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 04/06/2017

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

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F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 155		5/3/17

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

Electronically Signed | 05/02/2017

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

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F 155	Continued From page 1 with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to clarify resident choice for code status for 1 of 1 resident reviewed for advance directives (Resident #2). The findings included: Resident #2 was admitted to the facility on 03/24/17 with diagnoses including prostate cancer with metastasis to the bone, among others. Resident #2 did not have a completed admission Minimum Data Set (MDS) at the time of this investigation. Record review of the nursing admission data collection tool, completed on 03/24/17 upon admission to the facility for Resident #2, indicated he was alert and oriented to person, time and place with no memory problems. The data collected also indicated Resident #2 was independent for decision making and had clear	F 155	155 Resident #2 No longer resides at the facility. Advanced Directives Quality Review was completed on current residents by the Director of Clinical Services/or Nurse Supervisor on 4/13/2017 to identify any further issues. Issues identified were addressed by Assistant director of Nursing. The Regional Director of Clinical Services in-serviced Social Worker on obtaining Advanced Directives upon admission and Advance Directive policy and procedure on 4/6/2017. The Director of Clinical Service and/or Nursing Supervisor re-educated Licensed Nurses 4/13/2017-5/2/2017 on honoring resident	

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F 155	Continued From page 2 speech. Record review of the policies and procedures for advance directives for admission/social service with an effective date of 11/30/2014 indicated the following: "3. Social Services and/or Admissions staff must complete the Advance Directives Discussion Document a. indicate the resident's wishes to provide or withhold Cardiopulmonary Resuscitation (CPR)". Record review of the Advance Directive Discussion Document dated 03/24/17 indicated Resident #2 signed the document which indicated his wishes were for the facility to "withhold" CPR. A facility representative, the Admissions Coordinator, also signed the document, but was no longer employed by the facility at the time of this investigation. Record review of physician's orders dated 03/24/17 indicated "resident to be full code." During a staff interview with the Social Services Director (SSD) at 9:10 AM on 04/06/17, the SSD stated the Admissions Coordinator talked with all parties about advance directives upon admission. The SSD also stated there should be a Medical Orders for Scope of Treatment (MOST) form for every resident in the facility. Upon review of the chart for Resident #2, the SSD verified there was no MOST form present. During a staff interview with the Regional Director of Clinical Services (RDCS) at 9:34 AM on 04/06/17, the RDCS stated her expectations were	F 155	rights concerning the right to accept or refuse medical or surgical treatment and to formulate advanced directives. Quality Improvement Monitoring of MOST/advanced Directive/physicians order for matching qualities one time a week for three months then every other week thereafter for one year by Executive Director, Director of Clinical Services. The Director of Clinical Services introduced the plan of correction to Quality Assurance Performance Improvement Committee on 5/1/2017. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services or designee upon DCS absence. The Quality Assurance Performance Improvement committee members consist of but not limited to Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and minimum of one direct care giver. Quality Improvement monitoring schedule monitoring modified based on findings.	

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F 155	Continued From page 3 for clarification of advance directives to be made so a resident's wishes could be honored. The RDCS further acknowledged Resident #2 had been in the facility for 14 days and she would have expected this to be clarified before his 14th day in the facility. During a staff interview with the Director of Nursing (DON) at 10:14 AM on 04/06/17, the DON stated her expectations for clarification about a resident's preference for either a full code or do not resuscitate either on admission or shortly thereafter. During a staff interview with the Medical Records Director (MRD) at 11:17 AM on 04/06/17, the MRD stated she dropped off and picked up physician's orders from the physician's office on her way home from work every Friday. The MRD verified there was not a MOST form or a physician's order for a full code that had been signed and waiting to be filed for Resident #2 in medical records. During an interview with Resident #2 at 1:06 PM on 04/06/17, Resident #2 validated he wanted CPR withheld in the event he was found without a pulse and not breathing.	F 155		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting,	F 441		5/3/17

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investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

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F 441	Continued From page 5 contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their infection control policy and procedure for 1 of 1 residents reviewed with head lice (Resident #6) resulting in infestation to 5 employees (Housekeeper, Nurse Aide, Occupational Therapist, Speech Therapist, and Physical Therapist) who had provided Resident #6 with direct care. Findings included: Review of the facility's "Lice Infestation" policy and procedure, with an effective date of 11/30/14, indicated its purpose was "to prevent the spread of lice and to provide treatment to resident's with a diagnosis of lice." The policy procedure included the following steps: 1) "1. Notify physician of resident's symptoms. Initiate treatment per orders and place resident in	F 441	F441 Resident #6 was assessed for further evidence of lice on 4/7/2017 by the Director of Clinical Services and/or Nursing Supervisor. No further issues identified. The Director of Clinical Services and/or Nursing Supervisor did assessments of current residents and staff on 4/7/2017 to identify any new or re-occurring lice. The Director of Clinical Services and/or Nursing Supervisor re-educated current nursing staff on infection control/Lice Infestation/Isolation Precautions and proper handling of linen 4/7/2017-5/2/2017. The Director of Clinical Services and or Nursing	

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F 441	Continued From page 6 contact isolation..." 2) "12. Facility will perform a head check of all other residents in the facility..." 3) "13. Facility will perform a head check of all the staff ..." Resident #6 was admitted to the facility on 3/15/17. Review of the nurses' notes for Resident #6 revealed an entry dated 3/21/17 which read in part, resident has what looks like lice in hair. Physician notified and new order received. Review of Resident #6's medical record revealed the following Physician Orders: 1) 3/21/17: "Treat hair with NIX lice treatment." 2) 3/21/17: "Treat with NIX shampoo 3/22/17 for second treatment." 3) 3/31/17: "Ivermectin (medication used to treat infections such as head lice) 12 milligram by mouth times one dose." 4) 4/3/17: "Late entry 3/31/17: contact isolation - lice infestation. Apply topical lice shampoo per manufacturer guidelines. Comb hair, check for nits/lice every 2-3 days for 2-3 weeks until gone." An interview with Resident #6 on 4/5/17 at 9:49 AM revealed she had been notified by staff, "about 3 or 4 days ago" that she had head lice. Resident #6 could not recall being told she was on isolation precautions, but they had told her she could not leave her room. Resident #6 added staff had not worn gowns or gloves when coming into her room to provide care. An interview with the Director of Nursing (DON) on 4/5/17 at 2:15 PM revealed she was	F 441	Supervisor to preform hair inspections on nursing staff and residents twice a week for eight weeks and once a week for four weeks for reoccurrence of lice. Follow up based on findings. Director of Clinical Services introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 5/1/2017. The results of the Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee by the Director of Clinical Services or designee in DCS absence. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical Services, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver.	

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responsible for infection control as of 4/3/17 when the facility's Infection Control Nurse had quit. The DON indicated the physician had been notified of Resident #6's symptoms and was treated for head lice on 3/21/17 and 3/22/17 per physician orders. The DON was not positive isolation precautions were initiated on 3/21/17 and confirmed a facility-wide head check of all other residents and staff had not been conducted on 3/21/17. The DON stated evidence of more head lice was found when Resident #6 had been rechecked on 3/31/17 and was retreated with oral medication per physician orders. She confirmed a facility-wide head check of all other residents and staff was conducted on 3/31/17 which revealed 5 employees (Housekeeper, Nurse Aide, Occupational Therapist, Speech Therapist, and Physical Therapist who all had been in direct contact with Resident #6 since 3/21/17) were found to be infected with head lice. She added only one other resident was suspected to have been infected, but upon assessment no evidence of head lice was identified. The DON confirmed all the employees mentioned were sent home and had all received treatment for head lice prior to returning to work.

An interview with the Regional Director of Clinical Services (RDCS) on 4/6/17 at 9:34 AM revealed she had not been informed Resident #6 had head lice until 3/31/17. The RDCS stated it was her expectation that staff would have followed the infection control policy and performed a facility-wide head check of all residents and staff on 3/21/17 when the head lice was first discovered. She further indicated she would have expected for staff to have implemented contact isolation precautions for Resident #6.

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A follow-up interview with the DON was conducted on 4/6/17 at 10:14 AM. The DON stated "the ball was dropped the first time the head lice was discovered" and confirmed infection control protocol had not been initially followed.

An interview with the Medical Director on 4/6/17 at 11:34 AM revealed he would expect to be notified when it was determined a resident had head lice and would give an order for treatment. He further indicated contact isolation should be implemented until the resident had been treated for at least 24 hours.

An interview with the Administrator on 4/6/17 at 4:54 PM revealed he was unaware that other residents and staff should have been checked on 3/21/17 when the head lice was first discovered since Resident #6 was the only known person to be affected at that time. He reviewed the facility's infection control policy and procedure and confirmed protocol had not been initially followed.