

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 04/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=G (INJURY/DECLINE/ROOM, ETC)

F 157

A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a)

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff and physician interviews and medical record review, the facility failed to notify

- A. F157 Resident #39 bowel documentation was reviewed on 3/27/13 for any other indications of change in bowel habits to indicate constipation or risk of fecal impaction and none were noted
- B. An audit of all current facility residents for changes in bowel consistency was completed on 3/27/13 and no other resident were noted to have changes or presence of fecal impaction.
- C. All Licensed Nurses and C.N.A.'s were re-educated beginning 3/27/13 on the responsibility to report changes in bowel habits to include changes in consistency or unexpected results to treatments to the Licensed Nurses via the Stop And Watch INTERACT tool. The Licensed Nurses will evaluate the resident and notify the Physician of any changes in condition

4-25-B

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

TITLE

(X6) DATE

Darlene Ruffin

Administrator

4-18-13

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 required to continue program participation.



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F 157	<p>Continued From page 1</p> <p>the physician regarding resident response to treatments of constipation to prevent a fecal impaction for 1 of 3 residents reviewed for notification of change. (Resident #39) The findings included:</p> <p>Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia</p> <p>A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder. The care plan goal was to keep the resident clean and dry and decrease the number of incontinent episodes over next review period. Interventions included nurses would monitor bowel pattern.</p> <p>A physician's progress note dated 01/04/13 indicated the resident was seen by the physician related to constipation issues. The note specified Resident #39 had received enemas but was still not totally cleaned out. The physician's physical examination revealed the resident's abdomen was soft and non tender. His plan included decrease of pain medication dosage, increasing dosages of current laxatives with the addition of another daily laxative and 3 laxative suppositories to be administered on this date. A review of physician orders revealed written orders dated 01/04/13 to support the physician's plan.</p> <p>A review of a bowel and bladder detailed entry report from 01/05/13 through 01/10/13 revealed documentation by nurse aides regarding frequency and consistency of bowel movements. On 01/05/13 a large loose stool was documented at 3 04 AM by NA #3 and 4 56 AM by NA #4, a</p>	F 157	<p>D. The ED/DCS/Unit Manager will audit a maximum of 5 residents for bowel movement frequency to ensure resident is not experiencing a change in condition; and/or if they are experiencing a change in condition, that the physician was notified. Monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for 7 months. The results of the audits will be reported monthly to QI Committee monthly x 10 months for continued substantial compliance and/or revision.</p> <p>E. 4/25/13</p>	

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F 157	<p>Continued From page 2</p> <p>small loose stool at 2:40 PM by NA #5, and a large loose stool at 5:35 PM by NA #6. On 01/06/13 a large loose stool was documented at 5:25 AM by NA # 4 and at 2:32 PM by NA #5. There were no stools documented on 01/07/12 or 01/08/12. On 01/09/12 an extra-large loose stool was documented at 2:35 AM by NA #3 and a large loose stool documented at 5:01 AM by NA #4. No stools were documented on 01/10/13.</p> <p>An interview was conducted via phone with NA #3 on 03/27/13 at 2:55 PM. She described Resident #39's bowel movements on 01/05/13 and 01/09/13 as loose and runny and not dark in color. NA #3 stated the stools were so large, complete bed changes were required. She stated she reported the loose stools to the hall nurse.</p> <p>An interview was conducted via phone with NA #4 on 03/27/13 at 2:59 PM. NA #4 described Resident #39's stools on 01/05/13 and 01/06/13 as runny and watery and not hard. She stated she reported the loose stools to the hall nurse.</p> <p>An interview was conducted with NA #5 on 03/27/13 at 2:11 PM. NA #5 stated she worked 01/05/13 and 01/06/13. She stated she did report the stool to the hall nurse on 01/06/13 because it was so large.</p> <p>An interview was conducted via phone with NA #6 on 03/27/13 at 3:30 PM. NA #6 stated she recalled Resident #39 had large stools that required a complete bed change. She described the stools as grainy and not formed. NA #6 stated it was her normal practice to report diarrheal stools to the nurse but was unable to recall if she reported the loose stool on 01/06/13</p>	F 157	

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F 157	<p>Continued From page 3 to the hall nurse.</p> <p>An interview was conducted via phone with Nurse #3 on 03/27/13 at 3:05 PM. She stated she worked 01/05/13 and 01/06/13 at the facility. Nurse #3 did not recall any reports of loose stools regarding Resident #39. She stated during the first week in January several residents developed a stomach virus and had loose stools.</p> <p>A review of Resident #39's nursing notes from 01/05/13 through 01/10/13 revealed no documentation of reporting laxative results or stool consistency and frequency to the physician.</p> <p>Review of a nursing note dated 01/10/13 at 9:00 AM revealed documentation that Resident #39 had been sent to an acute care facility for evaluation of nausea and vomiting.</p> <p>A review of a History and Physical (H&P) dated 01/10/13 and written by the acute care facility physician was conducted. The H&P specified Resident #39 was sent to the wound clinic for treatment of bilateral lower extremity wounds. The resident started to vomit. Nursing assessments in the wound clinic revealed an increase in pulse and a decrease in blood pressure. The resident was sent to the emergency department (ED) for evaluation. In the ED Resident #39 was assessed with a distended abdomen and no bowel sounds. A digital rectal examination by the ED physician resulted in palpation of hard impacted stool. An abdominal x-ray showed a fecal impaction with dilatation of the lower colon.</p> <p>Review of a Discharge Summary dated 01/18/13</p>	F 157		
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F 157	<p>Continued From page 4</p> <p>revealed Resident #39 was sent back to the long term care facility with diagnoses including severe fecal impaction.</p> <p>An interview was conducted via phone on 03/27/13 at 5:49 PM with the Medical Director (MD) and attending physician for Resident #39. The MD stated when he visited the facility on 01/04/13 he was verbally informed by the nurses regarding administration of enemas and the constipation problems exhibited by the resident. He stated he examined Resident #39 and described his findings in the physician's progress notes of 01/04/13. The MD stated he changed the resident's medications as was also documented in the progress notes. He stated he does not recall being notified regarding consistency of bowel movements after his orders were written on 01/04/13. He added he remembered being told the resident was having bowel movements. The MD stated he wanted the stools to be loose, but not watery. If he had known the consistency and frequency of the bowel movements, he would have adjusted the resident's medications, ordered an abdominal x-ray, and asked the nurses to perform a digital rectal examination to check for impaction. The MD explained loose bowel movements could mean stool was moving around an impaction.</p> <p>An interview with the Director of Nursing on 03/28/13 at 2:25 PM revealed she expected nurses to notify the physician of changes in condition and unexpected results from laxatives.</p>	F 157	
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program</p>	F 248	

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of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, review of activity interest assessments, and staff interviews, the facility failed to involve residents in preferred activities for 2 of 3 residents reviewed for activities. (Residents #3 and #12)

The findings included:

1. Resident #3 was admitted to the facility on 07/26/12 with diagnoses including dementia, congestive heart failure, and osteoarthritis. An admission Minimum Data Set (MDS) completed 06/07/12 included an interview for activity preferences. Resident #3 indicated listening to music, doing things with groups of people, going outside when the weather was good, and participating in religious practices were all very important to her. A quarterly MDS completed 01/13/13 revealed Resident #3 had short and long term memory problems, moderate difficulty with hearing, and was understood and usually understands. The quarterly MDS further revealed Resident #3 required extensive assistance with locomotion on the unit.

Review of Resident #3's most recent "Activity Interest Assessment" dated 11/13/12 stated her interests were music and TV (television) and the common settings for the resident's activities were in room and out of room. The assessment also

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A. Resident #3 and #12 whom are room mates, were provided a radio in their room for music on 4/3/13 by Activity Director. Resident #3 and #12 were given their baby dolls during the survey and several residents were noted to have baby dolls under their blankets as the residents stated it was cold outside and they were keeping them warm.

B. The Activity Director was inserviced on 4/3/13 by the Regional Director of Clinical services regarding activity assessments and documentation of preferences, documentation of activity participation, care planning the individual preferences of the resident and providing activities to residents according to their interest. An audit was completed by the Activity Director on 4/4/13 of all resident activity preferences and care plans reflecting the resident preferences, Care Plans were revised at the time of the audit

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noted babies as an additional interest.

A care plan last reviewed 01/2013 stated Resident #3 had an activity intolerance due to little involvement in activities related to impaired thought process. The goal was for Resident #3 to participate in at least two activities a week by the next review. Interventions included providing passive activities and listed listening to music and watching TV as examples.

Review of Resident #3's activity attendance log for February 2013 revealed she observed Bingo on two occasions, had six one to one visits, attended two music activities, and attended three special events. During the month of March 2013 Resident #3 observed Bingo on four occasions, had six one to one visits, attended two music activities, and attended a book reading by a library volunteer. Watching TV was marked daily as a passive activity during February and March of 2013.

Observations of Resident #3 were as follows
 - 03/25/13 at 12:25 PM- Sitting in her wheel chair at a dining room table with the TV on the wall to her right. The TV was on with no sound.
 - 03/25/13 at 2:15 PM- Sitting in her wheel chair in the hallway across from her room. Resident #3 had her eyes closed and was holding a baby doll.
 - 03/26/13 at 10:15 AM- Sitting in her wheel chair just outside of the dining room doors. No baby doll was observed at that time. Resident #3 was awake and the Activity Director was observed in the dining room reading to a group of residents. The Activity Director was not observed inviting Resident #3 prior to the activity.

C. The ED will audit 5 residents per week for 4 weeks, 3 residents per week for 4 weeks, then 5 residents per month for 10 months. The audit will reflect resident preferences for activities, care plans reflecting the resident preferences and that the resident is provided activities per resident preferences.

D. the results of the audits will be reviewed monthly by the QI Committee and adjustment will be made as necessary to the Plan of Correction

E. 4/25/13

4-25-13

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F 248	<p>Continued From page 7</p> <ul style="list-style-type: none"> - 03/26/13 at 3:35 PM- Sitting in her wheel chair in the hallway across from her room with her eyes closed. No baby doll was observed at that time. - 03/26/13 at 6:30 PM- Sitting in her wheel chair at a dining room table with the TV on the wall to her right. The TV was not on. - 03/27/13 at 8:15 AM- Sitting in her wheel chair at a dining room table with the TV on the wall to her right. The TV was not on. - 03/27/13 at 9:30 AM- Sitting in her wheel chair in the hallway across from her room. Talking with a staff member. No baby doll was observed at that time. - 03/27/13 at 10:50 AM- Several baby dolls were noted on Resident #3's bed. - 03/27/13 at 2:15 PM- Sitting in her wheel chair in the hallway across from her room with her eyes closed. Bingo was in progress in the dining room. Staff were not observed inviting Resident #3 to Bingo. No baby doll was observed at that time. - 03/27/13 at 2:45 PM- Nurse Aide took Resident #3 to her room to provide care and returned her to the hallway outside of her room. No baby doll was observed at that time. - 03/28/13 at 8:20 AM- Sitting in her wheel chair at a dining room table with her back to the TV. - 03/28/13 at 9:14 AM- Sitting in her wheel chair in the hallway across from her room holding a baby doll. <p>An interview was conducted with the Activity Director on 03/28/13 at 8:50 AM regarding Resident #3's activity interests listed on the assessment she completed 11/13/12. The Activity Director stated she had a CD player and a</p>	F 248		
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TV on a rolling cart she could bring to resident rooms but had not provided this activity for Resident #3. The Activity Director felt Resident #3 could identify types of music she enjoyed. When observations of the dining room TV being off and/or with out sound were shared with the Activity Director she stated TV was marked daily on the activity attendance log as a passive activity when a resident ate in the dining room. The Activity Director further stated she was aware Resident #3 enjoyed holding a baby doll and tried to give baby dolls to the residents when she was able but thought the nurse aides (NAs) assisted with this as well. With regards to the reading activity on 03/26/13 the Activity Director stated she took as many residents to the activity as her time allowed and she did not take Resident #3.

An interview with Nurse Aide (NA) #7 on 03/28/13 at 10:50 AM revealed she was aware Resident #3 enjoyed holding baby dolls. When asked why Resident #3 spent the majority of her day in the hallway NA #7 stated Resident #3 was at risk for falls and therefore was placed in the hallway so staff could keep an eye on her.

During an interview on 03/28/13 at 11:15 AM the Administrator stated she expect Resident #3 to be provided with her preferred activities including music, TV, and baby dolls to hold. The Administrator further stated Resident #3 was hard of hearing and probably could not hear the TV in the dining room unless it was turned up very loud. The interview further revealed the NAs usually gave the residents their dolls when they got them up in the morning. At the conclusion of the interview the Administrator stated the facility could do a better job with activities and would

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F 248	<p>Continued From page 9 correct the problem.</p> <p>2. Resident #12 was readmitted to the facility on 11/28/09 with diagnoses including Alzheimer's Disease, dementia, coronary artery disease, and osteoarthritis. An annual Minimum Data Set (MDS) completed on 10/11/12 revealed Resident #12 had long and short term memory loss, was understood and could sometimes understand, and could not complete the interview for activity preference. Staff assessment for activities was completed and indicated Resident #12 liked to participate in religious activities. In addition, the annual MDS noted Resident #12 required extensive assistance with locomotion on the unit and had moderate difficulty with hearing.</p> <p>A Care Area Assessment (CAA) summary completed with the annual MDS stated activities triggered because Resident #12 was unable to complete the activity preference assessment. The CAA summary further stated Resident #12 had to be assisted to activities and seemed to enjoy church services and singing. The CAA summary revealed Resident #12 enjoyed sitting in the hall way watching staff and keeping her baby doll when she was up in her wheel chair and/or in bed.</p> <p>A care plan last reviewed 12/2012 stated Resident #12 had an activity intolerance due to little involvement in activities related to an impaired thought process. The goal was for Resident #12 to participate in at least two activities a week by the next review. Interventions included providing passive activities and listed listening to music, watching TV, books, and puzzles as examples. In addition, the care</p>	F 248			

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F 248	<p>Continued From page 10</p> <p>plan noted Resident #12 should be provided with brief activities and had a baby doll she enjoyed holding.</p> <p>Review of Resident #12's most recent "Activity Interest Assessment" dated 01/17/13 stated her interests were music and TV (television) and the common settings for the resident's activities were in room and out of room.</p> <p>Review of Resident #12's activity attendance log for February 2013 revealed she observed Bingo on two occasions, had six one to one visits, attended one music activity, and had a manicure. During the month of March 2013 Resident #12 observed Bingo on three occasions, had three one to one visits, attended two music activities. Watching TV was marked daily as a passive activity during February and March of 2013.</p> <p>Observations of Resident #12 were as follows:</p> <ul style="list-style-type: none"> - 03/25/13 at 12:20 PM- Sitting at a table in the dining room with her back to the TV. The TV was on with no sound. - 03/25/13 at 2:15 PM- Sitting in her broda chair in the hall way near her room. Resident #12 had her eyes closed. No baby doll was observed at that time. - 03/26/13 at 10:10 AM- Sitting in her broda chair just outside of the dining room doors. No baby doll was observed at that time. Resident #12 was awake and the Activity Director was observed in the dining room reading to a group of residents. The Activity Director was not observed inviting Resident #12 prior to the activity. - 03/26/13 at 3:35 PM- Sitting in her broda chair in the hall way near her room. Resident #12 had her eyes closed. No baby doll was observed 	F 248		

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F 248	<p>Continued From page 11</p> <p>at that time.</p> <ul style="list-style-type: none"> - 03/27/13 at 8:15 AM- Sitting in the dining room at a table. The TV was not on and Resident #12 had her back to the TV. - 03/27/13 at 9:32 AM- Staff member returned Resident #12 to her room to provide care and then returned her to the hall way near her room. No baby doll was noted at that time. - 03/27/13 at 10:51 AM- A baby doll was noted on Resident #12's bedside table. - 03/27/13 at 2:15 PM- Sitting in her broda chair in the hall way near her room. Resident #12 had her eyes closed. No baby doll was observed at that time. Bingo was in progress in the dining room. - 03/28/13 at 8:20 AM- Sitting in the dining room at a table. The TV was not on and Resident #12 had her back to the TV. - 03/28/13 at 9:14 AM- Sitting in her broda chair in the hall way near her room. Resident #12 was awake and her baby doll was observed on the bedside table in her room. <p>An interview was conducted with the Activity Director on 03/28/13 at 8:50 AM regarding Resident #12's activity interests listed on the assessment she completed 01/17/13. The Activity Director stated she had a CD player and a TV on a rolling cart she could bring to resident rooms but she had not provided this activity for Resident #12. When observations of the dining room TV being off and/or with out sound were shared with the Activity Director she stated TV was marked daily on the activity attendance log as a passive activity when a resident ate in the dining room. The Activity Director further stated she was aware Resident #12 enjoyed holding a baby doll and tried to give baby dolls to the</p>	F 248		

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F 248	Continued From page 12 residents when she was able but thought the nurse aides (NAs) assisted with this as well. With regards to music Bingo on 03/25/13 the Activity Director stated she took as many residents to the activity as her time allowed and did not take Resident #12. An interview with Nurse Aide (NA) #7 on 03/28/13 at 10:50 AM revealed Resident #12 spent the majority of her day in the hallway NA #7 stated Resident #12 was at risk for falls and therefore was placed in the hallway so staff could keep an eye on her. During an interview on 03/28/13 at 11:15 AM the Administrator stated she expect Resident #12 to be provided with her preferred activities including music, TV, and baby dolls to hold. The Administrator further stated Resident #12 was hard of hearing and probably could not hear the TV in the dining room unless it was turned up very loud. The interview further revealed the NAs usually gave the residents their dolls when they got them up in the morning. At the conclusion of the interview the Administrator stated the facility could do a better job with activities and would correct the problem.	F 248			
F 253 SS=E	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 interviews, the	F 253			

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F 253	<p>Continued From page 13</p> <p>facility failed to keep a shower room and resident rooms in good repair and wheelchairs clean for 1 of 1 shower rooms and 10 of 41 rooms observed</p> <p>The findings included</p> <p>On 03/28/13 at 8:26 AM during a tour of the facility with the Maintenance Director, the following environmental concerns were observed.</p> <p>a. In Room 109, no call bell cords were attached to the wall unit for both A and B beds. Bed A was not occupied and Bed B was occupied by an alert and oriented resident. Cow bells were observed on the bedside tables for both Beds A and B</p> <p>b. In Room 115, a break through the gypsum layer of drywall behind the headboard of Bed B was observed, measuring approximately 2 inches wide by 12 inches long, with multiple deep scrapes into the gypsum layer on either side of the break. Drywall on a corner section of wall to the right of the bathroom door was cracked approximately two feet up from floor, exposing a metal corner support under the drywall. On the inside of the door frame of the bathroom were noted scrapes and chips in the paint. An electrical outlet cover to the right of and into which the wall heating/air conditioning unit was plugged was cracked, the upper right hand corner of the cover missing and exposing the electrical box. The lower metal frame of Bed A was observed covered in rust.</p> <p>c. In Room 116, a crack in the drywall was observed along a corner wall in the vicinity of the window, running from floor to ceiling</p>	F 253	<p>A. a. "Cow bell" was replaced with different type of bell. Simplex Grinnell repaired call bell system in 109 on 4/17/13. In the interim, a walkie talkie was given to the resident to allow the resident access to be able to notify the nurses station. b. Room 115 wall bed guards were installed, installed corner guard, door frame was repainted, outlet cover was replaced, bed a was sanded, primed, and painted. c. Room #116 corner guard was installed. d. Room # 118 wheelchair was cleaned, door frame was painted, resealed commode. e. Room #119 wheel chair was cleaned, arm rest were replaced. f. # 121 area was repainted and light cover was replaced. g. Bathroom between #128 and #132 commode base was re grouted and base board was repaired h. Room #132 window has been ordered and will be replaced by 4-19, arm rests have been replaced, and light cover replaced i. room 136 light cover replaced. j. room 139 floor and commode were regouted. k. Shower room on D hall tiles were replaced and ventilation cover in ceiling was cleaned.</p> <p>B. The facility acknowledges that all residents have the potential to be affected by these deficient practices and corrective action is accomplished by checking all rooms to assure call bells are functioning, have checked all windows for obstruction of view to the outside, bed guards being installed in rooms identified having cracks, installing corner guards in areas identified as needing them, all door frames have been repainted, all commodes have been regouted, all wheel chairs have been cleaned, all light covers and outlet covers with cracks have been replaced, all armchair pads with cracks or rips have been replaced.</p>

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d. In Room 118, the metal frame of a wheelchair was covered in dust and debris. On the inside and outside of the door frame of the bathroom were scrapes and chips in the paint. The bathroom floor at the base of the commode was discolored brown.

e. In Room 119, the metal frame of a wheelchair was covered in dust and debris with cracked armrests. Small pieces of vinyl covering were missing from the armrests exposing fabric covering underneath.

f. In Room 121, drywall on right hand side when entering the room near bed A was scraped. Brown stains were observed on the ceiling in the vicinity of the privacy curtain track between Beds A and B. In the bathroom, the wall to the right of the door upon entering the bathroom was scraped. The plastic light cover on the light over bed A was cracked and missing a piece measuring approximately 2 inches by 2 inches.

g. In the shared bathroom between Rooms 128 and 130, the floor and grout at the base of the commode were discolored brown. In the vicinity of the commode, vinyl baseboard was observed pulling away from the wall.

h. In Room 132, the bottom half of the double-paned window was observed covered with a white opaque film, sandwiched between the layers of the glass, which obstructed approximately 50 percent of the view to the outside. On the armrests of a wheelchair, small pieces of vinyl covering were missing, exposing fabric covering underneath.

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C. All above areas addressed will be monitored Monday thru Friday during "mock Survey" rounds for issues not in compliance. A "homework" sheet will be filled out and given to the person responsible for correcting the problem. Will be discussed daily Monday thru Friday at morning meeting. Once corrections are made, the homework sheets will be turned in to Administration. Mock Survey rounds are done by all department managers with the exception of the MDS Co-ordinator.

D. Monitoring will be done daily Monday thru Friday during mock survey rounds. Results of findings will be reported at morning stand up meeting. Mock Survey rounds are done by department managers with the exception of the MDS co-coordinator. Results of monitoring will also be reported to QI committee monthly for 4 months.

E. 4/25/13

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F 253	<p>Continued From page 15</p> <p>i. In Room 136, a cracked light cover on the wall light over Bed A was observed, with a missing irregular shaped piece measuring approximately 2 inches by 3 inches</p> <p>j. In Room 139, the floor and grout at the base of the commode were discolored brown</p> <p>k. In the Shower Room located on D Hall, 7 ceramic floor tiles, each measuring 2 inches by 2 inches and located between the shower and the tub, were loose without surrounding grout. A square metal ventilation cover in the ceiling by the entrance to the shower was covered in a black substance, along the sides facing the shower and in the middle of the cover.</p> <p>On 03/28/13 at 8:26AM and during the tour of the facility, the Maintenance Director was interviewed. He stated nursing and housekeeping staff would page him with maintenance concerns, show him in person what the problem was, or if he was not in the facility they would place a self-stick note on his door. He stated the drywall was easily marred and broken behind beds, by wheelchairs and other equipment. In Room 113 the Maintenance Director showed where a piece of painted wood was attached to the wall behind the head of a Bed A to protect the wall, stating this is a project he would like to complete with painting, pending receipt of supplies and warmer weather. He stated department heads walked through rooms assigned to their oversight each morning, identifying and reporting issues during morning meetings. The Maintenance Director stated the nurse call bell system was tested daily with rooms checked at random per corporate policy. He</p>	F 253			

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F 253	<p>Continued From page 16</p> <p>stated Room 109 had an electronic problem in the call bell wall box and had not been functioning for a couple of months. He stated he was awaiting approval for funding of another wall box. The Maintenance Director requested his assistant to immediately replace the electrical outlet cover in Room 115 during the facility tour. He stated he had a window specialist assess the condition of the window in Room 132 on an unspecified date and was told it would have to be replaced. He stated if replacement light covers over the beds could not be found on the Internet he would replace the entire fixture. The Maintenance Director stated loose floor tile in the shower room required repair to prevent accidents. He stated that he had no printed records of recent work requests or planned projects. He stated the Maintenance Department was responsible for wheelchair repairs and the Housekeeping Department was responsible for cleaning them.</p> <p>On 03/28/13 at 9:40 AM the Environmental Services Manager was interviewed. She stated her department was responsible for cleaning wheelchairs and she directed the floor technician to do this every Wednesday based on a rotating schedule. She stated this rotating schedule should have resulted in each wheelchair being looked at every two weeks, but the amount of dust and debris noted on tour was not consistent with the schedule. The Environmental Services Manager stated if during the cleaning of wheelchairs mechanical or repair concerns were noted, she expected Housekeeping staff to report these findings to the Maintenance Department. She stated her expectation of Housekeeping staff to notice repair concerns in resident rooms and report these findings using a printed checklist for</p>	F 253			

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F 253	<p>Continued From page 17 this purpose.</p> <p>On 03/28/13 at 4:05 PM the Administrator was interviewed. She stated the facility was waiting for warmer weather to permit drywall repair and painting where required. She stated a maintenance assistant was recently hired to assist with facility concerns. The Administrator stated Department Heads used a Mock Survey/Quality Assurance form during their morning rounds of assigned rooms. She stated upon completion of morning rounds any facility issues were discussed at morning meetings and communicated to the Maintenance Director. She stated communication was facilitated by use of a Homework Sheet with room number, date, task description, a column for noting completion of tasks and another column for additional comments for record keeping. The Administrator stated approval was given to purchase the parts required to repair the call bell in Room 109. She stated her expectation of the Maintenance Director and Environmental Services Manager to develop plans addressing the noted facility concerns.</p> <p>F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 253	<p>F309</p> <p>A. Resident #39 bowel documentation was reviewed on 3/27/13 for any other indications of change in bowel habits to indicate constipation or risk of fecal impaction and none were noted</p> <p>B. An audit of all current facility residents for changes in bowel consistency was completed on 3/27/13 and no other resident were noted to have changes or presence of fecal impaction.</p> <p>C. All Licensed Nurses and C.N.A.'s were re-educated beginning 3/27/13 on the responsibility to report changes in bowel habits to include changes in consistency or unexpected results to treatments to the Licensed Nurses via the Stop And Watch INTERACT tool. The Licensed Nurses will evaluate the resident and notify the Physician of any changes in condition</p>	

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by:

Based on staff and physician interviews, and medical record review, the facility failed to assess a resident regarding bowel movement frequency and consistency for 1 of 11 residents reviewed for bowel movements (Resident #39). The findings included:

Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia.

An admission Minimum Data Set (MDS) dated 09/11/12 indicated impaired cognition and dependence on extensive staff assistance for all care including eating. The MDS specified the resident was incontinent of bladder frequently and bowel always and no problems with constipation were identified. The MDS pain assessment noted Resident #39 received pain medications as needed and no signs of experienced pain were observed in the past 5 days. A quarterly MDS dated 12/09/12 was unchanged.

A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder. The care plan goal was to keep the resident clean and dry and decrease the number of incontinent episodes over next 3 months. Interventions included nurses would monitor bowel patterns. A care plan related to alteration in comfort and dated 09/11/12 specified Resident #39 experienced acute pain episodes. The care plan goal was for the resident not to experience unrelieved pain. Interventions included administer pain medication per physician's order and monitor effectiveness. There was no

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D. The ED/DCS/Unit Manager will audit a maximum of 5 residents for bowel movement frequency to ensure resident is not experiencing a change in condition; and/or if they are experiencing a change in condition, that the physician was notified. Monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for 7 months. The results of the audits will be reported monthly to QI Committee x 10 months for continued substantial compliance and/or revision.

4-25-13

E. 4/25/13

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day and Miralax 17 g to twice a day, and the addition of Chronulac 30 milliliters (ml) at bedtime. The physician also ordered 3 Dulcolax suppositories to be administered on this date. A review of physician orders revealed written orders dated 01/04/13 to support the physician's plan.

A review of the 01/01/13 through 01/10/13 MAR revealed the laxative suppositories were added to the MAR but were not initialed as administered. The MAR indicated the additional doses of Senna-S and Miralax were added and initialed as administered twice everyday. The Chronulac was added and initialed as administered daily.

An interview was conducted via phone with Nurse #2 on 03/27/13 at 6:15 PM. Nurse #2 confirmed she worked nights at the facility. Nurse #2 stated she administered the 3 laxative suppositories ordered by the physician on 01/04/13 and did not initial the MAR. Nurse #2 added the results were documented by the NA on the bowel and bladder detailed entry report.

A review of a bowel and bladder detailed entry report reveled documentation by nurse aides regarding frequency and consistency of bowel movements. On 12/31/12 through 01/03/12 no bowel movements were documented. A medium formed and was documented on 01/03/13. On 01/04/13 a medium formed stool was documented at 2:16 PM by Nurse Aide (NA) # 1 and a large loose stool by NA #2 at 10:16 PM.

An interview with Nurse #1 was conducted on 03/28/13 at 8:29 AM. Nurse #1 stated she worked 01/03/13 and 01/04/13 and had administered a total of 3 enemas to Resident

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#39. She described the results as a small to medium amount of formed to loose stools. Nurse #4 stated when the physician made rounds around 3:00 PM on 01/04/13, she reported the results of the enemas to him. Nurse #1 explained she did not document the enemas, results of the enemas, or notification of the physician. She added she should have documented her assessments and all she did regarding Resident #39's bowel status.

Continued review of the bowel and bladder detailed entry report revealed on 01/05/13 a large loose stool was documented at 3:04 AM by NA #3 and 4:56 AM by NA #4, a small loose stool at 2:40 PM by NA #5, and a large loose stool at 5:35 PM by NA #6. On 01/06/13 a large loose stool was documented at 5:25 AM by NA # 4 and at 2:32 PM by NA #5. There were no stools documented on 01/07/12 or 01/08/12. On 01/09/12 an extra-large loose stool was documented at 2:35 AM by NA #3 and a large loose stool documented at 5:01 AM by NA #4.

An interview was conducted via phone with NA #3 on 03/27/13 at 2:55 PM. She described Resident #39's bowel movements on 01/05/13 and 01/09/13 as loose and runny and not dark in color. NA #3 stated the stools were so large, complete bed changes were required. She stated she reported the loose stools to the hall nurse.

An interview was conducted via phone with NA #4 on 03/27/13 at 2:59 PM. NA #4 reported there was a stomach virus going around the facility during the first of January 2013. She described Resident #39's stools as runny and watery and not hard. She stated she reported the loose

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901	
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F 309	<p>Continued From page 22 stools to the hall nurse.</p> <p>An interview was conducted with NA #5 on 03/27/13 at 2:11 PM. NA #5 stated she worked 01/05/13 and 01/06/13. She stated she did report the stool on 01/06/13 because it was so large. NA #5 described Resident #39 without demonstrating signs of discomfort. NA #5 added at the time the resident was having loose stools, other residents in the facility were doing the same. She stated there was a virus going around involving residents and staff.</p> <p>An interview was conducted via phone with NA #6 on 03/27/13 at 3:30 PM. NA #6 stated she recalled Resident #39 had large stools that required a complete bed change. She described the stools as grainy and not formed. NA #6 stated it was her normal practice to report diarrheal stools to the nurse but was unable to recall if she reported the loose stool on 01/06/13 to the hall nurse.</p> <p>An interview was conducted via phone with Nurse #3 on 03/27/13 at 3:05 PM. She stated she worked 01/05/13 and 01/06/13 at the facility. Nurse #3 did not recall any reports of loose stools regarding Resident #39. She stated during the first week in January several residents developed a stomach virus and had loose stools.</p> <p>A review of Resident #39's nursing notes from 12/31/12 through 01/10/13 revealed no documentation of enemas received or results of these enemas. No assessments related to frequency or consistency of bowel movements or abdominal status were documented. Continued review of nursing notes revealed no</p>	F 309	

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F 309	Continued From page 23 documentation of administration of laxative suppositories or results produced by the suppositories. Review of a nursing note dated 01/10/13 at 9:00 AM revealed documentation of a phone call from Resident #39's attending physician. The note specified the physician notified the facility that the resident had been admitted to an acute care facility from the wound clinic. A review of a History and Physical (H&P) dated 01/10/13 and written by the acute care facility physician was conducted. The H&P specified Resident #39 was sent to the wound clinic for treatment of bilateral lower extremity wounds. The resident started to vomit. Nursing assessments in the wound clinic revealed the resident exhibited an increased in pulse and a decrease in blood pressure. The resident was sent to the emergency department (ED) for evaluation. In the ED Resident #39 was assessed with a distended abdomen and no bowel sounds. A digital rectal examination by the ED physician resulted in palpation of hard impacted stool. An abdominal x-ray showed a fecal impaction with dilatation of the lower colon. The H&P specified the pain medication more than likely contributed to the constipation. A review of a Discharge Summary (DS) dated 01/18/13 revealed Resident #39 was sent back to the long term care facility in stable condition. The DS described the resident's hospital course involved resolution of a fecal impaction that included a variety of treatments. Discharge diagnoses included severe fecal impaction and abdominal discomfort with distended lower bowel.	F 309			

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F 309 Continued From page 24

F 309

A review of Resident #39's medical record revealed when the resident returned to the long term care facility, the care plan was not updated to address constipation monitoring or treatment.

An interview was conducted via phone on 03/27/13 at 5:49 PM with the Medical Director (MD) that was the attending physician for Resident #39. The MD stated when he visited the facility on 01/04/13 he was verbally informed by the nurses regarding administration of enemas and the constipation problems exhibited by the resident. He stated he examined Resident #39 and described his findings in the physician's progress notes of 01/04/13. The MD stated he changed the resident's medications as was also documented in the progress notes. He stated he does not recall being notified regarding consistency of bowel movements after his orders on 01/04/13. He added he remembered verbal reports that the resident was having bowel movements. The MD stated he wanted the stools to be loose, but not watery. If he had known the consistency and frequency of the bowel movements, he would have adjusted the resident's medications, ordered an abdominal x-ray, and asked the nurses to perform a digital rectal examination. The MD explained loose bowel movements could mean stool was moving around an impaction.

An interview was conducted with the Director of Nursing (DON) on 03/27/13 at 6:21 PM. She stated she reviewed a bowel movement report in January and noted Resident #39 was having bowel movements. This report did not specify consistency and she stated she was unaware of

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F 309 Continued From page 25
the consistency of the stools. The DON explained if she had noted the stools were loose, she would have thought the resident had the stomach virus diagnosed in many other residents and staff at that time.

F 309

An additional interview with the Director of Nursing (DON) was conducted on 03/28/13 at 10:47 AM. The DON stated she reviewed the bowel reports for Resident #39 from 10/01/12 through 01/10/13. She reported the documentation revealed 38% of the resident's bowel movements were loose and 62% were formed. The DON added no stools were documented as hard. The DON stated she expected nurses to assess residents with bowel concerns and to document assessments performed and medications administered.

F 329 483 25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=E

F 329

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

F 329

- a. Resident # 43's Physician was notified on 3/26/13 upon notification of the error by the State Surveyor. An order was obtained to increase the Wellbutrin to 150 mg every morning and daily at 3:00 pm. There was no harm suffered by the resident.

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F 309	Continued From page 25 the consistency of the stools. The DON explained if she had noted the stools were loose, she would have thought the resident had the stomach virus diagnosed in many other residents and staff at that time. An additional interview with the Director of Nursing (DON) was conducted on 03/28/13 at 10:47 AM. The DON stated she reviewed the bowel reports for Resident #39 from 10/01/12 through 01/10/13. She reported the documentation revealed 38% of the resident's bowel movements were loose and 62% were formed. The DON added no stools were documented as hard. The DON stated she expected nurses to assess residents with bowel concerns and to document assessments performed and medications administered.	F 309	
F 329 SS=E	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	F 329	

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F 329	<p>Continued From page 26</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews, and staff and pharmacy personnel interviews, the facility administered an incorrect dosage of an antidepressant medication for 45 doses to 1 of 7 residents reviewed during medication reconciliation (Resident #43). The findings included:</p> <p>Resident #43 was admitted to the facility 06/16/06 with diagnoses including depression and mood disorder.</p> <p>A review of Resident #43's medical record revealed a physician's order dated 02/01/12 for Wellbutrin (an antidepressant medication) 100 milligrams (mg). The order specified the medication was to be administered every morning and at 3:00 PM daily.</p> <p>A review of Resident #43's Medication Administration Records (MAR) dated February 2013 and March 2013 was conducted. The February 2013 MAR contained facility nurses' initials indicating Wellbutrin 100 mg was administered twice a day. The March 2013 MAR contained facility nurses' initials indicating</p>	F 329	<p>B. DCS/Nurse Manager reviewed all current residents medication to ensure that the correct dosages are indicated on the Medication Administration Record (MAR) per the physicians' orders. Inconsistencies were reported to the resident's physician medication error report was completed by the nurse.</p> <p>C. All Licensed Nurses were re-educated on Medication Administration to include ensuring the correct dose was sent from the pharmacy.</p> <p>D. The DCS / Unit Manager will observe medication pass on 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, then 4 residents per month for 10 months. The results of the medication pass observations will be reported to the QI Committee monthly x 10 months for continued substantial compliance and/or revision.</p> <p>E. 4/25/13</p>
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F 329	<p>Continued From page 27</p> <p>Wellbutrin 100 mg was administered twice a day through 03/24/13 and once on 03/35/13.</p> <p>An annual Minimum Data Set (MDS) dated 03/08/13 indicated cognition was intact and the resident required extensive staff assistance for all activities of daily living except eating. The MDS specified Resident #43 acknowledged feelings of depression. A Care Area Assessment stated the resident received Wellbutrin 100 mg twice a day for depression.</p> <p>A care plan dated 03/08/13 identified Resident #43 at risk for potential side effects from an antidepressant drug. The care plan goal specified the resident would have no side effects from the medication or increased depression for the next 3 months. Interventions included monitoring the resident for potential side effects of medications and effectiveness of therapeutic dosing.</p> <p>An observation on 03/26/13 at 3:44 PM revealed Nurse #4 preparing medications to be administered to Resident #43. Nurse #4 compared a blister pack of Wellbutrin to the physician's order on the March Medication Administration Record (MAR). She found the blister pack contained Wellbutrin 150 mg tablets and the order on the MAR specified Wellbutrin 100 mg. Nurse #4 looked through the medication cart and was unable to find another blister pack for Resident #43 containing Wellbutrin 100 mg. Nurse #4 reported the discrepancy to the Director of Nursing and did not administer the medication at this time.</p> <p>An interview with the Administrator was</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>conducted on 03/26/13 at 4:15 PM. The Administrator acknowledged Wellbutrin 150 mg had been administered for a period of time instead of Wellbutrin 100 mg as ordered by the physician. The Administrator added the physician had been notified via phone and he changed the order to Wellbutrin 150 mg every morning and at 3:00 PM daily.</p> <p>An interview with Resident #43's attending physician on 03/28/13 at 8:34 AM revealed the resident was not harmed due to the increased dosages of Wellbutrin she received.</p> <p>An interview via phone with the facility Pharmacy Manager was conducted 03/28/13 at 11:55 AM. The Manager stated the pharmacy received a faxed physician's order on 02/01/12 for Resident #43 to have Wellbutrin 100 mg in the morning and at 3:00 PM every day. The Manager explained when the pharmacy technician keyed the medication into the pharmacy computer system, the dosage was keyed as 150 mg. She stated a blister pack containing 150 mg tablets was sent to the facility at that time. The Manager added before the medication was administered, a facility nurse caught the error in the dosage and notified the pharmacy. The facility returned the blister pack of Wellbutrin 150 mg. The pharmacy resent the medication in the correct dose of 100 mg but did not remove the 150 mg dosage from the computer. The Manager stated Wellbutrin 100 mg was sent to the facility until 02/14/13 when a refill was requested by the facility. The Manager stated the facility nurse requested the medication via computer and checked Wellbutrin 150 mg instead Wellbutrin 100 mg. When the facility requested the next refill, it was done by</p>	F 329	

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F 329 Continued From page 29

F 329

scanning the bar code on the Wellbutrin 150 mg package. The Manager stated therefore blister packages containing Wellbutrin 150 mg were sent to the facility on 02/14/13 and 03/11/13

An interview was conducted with the Director of Nursing (DON) on 03/28/13 at 2:20 PM. She stated her expectation was for nurses to check dosages on medication containers and compare the dose to the order on the MAR before the medication was administered.

On 03/28/13 at 2:37 PM, Nurse #1 was observed counting the Wellbutrin 150 mg left in the blister package sent to the facility on 03/11/13. She stated the blister packs contained 30 tablets. Nurse #1 determined Resident #43 received 45 doses of Wellbutrin 150 mg.

F 367 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN
SS=D

F 367

Therapeutic diets must be prescribed by the attending physician.

This REQUIREMENT is not met as evidenced by

Based on medical record reviews and staff interviews, the facility failed to verify the attending physician received and responded to a faxed dietary recommendation for 1 of 3 sampled residents reviewed for nutrition (Resident #39)

The findings included:

Resident #39 was admitted to the facility 09/02/12. Admitting and added diagnoses included chronic constipation, chronic pain,

F 367

A. RD recommendation for resident # 39 was re-faxed to physician and enriched was added to diet order. MVI with Minerals and 60 ml. Med pass supplement was ordered and started. on 3-28-13

B. The facility acknowledges that all residents have the potential to be affected by this deficient practice and corrective action has been achieved by educating the DM on the process for follow up of RD recommendations. On 4/9/13 all current RD recommendations have been reviewed to assure all current RD recommendations have been addressed.

C. DM will keep a log of all recommendations each month to assure they have been reviewed and responded to by the physician. Regional Dietician will review monthly for compliance x 10 months.

D. Regional Dietician will report results of monitoring to QI Committee monthly for 10 months for continued substantial compliance and/or revision.

E. 4-25-13

4-2-13

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F 367	<p>Continued From page 30</p> <p>muscle weakness, dementia, and lower extremity wounds.</p> <p>An admission Minimum Data Set (MDS) dated 09/11/12 indicated Resident #39 was severely cognitively impaired and required extensive staff assistance for all activities of daily living including eating. The MDS assessed the resident's admission weight at 110 pounds. A Care Area Assessment (CAA) with this assessment specified Resident #39 was on a pureed enriched diet. The resident was tolerating the diet well and weight had been stable since admission. A Registered Dietician (RD) consult would be provided routinely and as needed to evaluate nutritional status.</p> <p>A care plan dated 09/11/12 identified Resident #39 was at risk for weight loss related to a mechanically altered diet. The care plan goal specified the resident would maintain adequate nutrition and not loose more than 5% of her present weight. Interventions included a diet ordered as pureed with enriched foods and RD consults as indicated.</p> <p>A review of Resident #39's medical record revealed a physician's order dated 09/19/12. The order specified 60 milliliters (ml) of a nutritional supplement was to be administered 4 times daily with medication administration.</p> <p>Continued review of Resident #39's medical record revealed she was admitted to an acute care facility on 01/10/13. A History and Physical (H&P) completed by the physician in the acute care facility on 01/10/13 was reviewed. The H&P specified admitting diagnoses included vomiting,</p>	F 367
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F 367	Continued From page 31 fecal impaction and mild malnutrition. In the H&P, the physician documented the resident's appearance as frail looking and very emaciated. A review of discharge instructions dated 01/18/13 revealed the request for a dietary consult regarding poor calorie intake. The diet order at discharge was for pureed foods with regular liquids. A review of weights after Resident #39 returned to the long term facility on 01/18/13 revealed the resident's weight on 01/22/13 was 99.5 pounds. The latest recorded weight was 109 pounds on 03/01/13. Additional medical record review revealed a dietary nutrition review was completed. The review was dated 01/24/13 and signed by the facility RD. The recommendations on the review included the following: (1) re-order 60 ml of a nutritional supplement to be provided with all routine medication administrations, (2) add enriched to current diet order, and (3) add a multivitamin with minerals every day to help meet daily nutritional needs. A review of the resident's current diet on the monthly physician orders dated March 2013 revealed a diet order for puree with regular liquids. No request for the addition of enriched foods, nutritional supplement or multivitamin was noted on the March orders. An interview with the RD was conducted 03/28/13 at 9:39 AM. The RD explained after she completed a nutritional consult, she filled out a Consulting Dietician Recommendation form. The	F 367			

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F 367 Continued From page 32
RD verified the Consulting Dietician form contained the recommendations as stated in the dietary nutrition review was faxed to Resident #39's attending physician. Review of this form with the RD revealed a place was provided for the physician to indicate he agreed or disagreed with the recommendations. The RD added after she completed nutritional reviews, she provided a verbal report to the Dietary Manager (DM).

An interview with the DM was conducted 03/28/13 at 10:52 AM. The DM verified she received a verbal report from the RD regarding dietary supplement recommendations on 01/24/13. The DM explained the process was the physician would return the Consulting Dietician Recommendation form via fax. The nurses receiving the fax would write a physician's order according to his request and provide a dietary slip to the DM containing changes to dietary orders. The DM stated she had not received any change for Resident #39's dietary order. The DM verified she was the only facility staff that knew what RD recommendations were faxed to physicians. She stated there was no system in place to assure the physician received and responded to the recommendation.

Continued interview with the RD on 03/28/13 at 11:10 AM revealed the facility should have a system in place to verify physicians received and responded to her recommendations.

F 431 463 60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all

F 367

F 431

A. The identified bottle of insulin was discarded immediately upon notification of the State Surveyor on 3/28/13. The resident suffered no harm.

B. All insulin vials were checked for expiration on 3/28/13 and no others were found out of date.

C. All Licensed Nurses were re-educated on the dating and expiration of insulin vials. Third shift Licensed Nurses will be responsible to check their med cart nightly to ensure no expired insulin remains on the carts.

D. The DCS/Unit Manager will Q1 monitor review insulin vials 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly x 7 months. The results of the Q1 monitoring will be reported to the QI Committee monthly x 10 months for continued substantial compliance and/or revision.

E. 4/25/13

4-25-13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/28/2013
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 431	<p>Continued From page 33</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to discard an opened medication vial per manufacturer's recommendation for 1 of 1 medication refrigerators. Findings included:</p>	F 431		

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F 431	Continued From page 34	F 431		
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A review of prescribing information by the manufacturer of Novolog insulin, revised June 2011, indicated after opening a vial may be used for up to 28 days. A review of medication refrigerator check sheets for medication expiration dates revealed the most recent entry as 03/10/13.

On 03/28/13 at 2:30 PM, an observation of the medication refrigerator in the facility's medication preparation room revealed a plastic basket with open vials of insulin. An open vial of Novolog insulin, 100 units per milliliter, was observed inside a plastic container with a prescription label. On the plastic container, a yellow label with a space for writing the date of the 28th day after opening the vial was left blank. No written dates were noted on the vial.

On 03/28/13 at 2:50 PM, Nurse #1 was interviewed. She stated she gave the resident noted on the prescription label Novolog insulin the morning of 03/28/13 and this was the vial from which she obtained the insulin. She stated per facility policy the nurse who originally opened the vial should have written the date of the 28th day after opening, either on the yellow label on the container, on a sticker placed on the bottom of the vial or with ink on the vial itself. Nurse #1 stated she should have checked for the date of the 28th day after opening when she performed her medication check before drawing up and administering the insulin. She stated in the absence of the date of the 28th day after opening and based on the pharmacy fill date of 02/15/13, the 28th day after opening could have been as early as 03/15/13. Nurse #1 stated Monday night

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F 431	<p>Continued From page 35</p> <p>shift nurses were to check the medication refrigerator for expired medications as an additional check.</p> <p>On 03/28/13 at 3:00 PM, Nurse #1 was observed disposing the open vial of Novolog insulin in the sharps container on a medication cart.</p> <p>On 03/28/13 at 3:05 PM, the Director of Nursing (DON) was interviewed. She stated her expectation of nurses noting the date of the 28th day after opening a vial of insulin, on the label provided for it on the plastic container or on the vial itself. The DON stated nurses are to check for this date before drawing up and administering a dose of insulin as part of their medication check. She stated that as an additional check, the Monday night shift nurse is expected to check for expiration dates on medications in the medication refrigerator but this is not to replace the checking of dates performed by nurses drawing up and administering medications.</p>	F 431		
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