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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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

E 000 Initial Comments

An unannounced Emergency Preparedness survey was conducted 01/23/18 through 01/26/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. Three complaints were investigated during the survey.

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 01/23/18 through 01/26/18. Three complaints were investigated during the survey.The facility was not in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirement(s). The Life Safety Code survey/report will follow.

The census in this 180 certified bed facility was 156 at the time of the survey. The final survey sample consisted of 13 current Resident reviews and 5 closed record reviews.

F 578 SS=D Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,

E 000 **The filing of this plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of corrections is filed as evidence to comply with requirements of participation and continue to provide high quality resident centered care.**

F 000

F 578 F578-D

1) **Corrective Action for those residents found to be affected by the alleged deficient practice**
Resident #27 status code was immediately updated to her preference of being a Full Code.

2) **Like Residents-** Residents residing in the center had the potential to be affected.

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

TITLE: Administrator

(X6) DATE: 2/23/18

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 578	Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review and the State Code of Virginia, the facility staff failed to have an accurate DDNR (Durable Do Not Resuscitate) for 1 of 31 residents in the survey sample (Resident #27). The findings included: The facility staff failed to have an accurate DDNR (Durable Do Not Resuscitate) in the clinical record for Resident #27. § 54.1-2987.1. Durable Do Not Resuscitate Orders states in part "D. If a	F 578	3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education completed to licensed nurses and social services to ensure that the code status in the resident chart is consistent with the physician order. 4) **Corrective actions to ensure that the deficient practice will not recur.** Director of Social Services or designee will audit current resident record and each new admission record to verify code status is consistent with physician orders and resident preference for 3 months. Audits findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance: 2/23/18	

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F 578	Continued From page 2	F 578		

patient is able to, and does, express to a health care provider or practitioner the desire to be resuscitated in the event of cardiac or respiratory arrest, such expression shall revoke the provider's or practitioner's authority to follow a Durable Do Not Resuscitate Order. In no case shall any person other than the patient have authority to revoke a Durable Do Not Resuscitate Order executed upon the request of and with the consent of the patient himself."

Resident #27 was admitted to the facility on 8/9/2016 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression, chronic renal failure, dialysis and psychotic disorder. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/3/17 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 2 staff member for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor performed a clinical record review on 1/24/18. It was noted by the surveyor that Resident #27 had a DDNR completed and signed on the front of the paper clinical record. The physician's orders dated December 2017 were also reviewed at that time. On the physician order sheet, the surveyor noted that Resident #27 was a "Full Code".

On 1/24/18 at approximately 5 pm, the surveyor notified the administrative team of the above documented findings. The DON (director of nursing) stated she would look into this and get

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F 578	Continued From page 3 back with the surveyor regarding the code status of the resident. On 1/25/18 at approximately 9 am, the DON provided a copy of a physician order written on 1/24/18 which stated the "Resident wishes to be Full Code status." The DON stated, "We spoke to the resident and she wishes to be a full code." No further information was provided to the surveyor prior to the exit conference on 1/26/18.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review it was determined the facility failed to provide appropriate food tray set-up for 1 of 13 residents (Resident #140) who was visually impaired. Findings. Facility staff failed to set-up Resident #140's tray for her in a manner that enabled the visually impaired resident to find and eat her foods. The resident's clinical record was reviewed on 1/24/18 at 4:00 PM Resident #140 was admitted to the facility on 12/15/17. Her diagnoses included: Blindness, hypertension, anxiety, and depression.	F 677	F677-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice** CNA II immediately educated on resident #140 "legally blind" diagnosis and the need to describe resident tray set up at each meal. 2) **Like Residents** Residents with visual deficits have the potential to be affected. 3) **Systemic changes put into place to ensure the alleged deficient practice does not recur.**	

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F 677	Continued From page 4	F 677		

The latest MDS (minimum data set) dated 1/12/18 coded the resident with highly impaired vision. She was coded with some cognitive impairment with respect to her memory. The resident's communication skills were unimpaired.

Resident #140 required the assistance of at least one staff member for all the ADLS (activities of daily living). She was coded as able to eat independently with a tray set-up by staff.

The resident's CCP (comprehensive care plan) reviewed and revised 12/27/17 documented the problem of impaired vision related to legally blind d/t/ macular degeneration. A second problem was the potential risk for developing compromised nutritional status related to increased needs for healing. The interventions recommended for staff were as follows:
1. Describe the set-up of meal tray to facilitate seal-feeding.
2. Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals.
3. Honor food preferences.
4. If meals refused, offer/provide extra nourishments.

Resident #140's physician orders, signed and dated on 1/5/18, documented the resident was "Legally Blind". The physician had ordered a regular diet with no food restrictions.

On 1/24/18 at 1:10 PM the surveyor was in Resident #140's room when her tray was delivered by CNA II. The CNA placed the tray on the overbed table and took the lid off the food. She opened the coffee but did not open the milk carton. The CNA did not cut up the resident's

Education completed by the Director of Nursing/Designee to nursing department regarding providing the visually impaired with assistance and set up of meal tray to facilitate self feeding if applicable.

4) **Corrective actions to ensure that the deficient practice will not recur.**

Director of Nursing/Designee will complete meal observations each meal 3x week x 3 months.

Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance-2/23/18

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F 677	Continued From page 5	F 677		

meat (turkey with gravy) or tell her where her food selections were on her tray. A sandwich, still in the wrapper was set off to the right side of the plate.

The surveyor asked the resident why she was not eating her foods and mentioned the turkey with gravy looked very good. The resident told the surveyor she did not like turkey or gravy and couldn't see to cut it up even if she did want it.

The surveyor asked the resident if she wanted her (unopened) milk which was set at the back of the tray behind the plate. The resident responded, "What milk, I cannot see it." The roomate spoke up and told the surveyor that Resident #140 could not see.

The resident went on to tell the surveyor she did like beef, but never chicken or turkey and never any gravy. She stated, "It's hard to eat when you don't feel good and can't cut up your food."

Resident #140 said she usually found her food with the assistance of her roommate--who could see what she had and tell her where to find it. The resident's roommate told the surveyor she would help Resident #140 find her foods on her tray, because the CNAs did not tell her where it was.

At 1:55 PM, the surveyor was in the room when CNA II picked up Resident #140's tray and returned it to the kitchen. The resident told her she didn't like turkey or gravy. CNA II observed the food was uneaten and the milk still unopened and did not ask the resident if she wanted a substitute meal--or even leave behind the untouched sandwich.

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F 677	Continued From page 6	F 677		

On 1/25/18 the DON was informed of these observations and asked about Resident #140's tray set-up and choice of foods. The DON said the staff had been trained to deliver food to visually impaired residents by using the "face of the clock" as an example. They should be telling the resident if her meat is at six o'clock and peas are at nine o'clock, etc.

At 10:28 AM the DON reported back to the surveyor that she had spoken to CNA II and CNA I and both of them acknowledged they were supposed to use the face of the clock to tell the resident where her food was located. "They don't practice what they preach. When I asked about the unopened milk the CNA told me she never opened it because the resident never drank it anyway. My question to her was if she doesn't want milk--why didn't you offer her something else?"

The DON said the resident's preferences were not honored and the staff did not offer adequate assistance to set-up her tray.

On 1/25/18 at 11:30 these observations were shared with the administrator and DON.

F 692 SS=D Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

F 692 F692-D

1) Corrective Action for those residents found to be affected by the alleged deficient practice.

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F 692	Continued From page 7	F 692		

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to follow physician prescribed fluid restrictions for 1 of 31 residents in the survey sample (Resident # 27).

The findings included:

The facility staff failed to follow physician prescribed fluid restrictions for Resident #27.

Resident #27 was admitted to the facility on 8/9/2016 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression, chronic renal failure, dialysis and psychotic disorder. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/3/17 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #27 was also coded as requiring extensive assistance of 2 staff member for dressing, extensive assistance of 1 staff member

Cited Resident #27- Order clarification on fluid restriction was completed and placed on the medication administration record.

2) **Like Residents**

Audit completed on residents with fluid restriction orders and corrected as appropriate. Review completed by the Registered Dietician/Director of Nursing.

3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**

Education to licensed nurses and dietary management on indicating the amount of fluid allotted for distribution with medications and meals on each shift.

4) **Corrective actions to ensure that the deficient practice will not recur.**

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F 692	Continued From page 8	F 692		

for personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor reviewed the clinical record of Resident #27 on 1/24 and 1/25/18. During the clinical record review, the surveyor noted on the MAR (Medication Administration Record) dated for 1/1/18 through 1/31/18; the surveyor noted the following documentation:

" ..." Fluid Restriction : Total 1500 ml (milliliters) Kitchen : 600 ml Nursing 900 ml ..."

The boxes under each date for the month of January 2018 were left blank. There was no other documentation found in the clinical record that referred to the fluid restriction that the physician had ordered or to the amounts that the resident had consumed in a 24-hour period.

On 1/24/18 at approximately 5 pm, the surveyor notified the DON (director of nursing) of the above documented findings. The surveyor also requested a copy of the facility's policy on documentation of fluid restriction for a resident.

At 6 pm, the DON provided the surveyor with a copy of the facility's policy titled "Fluid Restriction Management" under the section of "Process" the surveyor noted the following:

" ...3. The nurse or designee will document the fluid restriction order on the MAR (Medication Administration Record)

4. The nurse will document the maintenance of prescribed fluid restriction each shift on the MAR

5. The nurse will oversee documentation of the actual fluid intake on each shift and monitor to insure that restriction is maintained ..."

Director of Nursing/designee will complete audits on current and new residents with fluid restrictions to ensure fluids are allocated between dietary and nursing departments and placed on MARs weekly x 3 months and then monthly.

Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance-2/23/18

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F 692	Continued From page 9	F 692		

The surveyor interviewed the DON after the copy of the policy was provided. The surveyor asked the DON if the nursing staff monitored the fluid restriction of the resident according to this policy. The DON stated, "No, they did not."

No further information was provided to the surveyor prior to the exit conference on 1/26/18.

F 698 SS=D Dialysis
CFR(s): 483.25(l)

§483.25(l) Dialysis.
The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain communication and collaboration in regards to dialysis for 1 of 31 residents in the survey sample (Resident #27).

The findings included:

Resident #27 was admitted to the facility on 8/9/2016 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression, chronic renal failure, dialysis and psychotic disorder. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/3/17 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #27 was also coded as requiring

F 698 F698-D

1) **Corrective Action for those residents found to be affected by the alleged deficient practice.**

Cited Resident #27- Communication with the dialysis center management on ensuring that the communication form is properly completed.

2) **Like Residents**
Residents who receive offsite hemodialysis services have the potential to be affected.

3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**

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F 698 Continued From page 10

extensive assistance of 2 staff member for dressing, extensive assistance of 1 staff member for personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor conducted a review of Resident #27's clinical record on 1/24 and 1/25/18. During this review, the surveyor noted that the documentation on the form titled "Dialysis Progress Notes" had documentation missing or left blank by the dialysis center staff. The dates of the notes was 1/13/18, 1/8/18, 1/5/18, 1/3/18 and 12/27/17.

On 1/26/18 at approximately 10 am, the surveyor notified the DON (director of nursing) of the above documented findings. The DON stated, "The dialysis center staff should had filled in this area that is left blank. The nurses here at facility should have called the dialysis center to obtain the missing information so that we would have the whole picture of the resident while at dialysis." The surveyor requested a copy of the contract with the dialysis center.

The DON provided a copy of the dialysis contract to the surveyor at 11 am. Under #5, section D, the contract read in part ..."To provide to the Nursing Facility information in all aspects of the management of the residents care related to the provision of dialysis services ..." The DON also provided the surveyor with a copy of the facility's policy titled "Hemodialysis Pre and Post Care". Under section titled "Purpose" , the surveyor noted the following documentation that read in part ..."To establish guidelines for communication with the dialysis center to ensure continuity of care to residents requiring hemodialysis ..."

F 698

Education to Licensed nurse managers to ensure that the dialysis communication form is filled out upon return by the dialysis facility.

4) **Corrective actions to ensure that the deficient practice will not recur.**

Director of Nursing or designee will complete audits of dialysis communication forms 3x week x 3 months.

Audit findings will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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F 698	Continued From page 11 No further information was provided to the surveyor prior to the exit conference on 1/26/18.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755	F755-D **1) Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited Medication box was immediately removed from facility by pharmacy services. **2) Like Residents** Narcotic medications delivered in medication boxes by pharmacy services have the potential to follow the same practice. **3) Systemic Changes put into place to ensure the alleged deficient practice does not recur.** Education to pharmacy transportation to ensure that all medications are securely locked as appropriate when delivering to the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 755	Continued From page 12 Based on observation, staff interview and facility document review, the facility staff failed to establish a system of records of receipts and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of medication deliveries in 1 of 3 medication storage rooms Unit 1. The findings included: The facility staff failed to ensure a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation on 1 of 3 medication storage rooms Unit 1. The surveyor and licensed practical nurse #5 checked the medication storage room on unit 100. L.P.N. #5 stated the facility has a Pixus where all medications were kept. While checking the medication room, the surveyor observed an orange tool box that did not contain any type of lock. When L.P.N. #5 opened the tool box, a vial of Morphine Sulfate 100 mg/5 ml (20 mg/ml) with a syringe was found inside a clear, plastic box within the tool box. LPN #5 thinks it's a refill for the Pixus but stated the morphine sulfate should still be locked up. L.P.N. #5 stated she would put a tie back on the tool box. The surveyor asked for the manifest for the morphine sulfate. 01/24/18 07:54 AM The surveyor interviewed the DON. She stated she thinks the tool box was tied when it arrived at the facility. The tool box does not have a list of contents. The DON stated nurses cannot put medications in the Pixus. The DON stated the pharmacist from Richmond was made aware of the concern. Nurses do not have access to the Pixus to load the drugs. The	F 755	**4) Corrective actions to ensure that the deficient practice will not recur.** Director of Nursing/designee will complete audits of locked medication boxes on facility delivery days weekly for 3 months to ensure box is properly secured. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance:2-28-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 755	Continued From page 13	F 755		

surveyor requested the facility policy on medication storage and the pharmacy manifest for the morphine sulfate from the DON.

01/24/18 03:07 PM The surveyor spoke with other #1, Care 1 pharmacy accountant. Other #1 stated the pharmacy was trying to figure out why/when the Morphine Sulfate was sent to facility. Other #1 stated the pharmacy was trying to figure out if the driver may have left the wrong box. Two ties are supposed to be used and a lock for narcotics. Other #1 stated she was awaiting pharmacy manifest. Other #1 stated a local technician (other #2) was supposed to switch out the tool boxes over the weekend but she didn't. She came in early this morning and did that. The facility staff have no idea where the MS is currently. Registered nurse #3 stated the nurse has to call and get a code to get narcotics out of the Pixus. The surveyor asked other #1 who was called and got the code to unlock the tool box/ties. The surveyor asked other #1 if there should be a trail/manifest of what code was used to access the tool box? Are the locks coded with a #? Is there a log kept who provides the code and access to the locked tool box?

01/25/18 08:18 AM The surveyor spoke with the DON. The DON stated she had not yet received the manifest for the MS. The DON stated she had no clue what was in the box. "There was no label." The DON stated the tool boxes are sealed containers with a zip tie. "I've never seen a lock on any of the tool box."

01/25/18 10:30 AM The surveyor spoke with the DON. The facility manifest was dated 1/19/18. The manifest had no identifiable information as to who filled the RX at the contracting pharmacy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 755	Continued From page 14 name and date (all blank) and did not have a signature as to when received, name, and date at the nursing home facility. The surveyor requested the facility policy on the process of receiving medications from the pharmacy. No further information was provided prior to the exit conference on 1/26/18.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure 3 of 31 residents	F 757	F757-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited Residents #304, #129, and #1- MD/RP notified of omitted documentation of insulin coverage/blood sugar results, with no new orders or concerns. 2) **Like Residents** Diabetic residents who receive insulin have the potential to be affected. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 757	Continued From page 15	F 757		

were free of an unnecessary medication (Resident #304, Resident #129, and Resident #1).

The findings included:

1. The facility staff failed to follow the physician ordered parameters for the administration of Humalog insulin based on blood sugars ordered four times a day (before meals and at bedtime) for Resident #304.

Resident #304 was admitted to the facility 1/16/18 with diagnoses that included but not limited to CVA, diabetes mellitus, hyperlipidemia, dementia, chronic back pain, atrial fibrillation, hypertension, acute renal failure, hypercalcemia, and gastroesophageal reflux disease.

Resident #304's admission minimum data set (MDS) was not completed.

Resident #304's current comprehensive care plan dated 1/22/18 identified an area of focus for endocrine system related to Insulin Dependent Diabetes and interventions/tasks included administer medications per physician orders.

Resident #304's physician orders dated 1/16/18 read in part "Check BS (blood sugar) qid (four times a day) AC (before meals) & HS (bedtime). A second order dated 1/19/18 read in part "Humalog by sliding scale in addition to bid (twice a day) 0-150 no units; 151-200=2 units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units; > (greater than) 400 12 units and call MD."

The surveyor reviewed the January 2018 Diabetic

Education completed by the Director of Nursing/Designee to Licensed Nurses on the Blood Glucose Monitoring protocol to include recording results on blood glucose monitoring sheets, on charting and documentation policy, the charting errors, and/or omissions policy.

4) **Corrective actions to ensure that the deficient practice will not recur.**

Director of Nursing/Designee will complete diabetic flowsheet audits 3x week x 3 months to ensure proper insulin coverage is given. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 2/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
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F 757	Continued From page 16	F 757		

Flowsheet on 1/25/18 at 11:51 a.m. On 1/20/18 at 11:30 a.m., the blood sugar reading was 293. In the column for the amount of insulin to be administered there was a dash mark. The initials were JL. Based on the sliding scale orders, Resident #304 should have been administered 6 units of Humalog.

01/25/18 12:17 PM The surveyor requested the assistance of the unit manager registered nurse #1. Upon reviewing the blood sugar result, R.N. #1 stated there was no insulin recorded. R.N. #1 stated that she would have the nurse with the initials "JL" speak with the surveyor.

The surveyor interviewed licensed practical nurse #2 on 01/25/18 12:24 PM. L.P.N. #2 stated "I gave it." The surveyor asked how the surveyor would know if a medicine had been administered. L.P.N. #2 stated "You wouldn't." A review of the progress notes for 1/20/18 did not identify a note concerning blood sugars and insulin administration.

On 1/23/18 at 9:00p.m., the blood sugar reading was 259. In the column for the amount of insulin to be administered, "20 scheduled" was written. Based on the sliding scale insulin, Resident #304 should have received 6 units of Humalog in addition to the 20 units of Humalog scheduled. The surveyor informed the unit manager registered nurse #1 of the above concern. R.N. #1 reviewed the documentation and stated "You're right. There's no sliding scale insulin documented."

The surveyor informed the director of nursing of the above concern with diabetic management on 1/26/18 at 8:51 a.m. and requested the policy on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 757	Continued From page 17	F 757		

diabetic management.

The facility policy title "Diabetes-Clinical Protocol" was reviewed 1/26/18. The policy read in part "Monitoring and Follow-Up 4. The Physician will order desired parameters for monitoring and reporting related to diabetes or blood sugar management. a. The staff will incorporate such parameters into the Medication administration record and care plan."

The facility policy titled "Insulin Administration" was also reviewed 1/26/18. The policy read in part "Steps in the Procedure 2. Check blood glucose per physician order or facility protocol. 8. Check the order for the amount of insulin. 12. Double check the order for the amount of insulin. 15. Recheck that the amount of insulin drawn into the syringe matches the amount of insulin ordered. Documentation 1. The resident's blood glucose result, as ordered: 2. The dose and concentration of the insulin injection; 4. Injection site."

No further information was provided prior to the exit conference on 1/26/18.

2. The facility staff failed to follow the physician ordered parameters for the administration of Humalog insulin based on blood sugars ordered four times a day (before meals and at bedtime) for Resident #129. The facility staff failed to obtain a blood sugar on 1/24/18 at 11:30 a.m.

The clinical record of Resident #129 was reviewed 1/26/18. Resident #129 was admitted to the facility 8/4/16 and readmitted 7/31/17 with diagnoses that included but not limited to right leg above the knee amputation, type 2 diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 757	Continued From page 18	F 757		

mellitus, hypertension, major depressive disorder, convulsions, insomnia, gastroesophageal reflux disease, hyperlipidemia, chronic kidney disease, and peripheral vascular disease.

Resident #129's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/7/18 coded the resident with a BIMS of 12/15.

Resident #129's current comprehensive care plan dated 1/10/18 included the focus area of endocrine system related to Insulin Dependent Diabetes and hx (history of) hypothyroidism. Interventions: Administer medications per physician orders, obtain glucometer readings and report abnormalities as ordered.

Resident #129's January 2018 physician orders were reviewed. The physician orders read "Humalog Kwikpen 100 unit/ml (milliliter) sol (solution) fingerstick blood sugar before meals and at bedtime, inject subcutaneously per sliding scale for diabetes. Humalog Kwikpen 100unit/ml sol 151-200=3units; 201-250=5 units; 251-300=7 units; 301-350=9 units; 351-400=11 units; greater than 400=13 units."

The surveyor reviewed the January 2018 Diabetic Flowsheet. On 1/24/18 at 11:30a.m., the flowsheet did not contain the results of a blood sugar. The surveyor informed the unit manager registered nurse #1.

The surveyor informed the DON of the above concern with diabetic management on 1/26/18 at 8:51 a.m. The DON stated "Let me see if she was out of the building. Her sister sometimes takes her out." Upon reviewing the clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 757	Continued From page 19	F 757		

record, the DON stated she was not out of the facility.

No further information was provided prior to the exit conference on 1/26/18.

3. The facility staff failed to follow the physician ordered parameters for the administration of sliding scale insulin for Resident #1. The facility staff administered the incorrect amount of insulin on 1/18/18 at 11:30 a.m.

The clinical record of Resident #1 was reviewed 1/26/18. Resident #1 was admitted to the facility 12/20/11 and readmitted 1/3/17 with diagnoses that included but not limited to hypertension, type 2 diabetes mellitus, gastroesophageal reflux disease, chronic pain, Vitamin B12 deficiency, insomnia, Vitamin D deficiency, dysphagia, polyneuropathy, and blindness right eye.

Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/17/17 assessed the resident with a BIMS of 11/15 in Section C.

Resident #1's current comprehensive care plan reviewed 1/25/18 included the focus area of endocrine system related to Insulin Dependent Diabetes and hx (history of) hypothyroidism. Interventions: Administer medications/insulin per physician orders, obtain glucometer readings and report abnormalities as ordered

The surveyor reviewed Resident #1's clinical record on 1/26/18 at 8:35 AM. Resident #1's physician orders read for diabetic management as follows: Humalog Kwikpen 100units/ml (milliliter) sol (solution) Fingerstick blood sugar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 757	Continued From page 20	F 757		

before meals & at bedtime, 1 dose subcutaneously per sliding scale use as directed for diabetes. Humalog Kwikpen 100unit/ml sol: 150-200=4 units; 201-250=7 units; 251-300=11 units; 301-400=16 units; > 400=22 units. Do not need to notify MD.

The surveyor reviewed the January 2018 Diabetic Flowsheets. On 1/18/18 at 1130 a.m., the blood sugar was 274 and 7 units of Humalog insulin were documented. Based on the physician order, 11 units of Humalog insulin should have been administered-not 7 as documented on the flowsheet. The surveyor interviewed the unit manager registered nurse #1 on 1/26/18 at 8:39 a.m. After reviewing the blood sugar flowsheet, R.N. #1 agreed an incorrect amount of insulin was given.

The surveyor informed the director of nursing of the above concern on 1/26/18 at 8:51 a.m.

No further information was provided prior to the exit conference on 1/26/18.

F 760 SS=D Residents are Free of Significant Med Errors
CFR(s): 483.45(f)(2)

F 760 F760-D

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow physician orders for the administration of medication for 2 of 31 residents (Resident #304 and Resident #40).

1) Corrective Action for those residents found to be affected by the alleged deficient practice.

Cited Residents #304, and #40 physician and responsible party notified with no new orders or concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 760	Continued From page 21 The findings included: 1. The facility staff failed to follow physician orders for Resident #304's administration of Digoxin. The physician order read "Digoxin 125 mg (milligrams) 1 tab (tablet) po (by mouth) q (every) day Hold for HR (heart rate) < (less than) 60-a fib." Licensed practical nurse #1 failed to obtain the heart rate prior to the administration of Digoxin. The surveyor observed a medication pass on 1/24/18 with licensed practical nurse #1. L.P.N. #1 prepared ten medications for Resident #304 including Digoxin 0.125 mg. L.P.N. #1 administered Resident #304's digoxin on 1/24/18 at 8:52 a.m. L.P.N. #1 did not obtain the heart rate of Resident #304 prior to administering the Digoxin. The surveyor interviewed L.P.N. #1 on 01/24/18 11:41 AM. L.P.N. #1 stated "I did not check pulse prior to giving the digoxin. I usually check a radial pulse. I've already self- reported myself to the DON." The surveyor informed the director of nursing of the concern with the medication pass on 1/24/18 at 12:00 noon and requested the facility policy on medication administration and the facility standards of nursing practice for administration of Digoxin. The surveyor reviewed the facility policy on medication administration on 1/24/18 at 2:27 p.m. The policy titled "Administering Oral Medications" read "6. Check the label on the medication and confirm the medication name and dose with the MAR. 13. Perform any pre-administration	F 760	2) **Like Residents** Residents who receive digoxin and residents who are on insulin have the potential to be affected. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur** Education completed by the Director of Nursing/Designee with licensed nurses to ensure apical pulse is obtained before administration of applicable medication and following sliding scale coverage. 4) **Corrective actions to ensure that the deficient practice will not recur.** Director of Nursing or designee will complete audits of medication administration observations to ensure appropriate vital signs are obtained and medications administered as ordered 3x week x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 760	Continued From page 22	F 760	Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance: 2/23/18	

assessments."

The DON provided the surveyor on 1/24/18 the policy titled "Examples of Medications Requiring Blood Pressure and/or Pulse Rate Monitoring Include but Limited to the Following:"

II. A Daily Pulse is recommended with the use of the following group of medications:

A. Cardiac Glycosides

Brand name	Generic Name
Crystodigin	Digitoxin
Lanoxin	Digoxin
Lanoxicaps	Digoxin

No further information was provided prior to the exit conference on 1/26/18.

Resident #304 was admitted to the facility 1/16/18 with diagnoses that included but not limited to CVA, diabetes mellitus, hyperlipidemia, dementia, chronic back pain, atrial fibrillation, hypertension, acute renal failure, hypercalcemia, and gastroesophageal reflux disease.

Resident #304's admission minimum data set (MDS) was not completed.
2. The facility staff failed to administer insulin to Resident #40 as ordered by the physician.

Resident #40 was readmitted to the facility on 11/6/17 with the following diagnoses of, but not limited to anemia, coronary artery disease, heart failure, high blood pressure, diabetes and end stage renal disease. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/13/17 coded the resident as having a BIMS (Brief Interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 760	Continued From page 23	F 760		

Mental Status) score of 13 out of a possible score of 15. Resident #40 was also coded as requiring limited assistance of 1 staff member for dressing and personal hygiene

The surveyor performed a review of the resident's clinical record on 1/25/18. The "Diabetic Flowsheet" for the month of January 2018 was also reviewed. The surveyor noted the following documentation as to the amount of insulin the resident received for the following dates and times: 1/1/18 at 4:30 pm Blood sugar was 223 with no insulin given, 1/4/18 at 11:30 am Blood sugar was 115 with 2 units of insulin given, 1/7/18 at 4:30 pm Blood sugar was 214 with 6 units of insulin given and 1/22/18 at 11:30 am Blood sugar was 195 with no insulin given.

The surveyor also reviewed the physician orders for insulin on 1/25/18. The orders for insulin were as follows per sliding scale:

" "151 to 200 2 units
201 to 250 4 units
251 to 300 6 units
301 to 350 8 units
351 to 400 10 units
If BS (blood sugar) >400, give 12 units of insulin and notify MD (medical doctor) ..."

When the surveyor reviewed the physician orders for insulin and compared it to the above sliding scale for the amount of insulin to be given, the surveyor noted that the above documented units of insulin was given incorrectly by the facility staff to Resident #40.

The surveyor notified the DON (director of nursing) of the above documented findings on 1/25/18 at approximately 5 pm in the conference

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 760	Continued From page 24 room. No further information was provided to the surveyor prior to the exit conference on 1/26/18.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to label and date opened bottles of medication and failed to discard medications	F 761	F761-E 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** All undated and expired medications were immediately dated or discarded. 2) **Like Residents** Medication carts/refrigerators were audited immediately for expired meds/vials. Also audited for proper dating of vials/medications.-Review completed by the Director of Nursing/designee. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

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F 761	Continued From page 25	F 761		

when they were expired for 4 of 31 residents (Resident #62, Resident #86, Resident #251, and Resident #129) and failed to ensure narcotics were stored in a permanently affixed compartment in 1 of 3 medication storage rooms (Unit 1).

The findings included:

A). The facility staff failed to date medications when opened and failed to discard medication that had expired.

The surveyor toured the first floor and observed both of the medication carts beginning at 01/23/18 06:14 PM.

The surveyor and licensed practical nurse #5 checked medication cart #1 and checked the insulins for dates when opened and found the Levemir Flex Touch pen for Resident #129 was not dated when opened. L.P.N. #5 stated insulin pens were supposed to be dated when opened. L.P.N. #5 stated insulin pens were good for 30 days after opening. "I will waste this one," L.P.N. #5 stated.

The surveyor and L.P.N. #5 also observed a bottle of eye drops for Resident #62. Combigan sol 0.2% had no date when opened on the box or on the bottle. L.P.N. #5 stated medications opened were supposed to be dated when opened.

The surveyor and L.P.N. #5 observed an opened inhaler (ProAir HFA) for Resident #86 that did not have a date when opened. L.P.N. #5 stated the inhaler was to be dated when opened.

Education completed by the Director of Nursing/Designee with licensed nursing staff on dating vials/medications after opening & discarding vials/medications before expiration dates.

4) **Corrective actions to ensure that the deficient practice will not recur.**

Director of Nursing or designee will complete medication cart/refrigerator audits 3x week x 3 months and then monthly x 2.

Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 761	Continued From page 26	F 761		

The surveyor and licensed practical nurse #3 checked the medication cart on the dementia care unit at 01/23/18 07:01 PM. The medication cart contained an insulin pen for Resident #251 for Humalog 100 unit/ml dated 12/20/17. L.P.N. #3 stated she thought the insulin pen was good for 28 days. The surveyor asked L.P.N. #3 if the insulin pen had expired. L.P.N. #3 stated "Yes."

The surveyor requested the facility policy on labeling and dating drugs, medication storage and insulin from the director of nursing on 1/24/18 at 7:54 a.m. The DON stated she would expect nurses to date medications when opened.

The surveyor reviewed the facility policy titled "Medication Labeling" on 1/25/18 at 10:27 a.m. The policy read in part "All resident specific medications will be labeled with the following minimum information: k) expiration date."

The surveyor reviewed the Drug Storage Requirements" for insulin on 1/25/18 at 1:58 p.m. Humalog (Insulin Lispro) read to discard after 28 days after 1st use. Levemir (Insulin Detemir) read to discard after 42 days.

The surveyor reviewed the facility policy titled "Insulin Administration" on 1/26/18. The policy read in part "4. Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on vial (follow manufacturer's recommendations for expiration after opening."

B). The facility staff failed to ensure narcotics were firmly affixed in 1 of 3 medication storage rooms Unit 100.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 761	Continued From page 27	F 761		

The surveyor and licensed practical nurse #5 checked the medication storage room on unit 100. L.P.N. #5 stated the facility has a Pixus where all medications were kept. While checking the medication room, the surveyor observed an orange tool box that did not contain any type of lock. When L.P.N. #5 opened the tool box, a vial of Morphine Sulfate 100 mg/5 ml (20 mg/ml) with a syringe was found inside a clear, plastic box within the tool box. LPN #5 thinks it's a refill for the Pixus but stated the morphine sulfate should still be locked up. L.P.N. #5 stated she would put a tie back on the tool box.

01/24/18 07:54 AM The surveyor interviewed the DON. She stated she thinks the tool box was tied when it arrived at the facility. The tool box does not have a list of contents. The DON stated nurses cannot put medications in the Pixus. The DON stated the pharmacist from Richmond was made aware of the concern. Nurses do not have access to the Pixus to load the drugs. The surveyor requested the facility policy on medication storage from the DON.

01/24/18 03:07 PM The surveyor spoke with other #1, Care 1 pharmacy accountant. Other #1 stated the pharmacy was trying to figure out why/when the Morphine Sulfate was sent to facility. Other #1 stated the pharmacy was trying to figure out if the driver may have left the wrong box. Two ties are supposed to be used and a lock for narcotics. Other #1 stated she was awaiting pharmacy manifest. Other #1 stated a local technician (other #2) was supposed to switch out the tool boxes over the weekend but she didn't. She came in early this morning and did that.

01/25/18 08:18 AM The surveyor spoke with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 761	Continued From page 28 DON The DON stated she had not yet received the manifest for the MS. The DON stated she had no clue what was in the box. "There was no label." The DON stated the tool boxes are sealed containers with a zip tie. "I've never seen a lock on any of the tool box." 01/25/18 10:30 AM The surveyor spoke with the DON. The facility manifest was dated 1/19/18. The manifest had no identifiable information as to who filled the RX, name and date (all blank) and did not have a signature as to when received, name, and date at the facility. The surveyor requested the facility policy on process once received from the pharmacy. The current policy does not address that issue. The surveyor reviewed the facility policy titled "Storage of Medications" on 1/25/18. The policy read "Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others." No further information was provided prior to the exit conference on 1/26/18.	F 761		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.	F 800	F800-D **1) Corrective Action for those residents found to be affected by the alleged deficient practice.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 800	Continued From page 29	F 800		

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and facility staff interviews and clinical record review it was determined the facility staff failed to honor food preferences for 3 of 13 residents (Residents #140, 76 & 130).

Findings:

1. Facility staff failed to honor Resident #76's food preferences. The resident's clinical record was reviewed on 1/24/18 at 9:00 AM.

Resident #76 was admitted to the facility on 6/14/17. Her diagnoses included Parkinson's disease and depression.

The resident's latest MDS (minimum data set) assessment, dated 12/12/17 coded the resident as cognitively unimpaired. She required the assistance of at least one staff member to assist her with the ADLS (activities of daily living). She could eat unassisted with a tray set-up only by staff members.

The resident's CCP (comprehensive care plan) reviewed and revised on 12/12/17 documented the resident at risk for compromised nutritional status related to variable intake of meals and increased nutrient needs for healing. The staff interventions were recommended as follows:
1. Honor food preferences.
2. If meals refused, offer/provide extra nourishments.

The resident's physician orders, signed and dated on 1/2/18, contained an order for a regular diet. The resident was not restricted to her choice of

CNA I/II were immediately educated on reviewing tray card before meal setup, honoring food preferences, and offering substitutions.

2) **Like Residents**

Residents residing in the center had the potential to be affected.

3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**

Education completed by the Director of Nursing/Designee to CNAs to review tray cards to validate that resident is receiving the appropriate meal including preferences and offering substitutions if applicable.
Education completed by Culinary Services Manager to dietary staff to read tray cards and ensure that the residents are receiving their preferences as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 800	Continued From page 30	F 800	4) **Corrective actions to ensure that the deficient practice will not recur.**	

foods.

On 01/23/18 at 07:12 AM Resident #76 was asked about her meals. She replied, " The food here leaves a lot to be desired. It's unidentifiable. I get stuff that looks like a green omelet and they call it something else. I don't like all these new foods they serve. I like to get food like we had on the farm, beans and potatoes and corn bread. The simple foods are the best. That shouldn't be so hard, right? They don't follow the tray card or pay any attention to foods I don't like-- they go right on the plate with the rest of it. I mean I guess the mashed potatoes are instant and they're ok if they're fixed right. But half the time they're all dried up like they didn't put enough milk or butter in them or they sat for too long before they were served. It's a shame."

On 1/24/18 @ 12:30 PM the surveyor checked on Resident #76 to review her lunch meal. There were no lunch trays yet, and both room residents waiting in the room say the trays are always late.

The lunch tray arrived at 1:04 PM--CNA I set the tray up for Resident #76 in her room. The surveyor reviewed the tray card which listed cooked carrots as one of the resident's "dislikes". There were cooked carrots on plate. The resident says "they do that all the time".

The surveyor asked the resident (while CNA I was setting up the tray) if she liked cooked carrots. The resident said "no". The surveyor again spoke up while the CNA was still at the bedside and said "I can see they listed cooked carrots as one of your dislikes on the tray card."

The tray also contained a marinated salad bowl

Director of Nursing/designee will complete observation of meal service to validate accuracy of meal and honoring of preferences 3 x week x 3 months.

Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 2/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 800	Continued From page 31	F 800		

with cooked carrots, cauliflower and broccoli in it. The surveyor brought this to the attention of the resident and CNA I didn't offer a substitute for that either. The CNA heard this conversation, but did not ask resident if she would like a substitute for carrots or the salad. She left the room.

The surveyor was present at 1:55 PM when the CNA I returned to pick up tray and saw the carrots on the plate and the marinated salad in it was untouched. She never offered a substitute--or asked her if she wanted anything else.

On 1/25/18 at 9:07 AM the RD (registered dietician) was interviewed about the process of food substitutions if the resident received a food they did not like and wished to substitute it with another. The RD said the CNA should report the issue to be added to a list compiled for each meal. The RD said when all meals were served--then the dietary staff would call each nursing station for the list and supply the substituted foods directly to each unit.

This observation was reported to the administrator and DON on 1/25/18 at 11:30 AM.

2. Facility staff failed to honor Resident #140's food prefereneces and offer substitute foods when she expressed dissatisfaction with the meal she was given.. The resident's clinical record was reviewed on 1/24/18 at 4:00 PM

Resident #140 was admitted to the facility on 12/15/17. Her diagnoses included: Blindness, hypertension, anxiety, and depression.

The latest MDS (minimum data set) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 800	Continued From page 32	F 800		

1/12/18 coded the resident with highly impaired vision. She was coded with some cognitive impairment with respect to her memory. The resident's communication skills were unimpaired.

Resident #140 required the assistance of at least one staff member for all the ADLS (activities of daily living). She was coded as able to eat independently with a tray set-up by staff.

The resident's CCP (comprehensive care plan) reviewed and revised 12/27/17 documented the problem of impaired vision related to legally blind d/t/ macular degeneration. A second problem was the potential risk for developing compromised nutritional status related to increased needs for healing. The interventions recommended for staff were as follows:
1. Describe the set-up of meal tray to facilitate seal-feeding.
2. Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals.
3. Honor food preferences.
4. If meals refused, offer/provide extra nourishments.

Resident #140's physician orders, signed and dated on 1/5/18, documented the resident was "Legally Blind". The physician had ordered a regular diet with no food restrictions.

On 1/24/18 at 1:10 PM the surveyor was in Resident #140's room when her tray was delivered by CNA II. The CNA placed the tray on the overbed table and took the lid off the food. She opened the coffee but did not open the milk carton. The CNA did not cut up the resident's meat (turkey with gravy) or tell her where her food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 800	Continued From page 33	F 800		

selections were on her tray. A sandwich, still in the wrapper was set off to the right side of the plate.

The surveyor asked the resident why she was not eating her foods and mentioned the turkey with gravy looked very good. The resident told the surveyor she did not like turkey or gravy and couldn't see to cut it up even if she did want it.

The surveyor asked the resident if she wanted her (unopened) milk which was set at the back of the tray behind the plate. The resident responded, "What milk, I cannot see it." The roomate spoke up and told the surveyor that Resident #140 could not see.

The resident went on to tell the surveyor she did like beef, but never chicken or turkey and never any gravy. She stated, "It's hard to eat when you don't feel good and can't cut up your food."

Resident #140 said she usually found her food with the assistance of her roommate--who could see what she had and tell her where to find it. The resident's roommate told the surveyor she would help Resident #140 find her foods on her tray, because the CNAs did not tell her where it was.

At 1:55 PM, the surveyor was in the room when CNA II picked up Resident #140's tray and returned it to the kitchen. The resident told her she didn't like turkey or gravy. CNA II observed the food was uneaten and the milk still unopened and did not ask the resident if she wanted a substitute meal--or even leave behind the untouched sandwich.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 800	Continued From page 34	F 800		

On 1/25/18 the DON was informed of these observations and asked about Resident #140's tray set-up and choice of foods. The DON said the staff had been trained to deliver food to visually impaired residents by using the "face of the clock" as an example. They should be telling the resident if her meat is at six o'clock and peas are at nine o'clock, etc.

At 10:28 AM the DON reported back to the surveyor that she had spoken to CNA II and CNA I and both of them acknowledged they were supposed to use the face of the clock to tell the resident where her food was located. "They don't practice what they preach. When I asked about the unopened milk the CNA told me she never opened it because the resident never drank it anyway. My question to her was if she doesn't want milk--why didn't you offer her something else?"

The DON said the resident's preferences were not honored and the staff did not offer adequate assistance to set-up her tray.

On 1/25/18 at 11:30 these observations were shared with the administrator and DON.
3. The facility staff failed to honor food choices made by Resident #130

Resident #130 was admitted to the facility on 8/25/16 and readmitted 10/27/17 with diagnoses that included but not limited to hypertension, insomnia, type 2 diabetes mellitus, muscle weakness, difficulty walking, iron deficiency anemia, and bilateral below the knee amputations.

Resident #130's latest MDS (minimum data set)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 800	Continued From page 35	F 800		

assessment dated 1/8/18 coded the resident as cognitively intact with a BIMS score of 15/15. Resident #130 was not coded with any negative behaviors to other residents or staff members. The MDS coded Resident #130 as independent in eating with staff providing set up help only.

Resident #130's latest CCP (comprehensive care plan) updated 1/8/18 documented the resident with the problem that read "Potential for developing compromised nutritional status related to therapeutic diet." Interventions/Tasks read "Honor food preferences. If meals refused, offer/provide extra nourishments, liberalized diet, provide diet/supplements per orders."

Resident #130's December 2017 dietary orders were for a no added salt (NAS) and low concentrated sweets (LCS) diet.

The surveyor observed Resident #130 during the initial tour on 1/23/18 at 6:30 p.m. The resident stated "I hope you can do something about the food but told tell them it was me."

The surveyor observed and interviewed Resident #130 on 1/24/18 at 10:59 a.m. When the question about food was asked, Resident #130 replied "not good. Breakfast is the best meal of the day."

The surveyor observed the lunch meal on 1/24/18 at 12:45 p.m. Resident #130's tray was observed to have a bowl of mixed vegetables in some type of sauce. Resident #130 was asked if he were going to eat the mixed vegetable bowl. Resident #130 stated "I don't like cauliflower" and showed the surveyor the food tray ticket which list cauliflower as a "dislike" food item. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 800	Continued From page 36	F 800		

#130 stated "I try to control my diabetes with my diet but the kitchen sends fried food, sugary desserts, and foods a diabetic shouldn't have." The resident stated he liked ham and cheese and peanut butter but then that's all they would send. "I would like a little variety."

The diet ticket had multiple instructions for Resident #130's food preferences: When send sandwich as a substitute do not send ham and cheese, do not send any foods made with tomatoes, do not put brown gravy on any of his food, 2% milk, dislikes: spicy foods (spaghetti, lasagna, pizza, kielbasa, Italian sausage); dessert (ice cream, gelatin); beverages (coffee, lemonade, tea); vegetables (tomatoes, pinto beans, Brussel sprouts, broccoli, spinach, greens, zucchini, squash, cabbage, grits, coleslaw, lima beans, baked beans, cauliflower); fruit (oranges, orange juice).

01/25/18 09:23 AM Spoke with resident this morning. States last night dinner was chicken and "I had to wipe a layer of grease off of it. I didn't eat it." Resident states he would like to have chicken salad. No more peaches, no more fruit. The resident stated he would also like some cottage cheese.

01/25/18 09:38 AM The surveyor discussed Resident #130's food concerns with the RD. The RD stated that she had visited with him and had modified his meal plan and that the facility does not fry anything. The chicken last night had a honey orange glaze. The RD stated that Resident #130 had so many dislikes that they all don't fit on the card. She stated he has a copy of the posted menu and stated he knows he can request items and he has done so. The RD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 800	Continued From page 37 stated she would visit with him again. Also informed her of the cauliflower on the tray at lunch 1/24/18. She stated the resident has so many dislikes there's not enough room. Cauliflower is listed as a dislike. The facility administrator and DON were informed of the surveyor's findings prior to the survey team exit on 1/26/18. No additional info was provided.	F 800		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and clinical record review it was determined the facility staff failed to offer/provide a reasonable substitute food for 1 of 13 residents (Resident #76). Findings: Facility staff failed to offer Resident #76 a substitute for a food she expressed a dislike for it. The resident's clinical record was reviewed on 1/24/18 at 9:00 AM. Resident #76 was admitted to the facility on 6/14/17. Her diagnoses included Parkinson's disease and depression.	F 806	F806-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** CNA I/II were immediately educated on honoring food preferences, and offering substitutions. 2) **Like Residents** Residents residing in the center had the potential to be affected. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 806	Continued From page 38	F 806		

The resident's latest MDS (minimum data set) assessment, dated 12/12/17 coded the resident as cognitively unimpaired. She required the assistance of at least one staff member to assist her with the ADLS (activities of daily living). She could eat unassisted with a tray set-up only by staff members.

The resident's CCP (comprehensive care plan) reviewed and revised on 12/12/17 documented the resident at risk for compromised nutritional status related to variable intake of meals and increased nutrient needs for healing. The staff interventions were recommended as follows:
1. Honor food preferences.
2. If meals refused, offer/provide extra nourishments.

The resident's physician orders, signed and dated on 1/2/18, contained an order for a regular diet. The resident was not restricted to her choice of foods.

On 01/23/18 at 07:12 AM Resident #76 was asked about her meals. She relied, " The food here leaves a lot to be desired. It's unidentifiable. I get stuff that looks like a green omelet and they call it something else. I don't like all these new foods they serve. I like to get food like we had on the farm, beans and potatoes and corn bread. The simple foods are the best. That shouldn't be so hard, right? They don't follow the tray card or pay any attention to foods I don't like they go right on the plate with the rest of it. I mean I guess the mashed potatoes are instant and they're ok if they're fixed right. But half the time they're all dried up like they didn't put enough milk or butter in them or they sat for too long before they were

Education completed by the Director of Nursing/Designee to CNAs to review at tray cards to validate that resident is receiving the appropriate meal including their preferences and offering substitutions if applicable. Education completed by Culinary Services Manager to dietary staff to read tray cards and ensure that the residents are receiving their preferences as appropriate.

4) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**

Director of Nursing/designee will complete observation of meal service to validate accuracy of meal and honoring of preferences 3 x week x 3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806	Continued From page 39	F 806	Audit findings will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance: 2/23/18	

served. It's a shame."

On 1/24/18 @ 12:30 PM the surveyor checked on Resident #76 to review her lunch meal. There were no lunch trays yet, and both room residents waiting in the room say the trays are always late.

The lunch tray arrived at 1:04 PM--CNA I set the tray up for Resident #76 in her room. The surveyor reviewed the tray card which listed cooked carrots as one of the resident's "dislikes". There were cooked carrots on plate. The resident says "they do that all the time".

The surveyor asked the resident (while CNA I was setting up the tray) if she liked cooked carrots. The resident said "no". The surveyor again spoke up while the CNA was still at the bedside and said "I can see they listed cooked carrots as one of your dislikes on the tray card."

The tray also contained a marinated salad bowl with cooked carrots, cauliflower and broccoli in it. The surveyor brought this to the attention of the resident and CNA I didn't offer a substitute for that either. The CNA heard this conversation, but did not ask resident if she would like a substitute for carrots or the salad. She left the room.

The surveyor was present at 1:55 PM when the CNA I returned to pick up tray and saw the carrots on the plate and the marinated salad in it was untouched. She never offered a substitute--or asked her if she wanted anything else.

On 1/25/18 at 9:07 AM the RD (registered dietician) was interviewed about the process of determining the resident's food choices. She said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 806	Continued From page 40 she would interview them soon after their admission and determine their likes and dislikes. She said the dietary staff were not supposed to put foods on the plate that were listed on the dietary card as "dislikes". This observation was reported to the administrator and DON on 1/25/18 at 11:30 AM.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, prepare, and distribute food under sanitary conditions. The findings included.	F 812	F812-E **1) Corrective Action for those residents found to be affected by the alleged deficient practice.** Cited cooler floor immediately cleaned and cited employees hair nets were applied to cover all hair. **2) Like Residents** Entire dietary area assessed for further spillage and cleaned if necessary. Review completed by the Culinary Services Manager. **3) Systemic Changes put into place to ensure the alleged deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 812 Continued From page 41

The milk cooler in the dietary department was observed by the surveyor to have soured milk in the bottom of the container. Three of the dietary staff failed to secure their hair in hairnets during food preparation.

On 01/23/18 beginning at approximately 6:00 p.m., the surveyor accompanied by the dietary supervisor toured the dietary department. When checking the milk cooler the surveyor was able to observe a white substance resembling milk in the bottom of the cooler. Upon opening the cooler, the surveyor was able to smell a strong soured odor. The dietary supervisor verbalized to the surveyor that she also smelled the odor and identified the soured substance in the bottom of the cooler as being milk. The milk cooler contained one crate of milk.

The milk cooler was rechecked on 01/24/18 at 8:00 a.m. with no problems being identified.

On 01/24/18 at approximately 1:00 p.m., the surveyor observed three female dietary staff that were involved in food preparation. These three staff were observed wearing hairnets. However, these hairnets did not completely cover the staff's hair two were observed with their hair uncovered in the back and one staff persons hair was hanging out from the sides. This was brought to the attention of the dietary supervisor who acknowledged to the surveyor that the employee's hair was not completely secured.

The administrator was notified of the above issues on 01/25/18 at 8:00 a.m.

No further information regarding this issue was provided to the surveyor team prior to the exit

F 812

Education completed by the Culinary Services Manager to food service employees to ensure that floors are free from spillage to include coolers and freezers and for all food service staff to ensure all hair is to be covered at all times.

4) **Corrective actions to ensure that the deficient practice will not recur.** Culinary Services Manager will complete kitchen floor/hair net audits 3x week for 2 months then monthly.

Audit information will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 2/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 812	Continued From page 42 conference.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483 70(o)(1)-(4)	F 849	F849-D	

§483.70(o) Hospice services.
§483.70(o)(1) A long-term care (LTC) facility may do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.

1) **Corrective Action for those residents found to be affected by the alleged deficient practice.**

Contacted Hospice company and received hospice notes for resident #95.

2) **Like Residents**

Residents who receive hospice services from Southwest Home Health and Hospice have the potential to be affected.

3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**

Education completed by the Director of Nursing/Designee to nurse managers to ensure current hospice documentation is in the resident chart weekly for CNA and nursing visits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 849 Continued From page 43

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility

F 849

4) **Corrective actions to ensure that the deficient practice will not recur.**

Director of Nursing or designee will complete hospice chart audits weekly x 3 months to ensure that hospice visit notes are on the resident medical chart.

Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 2/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 849	Continued From page 44	F 849		

personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 849	Continued From page 45	F 849		

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness. related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(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 849	Continued From page 46	F 849		

facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to coordinate Hospice Services for 1 of 31 residents in the survey sample (Resident #95).

The findings included:

The facility staff failed to coordinate Hospice Services for Resident #95.

Resident #95 was readmitted to the facility on 9/9/16 with the following diagnoses of, but not limited to dementia, Alzheimer's disease, depression and chronic obstructive pulmonary disease. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/21/17; the resident was coded as having short term and long-term memory problems with being moderately impaired in daily decision-making process. Resident #95 was also coded as being totally dependent of 1 staff member for dressing, personal hygiene and bathing.

The surveyor conducted a review of Resident #95's clinical record on 1/26/18. The resident was noted to be admitted to hospice services on 12/20/17. The surveyor could not find any hospice service documentation or hospice care plan in the electronic or paper clinical record at the time of the review.

The surveyor notified Registered Nurse (RN) #1 of the above documented findings on 1/26/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 849	Continued From page 47 RN #1 stated to the surveyor "I have to call the hospice agency and get them to fax the notes and care plan to me. We don't have it here." The DON (director of nursing) provided the surveyor a copy of the hospice nursing notes and care plan on 1/26/18 at approximately 2:30 pm. No further information was provided to the surveyor prior to the exit conference on 1/26/18.	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies and procedures for the program, which must include,	F 880	F880-D 1) **Corrective Action for those residents found to be affected by the alleged deficient practice.** CNA #1 received immediate education on the proper seating arrangement when providing feeding assistance to residents. 2) **Like Residents** Residents who receive feeding assistance have the potential to be affected. 3) **Systemic Changes put into place to ensure the alleged deficient practice does not recur.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

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F 880	Continued From page 48 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880	Education completed by the Director of Nursing/Designee with nursing staff on proper seating arrangement when providing feeding assistance per policy. 4) **Corrective actions to ensure that the deficient practice will not recur.** Director of Nursing or designee will complete audits of meal observations 3x week x 3 months. Audit findings will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance: 2/23/18	

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F 880	Continued From page 49	F 880		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review the facility staff failed to follow established infection control guidelines for 1 of 31 Residents, Resident #123.

The findings included:

For Resident #123 the facility staff failed to follow established infection control guidelines by sitting on Resident's bed while assisting Resident with eating.

Resident #123 was admitted to the facility on 07/09/13 and readmitted on 10/23/17. Diagnoses included but not limited to anemia, peripheral vascular disease, hyperlipidemia, aphasia, hemiplegia, depression and chronic obstructive pulmonary disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/08/18 coded the Resident as 15 of 15 in section C, cognitive status. Section G, functional status, coded the Resident as 3 of 2 in eating. This is the equivalent of extensive assistance, one-person physical assist. This is a quarterly MDS.

The surveyor observed Resident #123 eating breakfast on 01/24/18 at approximately 0835. CNA (certified nurse's aide) #1 was assisting Resident with eating. Resident was seated in wheelchair at side of bed, and CNA #1 was seated on Resident's bed. There was a chair in Resident's room.

Surveyor spoke with CNA #1 on 01/25/18 at approximately 0840 regarding sitting on

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F 880	Continued From page 50	F 880		

Resident's bed. Surveyor asked CNA #1 if she normally sat on Resident's bed while assisting him with eating and CNA #1 stated that she asks Resident if it is ok to sit, "I don't just sit down".

Surveyor spoke with DON (director of nursing) on 01/25/18 at approximately 0925 regarding CNAs sitting on Residents bed while assisting with feeding. Surveyor asked DON if this should be done, and DON stated that CNA's should not be sitting on Residents beds.

Surveyor requested policies on infection control and feeding assistance. DON provided surveyor with policy entitled "Assistance with Meals" which read in part "Residents requiring full assistance: 2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity....". DON also provided surveyor with a policy entitled "Infection Control" which read in part "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment to help prevent and manage transmission of diseases and infection".

The concern of the CNA sitting on Resident's bed was discussed with the administrative staff during a meeting on 01/25/18 at approximately 1130.

No further information was provided prior to exit.