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 05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HWY 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 The statement of deficiencies was amended on 08/14/13 following the Informal Dispute Resolution results notice from the Centers for Medicare and Medicaid Services. Based on these results tag F-325 was removed from the statement of deficiencies.	F 000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to provide residents with the amount or type of baths/showers that they wanted each week for three of three residents (#94, #180, and #105). Findings Included: 1. Resident #94 was admitted with diagnoses including coronary artery disease, diabetes, and cerebrovascular accident. The latest quarterly Minimum Data Set (MDS) dated 03/13/13 assessed the resident as cognitively intact and able to understand and make herself understood. Interview with Minimum Data Set (MDS) nurse on 05/22/13 at 10:08 am revealed admission	F 242	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** The Social Workers interviewed residents #94, #105, and #180 for specific bathing preferences and those preferences were implemented and indicated on the bathing schedules on 5/24/13. **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** The Social Workers completed interviews of all interviewable residents concerning bathing preferences. The residents were given choices including the type of bath/shower, time of day preferred, and the frequency of occurrence. These preferred choices were documented and communicated to the nursing department and the bathing schedules were updated to reflect the stated preferences on 5/29/13. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** The initial Social Admission Assessment form was revised to include the type of bath/shower, time of day preferred, and the preferred frequency of occurrence for bathing. The Admissions Director or Social Worker is now	6/1/13

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

Sandra G Griffin — Administrator — 6/15/13

Black Mountain Received AUG 21 2013 DHSR by: PAM

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 242	Continued From page 1 assessments are completed by one of three MDS nurses. The MDS nurse reported that standard shower/bath times are scheduled for each new resident twice a week. The MDS nurse stated the residents are not assessed regarding how often residents would like to have a shower/bath, but there were several residents in the facility who had requested more frequent shower/baths and they were receiving them. Interview with Resident #94 on 05/22/13 at 3:43 PM revealed each resident is told when their scheduled two bath days per week are. Resident #94 said she has never been asked if she wanted more than two showers weekly or what time of day she would prefer to shower. Resident #94 stated she wished she could have more than two showers a week. Resident #94 also stated she had always used night-time showers to relax herself when she felt anxious and she felt is was unfair that she was no longer able to do that now. Interview with Director of Admission on 05/23/13 at 11:16 AM revealed that bathing is discussed with new residents and families during the preadmission screen and daily schedule preferences are documented on a sheet she had developed. She stated she does not currently ask residents about their preferences regarding frequency and type of bath or showers or the time of day they prefer to take a bath. When asked how it is decided how often residents get baths, the Director of Admissions said baths and showers are automatically scheduled two times a week, and if a resident made a request to have additional showers, baths instead of showers, or baths or showers during the evening, the staff does everything possible to accommodate that request.	F 242	asking these questions to all newly admitted interviewable residents or their representative (if the resident is unable to answer) about bathing preferences. The bathing information is then also forwarded to the Nursing Supervisor to put into the bathing schedules for the CNA staff. The bathing preferences will now be included in Social Worker quarterly reviews for each resident and updated as desired. QA audit to begin 6/1/13: The Social Workers will interview a total of 20 residents and or their resident representatives weekly for 4 weeks, then 10 per week for 2 months, then 10 per month for 3 months to ensure bathing preferences are being met. **Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring program was initiated by the Quality Assurance Committee. It will be supervised by the Director of Admissions and Social Work, and will be implemented as follows:** The results of the above stated bathing preference audits will be reported to the Director of Admissions and Social Work who will review the data and ensure that any requested changes have been communicated to the Nursing Supervisor and the bathing schedules reflect stated preferences. The Director of Admissions and Social Work will review data for trends or patterns and will report the results to the QA Committee monthly for 6	

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F 242	Continued From page 2 Review of the preadmission preference sheet for Resident #94 did not reveal any information regarding Resident #94's preferences for frequency of showers or time of day of showers. Interview with RN Supervisor/Acting Director of Nursing (DON) on 05/23/13 at 02:36 PM revealed residents who request baths or showers more frequently than twice weekly are accommodated to the best of the staff's ability. The RN Supervisor/Acting DON showed this surveyor the facility shower sheet, which assigned each resident two shower times per week. The RN Supervisor/Acting DON stated new residents are told the bathing policy is that they will have two baths per week and on an as needed basis. The RN/Supervisor/Acting DON stated residents would have to ask if they could have a bath more frequently if they wanted that. 2. Resident #180 was admitted with diagnosis including Alzheimer's disease and chronic urinary tract infection. The last minimum data set (MDS) dated 03/18/13 assessed the resident as moderately impaired and able to understand and make herself understood. Resident #180's Minimum Data Set (MDS) assessment, dated 03/18/13 also revealed it was very important for Resident #180 to choose whether she had a tub, bath, shower, or sponge bath. Interview with Resident #180 on 05/20/13 at 2:41 PM revealed residents are given a bath or shower, depending on what is available for nursing assistants to use. Resident #180 stated she doesn't like baths, but has never been asked by a staff member, and sometimes she is given a shower and sometimes she is given a bath.	F 242	months (June through November) The QA committee will determine if further intervention or systemic changes are needed to assure sustained compliance with F 242.	

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F 242	Continued From page 3	F 242		

Resident #180 also stated she is very uncomfortable getting in and out of the bathtub and doesn't like the feeling of sitting in the water. Resident #180 stated she had not told any staff about this preference because she was unaware she had any choice regarding a bath or shower.

Interview with Minimum Data Set (MDS) nurse on 05/22/13 at 10:08 am revealed admission assessments are completed by one of three MDS nurses. The MDS nurse stated the residents are not assessed regarding whether they would prefer to have a shower, bath, or sponge bath, but there were several residents in the facility who had requested baths or showers and they were receiving them.

Interview with Director of Admission on 05/23/13 at 11:16 AM revealed that bathing is discussed with new residents and families during the preadmission screen and daily schedule preferences are documented on a sheet she had developed. She stated she does not currently ask residents about their preferences regarding frequency and type of bath or showers or the time of day they prefer to take a bath. When asked how it is decided how often residents get baths, the Director of Admissions said baths and showers are automatically scheduled two times a week, and if a resident made a request to have additional showers, baths instead of showers, or baths or showers during the evening, the staff does everything possible to accommodate that request.

Review of the preadmission preference sheet for Resident #94 did not reveal any information regarding Resident #180's preferences for type of shower or bath she preferred.

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F 242	Continued From page 4	F 242		

Interview with RN Supervisor/Acting Director of Nursing (DON) on 05/23/13 at 02:36 PM revealed residents who request to have baths and not showers or showers and not baths are accommodated to the best of the staff's ability. The RN Supervisor/Acting DON showed this surveyor the facility shower sheet, which assigned each resident two shower/bath times per week. The sheet did not designate the resident's choice of type of shower/bath preferred. The RN Supervisor/Acting DON stated new residents are told the bathing policy is that they will have two shower/baths per week and on an as needed basis. The RN/Supervisor/Acting DON stated residents would have to ask if they had a preference for a specific type of shower or bath.

3. Resident #105 was admitted to the facility on 02/25/13 with diagnoses which included depression, anorexia, arthritis, and dysuria. Resident #105 was assessed a being cognitively intact. Review of admission Minimum Data Set (MDS) dated 03/04/13 revealed Resident #105 was totally dependent for bathing needing the assistance of one person.

Review of Resident #105's care plan dated 2/26/13 for activities of daily living (ADLs) revealed the goal ADLs would be met according to Resident's need every day for bathing. Also care planned were ADL deficits impaired mobility related to history of congestive heart failure, coronary artery disease, Rheumatoid arthritis and general weakness with the goal of staff will assist

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F 242	Continued From page 5	F 242		

and meet all daily care needs.

On 05/21/13 at 11:40 AM an interview was conducted with the Resident #105 who stated prior to coming to the facility she took a shower every morning. She stated, "here you get two showers per week." Resident #105 further stated she understood there were rules and so she'd just get two showers per week.

On 05/22/13 at 8:40 AM during an interview with Nursing Assistant #1 she stated that residents usually get two showers per week. NA #1 went on to say if families or residents request more showers per week they will give them.

On 05/22/13 at 8:50 AM a interview was conducted with NA #2 who worked with Resident #105. NA #2 stated residents get tow showers per week unless they ask for more. She further stated the residents would have to ask for more showers if they wanted them. NA #2 indicated she was unaware that Resident #105 would like to have more than two showers per week.

On 05/22/13 at 10:08 AM an interview was conducted with the MDS Nurse. She stated the admission assessments are done by one of the three MDS nurses, The MDS Nurse went on to stay standard showers are given twice per week to residents. She indicated during the admission assessment MDS Nurses did not assess how many times per week residents would like to have a bath or a shower. The MDS nurse stated this assessment would be done by the hall nurse or the nursing assistants. She stated Section F of the MDS was completed by the Activity Director and to her knowledge that was the only section which addressed bathing. The MDS Nurse further

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F 242	Continued From page 6 stated to her knowledge there was not a system in place to assess how often residents would like to shower. An interview was conducted on 05/22/13 at 11:05 PM with the Social Worker (SW)/Admissions Coordinator (AC). The SW stated she assess the residents' usual routine when they are admitted. She stated this assessment does not go into specifics regarding ADLs or bathing. The SW/AC stated lets the resident and family know that the residents get three baths per week or as often as needed for hygiene purposes. She stated residents can have fewer baths as well if the request. She stated she did assess if residents would like to bathed morning or evening but if they wanted to have baths or showers more frequently than three times per week the resident or family would have to make this request. An interview was conducted on 05/22/13 at 4:14 PM with the Assistant Director of Nursing (ADON). The ADON stated typically residents receive baths or showers twice per week unless they request more. The ADON further stated upon request the resident could have more baths or if they needed one for hygiene reasons. She stated, "we do not ask the residents or families about bath frequency we tell them what the policy is."The ADON went on to say, "there have been residents who have requested more than two showers per week and we do our best to accommodate that."	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** The Nurse who failed to initiate the bowel protocol and administer laxative to resident #117 on the morning of the 4th day with no BM	**6/13/13**

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F 309	Continued From page 7 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to identify the need for nursing assessment for 1 of 10 (Resident #117) residents reviewed for constipation. The findings included: Resident #117 was admitted to the facility on 09/23/12 with diagnoses which included Alzheimer's Disease, Edema, and Constipation. Review of Resident #117's most recent Quarterly Minimum Data Set (MDS) dated 02/02/13 revealed he was severely cognitively impaired. The MDS indicted Resident #117 was occasionally incontinent of bowel and bladder. Review of physician orders dated for the month of May 2013 revealed the following orders: a. Miralax powder 17 grams, in 4-6 ounces of fluids every day for constipation b. 2 tablets Dulcolax, 5 milligrams each, to be given at 6:30 AM if no BM on the 4th AM c. Dulcolax suppository, 10 milligrams, administer if no results by 3:00 PM on the 4th day, give between 3:00 - 5:00 PM d. Fleets Enema, administer on 5th day between 8:00 - 10:00 AM if no BM. Contact MD if no results after Fleets Enema. e. Lasix 20 milligrams, 1 tablet every day	F 309	received administrative intervention due to the fact Resident #117 received laxative on the 5th day, instead of the 4th day per the Standing Orders. **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** The Nursing Supervisors audited the current daily "BM Roster" for ALL residents to ensure that any other resident with no documented BM (bowel movement) for greater than 3 days received medication administration on the 4th day per the Standing Orders for BM Protocol. There were no other residents identified by this audit as not receiving timely implementation of the bowel protocol. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** The Nursing Supervisors and DON conducted detailed in-service training with Nurses and Medication Aides to assure that they fully understand that the Standing Orders for constipation be initiated on the 4th morning if no BM is recorded for 3 days. All new Nurses and Medication Aides will be thoroughly trained to initiate the standing orders for BM Protocol for constipation on the 4 morning of no recorded bowel movement, unless ordered otherwise by the physician. The Nursing Supervisors will conduct audits of the daily "BM Roster" for all residents 5 times	

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F 309	Continued From page 8 Review of records revealed no bowel movements were documented for Resident #117 between 05/07/13 and 05/12/13. No other time during the month of May was there documented fewer than one bowel movement every day or every other day. Review of the Medication Administration Records for the month of May 2013 revealed Resident #117 received 2 tablets of Dulcolax, 5 milligrams each, on 05/12/13 at 6:00 AM. Resident #117 had a large bowel movement at 10:30 AM on 05/12/13. An interview was conducted on 05/02/13 at 12:16 PM with Nurse #3, who worked with Resident #117. Nurse #3 stated if Resident #117 had not had any bowel movement documented for three days, the night nurse should have put his name on the bowel movement list so that she would know to administer 2 Dulcolax on the 4th day at 6:30 AM. She stated every morning nurses are given a list with resident names who had not had bowel movements in three days. She said all nurses and nursing assistants are told to document every bowel movement and if no documentation of a bowel movement exists, they are to follow the established protocol for bowel movements. On 05/24/13 at 3:06 PM the RN Supervisor/Acting Director of Nursing (DON) was interviewed. The RN Supervisor/Acting DON stated the established protocol for bowel movements included training for all nurses and nursing assistants to document every bowel movement into the computer. Night nurses are to review bowel movement data and to add the	F 309	weekly for 2 months, then 3 X weekly for 4 months to ensure that all residents receive timely interventions for constipation as written per the standing orders. The Nursing Supervisors will document the results of the audits and report them to the DON. Any nurse or medication aide that did not initiate Bowel Protocol per the Standing Orders will receive immediate re-education or progressive actions as appropriate. **Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring programs was initiated by the Quality Assurance Committee. It will be supervised by the DON, and will be implemented as follows:** The DON will review the results of above stated audits of the daily "BM Roster" and report the data and any identified trends or patterns to the QA committee monthly for 6 months to include data from June through November 2013. The QA committee will determine if further intervention or systemic changes are needed to assure sustained compliance with F 309.	

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F 309	Continued From page 9 resident's name to a bowel movement log in any case there has not been documented a bowel movement in three days. Every morning, day nurses are to look at the bowel movement log and administer 2 Dulcolax at about 6:30 AM for the residents entering the 4th day without a documented bowel movement. The nurse is then to document the medication on the bowel movement log, as well as on the resident's medication administration record (MAR). If there are no results from the Dulcolax pills, the resident is given a Dulcolax suppository that afternoon and the nurse is to document that treatment on the bowel movement log as well as on the resident's MAR. If there are no results from the Dulcolax suppository by the next morning, the resident is to be given a Fleets enema and the nurse is to document that on the bowel movement log and also on the resident's MAR. After reviewing Resident #117's MAR, the nursing supervisor reported the correct protocol for bowel movements had not been followed and he should have been added to the bowel movement log on the night of 05/09/13 and given the Dulcolax pills on 05/10/13 when he had not had a bowel movement for three days. The RN Supervisor/Acting DON stated that when no bowel movement has been documented, the bowel protocol is to be initiated without exception.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** Leg Straps were applied to both resident #49 and #148 on 5/23/13. On 5/27/13, CNA #4 received interventions including detailed re-education and visual	6/13/13

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F 315	Continued From page 10 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and resident and staff interviews the facility failed to place leg straps to secure urinary catheters for 2 of 3 residents, Residents # 49 and #148. The facility staff also failed to secure catheter tubing prior to wiping for 1 of 3 residents observed with catheters, Resident #49. The findings include: 1. Resident #49 was admitted to the facility on 01/09/13 with diagnoses that included chronic respiratory failure, respirator dependency, tracheotomy and urinary catheter. The most recent Minimum Data Set (MDS) dated 04/24/13 indicated the resident had long and short term memory problems and rarely made decisions. The MDS further specified the resident was dependant for activities of daily living (ADL) and had a urinary catheter. An observation was made on 05/22/13 at 10:30 AM of catheter care for Resident #49. During catheter care it was noted the resident did not have on a leg strap to secure the catheter and prevent tugging. While cleaning the catheter NA #4 did not secure the catheter next to the resident's body prior to wiping the catheter tubing away from the resident's body. An interview was conducted on 05/22/13 at 2:27	F 315	instruction from Nursing Supervisor on properly securing urinary catheter tubing when providing care to residents with catheters and received personnel action . **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** The Nursing Supervisor checked all residents with urinary catheters for the use of leg straps. Leg straps were placed on residents that were not wearing one except the residents who refused to have them. The refusals were documented in each resident's medical record. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** In-service training provided by the Nursing Supervisors and DON for Nursing and CNA staff for use of urinary leg straps unless refused or contraindicated and for proper anchoring of urinary catheters while giving care to prevent pulling. The DON or designee will observe care by CNA staff for 5 residents with urinary catheters weekly X 4 weeks then 10 X monthly for 4 months. The resident will be observed for leg strap usage (unless documented refusal or contraindication) and proper anchoring of the tubing by the CNA to prevent pulling during care. Any issues with care provided or use of leg strap will be identified, documented, and corrected during observation by the Nurse observing care. Staff involved will be re-educated or issued other progressive measures as necessary.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HWY 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 315	Continued From page 11 PM with NA #4. She stated she should have secured the catheter next to the resident's body prior to wiping the catheter tubing. She further stated that would hurt [the resident]. She further stated that she usually does secure the tubing prior to wiping. She did not give an explanation as to why she did not secure the tubing prior to wiping. NA #4 did not mention why Resident #49 did not have a leg strap to help secure the catheter. On 05/23/13 at 4:14 PM an interview was conducted with the acting Director of Nursing (DON). The DON stated there is not a leg strap policy at this time. She further stated Resident #49 did not have a leg strap on her catheter and she should have one. She stated anyone with a urinary catheter could benefit from having a leg strap to secure the catheter. 2. Resident #148 was admitted to the facility on 03/06/12 with diagnoses that included chronic respiratory failure, respirator dependency, tracheotomy and neurogenic bladder. The most recent Quarterly Minimum Data Set (MDS) dated 04/24/13 assessed Resident #148 as needing extensive assistance with all activities of daily living. The MDS further assessed him as having a urinary catheter. An observation was made on 05/23/13 at 4:20 PM of Resident #148 revealed he did have a catheter and he was not wearing a leg strap to secure the catheter. During an interview on 05/23/13 at 4:20 PM with Resident #148 he confirmed that sometimes the catheter tugged and pulled. He stated it was painful when this occurred.	F 315	**Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring program was initiated by the Quality Assurance Committee. It will be supervised by the DON, and will be implemented as follows:** The DON will monitor the results of above stated audits and report the results and any identified trends or patterns to the QA committee monthly for 6 months to begin with data collected in June and end with data collected through November 2013. The QA committee will determine if further intervention or systemic changes are needed to assure sustained compliance with F 315.	

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F 315	Continued From page 12 An Interview was conducted on 05/23/13 at 4:25 PM with the acting Director of Nursing (DON). The DON stated Resident #148 should have a leg strap to secure his catheter especially if not having one was causing him discomfort.	F 315		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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.	F 356	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** The form "Daily Nursing Staff for Valley Nursing Center" was revised immediately on 5/23/13 and posted correctly when we were informed that the posted form was incorrect. **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** The form "Daily Nursing Staff for Valley Nursing Center" was revised immediately on 5/23/13 to include not only the total hours worked per discipline (RN, LPN, and CNA) per shift, but also the actual number of (RN, LPN, and CNA) employees per discipline per shift. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** The form was revised and the Staffing Coordinator and Medical Records Clerk were educated on the need to include not only the total hours worked per discipline (RN, LPN, and CNA) per shift, but also the actual number of employees working per discipline each shift.	5/23/13

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F 356	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post the actual number of licensed and unlicensed nursing staff for the 4 days of the recertification survey. Findings included: On 05/20/2013 at 11:00 AM, an initial tour of the facility was conducted. On the bulletin board, on the right side of the first hall after entering the building was posted the census and staffing sheet: "Daily Nurse Staffing For Valley Nursing Center." The facility resident census and hours worked by licensed and unlicensed nursing staff was posted; however the actual number of licensed and unlicensed nursing staff working for all three shifts was not recorded on the staffing sheet. Subsequent observations of the daily posted census and staffing sheet were made on 05/21/2013 at 8:30 AM; 05/22/2012 at 8:30 AM; and 05/23/2013 at 8:30 AM. The census and staffing sheet did not include the number of licensed and unlicensed nursing staff for any of the three shifts working in the facility on any of the days posted. An interview on 05/23/2013 at 9:15 AM with the Assistant Administrator revealed the Staffing Coordinator was the one who generated and posted the nurse staffing sheet for the bulletin board. The Assistant Administrator confirmed the facility had done it this way ever since the mandate had come out. She noted the nursing	F 356	**Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring programs was initiated by the Quality Assurance Committee. It will be supervised by the Assistant Administrator, and will be implemented as follows:** The Staffing Coordinator and the Medical Records clerk will ensure that this form is filled in with all of the required elements daily before posting. The Assistant Administrator will review the form for accurate completion 4 times weekly for 4 weeks and then twice weekly for 1 month and record results to ensure that all required elements are filled in correctly. The Assistant Administrator or her designee will compile collected data from the above stated audit and present the results to the Quality Assurance Committee monthly for a minimum of 2 months. To begin 6/03/13 and end with data collected through July 2013. **The QA committee will review the results of this audit, evaluate effectiveness, and recommend changes or extend monitoring if needed to assure compliance is sustained with F356.**	

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F 356	Continued From page 14 staff worked different shift hours so they posted total hours to cut down on confusion. An interview on 05/23/2013 at 9:25AM with the Staffing Coordinator revealed she had office training and the former Staffing Coordinator had trained her to fill out the census and staffing form the way it was currently posted. She confirmed she had never been told to include the actual number of licensed and unlicensed nursing staff working for all three shifts in the 3 ½ years since she had been generating it.	F 356		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all 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. 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. 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. The facility must provide separately locked,	F 431	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** The undated vials were removed from storage and disposed of immediately by the Nursing Supervisor on 5/23/13. **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** All medication storage rooms and medication carts were thoroughly checked for other undated or expired medications on 5/23/13 by the Nursing Supervisors None were located. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** The Nursing Supervisors provided in-service training to Nurses and Medication Aides on	6/13/13

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F 431	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interviews the facility failed to date 2 of 3 open multi-dose vials of Tuberculin Purified Protein Derivative in 2 of 3 medication storage rooms and 1 open multi-use 20 ml vial of 1% Lidocaine HCL in 1 of 8 medication carts checked for storage. Findings included: The facilities policy for "Medication Storage in the Facility" effective 05/17/2010 was reviewed. The policy stated: "Injectable medications dispensed by pharmacy in multi-dose vials will be discarded thirty (30) days after opening or according to manufacturer recommended discard date. The medication will be noted with the date the med was initially opened." An observation of the main central medication room was made on 05/23/2013 at 10:55 AM. There was 1 multi-dose vial of Tuberculin Purified Protein Derivative (PPD) that was open, undated and available for use. Interview on 05/23/2013 at 10:56 AM with	F 431	dating vials when opening and discarding if undated. The Pharmacy staff conducted extensive in-service training for Nurses and Medication Aides including requirements for labeling, dating, and discarding multi-dose vials of medications. All new Nurses and Medication Aides will receive training by the DON or her designee specific to the requirements for dating and discarding opened multi-dose vials. The DON has implemented weekly audits of the medication storage areas as follows: Beginning 6/3/13 the Medication Storage Rooms and Carts will be audited by the DON or her designee 4 times weekly for 2 months, then 2 times weekly for 4 months, then once weekly thereafter to ensure no undated or expired drugs. Variances will be corrected if observed. **Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring programs was initiated by the Quality Assurance Committee. It will be supervised by the Assistant Administrator, and will be implemented as follows:** The DON will monitor the results of med storage audits and report the results and any trends or patterns to the QA committee monthly for 6 months (June through November 2013). **The QA committee will determine if further intervention or systemic changes are needed to assure sustained compliance with F 431.**	

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F 431	Continued From page 16	F 431		

Medication Aide #1, who was present in the medication storage room, revealed it was the facility policy to date a multi-dose vial when opened and discard after 30 days. She confirmed the PPD vial was open, not dated and available for use.

An observation was made on 05/23/2013 at 11:20 AM of 1 of 2 medication carts in use on the lower 400 hall revealed 1 open multi-use 20 ml vial of 1% Lidocaine HCL not dated.

An observation of the 600/Rehab hall medication room was made on 05/23/2013 at 11:35 AM. There was 1 of 2 multi-dose vials of PPD that were open, undated and available for use.

Interview on 05/23/2013 at 11:36 AM with the RN Supervisor, who was present in the medication storage room, confirmed the PPD vial was open, not dated and available for use. She revealed the facility policy was to date multi-dose vials when opened and discard after 30 days.

Interview on 05/23/2013 at 11:45 AM with the facility Pharmacist revealed multi-dose vials were to be stored in their packaging and if not dated should be discarded. She confirmed staff cannot make assumptions about when a multi-dose vial was opened if it was not dated.

Interview on 05/23/2013 at 12:15 PM with Nurse #1, Nurse for lower 400 hall carts, confirmed the 20 ml vial of 1% Lidocaine HCL multi-dose vial was open, undated and available for use. She revealed facility policy was multi-dose vials were suppose to be dated when opened.

Interview on 05/23/2013 at 1:50 PM with RN

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F 431	Continued From page 17 Supervisor and Acting Director of Nurses revealed she expected the nursing staff to follow the facility policy to properly date multi-dose vials when opened and discard items by facility expiration dates or if found not dated to discard the items.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:** The table in the room of resident #49 was cleaned and disinfected to remove contamination on 5/22/13. Resident #49 does not access her table herself and there was no negative outcome for resident #49. CNA #4 was re-educated on proper handling of dirty linen by the Nursing Supervisor and received administrative intervention. **Corrective actions taken for residents having the potential to be affected by the same alleged deficient practice:** Nursing Supervisors and DON conducted in-service training for CNA staff on proper handling of soiled linen to prevent contamination and spread of infection. **Measures taken and systems changed to prevent repeat of alleged deficient practice:** The DON or designated Administrative Nurse will observe direct resident care by CNA staff on various shifts, 5 times weekly for 4 months to ensure proper handling of soiled linen to prevent contamination of clean surfaces and prevent the	6/13/13

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F 441	Continued From page 18 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on facility policy, observations and staff interviews the facility failed to maintain infection control practices regarding soiled linen and cleaning of environmental surfaces during 1 of 2 observations of personal care. The findings included: The facility's Infection Control policy entitled "Laundry and Bedding, Soiled" dated October 2009 read in part, "Place contaminated laundry in a bag or container at the location where it is used. Further review of the Infection Control policy entitled "Standard precautions" dated December 2007, under the section "Linen" read in part, "Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments." An observation was made on 05/22/13 at 10:30 AM of incontinence/catheter care for Resident #49. During the observation of care Nursing Assistant #4 used a wash cloth to clean Resident #49's genital area. After wiping this area she laid the wet wash cloth down directly on the resident's over the bed table. She then cleaned the	F 441	potential to spread infections. Any variance from the proper procedures will be corrected during observations and the CNA will be re-educated. **Facility Monitoring to Assure Sustained Compliance:** **This Quality Assurance monitoring programs was initiated by the Quality Assurance Committee. It will be supervised by the DON, and will be implemented as follows:** The DON will review the results of above stated audits weekly and report the results and any identified trends or patterns to the QA committee monthly for a period of 6 months using data collected June through September 2013. **The QA committee will determine if further intervention or systemic changes are needed to assure sustained compliance with F 441.**	

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F 441	Continued From page 19	F 441		

resident's anal area with a clean wash cloth and again laid the wet wash cloth directly on the resident's over the bed table. When NA #4 was finished she wrapped the soiled wash cloths in a towel and NA #5 who was assisting disposed of the dirty linen outside of the room. NA #4 then wiped the over the bed table with a dry paper towel, washed her hands and exited the resident ' s room.

An interview was conducted on 05/22/13 at 2:27 PM with NA #4. NA #4 stated she was supposed to put the soiled wash cloths in a plastic bag. She stated she wiped the over the bed table down with a paper towel. She then stated she should have cleaned the table with disinfectant cleaner after sitting the dirty laundry on it.

An interview was conducted on 05/22/13 at 2:36 PM with the acting Director of Nursing (DON). The DON stated linens are to be bagged in a plastic bag after use. She went on to explain dirty linen should never be placed on the floor or any other surface in the room including the over the bed table. She stated her expectation was for the NA to have bagged the linen and cleaned the table with a Clorox wipe or she should have asked the housekeeper to clean the table.