STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 08/08/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cites as a result of the complaint investigation. Event ID #YWHT11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge location for 1 of 3 sampled residents (Resident #100) for closed record review. The findings included: Resident #100 was admitted to the facility on 05/09/18 with diagnoses that included pneumonia. A physician s order dated 05/24/18 read in part the resident was scheduled to discharge home on 05/27/18. A nurse's progress note dated 05/27/18 at 10:49 AM specified Resident #100 discharged from the facility to home with family. Resident #100's discharge MDS assessement dated 05/27/18 specified the resident was discharged to an acute hospital. On 08/08/18 at 1:40 PM MDS Coordinator #1 was interviewed and explained that when completing a discharge MDS she reviewed the electronic	F 641	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of qualify of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings. Criteria 1- Plan for correcting the specific deficiency and processes that lead to deficiency cited: MDS Coordinator #1 corrected the discharge MDS to reflect that resident	8/24/18

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

Electronically Signed | 08/27/2018

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F 641	Continued From page 1 record for resident status when determining the discharge location. She reviewed Resident #100's discharge MDS and stated it was coded incorrectly.	F 641	#100 was discharged to the community and submitted the correction on 8/8/18. A data entry error occurred when keying A2100, discharge location, on the Discharge MDS for resident #100. Criteria 2- Procedure for implementing the acceptable plan of correction for the specific deficiency cited: All Discharge MDS assessments from the previous 90 days were audited on 8/9/18 to ensure coding accuracy of the discharge location. There were no coding errors discovered during the audit. The MDS Coordinators received in-service education from the DON on 8/23/18 to ensure the accurate coding of question A2100 Discharge Status, per the RAI guideline. A Performance Improvement Project was initiated on accuracy of coding of MDS A2100, discharge status. The MDS discharge assessments will be monitored by the DON to ensure coding accuracy of the discharge location. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or incompliance with regulatory requirements: Beginning 8/10/18, the Director of Nursing will audit all discharge MDS assessments for accuracy of question A2100, Discharge Status, weekly for 12 weeks to ensure the plan of correction is effective and the facility remains in compliance with the regulatory requirement. Any errors	

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F 641	Continued From page 2	F 641	will be addressed by the DON and corrected by the MDS Coordinator as discovered. The results of these audits will be discussed in the monthly QAPI Committee meeting. The QAPI committee will evaluate and modify the action plan as needed to ensure continual compliance. Criteria 4- The Administrator is responsible for implementing the acceptable plan of correction. Criteria 5- Date when corrective action will be completed: 8/24/18	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		8/24/18

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F 732	Continued From page 3 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to update the daily nursing staff information for 5 shifts. The findings included: On 08/05/18 at 10:08 AM an initial tour was made of the facility. In the initial tour, observations were made of the State required postings located throughout the facility. The facility had the daily nurse staffing posted prominently and it was dated 08/03/18. Further review of the posting specified the census was 102 residents as of the evening shift on 08/03/18. On 08/05/18 at 10:28 AM the ward clerk was interviewed and stated the facility census was 104. She was also interviewed about the daily nurse staffing sheet and stated she was responsible for updating the document daily and that it had not been updated since 08/03/18 and was not correct. The ward clerk reported that it as an oversight and offered no explanation why the posted staffing had not been updated for 5	F 732	Criteria 1- Plan for correcting the specific deficiency and processes that lead to deficiency cited: The ward clerk updated the daily nursing staffing data to reflect the current census and nursing staff on duty on 8/5/18. The Nursing Staffing Information sheet has remained updated and accurate since 8/5/18. The process that lead to this deficiency was an oversight by the weekend ward clerk who had forgotten to update the Daily Nursing Staffing information per the requirement. Criteria 2- Procedure for implementing the acceptable plan of correction for the specific deficiency cited: The Medical Records Director updated the weekend ward clerk□ Weekend Duties assignment work sheet on 8/9/18. This work sheet now includes updating the Nursing Daily Staffing information at the beginning of each shift. The ward clerk is required to initial each duty as	

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F 732	Continued From page 4 shifts. On 08/08/18 at 9:33 AM the Director of Nursing (DON) was interviewed and explained the ward clerk was responsible for updating the daily staffing each shift. The DON stated she expected the daily staffing to be up-to-date and accurate.	F 732	completed, sign, and date the work sheet and return it to the Medical Records Director for review. The Administrator provided in-service training to the weekend ward clerk on 8/8/18 to ensure that the Nursing Staffing Information regulatory requirement is met every shift. All other Medical Records staff and the Nursing Staffing Coordinator were also in-serviced by administration to ensure all fully understand the Nursing Staffing Information requirement and it is met every shift on a continual basis to maintain regulatory compliance. A Performance Improvement Project has been initiated by the Medical Records Director to ensure the Daily Nursing Staffing information sheet is updated each shift per the regulation. Criteria 3- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or incompliance with regulatory requirements: The Medical Records Director will audit the Nursing Daily Staffing information sheets to ensure that the plan of correction is effective, and the facility remains in compliance with the regulatory requirement. Beginning 8/10/18, the Medical records Director will audit all Daily Nursing Staffing sheets for a period of 30 days then decrease the audit frequency to weekly audits of the previous weekend and one week day for a period of 8 weeks to ensure the actual census and staffing for each shift was correctly posted. Any	

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F 732	Continued From page 5	F 732	errors noted will be addressed by the Medical Records Director as discovered. The results of these audits will be discussed in the QAPI Committee monthly meeting. The QAPI committee will evaluate and modify this action plan as needed to ensure continual regulatory compliance. Criteria 4- The Medical Records Director is responsible for implementing the acceptable plan of correction. Criteria 5- Date when corrective action will be completed: 8/24/18	