimpaired cognition a assistance with one activities of daily living. Review of the Physic signed by the physic Risperdal 0.5 milligratablet (ODT), one tall was ordered for psycaggression/dementiably the physician on CRisperdal 0.5 mg OD twice daily was orde 02/10/2016. According order was transcribe at 4:43 AM. Review of the Medic (MAR) from 01/30/20 Resident #125 had ro ODT two times daily 02/10/2016. In additing received the morning ODT on 02/11/2016 Review of nurse's not from 01/25/2016 to 0 any verbal or written extend the above ord In an interview conditions.	nia, and dementia. Resident d on 02/24/2016. imum Data Set (MDS) dated dent #125 with moderately not requiring extensive to two person assist for ag. cian's Order Sheet (POS) ian on 01/30/2016 indicated am (mg) orally disintegrated olet sublingually twice daily chosis and a. Review of the POS signed 02/10/2016 revealed 0T, one tablet sublingually red to be discontinued on ag to the POS, the above d by Nurse #2 on 02/11/2016 ation Administration Records 016 to 02/29/2016 revealed eccived Risperdal 0.5 mg from 01/30/2016 to on, Resident #125 also g dose of Risperdal 0.5 mg	F3	facility the Ri the ev the or the m  2. Con the po deficie  On 08 audite that h medic ensur entere been other  3. Me chang practi  In-Sei on tim ensur date is discon This in for all Impro	y on 02/24/16. No further dostisperdal that was discontinue vening of 02/10/16 was given ne identified dose that was ginorning of 02/11/16.  Forective action for residents hotential to be affected by allegient practice:  8/01/16, Administrative Nurse and been written to discontinue cations for the month of July the rethat all Stop Orders had be and timely and the medication stopped as ordered. There we issues identified by that audit easures put in place or system ges made to ensure deficient ince will not occur:  ervice education provided by the mely Physician of the provided by the mely Physician of the medication is entered when medication is inservice was initiated on 07/11 Nurses then the Quality overment/Staff Development Noteted the training for Medication is officed.	ed on after ven on having ged es en slips le to een had were not t. hic he DOI and stop s	
	Risperdal 0.5 mg OI 02/11/2016 at 9:00 A above order was dis the computer during administration. She a entered into the facil	DT to Resident #125 on  M. She did not know the continued as it showed up in the morning medication added once a stop order was ity's computer system, the intinued instantly. She further		Aides remai Traini full-tin Medic	s, Medical Records staff and ining full-time and part-time N ing was completed for 100% me and part-time Nurses and cal Records staff on 08/19/16 dicate how facility plans to mo	lurses. of	

	OLIVILIV	O I OIT WEDIONITE &					<u> </u>	<del>7. 0000 000 1</del>
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  C 07/29/2016  STREET ADDRESS, CITY, STATE, ZIP CODE  581 NC HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28681			` '	1 ` ′			` ',	
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  581 NC HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28681  (X5)  PROVIDER'S PLAN OF CORRECTION  (X5)				71. 501251	_		(	C
VALLEY NURSING CENTER  581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681  (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)			345247	B. WING				
VALLEY NURSING CENTER  TAYLORSVILLE, NC 28681  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	VALLEYN	IURSING CENTER			58	81 NC HIGHWAY 16 SOUTH		
(A1)10	*/\	ionomo ozmizit			T	AYLORSVILLE, NC 28681		
	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 329 Continued From page 13 stated that the nurse who had transcribed the above stop order might have failed to input the order into the computer system in a timely manner. After reviewing the physician's orders for Resident #125s Risperdal in MAR and POS, Nurse #3 agreed that the Risperdal should have been discontinued after 02/10/2016. An interview was conducted with the Director of Nursing (DON) on 07/29/16 at 4:00 PM. She stated that it was her expectation for all nurses to transcribe physician's orders into the computer system correctly and in a timely manner. In this case, she believed that Nurse #2 had failed to input the above stop order into the system in a timely manner as the order stills existed on 02/11/2016 at 9:00 AM. All nurses who transcribed physician's orders into the system were expected to record the exact time of transcription. According to DON, Nurse #2 was no longer working in the facility. After reviewing the physician's orders into the system were expected to record the exact time of 12/10/2016. In an interview conducted on 07/29/2016 at 4:13 PM, the Nurse Practitioner agreed that the Risperdal dose on 02/11/2016 at 9:00 AM should not be administered. She stated that the nurse who transcribed the order failed to enter the order into the system in a timely manner. It was her expectation for all the nursing staff to execute her order correctly and in a timely manner.	F 329	stated that the nurse above stop order migorder into the comput manner. After review Resident #125's Risp Nurse #3 agreed that been discontinued af An interview was con Nursing (DON) on 07 stated that it was her transcribe physician's system correctly and case, she believed the input the above stop timely manner as the 02/11/2016 at 9:00 At transcribed physician were expected to rec transcription. According longer working in the physician's orders Resident #125's antip Risperdal should hav 02/10/2016. In an interview condup PM, the Nurse Practic Risperdal dose on 02 not be administered. who transcribed the conto the system in a tile expectation for all the	who had transcribed the ght have failed to input the ter system in a timely ing the physician's orders for perdal in MAR and POS, at the Risperdal should have ther 02/10/2016. Inducted with the Director of 17/29/16 at 4:00 PM. She expectation for all nurses to so orders into the computer in a timely manner. In this nat Nurse # 2 had failed to order into the system in a corder still existed on M. All nurses who has orders into the system for the exact time of fing to DON, Nurse # 2 was the facility. After reviewing so, the DON agreed that posychotic therapy with the been discontinued after failed to enter the order imely manner. It was her enursing staff to execute her	F	329	performance to make sure solutions are sustained and how the plan will be implemented and corrective actions evaluated for effectiveness and integra into QA system:  The Quality Improvement/Staff Development Nurse began conducting audits of Physicians Orders to stop medication (stop orders) on 07/29/16. These audits are to ensure that timely a accurate medication stop dates are entered into the electronic medical reconsystem and to ensure that no medication doses are given after the order to stop has been written.  These audits are being conducted on 1 random residents each week X 4 week then 10 residents each month X 3 months, then 10 residents each quarter for 2 consecutive quarters.  The Quality Improvement/Staff Development Nurse will report the resurd these audits to the Director of Nursin for review. Any issues or concerns will noted and addressed at the time of discovery.  Results of the monitor/audits will be reported by the Quality Improvement/S Development Nurse in the monthly Quartical Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committed will assess and modify the action plan and the gas and modify the action plan and the gas and modify the action plan and the gas and the gas and modify the action plan and the gas and the gas and modify the action plan and the gas and the gas and modify the action plan and the gas and th	and ord on 0 s, r alts ng be staff ality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY
		345247	B. WING _			C / <b>29/2016</b>
NAME OF PR	OVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2010
				581 NC HIGHWAY 16 SOUTH		
VALLEY NURSING CENTER				TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
SS=D	CONTROL PROGRA  The facility must main		F 4	69		8/19/16
	by: Based on observation and staff interviews the that all fly reduction may prevent fly activity in market fly activity in fly activity in fly activity fly activity fly and market fly and mood discontinuous fly and fly activity fly and fly activity extensive assistance mobility and dressing that Resident #94 requested fly and fly activity fly activi	mitted to the facility on ted to the facility on sees that included anoxic culbar affect disorder (labile order.  cent minimum data set of revealed that Resident #94 ely impaired and required of 2 staff members for bed.  The MDS also revealed cuired total assistance of 2 cansfers, toilet use, and had impairments to one emity.  Eview on 07/26/16 at 1:26 by samily member revealed sesident #94's face and se family member was effices with a napkin off of his member stated "I try to		F469 483.70(h)(4) Maintains Effect Pest Control Program  It is the policy of this facility to main effective pest control program and the facility free of pests including flie.  1. Corrective Action taken for reside affected by alleged deficient practic.  On 7/29/16 the Environmental Serv Director was made aware of the fly problem on the 300 hall in the room residents #94 and #108. She met whousekeeper #1 and made sure she to keep her fly swat on the cart and monitor for flies at all times. They the went into the rooms of resident #94 #108 to eliminate any flies present in those rooms and disinfected the sure.  2. Corrective action for residents has the potential to be affected by alleged deficient practice:  On 7/29/16, the Environmental Serv Director made rounds on each residently and checked all housekeep carts to ensure that fly swats were	tain an keep es. ents e: ices s of vith e knew en and en faces. eving ed	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		OATE SURVEY OMPLETED
		345247	B. WING _			C <b>07/29/2016</b>
	ROVIDER OR SUPPLIER  URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		0172072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 469	bed. Observation and interest AM with Resident #9 2 flies flying around I mouth. The family miles come in here and to keep them away find the family member playing on the dresser bed. Observation of Reside bedside and there wand mouth. There wand mouth. There wand mouth. There wand mouth are the foot of Observation of Reside there was an open of the bedside table with edge of the cup of the Interview with House 9:07 AM revealed that problem in Resident	rview on 07/27/16 at 11:40 4's family member revealed Resident #94's face and member stated "at times the d I keep a fly swatter in here om his face and mouth." pointed to the fly swatter at the foot of Resident #94's ment #94 on 07/28/16 at 9:27 mt #94 was up in a chair at as a fly flying around his face as a fly swatter laying on the Resident #94's bed. ment #94's room on 07/28/16 mt #94 was not in the room, mup of thicken liquids sitting on much a fly resting on the inside	F 4		r for flies nem on an lisinfect the ity observed stemic cient al Services n-service ervices staff f eliminating t all times, es on, and rocedures company and applied utside the	
	that was all the facilit problem. House keep swatter on her cart a Interview with the Ho 07/29/16 at 9:23 AM aware of any probler House Keeping Super a fly they would kill it housekeepers had o Keeping Supervisor company came regular sprayed both inside a	y was doing about the fly oer #1 did not have fly t that time. use Keeping Supervisor on revealed that she was not n with flies in the facility. The ervisor stated that if they saw with the fly swat that all n their carts. The House stated the pest control arly to the facility and and outside and that e used covered all types of		obtained additional Fly Light T the pest control company for u the facility.  On 8/3/16, the Environmental Director completed audit on so resident room windows on and adjustments as needed to ens fit well in effort to prevent flies entering.  4. Indicate how facility plans to performance to make sure sol sustained and how the plan wi	raps from use inside  Service creens on d made ure screens from o monitor its utions are	

OLIVILIY	OT OIL MEDIO, ILLE	WEDIO/ ND GET WIGEG				CIND ITE	7. 0000 000 I
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
						(	С
		345247	B. WING				29/2016
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEVI	URSING CENTER			58	B1 NC HIGHWAY 16 SOUTH		
VALLETIN	OKSING CENTER			T/	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 469	o7/29/16 at 10:22 AM aware any specific profacility. The AA stated company came to the baited the flies with a they have also invest they have placed on The AA also stated the outside doors that blo open to keep the flies. The AA also stated the bemore prevalent be that hall to bring in lath that door, and supplied The AA also stated the infout activity, plus it hot and humid. The AC combating the flies to ability."  2. Resident #108 was 07/06/12 and readmit 05/06/16 with diagnote cerebrovascular accident atrial fibrillation. Review of the most reminimum data set (Morevealed that Reside intact and required extremity. Observation and inte 07/26/16 at 2:59 PM	sistant Administrator (AA) on a revealed that she was not soblem with flies in the did that the pest control a facility every 2 weeks and powder substances, and ared in a "Fliaway" strip that the exit doors of the facility. In the exit doors of the facility and they had the fans on the low air out when the door is a from flying into the facility. In the area of the solution of the solution of the country, trash went in/out of the solution of the door on 300 had more was summer time and very that attended to the facility on the absolute best of their of the absolute best of their they are the absolute best of their they are the absolute best of their they are they are the absolute best of their they are th	F	469	implemented and corrective actions evaluated for effectiveness and integral into QA system:  The Environmental Services Director began conducting observation rounds each hallway on 08/01/16 to ensure and document that housekeeping carts have fly swats available, to observe that fly activity is being addressed timely, and the current pest control procedure is effective as evidenced by no noticeable activity.  These rounds will be conducted weekly 8 weeks, then every other week for 2 months. The Environmental Services Director will report the results of these audits to the Assistant Administrator.  Results of the monitor/audits will be reported by the Assistant Administrator the monthly Quality Assurance Performance Improvement meetings. The results will be reviewed and discussed and the QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F469.	on d e that e fly / x	
	on her left leg and ha swatting at them to g	ght side, 2 flies were noted and. Resident #108 kept et the flies off her left leg and of returning. Resident #108					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		1 ,	С
		345247	B. WING			1	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	23/2010
					581 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER				TAYLORSVILLE, NC 28681		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 469	Continued From pag	ge 17	F	469			
		ing me crazy, I wish they					
	would leave me alor						
		erview with Nursing Assistant					
		at 2:59 PM revealed that					
	. ,	ter in Resident #108's room					
	and she used the fly	swatter to swat the flies					
	away from Resident						
	want to kill the flies						
	bed." The flies rema						
	#108 during the rem						
	Interview with House						
	9:07 AM revealed th						
	problem in Resident						
		use and to her knowledge					
		ity was doing about the fly sper #1 did not have fly					
	swatter on her cart a	•					
		ouse Keeping Supervisor on					
		I revealed that she was not					
		m with flies in the facility. The					
		ervisor stated that if they saw					
		t with the fly swat that all					
		on their carts. The House					
		stated the pest control					
	company came regularly to the facility and						
	sprayed both inside						
	chemical he used co						
	insects including flie						
		ssistant Administrator (AA) on					
		M revealed that she was not					
		problem with flies in the					
	_	ed that the pest control					
		e facility every 2 weeks and					
		a powder substances, and					
	_	sted in a "Fliaway" strip that					
		the exit doors of the facility.					
		hat they had the fans on the					
		low air out when the door is					
	open to keep the file	es from flying into the facility.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			C <b>07/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER			,	STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 469	The AA also stated the be more prevalent be that hall to bring in late that door, and supplied the AA also stated the in/out activity, plus it whot and humid. The AA	at on the 300 hall flies may cause they used the door on undry, trash went in/out of es came in through that door. e door on 300 had more was summer time and very	F	169		