PRINTED: 02/13/2018
FORM APPROVED

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			OWR NO. 093			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED			
		495133	B. WING		01/26/20	18		
NAME OF PR	OVIDER OR SUPPLIER	I	- 	STREET ADDRESS, CITY, STATE, ZIP CODE				
				40 EAST LEE HIGHWAY	•			
VALLEY H	EALTH CARE CENTER			CHILHOWIE, VA 24319				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COM	(X5) PLETION OATE		
E 000	Initial Comments		E 000	The filing of this plan of correction does not con-	stitute an			
		nergency Preparedness		admission that the alleg				
	survey was conducte			deficiencies did, in fact,	exist.			
	01/26/18. The facilit			This plan of corrections	is tiled			
	compliance with 42 (og-Term Care Facilities.		as evidence to comply w	vita			
	Three complaints we	ere investigated during the		requirements of partici	pation			
	survey.			and continue to provide	high			
F 000	INITIAL COMMENT	S	F 000	quality resident centere	ed care.			
:	survey was conduct 01/26/18. Three conduring the survey.The substantial complian	mplaints were investigated ne facility was not in nce with 42 CFR Part 483 Care requirement(s). The Life						
	156 at the time of th	80 certified bed facility was the survey. The final survey f 13 current Resident reviews reviews.		. Dega 15				
F 578	*	cntnue Trmnt;Formite Adv Dir	F 57	F578-D				
	CFR(s): 483.10(c)(6			1) Commenter 4 - 41	fa.u			
	discontinue treatme to participate in exp formulate an advan			1) Corrective Action those residents to the affected by the deficient practice Resident #27 states the control of the control	ound to ne alleged se us code			
		ing in this paragraph should be		was immediately	•			
		ght of the resident to receive		her preference of	ocing a			
		dical treatment or medical nedically unnecessary or		Full Code.				
	inappropriate.	readaily unifected ally Of		2) Yilaa Danida-ta	Pasidonts			
	• •			2) Like Residents-	i			
		facility must comply with the		residing in the ce				
	•	fied in 42 CFR part 489,		the potential to b				
LABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	NTLE		DATE		
I	1 mms has			Administration	2/23	119		

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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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				T. T	OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILC		(X3) DATE SURVEY COMPLETED		
		495133	B. WING			C 01/26/2018	
MAME ()E DI	ROVIDER OR SUPPLIER			ST	PEET ADDRE	SS. CITY, STATE, ZIP CODE	01/20/2016
MANIE OF FI	POSIDELY OUT BOLL TIEN		940 EAST LEE HIGHWAY				
VALLEY H	EALTH CARE CENTER		CHILHOWIE, VA 24319				
							·····
(X4) IO PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD I ISS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 578	Continued From pag	no 1		578 ·	3)	Systemic Changes put	
1 310	, , ,	F	216		into place to ensure th		
	subpart I (Advance I	onectives). Ints include provisions to		-		alleged deficient pract	
	•	vritten information to all adult				does not recur.	ice
	•	the right to accept or refuse			1	Education completed to	
	medical or surgical treatment and, at the resident's option, formulate an advance directive.					licensed nurses and soc	· . •
					i		
	(ii) This includes a w	ritten description of the				services to ensure that t	
	facility's policies to in			1	code status in the reside		
	and applicable State					chart is consistent with	the
		mitted to contract with other			'	physician order.	
		s information but are still					
	legally responsible for				4)	Corrective actions to	1
	requirements of this	section are met. Jual is incapacitated at the				ensure that the deficien	nt
		nd is unable to receive				practice will not recur.	_
		late whether or not he or she	:				
	has executed an adv	vance directive, the facility				Director of Social Servi	ces
	may give advance d	irective information to the		-		or designee will audit	-
	individual's resident	representative in accordance	•			current resident record a	
	with State Law.					each new admission rec	,
		relieved of its obligation to					ora
	•	ion to the individual once he				to verify code status is	
		eive such information.		•	:	consistent with physicia	n
	• •	es must be in place to provide e individual directly at the			ĺ	orders and resident	
	appropriate time.	e addividual disectly at the			•	preference for 3 months	
		T is not met as evidenced					
	by:					Audits findings will be	
		view and clinical record			:	reviewed monthly in the	
	review and the State	Code of Virginia, the facility				quality assurance and	-
		n accurate DDNR (Durable				performance improveme	ent
	•	for 1 of 31 residents in the				process for	
	survey sample (Res	survey sample (Resident #27).				tracking/trending and an	s.
	: - The findings include					ני	
	The findings include					necessary additional interventions.	
	•	ed to have an accurate DDNR suscitate) in the clinical				interventions.	:
	-				~ -		
record for Resident #27. § 54.1-2987.1. Durab		•			Date of	compliance: 2/23/18	

Do Not Resuscitate Orders states in part "D. If a

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES				ON	1B NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION		I) DATE SURVEY COMPLETED
		495133	B. WING_				C 01/26/2018
	ROVIDER OR SUPPLIER			940 E	ET ADDRESS. CITY, STATE, ZIP CODE AST LEE HIGHWAY HOWIE, VA 24319	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREFI) TAG	K	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(XE) COMPLETION DATE
F 578	patient is able to, and care provider or practiresuscitated in the evarrest, such expression provider's or practition. Durable Do Not Resushall any person othe authority to revoke a Order executed upon consent of the patient. Resident #27 was ad 8/9/2016 with the folk limited to high blood glisorder, depression, dialysis and psychotic coded on the quarterl with an ARD (Assess 11/3/17 as having a EMental Status) score of 15. Resident #27 extensive assistance dressing, extensive a for personal hygiene on 1 staff member for 1/24/18. It was not Resident #27 had a E on the front of the paphysician's orders da also reviewed at that order sheet, the survey was a "Fuli Code".	idoes, express to a health iitioner the desire to be ent of cardiac or respiratory on shall revoke the ner's authority to follow a scitate Order. In no case or than the patient have Durable Do Not Resuscitate the request of and with the thimself." mitted to the facility on owing diagnoses of, but not pressure, diabetes, anxiety chronic renal failure, a disorder. The resident was by MDS (Minimum Data Set) ment Reference Date) of BMS (Brief Interview for of 14 out of a possible score was also coded as requiring of 2 staff member for ssistance of 1 staff member and being totally dependent	F	578			
		. The DON (director of					

nursing) stated she would look into this and get

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

CENTER	13 FUR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTIO)N	(X3) DATE SURVEY COMPLETED
·	! 	495133	B. WING			C 01/26/2018
	PROVIDER OR SUPPLIER HEALTH CARE CENTER	A	1	STREET ADDRES	SS, CITY, STATE, ZIP CODE	VIIZWEVEG
VALLE	RALIH CARE CENTER			CHILHOWIE, V	/A 24319	
(X4) ID PREFIX FAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	io Prefix Tag	(EAC	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 578	Continued From page	e 3	F 578	я		
		or regarding the code status		•		
	provided a copy of a p 1/24/18 which stated t Full Code status." The	timately 9 am, the DON physician order written on the "Resident wishes to be ne DON stated, "We spoke ne wishes to be a full code."				
	No further information surveyor prior to the e	n was provided to the exit conference on 1/26/18.		•		
F 677		or Dependent Residents	F 677	⁷ F677-I	D	
	out activities of daily liservices to maintain greesonal and oral hyging This REQUIREMENT by: Based on observation interview and clinical referenced the facility appropriate food tray services.	is not met as evidenced n, resident and staff record review it was		1)	Corrective Action for those residents found be affected by the alled deficient practice CNA II immediately educated on resident # "legally blind" diagnosand the need to describ resident tray set up at e- meal,	t to leged 140 sis
	Findings:			2)	Like Residents	ļ
	for her in a manner tha impaired resident to fir	set-up Resident #140's tray hat enabled the visually hind and eat her foods. The pord was reviewed on 1/24/18		,	Residents with visual deficits have the potento be affected.	
		dmitted to the facility on ses included: Blindness, , and depression.		3)	Systemic changes put place to ensure the all deficient practice doe recur.	leged

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

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STATEMENT	CF DEFICIENCIES	IN DECISION OF COMPANY				OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTR	UCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WING			С
NAME OF F	ROYIDER OR SUPPLIER	1 400100	10 71110			01/26/2018
	TOTAL OR GOLF BEX				CRESS, CITY, STATE, ZIP CODE	
VALLEY	HEALTH CARE CENTER			•	LEE HIGHWAY	
				CHILHOW	/IE, VA 24319	
(X4) ID FREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE COMPLETION
F 677	Continued From page	s 4	_		Education completed 1	
			F (677	Education completed by Director of	y the
	The latest MDS (mini-	sident with highly impaired		1		
	vision. She was code	d with some cognitive			Nursing/Designee to	
	impairment with respe	ect to her memory. The		•	nursing department	
	resident's communica		•	regarding providing the		
					visually impaired with	
	Resident #140 require			assistance and set up of		
	one staff member for	all the ADLS (activities of			meal tray to facilitate se	:lf
	daily living). She was	coded as able to eat			feeding if applicable.	
	independently with a t	ray set-up by staff.			0¥F	
	The maid-us cont			4	1) Corrective actions to	
	rne resident's CCP (comprehensive care plan)			ensure that the deficier	.
	nrohlem of impaired u	12/27/17 documented the ision related to legally blind				
	d/t/ macelar decenera	tion. A second problem was			practice will not recur.	
	the potential risk for de	eveloping compromised			Diment. S	
	nutritional status relate	ed to increased needs for	•		Director of	
		ions recommended for staff			Nursing/Designee will complete meal observation	
	were as follows:				ons	
		of meal tray to facilitate			each meal 3x week x 3	
	seal-feeding.				months.	
	2. Encourage and ass	ist as needed to consume				
		ents and fluids offered at			Audit findings will be	
	and between meals.				reviewed monthly in the	Í
	 Honor food preferer If meals refused, of 				quality assurance and	ļ
	nourishments.	enprovide extra			performance improvemen	nt I
	The Charles of the Control of the Co				process for	,tt.
	Resident #140's physi	cian orders, signed and			tracking/trending and any	.
	dated on 1/5/18, docu	mented the resident was	•			'
	"Legally Blind". The ph	ysician had ordered a			necessary additional	
	regular diet with no foo	od restrictions.			interventions.	
	On 1/24/18 at 1:10 PM			Date	of compliance-2/23/18	
	Resident #140's room					
	the overhed table and	he CNA placed the tray on took the lid off the food.				
		but did not open the milk				
		are not obout me may				i

carton. The CNA did not cut up the resident's

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495133	8. WING		C 01/26/2018		
	ROVIDER OR SUPPLIER IEALTH CARE CENTER		1 9	STREET ADDRESS, CITY, STATE, ZIP CODE 140 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 677	selections were on he the wrapper was set of plate. The surveyor asked the eating her foods and rigravy looked very good surveyor she did not licouldn't see to cut it us. The surveyor asked ther (unopened) milk with the tray behind the plate.	by) or tell her where her food or tray. A sandwich, still in off to the right side of the me resident why she was not mentioned the turkey with od. The resident told the like turkey or gravy and p even if she did want it. The resident if she wanted which was set at the back of the it. The resident responded, see it." The roomate spoke	F 677				
	up and told the survey not see. The resident went on a like beef, but never chany gravy. She stated don't feel good and care Resident #140 said shouth the assistance of see what she had and The resident's roomma would help Resident #	to tell the surveyor she did icken or turkey and never I, "It's hard to eat when you					
	CNA II picked up Residereturned it to the kitcheshe didn't like turkey on	en. The resident told her r gravy. CNA II observed and the milk still unopened					

untouched sandwich.

substitute meal--or even leave behind the

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		MEDICAID SERVICES				. 0	MB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIA	IPLE CONSTRU IG	ИСТЮ И		X3) DATE SURVEY COMPLETED
		495133	B. WNG_				С
	ROVIDER OR SUPPLIER			940 EAST L	DRESS, CITY, STATE, ZIP CODE	<u>l</u>	01/26/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 677	Continued From page	6	F 6	77			
	tray set-up and choice the staff had been trai visually impaired resic the clock" as an exam the resident if her mea are at nine o'clock, etc. At 10:28 AM the DON surveyor that she had I and both of them ack supposed to use the faresident where her foo practice what they prethe unopened milk the opened it because the anyway. My question to	ed about Resident #140's e of foods. The DON said ned to deliver food to fents by using the "face of ple. They should be telling at is at six o'clock and peas c. reported back to the spoken to CNA II and CNA					
	not honored and the st assistance to set-up he On 1/25/18 at 11:30 the	ese observations were					
F 692	shared with the admini Nutrition/Hydration Sta CFR(s): 483.25(g)(1)-(tus Maintenance	F 692	F692-1	D		j
! ! !	§483.25(g) Assisted nu (Includes naso-gastric a both percutaneous end percutaneous endoscop enteral fluids). Based o comprehensive assessi	and gastrostomy tubes, oscopic gastrostomy and pic jejunostomy, and on a resident's		1)	Corrective Action those residents for be affected by the deficient practice.	und to	

ensure that a resident-

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/SULA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUC	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495133	33 B. WING			C 01/26/2018	
	ROVIDER OR SUPPLIER			STREET ADDR 940 EAST LEI CHILHOWIE			1112012010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	id Prefix Tag		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD & CSS-REFERENCED TO THE APPROPRI DEFICIENCY)	36	IX5; COMPLETION DATE
F 692	of nutritional status, s desirable body weight	ins acceptable parameters uch as usual body weight or t range and electrolyte	F 692	2 2	Cited Resident #27- O clarification on fluid restriction was comple and placed on the medication administration	eted	
		esident's clinical condition s is not possible or resident otherwise;		2	record. Like Residents		
	Maintain proper hydra §483.25(g)(3) Is offerd there is a nutritional p provider orders a there. This REQUIREMENT by: Based on staff intervi- and clinical record rev- to follow physician pre-	ed a therapeutic diet when roblem and the health care apeutic diet. is not met as evidenced ew, facility document review riew, the facility staff failed escribed fluid restrictions for			Audit completed on residents with fluid restriction orders and corrected as appropriate Review completed by the Registered Dietician/Director of Nursing.	e. he	
	# 27). The findings included:	e survey sample (Resident		3)	Systemic Changes put into place to ensure the alleged deficient practidoes not recur.	e i	
	Resident #27 was adm 8/9/2016 with the follo limited to high blood p disorder, depression, of dialysis and psychotic coded on the quarterly with an ARD (Assessn 11/3/17 as having a BI Mental Status) score of of 15. Resident #27 w extensive assistance of	nitted to the facility on wing diagnoses of, but not ressure, diabetes, anxiety chronic renal failure, disorder. The resident was a MDS (Minimum Data Set) ment Reference Date) of MS (Brief Interview for 14 out of a possible score was also coded as requiring		4)	Education to licensed nurses and dietary management on indicating the amount of fluid allots for distribution with medications and meals of each shift. Corrective actions to ensure that the deficient practice will not recur.	n	

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		& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY
		IDEALISICATION NUMBER:	A. BUILDIN	IG	COMPLETED
		495133	B. WING		С
NAME OF F	PROVIDER OR SUPPLIER			PERCE ADDRESS OF A	01/26/2018
]	STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	HEALTH CARE CENTE	R		940 EAST LEE HIGHWAY	
IX4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		CHILHOWIE, VA 24319	
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 692	Continued From pa	ge 8		^^	i
		e and being totally dependent	F6	Director of	1
	on 1 staff member f	or bathing		Nursing/designee	
		To Tournig.		complete audits or	i current
	The surveyor review	ved the clinical record of		and new residents	
	Resident #27 on 1/2	24 and 1/25/18. During the		fluid restrictions to	ensure
	clinical record review	w, the surveyor noted on the		fluids are allocated	
	MAR (Medication Ad	dministration Record) dated		dictary and nursing	
	for 1/1/18 through 1.	/31/18; the surveyor noted the		departments and p	
following documentation:				MARs weekly x 3	manths
	" Fluid Re	estriction: Total 1500 ml			monus
	(minuters) Kitchen	: 600 ml Nursing 900 ml"		and then monthly.	
	The boxes under ea	ch date for the month of		Audit findings will be revi	ewed
	January 2018 were I	left blank. There was no	•	monthly in the quality assu	
	other documentation	found in the clinical record		and performance improven	
	that referred to the fi	luid restriction that the	ī	process for tracking/trending	
	physician nad order	ed or to the amounts that the			ig allu
	resident had consun	ned in a 24-hour period.		any necessary additional interventions.	
	On 1/24/18 at approx	ximately 5 pm, the surveyor		mior ventions.	
	notified the DON (dia	rector of nursing) of the		Data of compliance 2/23/19	n
	above documented f	indings. The surveyor also		Date of compliance-2/23/1	8
	requested a copy of	the facility's policy on			
	documentation of flu	id restriction for a resident.			
	At 6 pm, the DON pr	ovided the surveyor with a			
	copy of the facility's	policy titled "Fluid Restriction			
	Management" under	the section of "Process" the			
	surveyor noted the fo	ollowing:			
	"3. The r	nurse or designee will			
	document the fluid re	estriction order on the MAR			
	(Medication Administ	ration Record) se will document the			
		cribed fluid restriction each			
	shift on the MAR	CIDER HOR TERRICTION SACU			
		e will oversee documentation			
	of the actual fluid inta	ike on each shift and monitor			
	to insure that	restriction is maintained			
		USINGINGU			

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

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CENTERS FOR MEDICARE & MEDICAID SERVICE:	WEDICAID SERVICES			OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495133	8. WNG		С	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	01/26/2018	
V4115V1	F11711 0400 000000			940 EAST LEE HIGHWAY	<i>.</i>	
VALLET	HEALTH CARE CENTER		i	CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEF.CIENCY)	N SHOULD BE COMPLETION DATE	
F 692	Continued From page	9	F 69:	2		
	of the policy was prov the DON if the nursing	wed the DON after the copy ided. The surveyor asked a staff monitored the fluid ent according to this policy. they did not."				
	No further information					
		xit conference on 1/26/18.		-		
	Dialysis CFR(s): 483.25(l)		F 698	B F698-D	į	
33-2	§483.25(I) Dialysis. The facility must ensure require dialysis receive with professional stand comprehensive persor the residents' goals and This REQUIREMENT by: Based on staff intervie and clinical record revi	e such services, consistent dards of practice, the n-centered care plan, and d preferences. Is not met as evidenced ew, facility document review ew, the facility staff failed ation and collaboration in 1 of 31 residents in the		1) Corrective Act those residents be affected by deficient pract Cited Resident a Communication dialysis center a on ensuring that conumunication properly comple	found to the alleged ice. #27- a with the management t the form is eted.	
	limited to high blood pridisorder, depression, cidalysis and psychotic coded on the quarterly with an ARD (Assessmi 11/3/17 as having a BII	ving diagnoses of, but not essure, diabetes, anxiety hronic renal failure, disorder. The resident was MDS (Minimum Data Set) ent Reference Date) of		2) Like Residents Residents who a offsite hemodia services have th to be affected. 3) Systemic Chan into place to er alleged deficient does not recur.	receive alysis se potential sure the at practice	

of 15. Resident #27 was also coded as requiring

CENTER	S FOR MEDICARE &	MEDICAID SERVICES						NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DA	ATE SURVEY DMPLETED
		495133	B. WING					C
NAME OF P	ROVIDER OR SUPPLIER		1	S.	TREET ADDRE	ISS, CITY, STATE, ZIP CODE		1/26/2018
VALLEY	HEALTH CARE CENTER			94	40 EAST LEE HILHOWIE,	HIGHWAY		•
(X4) ID FREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(E/	PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	for personal hygiene on 1 staff member for The surveyor conduct #27's clinical record of this review, the survey documentation on the Progress Notes" had left blank by the dialys of the notes was 1/13 and 12/27/17. On 1/26/18 at approximation of the DON (dire above documented fir "The dialysis centers area that is left blank, should have called the the missing information the whole picture of the surveyor requeste with the dialysis center. The DON provided a to the surveyor at 11 at the contract read in part of the reprovision of dialysis seprovided the surveyor policy titled "Hemodial Under section titled" Proted the following do part"To establish great reconditions and the start of the surveyor policy it"To establish great in the surveyor gold of the start of the surveyor policy it"To establish great in the surveyor gold of the start of the start of the surveyor policy it"To establish great in the surveyor gold of the surveyor gold of the surveyor policy it"To establish great in the surveyor gold of the surveyor gold of the surveyor policy it"To establish great in the surveyor gold of the surveyor gold of the surveyor policy it"To establish great in the surveyor gold of the surveyor	of 2 staff member for ssistance of 1 staff member and being totally dependent bathing. Ited a review of Resident on 1/24 and 1/25/18. During yor noted that the form titled "Dialysis documentation missing or sis center staff. The dates 1/18, 1/8/18, 1/5/18, 1/3/18 Imately 10 am, the surveyor actor of nursing) of the notings. The DON stated, taff should had filled in this. The nurses here at facility e dialysis center to obtain on so that we would have he resident while at dialysis." ed a copy of the contract err. Copy of the dialysis contract err.	F	398		Education to Licensed nurse managers to ensith the dialysis communication form filled out upon return dialysis facility. Corrective actions to ensure that the deficience will not recurrent to designee will complet audits of dialysis communication forms week x 3 months. Audit findings will be reviewed in the quality assurance and perform improvement process tracking/trending and necessary additional interventions. f compliance: 2/23/18	is by the ient ar. The axis of the ient	
	with the dialysis cente care to residents requi	r to ensure continuity of iring hemodialysis"						

		MEDICAID SERVICES		*****	-		OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCT	ON	(X3) DATE SURVEY COMPLETED
		495133	B. WING				С
NAME OF F	ROVIDER OR SUPPLIER		1	erne	ETADOOC	00 0174 07470 77	01/26/2018
						SS, CITY, STATE, ZIP CODE HIGHWAY	
VALLEY	HEALTH CARE CENTER					VA 24319	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EA	PROVIDER'S PLAN OF CORRECTION NCH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(XS) E COMPLETION ATE DATE
F 698	Continued From page	e 11	F 69	,			
	No further information		F 0:	70			
	surveyor prior to the e	exit conference on 1/26/18.					
F 755	Pharmacy Srvcs/Proc	edures/Pharmacist/Records	F 75	55 F	755-D)	•
SS=D	CFR(s): 483.45(a)(b)(1)-(3)			2		
	\$402 AE Bharana a	- n. 3			1)	Corrective Action for	•
	§483.45 Pharmacy Se	ervices ide routine and emergency			•	those residents found to	0
	drugs and biologicals	to its residents, or obtain				be affected by the alleg	
	them under an agreer	nent described in				deficient practice.	
	§483.70(g). The facili	ty may permit unlicensed				p	
	personnel to administr	er drugs if State law				Cited Medication box wa	as
	permits, but only unde	er the general supervision of				immediately removed fro	
	a licensed nurse.					facility by pharmacy	***
	§483.45(a) Procedure	s. A facility must provide				services.	
	pharmaceutical service	es (including procedures					
	that assure the accura	ite acquiring, receiving,			2)	Like Residents	
	dispensing, and admir	nistering of all drugs and		İ	_,		
	biologicals) to meet the	e needs of each resident.				Narcotic medications	
	8483 45/b) Service Co	onsultation. The facility		•		delivered in medication	
	must employ or obtain	the services of a licensed		!		boxes by pharmacy servi	cos
	pharmacist who-	We solvidos of a licerases		:		have the potential to follo	
						the same practice.) W
	§483.45(b)(1) Provide:	s consultation on all		í		and buttle pructice.	
	aspects of the provision the facility.	n of pharmacy services in			3)	Systemic Changes put	
	ше тасту.			1		into place to ensure the	
	§483.45(b)(2) Establisi	hes a system of records of		ĺ		alleged deficient practic	10
	receipt and disposition sufficient detail to enab	of all controlled drugs in				does not recur.	.c
	reconciliation; and			Ì		Education to pharmacy	
	8/19/2 /E/h//2\ D-1	nan dhas daga -				transportation to ensure the	hat
	Order and that an acc	nes that drug records are in unt of all controlled drugs				all medications are secure	
	is maintained and perio	unt of all controlled drugs				locked as appropriate who	
	This REQUIREMENT	is not met as evidenced			,	delivering to the facility.	211
	hur	a cricalioca		}		converme to the facility.	1

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	•			_	FORM APPROVED
1	OF DEFICIENCIES	(X1) PROVIDER/SUPFLIER/CLIA	(V2) 18 (LTID	I C CONSTO			OMB NO. 0938-0391
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BUILDING	LE CONSTRI	CUCTION	[(X3) DATE SURVEY COMPLETED
		495133	8. WING		С		
NAME OF F	ROVIDER OR SUPPLIER				01/26/2018		
	•				DDRESS, CITY, STATE, Z.P CODE		
VALLEY	HEALTH CARE CENTER		1		LEE HIGHWAY		
2410	C) II	70.45		CHILHOW	VIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Of MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OUR	(X5) COMPLETION E GATE
F 755	Continued From page	12	F 75		4.		
		n, staff interview and facility	F / 3:	9 4	4) Corrective actions		ŧ
	document review, the	facility staff failed to			ensure that the def	ficient	
	establish a system of	records of receipts and			practice will not re	cur.	
	disposition of all contr	olled drugs in sufficient					
	detail to enable an acc	curate reconciliation of		l	Director of		
	medication deliveries i	n 1 of 3 medication storage			Nursing/designee w	ri11	
	rooms Unit 1.	•			complete audits of l		:
	·				medication boxes of	- OCKEU	
	The findings included:						ĺ
	Title on the chart of the second of				facility delivery day		
	The facility staff failed	to ensure a system to			weekly for 3 months		
	disposition in sufficient	medications' receipt and		ļ	ensure box is proper	rly	
	disposition in sufficient accurate reconciliation	detail to enable an		•	secured.		
	storage rooms Unit 1.	on i or a medication					ŧ
:	olologe looms one 1.			1	Audit findings will l	be	
	The surveyor and licen	sed practical nurse #5		ŀ	reviewed monthly in	a the	
	checked the medicatio	n storage room on unit			quality assurance an		
:	100. L.P.N. #5 stated	the facility has a Pixus			performance improv		
	where all medications	were kept. White checking			process for	- CILLOTTI	1
	the medication room, t	ne surveyor observed an		•	tracking/trending an	dane	
:	orange tool box that di	not contain any type of			necessary additional		
	of Marshins Culture 40	opened the tool box, a vial			interventions.		
	or morbuine Sunate 10	0 mg/5 ml (20 mg/ml) with			mica vehitoris.		
	within the tool boy ID	side a clear, plastic box N #5 thinks it's a refill for		Data	-C		1
	the Pixus but stated the	morphine sulfate should		Date (of compliance:2-28-18		
	still be locked up. L.P.	N. #5 stated she would put					1
	a tie back on the tool b	ox. The surveyor asked					
	for the manifest for the	morphine sulfate.					
•	DON. She stated she t when it arrived at the fa not have a list of conter	surveyor interviewed the hinks the tool box was tied cility. The tool box does ats. The DON stated cations in the Pixus. The					
	DON stated the pharma	cations in the Pixus. The icist from Richmond was					

made aware of the concern. Nurses do not have access to the Pixus to load the drugs. The

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495133	8. WING_		C 01/26/2018
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY	1 01/20/2015
VALLE:	TEALIN CARE CENTER			CHILHOWIE, VA 24319	
(X4) IĐ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR PROITDE AVITCE AND HOAE) PAHT OT CEDNERFERENCED PROISIFIED	SHOULD BE COMPLETION
F 755	Continued From page	≥ 13	F 7:	55	
	surveyor requested the medication storage are for the morphine sulfa	nd the pharmacy manifest	• • •	•• •	,
	#1, Care 1 pharmacy stated the pharmacy why/when the Morphin facility. Other #1 state to figure out if the drivibox. Two ties are supplied for narcotics. Other # pharmacy manifest. Ottechnician (other #2) with the tool boxes over the She came in early this facility staff have no id currently. Registered has to call and get a cuthe Pixus. The survey called and got the cod box/ties. The surveyor should be a trail/manifit to access the tool box? Is there a log key and access to the locker.	nurse #3 stated the nurse ode to get narcotics out of for asked other #1 who was the toulook the tool of asked other #1 if there test of what code was used? Are the locks coded without who provides the code ted tool box?			
	DON. The DON stated the manifest for the MS had no clue what was i label." The DON stated	e surveyor spoke with the ishe had not yet received S. The DON stated she in the box. "There was no d the tool boxes are sealed e. "I've never seen a lock			
•	01/25/18 10:30 AM The	e 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,

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES
CENTERS FOR MEDICARE & I	MEDICAID SERVICES

	CF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CHA	(X2) MI	TIDI C	CONSTRUC	CEOU	1	3 NO. 0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A BUILD			LIION		DATE SURVEY COMPLETED
					~~~~	·····	1	
		495133	B. WING				1	С
NAME OF F	PROVIDER OR SUPPLIER			S	REET ADD	RESS, CITY, STATE, ZIP CODE	<u> </u>	01/26/2018
VALLEY	UEALTH CARE SENTER	•				E HIGHWAY		
VALLET	HEALTH CARE CENTER					E, VA 24319		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			1127 101112			
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	<b>x</b>	(I CR	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B IOSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(XS) COMPLETION DATE
F 755	Continued From page	4.4					<del></del>	
			F	755				
	signature as to when in the nursing home facil	ank) and did not have a received, name, and date at lity. The surveyor						•
	receiving medications	policy on the process of from the pharmacy.	÷	1				
	No further information exit conference on 1/2	was provided prior to the 6/18.	•					
F 757 SS=D		from Unnecessary Drugs	F7	57	F757-	D		
	§483.45(d) Unnecessa Each resident's drug re	egimen must be free from			1)	those residents found t	0	,
	drug when used-	n unnecessary drug is any				be affected by the alleg deficient practice.	ed	
:	§483.45(d)(1) in exces duplicate drug therapy)	sive dose (including ); or				Cited Residents #304, #129, and #1- MD/RP		
	§483.45(d)(2) For exce	essive duration; or				notified of omitted		
;	§483.45(d)(3) Without	adequate monitoring; or				documentation of insulin coverage/blood sugar		
	§483.45(d)(4) Without a use; or	adequate indications for its				results, with no new orde or concerns.	ers	
	§483.45(d)(5) in the preconsequences which in	esence of adverse dicate the dose should be			2)	Like Residents		
	reduced or discontinued	d; or		-		Diabetic residents who		
	stated in paragraphs (d) section.					receive insulin have the potential to be affected.		
!	This REQUIREMENT is by: Based on observation, document review and classify staff failed to ens	staff interview, facility inical record review, the			3)	Systemic Changes put into place to ensure the alleged deficient practice does not recur.	e	

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1		MEDICAID SERVICES				OMB	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU'LDI	TIPLE CONST	RUCTION	(X3) D	ATE SURVEY OMPLETED
		495133	8. WING		7-44		C 01/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET	ODRESS, CITY, STATE, ZIP COI	DE L	01/20/2010
VALLEY !	HEALTH CARE CENTER			940 EAST	T LEE HIGHWAY		
				CHILHO	WIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES V MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From page	. 45				M-04-1	
	•		F7	757	Education com	pleted by the	
	were free of an unnec				Director of	parate by tale	
	#1).	lent #129, and Resident			Nursing/Design	see to	
	# 1).				Licensed Nurse		
	The findings included:			1			
	mo manga madaca.				Blood Glucose		
	1. The facility staff fai	led to follow the physician			protocol to incl		
	ordered parameters for	or the administration of			recording result		
	Humalog insulin base	d on blood sugars ordered		1	glucose monitor		
	four times a day (before	re meals and at bedtime)			on charting and		
	for Resident #304.				documentation	policy, the	
	<b>-</b>				charting errors,	and/or	
	Resident #304 was ad	mitted to the facility 1/16/18		Ì	omissions polic	v.	
	With diagnoses that in	cluded but not limited to	*		•	•	
	chronic back sain atti	i, hyperlipidemia, dementia, al fibrillation, hypertension,		i	4) Corrective acti	ions to	
	acute renal failure, hyp	er normation, hypertension,		!	ensure that the		
	gastroesophageal reflu		-		practice will no		
					practice will the	ne recur.	
	Resident #304's admis	sion minimum data set			Director of		
	(MDS) was not comple	eted.					
	<b>-</b>				Nursing/Design		
		nt comprehensive care plan			complete diabet		
	dated 1/22/18 identifie				audits 3x week		
	Diabetes and intervent	ted to Insulin Dependent			to ensure proper		
	administer medications				coverage is give		
		per prijatoliki Graela.			Audit findings w		
	Resident #304's physic	an orders dated 1/16/18			reviewed month	ly in the	
	read in part "Check BS	(blood sugar) qid (four			quality assurance	e and	
	times a day) AC (befor	e meals) & HS (bedtime).			performance imp	provement	
	A second order dated	1/19/18 read in part			process for		.
	"Humalog by sliding so	ale in addition to bid (twice			tracking/trending	g and any	1
	a day) 0-150 no units;			ŧ	necessary addition		
		800=6 units; 301-350=8			interventions.	O4 CELI	ĺ
	units and call MD."	s: > (greater than) 400 12			interventions.		1
	unica and vall IVID.			Dat	e of compliance 2/2	7/10	ļ
	The surveyor reviewed	the January 2018 Dishetic		I I I	e of compliance: 2/23	D/ 18	

The surveyor reviewed the January 2018 Diabetic

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CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495133	B. WING_			C 01/26/2018
NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER				940 EA	ET ADDRESS, CITY, STATE ZIP CODE AST LEE HIGHWAY HOWIE, VA 24319	
(X4) ID PREFIX FAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 757	Flowsheet on 1/25/18 at 11:30 a.m., the block in the column for the administered there was were JL. Based on the Resident #304 should units of Humalog.  O1/25/18 12:17 PM Trassistance of the unit #1. Upon reviewing the stated there was not stated that she would initials "JL" speak with The surveyor interview #2 on 01/25/18 12:24 gave it." The surveyor would know if a medic L.P.N. #2 stated "You progress notes for 1/2 concerning blood sugar administration.  On 1/23/18 at 9:00p.m was 259. In the column to be administered, "2/2 Based on the sliding sushould have received addition to the 20 units The surveyor informed registered nurse #1 of #1 reviewed the docum "You're right. There's a documented."	at 11:51 a.m. On 1/20/18 and sugar reading was 293. amount of insulin to be as a dash mark. The initials a sliding scale orders, have been administered 6 are surveyor requested the amanager registered nurse are blood sugar result, R.N. b insulin recorded. R.N. #1 and the nurse with the at the surveyor.  Ared licensed practical nurse PM. L.P.N. #2 stated "I asked how the surveyor and had been administered.  Wouldn't." A review of the D/18 did not identify a note are and insulin  and insulin  and insulin  scheduled" was written cale insulin, Resident #304 and insulin in	F7	57		

1/26/18 at 8:51 a.m. and requested the policy on

PRINTED: 02/13/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAIN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A BUILDING _ COMPLETED 495133 B. WING NAME OF PROVIDER OR SUPPLIER 01/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION FREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

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

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STATEVENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WNG		С
NAME OF F	PROVIDER OR SUPPLIER				01/26/2018
VALLEY	HEALTH CARE CENTER			STREET ADDRESS, CITY STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORE	HOURD DE CONTRACT
	convulsions, insomnia disease, hyperlipidemi and peripheral vascular Resident #129's quarts (MDS) assessment wit reference date (ARD) or resident with a BIMS or Resident #129's currendated 1/10/18 included endocrine system related Diabetes and hx (histor Interventions: Administrations)	n, major depressive disorder, a, gastroesophageal reflux hia, chronic kidney disease, ar disease.  Iterly minimum data set ith an assessment of 1/7/18 coded the of 12/15.  Int comprehensive care plan d the focus area of ited to Insulin Dependent bry of) hypothyroidism, ster medications per in glucometer readings and	F 7	57	

Resident #129's January 2018 physician orders were reviewed. The physician orders read "Humalog Kwikpen 100 unit/ml (millililer) 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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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		MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	+	495133	B. WING	* ************************************	C 01/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE	
VALLEY	HEALTH CARE CENTER			940 EAST LEE HIGHWAY	
				CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENT:FYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 757	Continued From page	19	F 75	7	
	record, the DON state facility.	d she was not out of the		•	
	No further information exit conference on 1/2	was provided prior to the 26/18.		•	
	ordered parameters for sliding scale insulin for	led to follow the physician or the administration of r Resident #1. The facility incorrect amount of insulin m.			
	1/26/18. Resident #1	Resident #1 was reviewed was admitted to the facility ed 1/3/17 with diagnoses			
	that included but not li 2 diabetes mellitus, ga	mited to hypertension, type astroesophageal reflux Vitamin B12 deficiency, eficiency, dysphagia,		į	į
	Resident #1's quarterly assessment with an as	y minimum data set (MDS) ssessment reference date essed the resident with a	part.		
	reviewed 1/25/18 incluendocrine system relational Diabetes and hx (histo Interventions: Administrations)	ted to Insulin Dependent ry of) hypothyroidism. ter medications/insulin per n glucometer readings and			
	The surveyor reviewed record on 1/26/18 at 8: physician orders read fas follows: Humalog K	35 AM. Resident #1's or diabetic management			

(milliliter) sol (solution) Fingerstick blood sugar

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	CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	OMB NO. 0938-039
	, wor grain o	COUNTECTION	IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED
-	'					i
I	NAME OF C	PROVIDER OR SUPPLIER	495133	B. WING		C
	MANIE OF F	WOAIDER OK 2014 TIEK			STREET ADDRESS, CITY, STATE, ZIP CODE	01/26/2018
I	VALLEY	HEALTH CARE CENTER			940 EAST LEE HIGHWAY	
l		21.1.1.1			CHILHOWIE, VA 24319	
I	(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	IO PREFIX	PROVIDER'S PLAN OF COR	RRECTION (X5)
	TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHIVIDSE
ŀ		•			DEFICIENCY)	THOUSAIC DAIE
ĺ	F 757	Continued From	00			
	. , 0,	Continued From page		F 75	5 <b>7</b> ]	
		before meals & at bed	time, 1 dose iding scale use as directed			
		for diabetes. Humaloc	Kwikpen 100unit/ml sol:			
		150-200=4 units; 201-	250=7 units; 251-300=11			
		units; 301-400=16 unit	s; > 400=22 units. Do not			
		need to notify MD.				
		The surrouse envisors	IAL. I BOLD			
		Flowsheets. On 1/18/	the January 2018 Diabetic 18 at 1130 a.m., the blood			
		sugar was 274 and 7 u	inits of Humalog insulin			
		were documented. Ba	sed on the physician order			
		11 units of Humalog in:	sulin should have been			
		administered-not 7 as a	documented on the			
		flowsheet. The survey	or interviewed the unit			
		am After registered no	rse #1 on 1/26/18 at 8:39			
		R.N. #1 agreed an inco	e blood sugar flowsheet			
	:	was given.	stock distributif di Bisula)			·
		The surveyor informed	the director of nursing of			
		the above concern on 1	/26/18 at 8:51 a.m.			
	i	No further information v	vas provided prior to the			
		exit conference on 1/26	/18.			
	F 760	Residents are Free of S	ignificant Med Errors	F 760	E760 D	
	SS=D (	CFR(s): 483.45(f)(2)		. 140	F760-D	
	7	The facility must ensure	that its-		1) Corrective Action	n for
		483.45(f)(2) Residents	are free of any significant		those residents fo	
	r	nedication errors.			be affected by the	
		This REQUIREMENT is	s not met as evidenced		deficient practice	
		ly: Rasad on observation	AAAM turk da aa aa			•
	,	Based on observation,	staff interview, facility linical record review, the		Cited Residents #3	104 and
	fa	acility staff failed to folio	mucal record review, the		#40 physician and	
	ti	he administration of me	dication for 2 of 31		responsible party r	
	F	esidents (Resident #30	4 and Resident #40)			
		_			with no new orders	SOT

concerns.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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	. 14.40 - 40.1-40.1
	ATE SURVEY OMPLETED
495133 B. WING	C 01/26/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	0172072010
VALLEY HEALTH CARE CENTER 940 EAST LEE HIGHWAY	
CHILHOWIE, VA 24319	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFY:NG INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 760 Continued From page 21 F 760 E 2) Like Residents	
The findings included	
Residents who receive	
1. The facility staff failed to follow physician digoxin and residents who	
orders for Resident #304's administration of are on insulin have the	
Digoxin. The physician order read "Digoxin 125 potential to be affected, mg (milligrams) 1 tab (tablet) po (by mouth) q	
(every) day Hold for HR (heart rate) < (less than)  3) Systemic Changes put	
60-a fib." Licensed practical nurse #1 failed to into place to ensure the	
cotain the healt rate prior to the administration or	
does not recur	
The surveyor observed a medication pass on 1/24/18 with licensed practical nurse #1, L.P.N. Education completed by the	
the amountain and foreign to the state of th	
including Disavin 0.125 mg   D.N. #1	
administered Resident #304's digoxin on 1/24/18  Nursing/Designee with	
at 8:52 a.m. L.P.N. #1 did not obtain the heart licensed nurses to ensure	
rate of Resident #304 prior to administering the apical pulse is obtained	
Digoxin. before administration of	-
The surveyor interviewed L.P.N. #1 on 01/24/18 applicable medication and	
following sliding scale	
prior to giving the digoxin. I usually check a radial coverage.	
pulse. I've aiready self- reported myself to the	
DON."  4) Corrective actions to	I
ensure that the deficient	
The surveyor informed the director of nursing of practice will not recur.  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 Director of Nursing or	
standards of nursing practice for administration of designee will complete	į
Digoxin. audits of medication	ļ
administration observations	7
The surveyor reviewed the facility policy on to ensure appropriate vital	Î
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 medications administered	
confirm the medication name and dose with the as ordered 3x week x 3	

MAR. 13. Perform any pre-administration

months.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAL

		MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·		OMB NO. 0938-039
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	9. WNS		С
NAME OF F	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	01/26/2018
VALLEY !	HEALTH CARE CENTER		1	AST LEE HIGHWAY	
			СНІЦ	HOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMBLETION
F 760	Continued From page	. 20			
	assessments."	: 22	F 760	Audit findings will be	
	a5555511181115.			reviewed monthly in the	2
	The DON provided the	e surveyor on 1/24/18 the		quality assurance and	
	policy titled "Example:	s of Medications Requiring		performance improvement	ant
	Blood Pressure and/o	Pulse Rate Monitoring		process for	
	Include but Limited to	the Following:"		tracking/trending and an	ha.
	'	_		necessary additional	')
	II. A Daily Pulse is red	commended with the use of		interventions.	
	the following group of	medications:		mer ventions.	İ
	A. Cardiac Glycosides		מ	ate of compliance: 2/23/18	j
	Brand name	Generic Name	D	and of compitance. 2/23/16	
	Crystodigin	Digitoxin			•
	Lanoxin	Digoxin			
	Lanoxicaps	Digoxin	:		
	No further information exit conference on 1/2	was provided prior to the 6/18.			
	Resident #304 was add	mitted to the facility 1/16/18 luded but not limited to			
	CVA. diabetes mellitus	, hyperlipidemia, dementia,			
	chronic back pain, atria	il fibrillation, hypertension,	•		
*	acute renal failure, hyp	ercalcemia, and			
	gastroesophageal reflu	x disease.			
	Resident #304's admis (MDS) was not complet	sion minimum data set ted.			
	<ol><li>The facility staff faile Resident #40 as ordere</li></ol>	ed to administer insulin to			
	Resident #40 was read	mitted to the facility on			
	11/6/17 with the following	ng diagnoses of, but not			1
i	imited to anemia, coror	ary artery disease, heart			j
1	failure, high blood press	sure, diabetes and end			I
	stage renal disease. O	n the significant change			
ŧ ſ	MDS (Minimum Data Se Assessment Reference	et) with an ARD Date) of 11/13/17 coded			
t	he resident as having a	BIMS (Brief Interview for			1
<u> </u>	···· y c	(energiate) view (0)			i

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FORM	APPROVED	)
~		

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO AGREGAT	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		495133	B. WING_			C 01/26/2018	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 01120/2010	
VALLEY	HEALTH CARE CENTER			940	EAST LEE HIGHWAY ILHOWIE, VA 24319		
(X4) ID PREFIX IAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(XS) IE COMPLETION ATE DATE	
F 760	Continued From page	23	F 7	'60			
	Mental Status) score	of 13 out of a possible score					
	of 15. Resident #40 v	vas also coded as requiring					
	limited assistance of a	staff member for dressing				,	
	and personal hygiene						
	. , , ,						
	The surveyor perform	ed a review of the resident's					
	clinical record on 1/25	V18. The "Diabetic					
	Flowsheet" for the mo	nth of January 2018 was					
	also reviewed. The si	rveyor noted the following					
	documentation as to ti	he amount of insulin the					
	resident received for t	he following dates and					
	times: 1/1/18 at 4:30 p	m 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 suga	ar was 214 with 6 units of				•	
	insulin given and 1/22	/18 at 11:30 am Blood					
	sugar was 195 with no	insulin given.				•	
:							
ì	The surveyor also revi	ewed the physician orders					
		The orders for insulin were					
	as follows per sliding s						
:	" "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				·	
	insulin and notify MD (	ugar) >400, give 12 units of					
	madici and notify MD (	medical doctor)					
	When the surveyor rev	iewed the physician orders					
	for insulin and compan	ed it to the above sliding					
	scale for the amount of	f insulin to be given, the					
	surveyor noted that the	above documented units					
	of insulin was given inc	correctly by the facility staff					
	to Resident #40.						
	The surveyor notified th	ne DON (director of				İ	
	nursing) of the above d	ocumented findings on					

1/25/18 at approximately 5 pm in the conference

CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				FURM APPROVE
SIMEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTIPI	E CONSTRUC	TON	OMB NO. 0938-039
AUTO PART	DE CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		TION	(X3) DATE SURVEY COMPLETED
		495133	B. WING			C
NAME OF	PROVIDER OR SUPPLIER			TOEST ADD		01/26/2018
VALLEY	HEALTH CARE CENTER				ESS, CITY, STATE. ZIP CODE	-
				940 EAST LEI CHILHOWIE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		JUNE TOWN		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(E CR	PROVIDER'S PLAN OF CORRECTION FACH CORRECTIVE ACTION SHOULD & DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETON
F 760	Continued From page	24		•		
	room.		F 760	-		
	No further information	was provided to the xit conference on 1/26/18.	:	:		
F 761	Label/Store Drugs and	Riclosiante				
SS=E	CFR(s): 483.45(g)(h)(	1)(2)	F 761	F761-	Е	
	§483.45(g) Labeling of	Drugs and Biologicals		1)		:
	Drugs and biologicals	used in the facility must be		1)	Corrective Action for	
	labeled in accordance	With currently accepted			those residents found	
	professional principles	, and include the			be affected by the alleg	ged
	appropriate accessory	and cautionary			deficient practice.	
	instructions, and the exapplicable.	piration date when				
					All undated and expired	
	§483.45(h) Storage of	Drugs and Riologicals			medications were	
		<del>"</del>	ī		immediately dated or	
	§483.45(h)(1) In accord	fance with State and			discarded.	
	rederal laws, the facilit	V Must store all drugs and	•			
	Diologicals in locked co	mpartments under proper		2)	Like Residents	
	nersonnel to bacca a	nd permit only authorized	\$	-		
1	personnel to have acce	ss to the keys.			Medication	ĺ
	§483.45(h)(2) The facili	ty must provide separately			carts/refrigerators were	
1	locked, permanently aff	ixed compartments for			audited immediately for	
	storage of controlled dru	JOS listed in Schedule II of			expired meds/vials. Also	
	ilie Comprenensive Dru	© Abuse Prevention and			audited for proper dating	of
,	Control Act of 1976 and	Other drugs subject to			vials/medicationsRevie	Ot.
6	Bouse, except when the	facility uses single unit			completed by the Directo	
Į.	package drug distributio	n systems in which the			of Nursing/designer	н
? 4	quantity stored is minim. De readily detected.	al and a missing dose can			of Nursing/designee.	1
י ק	This REQUIREMENT is	n mai mark an an dit		]		
b	ing vegolvement is	not met as evidenced		1 ~	C	
	Based on observation,	staff interview familie.		3)	Systemic Changes put	
d	locument review and cli	nical record review, the			into place to ensure the	-
15	scility staff failed to labe	and date opened bottles			alleged deficient practic	e l
0	f medication and failed	to discard medications			does not recur.	

CENTER	<b>LS FOR MEDICARE &amp;</b>	MEDICAID SERVICES					OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WING				C 01/26/2018
NAME OF P	ROVIDER OR SUPPLIER				STR	REET ADDRESS. CITY, STATE, ZIP CODE	
VALLEY H	HEALTH CARE CENTER		l	1	940	EAST LEE HIGHWAY	
				<u></u>	CHI	IILHOWIE, VA 24319	
(X411D PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 761	Continued From page	ue 25	F 7	761	<u> 1</u> :	Education completed by	w the
	• -	ired for 4 of 31 residents		,	۱ ا	Director of	y uic
	•	dent #86, Resident #251, and				Nursing/Designee with	
	Resident #129) and f	failed to ensure narcotics				licensed nursing staff of	
	were stored in a pern				1	dating vials/medication	
	•	3 medication storage rooms				after opening & discard	
	(Unit 1).				1	vials/medications before	
	The findings includer	d:				expiration dates.	e
	F 761 Continued From pa when they were ex (Resident #62, Res Resident #129) and were stored in a pe compartment in 1 of (Unit 1).  The findings includ  A). The facility staff when opened and that had expired.  The surveyor toure both of the medicat 01/23/18 06:14 PM  The surveyor and lichecked medication insulins for dates we Levemir Flex Touch not dated when openes were suppose L.P.N. #5 stated insulins days after opening. #5 stated.  The surveyor and L bottle of eye drops sol 0.2% had no day on the bottle. L.P.N. opened were suppopened.		•			expiration dates.	
		ailed to date medications				4) Corrective actions to	
		iled to discard medication			- 1	ensure that the deficie	
	that had expired.		-				
	The surreyor toured	the first floor and observed				practice will not recur	<b>`•</b>
			•		.		
	01/23/18 06:14 PM.					Director of Nursing or	
						designee will complete	
		ensed practical nurse #5				medication cart/refriger	
						audits 3x week x 3 mon	
					-		ims
:		ned. L.P.N. #5 stated insulin			į	and then monthly x 2.	
		to be dated when opened.				A 1*. (** 1* 128 1	
	that had expired.  The surveyor toured to both of the medication 01/23/18 05:14 PM.  The surveyor and lice checked medication of insulins for dates when Levemir Flex Touch point dated when open pens were supposed L.P.N. #5 stated insuling days after opening.	ilin pens were good for 30				Audit findings will be	
		"I will waste this one," L.P.N.				reviewed monthly in the	3
	#5 stated.					quality assurance and	
	The europer and I I	3 N #5 step observed a				performance improveme	ent
		or Resident #62. Combigan				process for	
	- ·	when opened on the box or				tracking/trending and ar	ıy
		#5 stated medications				necessary additional	
	opened were suppose	ed to be dated when				interventions.	
	. opened.				-		
	The surveyor and I (	P.N. #5 observed an opened			ļ	Date of compliance: 2/15/18	
	•	for Resident #86 that did not					`
		ened. L.P.N. #5 stated the					
	inhaler was to be date						

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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO, 0938-039
	FCORRECTION	iDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B WNG_	CROSS-REFERENCED TO THE APPR DEFICIENCY)	С
	VALLEY HEALTH CARE CENTER  (XALID SLIMMARY STATEMENT OF DEFICIENCES			940 EAST LEE HIGHWAY	01/25/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OLD 3E COMPLETION
F 761	The surveyor and lice checked the medicaticare unit at 01/23/18 cart contained an insufor Humalog 100 unit/#3 stated she thought for 28 days. The survinsulin pen had expired The surveyor requested labeling and dating drand insulin from the discourse checked the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor requested to the surveyor request	on sed practical nurse #3 on cart on the dementia 07:01 PM. The medication ulin pen for Resident #251 Iml dated 12/20/17. L.P.N. Ithe insulin pen was good reyor asked L.P.N. #3 if the Id. L.P.N. #3 stated "Yes."  ed the facility policy on ugs, medication storage irector of nursing on 1/24/18 It stated she would expect	F 76	; <b>1</b>	
	The surveyor reviewed	d the facility policy titled			

medications will be labeled with the following minimum information: k) expiration date."

The surveyor reviewed the Orug Storage Requirements" for insulin on 1/25/18 at 1:58 p.m.

"Medication Labeling" on 1/25/18 at 10:27 a.m. The policy read in part "All resident specific

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.

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			. FORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WING		01/26/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	HEALTH CARE CENTER			940 EAST LEE HIGHWAY	
				CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761	Continued From page	27	F 76	1	
		nsed practical nurse #5		•	
	checked the medication	on 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 d	id not contain any type of			
	lock. When L.P.N. #5	opened the tool box, a vial			
	of Morphine Sulfate 1	00 mg/5 ml (20 mg/ml) with			
	a synnge was found in	nside a clear, plastic box			
	Within the fool box. Li	PN #5 thinks it's a refill for			•
	the Pixus but stated th	e morphine sulfate should			
	a tie back on the tool i	.N. #5 stated she would put			
	a tie pacy oil tile fool i	30X.			÷ !
	01/24/18 07:54 AM TH	e surveyor interviewed the			
	DON. She stated she	thinks the tool box was tied			
	when it arrived at the t	acility. The tool box does			
	not have a list of conte	ents. The DON stated			,
-	nurses cannot put med	dications in the Pixus. The			
,	DON stated the pharm	acist from Richmond was			
	made aware of the cor	ncern. Nurses do not have			
:	access to the Pixus to	load the drugs. The			
	surveyor requested the	∍ facility policy on			
	medication storage fro	m the DON.			
	ጠ1/24/18 ጠ3-07 D&# T%</td><th>e surveyor spoke with other</th><td>•</td><td></td><td></td></tr><tr><td></td><td>#1, Care 1 pharmacy a</td><th>e surveyor spoke with other</th><td></td><td></td><td></td></tr><tr><td></td><td>stated the pharmacy w</td><th>as trying to figure out</th><td></td><td></td><td></td></tr><tr><td></td><td>why/when the Morphin</td><th>e Sulfate was sent to</th><td></td><td></td><td></td></tr><tr><td></td><td>facility. Other #1 state</td><th>d the pharmacy was trying</th><td></td><td></td><td></td></tr><tr><td></td><td>to figure out if the drive</td><th>r may have left the wrong</th><td></td><td></td><td></td></tr><tr><td></td><td>box. Two ties are supp</td><th>osed to be used and a lock</th><td></td><td></td><td></td></tr><tr><td></td><td>for narcotics. Other #1</td><th>stated she was awaiting</th><td></td><td></td><td></td></tr><tr><td></td><td>pharmacy manifest. O</td><th>ther #1 stated a local</th><td></td><td></td><td></td></tr></tbody></table>				

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

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

1			<del></del>		<del></del>		MB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER  (X4) ID SUMMARY: PREFIX (EACH DEFICIENTED REGULATORY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERT	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		NSTRUCTION		X3) DATE SURVEY COMPLETED			
		495133	8. WING				С		
NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FIXED REGULATORY OR LSC IDENTIFYING INFORMAT REGULATORY OR LSC IDENTIFYING INFORMAT REGULATORY OR LSC IDENTIFYING INFORMAT REGULATORY OR LSC IDENTIFYING INFORMAT REGULATORY OR LSC IDENTIFYING INFORMAT REGULATORY OR LSC IDENTIFYING INFORMAT THE DON STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED STATED ST			STREET ADDRESS, CITY, STATE, ZIP C 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319				01/26/2018 ODE		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID Prefi Tag	×	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE		
F 761	DON The DON states the manifest for the M had no clue what was label." The DON state containers with a zip t	d she had not yet received S. The DON stated she in the box. "There was no d the tool boxes are sealed ie. "I've never seen a lock	F	761 ·					
	DON. The facility man The manifest had no id who filled the RX, nam did not have a signatu name, and date at the requested the facility preceived from the phan	nifest was dated 1/19/18, dentifiable information as to be and date (all blank) and re as to when received, facility. The surveyor policy on process once the control of the current policy.							
:	"Storage of Medication read "Compartments (in drawers, cabinets, root and boxes) containing be locked when not in used to transport such unattended if open or compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the compared to the	s" on 1/25/18. The policy ncluding but not limited to, ms, refrigerators, carls, drugs and biologicals shall use, and trays or carls items shall not be left							
	exit conference on 1/26 Provided Diet Meets No		F 80	10 F8(	00-D	,			
	§483.60 Food and nutri The facility must provid nourishing, palatable, w meets his or her daily n dietary needs, taking in preferences of each res	e each resident with a rell-balanced diet that utritional and special to consideration the		11.	1) Corrective Act those residents be affected by deficient pract	found to the alleged			

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		MEDICAID SERVICES		•	OMB NO. 0938-039
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MJLTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WING		C
NAME OF F	PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	01/26/2018
VALLEY	HEALTH CARE CENTER			10 EAST LEE HIGHWAY	
7/1	TEALIS VAILE VEITIER			HILHOWIE, VA 24319	
(X4) ID PREFIX YAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 800	Continued From page	e 29	F 800	CNA I/II were imme	adiatal.
		T is not met as evidenced	P OUU	educated on reviewin	
	by:	15 HOUSEL 65 EVICEHES		card before moal set	ng tray
i	Based on observation	on, resident and facility staff		card before meal sen	ар,
	interviews and clinical	al record review it was		honoring food prefer	rences,
	determined the facility	y staff failed to honor food		and offering substitu	tions.
	preferences for 3 of 13	13 residents (Residents			
	#140, 76 & 130).			2) Like Residents	
	Findings:			Residents residing in	ı the
	1 Facility staff failed f	to honor Resident #76's food		center had the potent	rial to
	oreferences. The resi	to nanor Resident #76's food ident's clinical record was		be affected.	***************************************
	reviewed on 1/24/18 a	at 9:00 AM			
				3) Systemic Changes p	<b>&gt;&gt;&gt;</b>
	Resident #76 was adr	mitted to the facility on		into place to ensure	
-	<ul> <li>6/14/17. Her diagnose:</li> </ul>	es included Parkinson's		alleged deficient pra	
	disease and depression		•	does not recur.	icuce
	· · · · · · · · · · · · · · · · · · ·	·		MUCS HOLICLMI.	<u>;</u>
	The resident's latest to	MDS (minimum data set)		Education completed	
	assessment, uateu 12/	2/12/17 coded the resident		Education completed	by the
·	as cognitively unimpair assistance of at least of	ared. She required the one staff member to assist		Director of	<b>!</b>
	her with the ADLS (ac	one starr member to assist clivities of daily living). She		Nursing/Designee to	CNAs
	could eat unassisted v	with a tray set-up only by		to review tray cards to	
	staff members.	atti a tiby dot-up orny by		validate that resident	
4				receiving the appropri	iate
	The resident's CCP (cr	comprehensive care plan)		meal including prefer	rences
	reviewed and revised r	on 12/12/17 documented		and offering substituti	ions if
		compromised nutritional		applicable.	101-0
	status related to variab	ble intake of meals and		Education completed	har
•	increased nutrient neer	eds for healing. The staff		Culinary Services Ma	uy magar
	interventions were reco 1. Honor food preference			to dietary staff to read	
	2. If meals refused, offe			cards and ensure that	i tray
	nourishments.	anprovide extra			
	Abullatification.			residents are receiving	
	The resident's physicia	an orders, signed and dated		preferences as approp	riate.
	on 1/2/18, contained ar	in order for a regular diet.			

The resident was not restricted to her choice of

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		MEDICAID SERVICES					OMB NO. 0938-039
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		TRUCT	FION	(X3) DATE SURVEY COMPLETED
		495133	B. WING_			_	С
NAME OF P	ROVIDER OR SUPPLIER	* · · · · · · · · · · · · · · · · · · ·		STREET	ADDRE	SS, CITY, STATE, ZIP CODE	01/26/2018
VALLEY F	EALTH CARE CENTER						
				CHILHO	)WIE,	VA 24319	
(X4) ID PREFIX IAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(E,	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE
F 800	Continued From page	30	F 8	, D0	4)	Corrective actions to	
	foods.		· <del>-</del>		4)		.4
	0-04/00/40 07 40	<b>444 -</b> 14 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4					ıı
foods.  On 01/23/18 at 07: asked about her m here leaves a lot to I get stuff that look call it something el foods they serve. I the farm, beans an	On 01/23/18 at 0/:12	AM Resident #76 was		i		processor new morticent.	
	here leaves a lot to be	s. One replied, The 1000		i		Director of	
	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		ļ		Nursing/designee will		
	call it something else.	I don't like all these new		Į		complete observation of	
	foods they serve. I like	to get food like we had on				meal service to validate	:
	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 the	otatoes and corn bread.		ļ		accuracy of meal and	•
On 01/23/18 at 0 asked about her here leaves a lot I get stuff that lor call it something foods they serve the farm, beans The simple foods so hard, right? The pay any attention right on the plate guess the mashes	so hard, right? They d	on't follow the tray card or				honoring of preferences	3 x
	pay any attention to fo	ods I don't like they go				week x 3 months.	
	right on the plate with	the rest of it. I mean I				<b></b>	
	guess the mashed pot	atoes are instant and		STREET ADDRESS, CITY. STATE, ZIP CODE  940 EAST LEE HIGHWAY CHILHOWIE, VA 24319  PROVIDERS PLAN OF CORRECTIVE ACTION SECROSS-REFERENCED TO THE APDEFICIENCY)  300  4) Corrective actions ensure that the depractice will not respect to a complete observation meal service to valid accuracy of meal and honoring of prefere week x 3 months.  Audit findings will reviewed monthly in quality assurance are performance improve process for tracking/trending and			
	they're ok if they're fixe	of right. But half the time				4 33 M 97 A44	
	or butter in them or the	they didn't put enough milk by sat for too long before		•		~	
	they were served. It's a	shame."				-	
						· -	
	On 1/24/18 @ 12:30 P	M the surveyor checked on her lunch meal. There		,			I.
		t, and both room residents					
	waiting in the room say	the trays are always late.				necessary additional	

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

interventions.

Date of compliance: 2/23/18

		MEDICAID SERVICES				OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495133	6. WING			Ì	C
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		01/26/2018
	VALLEY HEALTH CARE CENTER  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800  Continued From page 31 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				AST LEE HIGHWAY		
VALLEY	EALTH CARE CENTER			1	HOWIE, VA 24319		
/VA) IO	TO VOAMMED	ATEREMS OF DESIGNATIONS		01110			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 800	Continued From page	<del>-</del> 31	F	800			
	with cooked carrots, o	auliflower and broccoti in it	, ,	550			
	resident and CNA I di	dn't offer a substitute for					
	that either. The CNA	heard this conversation, but					
	for carrots or the salad	d. She left the room.					
	The currowar was no	eent at 1:55 DN when the					
	CNA I returned to nick	sen at 1.33 FM when the					
	carrots on the plate ar	nd the marinated salad in it					
carrots on the plate an was untouched. She n		never offered a					
		er if she wanted anything					
	On 1/25/18 at 9:07 AN	I the RD (registered					
		wed about the process of					
	food substitutions if the	e resident received a food					,
	they did not like and w	rished 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 wh						
		ry staff would call each					
	nursing station for the						
-	substituted foods direct	ctly to each unit.					
	This observation was i	reported to the					
	administrator and DON	V on 1/25/18 at 11:30 AM.					
	2. Facility staff failed to	honor Resident #140's					
	food prefereneces and	offer substitute foods					
		lissatisfaction with the meal					
	she was given. The re	esident's clinical record was					į
	reviewed on 1/24/18 at	t 4:00 PM					
	Resident #140 was ad	mitted to the facility on					ļ
		es included: Blindness,					#
	hypertension, anxiety,						
	The latest MDS (minim	num data set) dated					

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		MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495133	B. WING		C 01/26/2018
VALLEY I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 800	vision. She was coder impairment with respersedent's communications. Resident #140 requires	d with some cognitive oct to her memory. The otton skills were unimpaired of the assistance of at least all the ADLS (activities of coded as able to eat	F 80	6	

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.
- 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

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	ĒΥ
NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER  VALLEY HEALTH CARE CENTER  VALLEY HEALTH CARE CENTER  VALUEY HEALTH CARE	
NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER  VALLEY HEALTH CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800 Continued From page 33  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	
VALLEY HEALTH CARE CENTER  940 EAST LEE HIGHWAY CHILHOWIE, VA 24319  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800 Continued From page 33  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	18
CHILHOWIE, VA 24319  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800 Continued From page 33  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	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MJST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800 Continued From page 33  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	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 800 Continued From page 33  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	
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	(XS) PLETION JATE
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	
the wrapper was set off to the right side of the plate.  The surveyor asked the resident why she was not	
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	
Resident #140 said she usually found her tood with the assistance of her roommatewho 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 mealor even leave behind the	
untouched sandwich.	

DEPART	PRINTED: 02/13/201 FORM APPROVEI OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495133	B. WING		С
NAME OF PROVIDER OR SUPPLIER  VALLEY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/26/2018
				940 EAST LEE HIGHWAY	
				CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD RE COMPLETION
F 800	Continued From page	34			
	On 1/25/18 the DON was informed of these		F 8	00	
	observations and aske	ed about Resident #140's			
	tray set-up and choice	of foods. The DON said			
	the staff had been train	ned to deliver food to			
	visually impaired resid	ents 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		*	•	
	I and both of them ack supposed to use the faresident where her foo practice what they pred the unopened milk the opened it because the anyway. My question to want milkwhy didn't yelse?"	spoken to CNA II and CNA nowledged they were ace of the clock to tell the d was located. "They don't ach. When I asked about CNA told me she never resident never drank it o her was if she doesn't ou offer her something			
	The DON said the residence honored and the stranssistance to set-up he	dent's preferences were aff did not offer adequate or tray.			
	made by Resident #130 Resident #130 was adn	strator and DON. ad to honor food choices  inited to the facility on 10/27/17 with diagnoses hited to hypertension, es mellitus, muscle			

amputations.

anemia, and bilateral below the knee

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

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		MEDICAID SERVICES				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495133	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER	1 744.44		STREET ADDRESS, CITY, ST		01/26/2018
				940 EAST LEE HIGHWAY	AIE, ZIP CUUS	
VALLE: 1 .	VALLEY HEALTH CARE CENTER			CHILHOWIE, VA 24319		
1X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
F 800	Continued From page	<u>35</u>	F 8	00		
	assessment dated 1/8/18 coded the resident as		FO	JU		
	cognitively intact with	a BIMS score of 15/15.				
	Resident #130 was no	ot coded with any negative				
	behaviors to other residents or staff members. The MDS coded Resident #130 as independent					
	in eating with staff pro	dent #130 as independent widing set up help only.				
	plan) updated 1/8/18 of with the problem that in developing compromis to therapeutic diet." In "Honor food preference offer/provide extra nou provide diet/supplement	sed nutritional status related hterventions/Tasks read les. If meals refused, urishments, liberalized diet.				
	were for a no added sa	moer 2017 dietary orders alt (NAS) and low		•		:
	concentrated sweets (I	LCS) diet.		•		
-	initial tour on 1/23/18 a	d Resident #130 during the at 6:30 p.m. The resident do something about the it was me."				
; ;	#130 on 1/24/18 at 10:5 question about food wa	I and interviewed Resident 59 a.m. When the as asked, Resident #130 akfast is the best meal of		,		
t : :	at 12:45 p.m. Resident to have a bowl of mixed of sauce. Resident #13 going to eat the mixed to	I the lunch meal on 1/24/18 t #130's tray was observed d vegetables in some type 30 was asked if he were vegetable bowl. Resident cauliflower" and showed ray ticket which list				

cauliflower as a "dislike" food item. Resident

DEPARTMENT OF HEALTH AN	D HUMAN SERVICES
OCHTEDO COO MARIA	· ·

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CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVE
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUIT	1D) E	CONSTRUCTION	OMB NO. 0938-03
MUPLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. EUILDII			(X3) DATE SURVEY COMPLETED
	,	495133	B. WNG			С
NAME OF	PROVIDER OR SUPPLIER		10.11110-			01/26/2018
VALLEY	UCALTU OADE DELE	,			TREET ADDRESS, CITY, STATE, ZIP CODE	
VALLE	HEALTH CARE CENTER				10 EAST LEE HIGHWAY HILHOWIE, VA 24319	
(X4) IO	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(7-0)
F 800	Continued From page	36	,	•		
		ontrol my diabetes with my	F 8	00		
	diet but the kitchen se	ends fried food, sugary				
	desserts, and foods a	diabetic shouldn't have "				
	The resident stated he	e liked ham and cheese and				
	peanut butter but ther	that's all they would send				
	"I would like a little va	riety."				
	The diet ticket had mu	ultinia inetzuationa far				•
	Resident #130's food	preferences: When send				
	sandwich as a substitu	ute do not send ham and				
	cheese, do not send a	iny foods made with				
	tomatoes, do not put b	rown gravy on any of his				
	100d, 2% milk, dislikes	: Spicy foods (spaghetti				
	lasagna, pizza, kielbas	ia. Italian sausage); dessert				
	(ice cream, gelatin); be	everages (coffee,		:		
	lemonade, tea); vegeta beans, Brussel sprouts	s brosseli seisest				
	greens, zucchini, squa	s, bioccoii, spinach, sh cabhage grite				
	colesiaw, lima beans, i	baked beans, cauliflower);				
	fruit (oranges, orange j	uice).				
	01/25/18 09:23 AM Sp	oko with engidens stil				
	morning. States last ni	ight dinner was chicken				
	and "I had to wipe a lay	er of grease off of it.				
4	didn't eat it." Resident	states he would like to				
	have chicken salad. N	o more peaches, no more				
i	fruit. The resident state	d he would also like some				
•	cottage cheese.					
(	01/25/18 09:38 AM The	SULVEVOL GISCHESEY				
i	Resident #130's food co	oncerns with the RD. The				
ŀ	RD stated that she had	visited with him and had				Į.
r	modified his meal plan a	and that the facility does				
r	not fry anything. The ch	nicken last night had a				
	noney orange glaze. Th	he RD stated that				
<u>;</u>	resident #130 had so n	nany dislikes that they all				Ì

don't fit on the card. She stated he has a copy of the posted menu and stated he knows he can

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

PRINTED: 02/13/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
		495133	B. WNG			C
	ROVIDER OR SUPPLIER			STREET ADDRI 940 EAST LEE CHILHOWIE,		01/26/2018
(X4) ID PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
	lunch 1/24/18. She s many dislikes there's Cauliflower is listed at The facility administra of the surveyor's findi	with him again. Also auliflower on the tray at tated the resident has so not enough room. s a dislike.  Itor and DON were informed ngs prior to the survey team	F	800		
	Resident Allergies, Pr CFR(s): 483.60(d)(4)(	5)	F	806 <u>F806-</u>		
		s and the facility provides- nat accommodates resident		1)	Corrective Action for those residents found be affected by the alle deficient practice.	
	food that is initially se different meal choice;	lents who choose not to eat rived or who request a		÷ + + + + + + + + + + + + + + + + + + +	CNA I/II were immediated on honoring for preferences, and offering substitutions.	ood
	Based on observation interviews and clinical determined the facility			2)	Like Residents  Residents residing in the center had the potential be affected.	
	a substitute for a food it. The resident's clinic 1/24/18 at 9:00 AM. Resident #76 was addr	s included Parkinson's		3)	Systemic Changes put into place to ensure the alleged deficient pract does not recur.	e

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

C

C

NAME OF PROVIDER OR SUPPLIER

95. WING

#### **VALLEY HEALTH CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY

CHILHOWIE, VA 24319

....

PREFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES ID
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX
REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

PRINTED: 02/13/2018

01/26/2018

#### F 806 Continued From page 38

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

F 806

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.

 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.

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES	·····		OMB NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495133	B. WING		C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	01/26/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 806	Resident #76 to reviewer no lunch trays y waiting in the room s.  The lunch tray arrived tray up for Resident # surveyor reviewed the cooked carrots as on	PM the surveyor checked on ew her lunch meal. There yet, and both room residents ay the trays are always late.  d at 1:04 PM—CNA I set the #76 in her room. The e tray card which listed e of the resident's "dislikes".	F 80	Audit findings will be reviewed in the quality assurance and performa improvement process for tracking/trending and an necessary additional interventions.  Date of compliance: 2/23/18	r	

The surveyor asked the resident (while CNA! 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

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

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495133	8. WING	C
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	01/26/2018

**VALLEY HEALTH CARE CENTER** 

940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) iD 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 812 Food Procurement, Store/Prepare/Serve-Sanitary SS=E 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

Based on observation and staff interview, the facility staff failed to store, prepare, and distribute food under sanitary conditions.

The findings included.

F 806

F812 | 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.

bv:

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMI	3 NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		495133	B. WING	i			C
NAME OF P	ROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE		01/26/2018
	NOTICE ( GIT OBI ) EXEN			1	· · · · · · · · · · · · · · · · · · ·		
VALLEY H	EALTH CARE CENTER			1	P40 EAST LEE HIGHWAY		
	<del></del>				CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 812	Cooks and Erom man	. 44	` _		-		
1 012	Continued From page		F	812	Education completed by	the	
		dietary department was			Culinary Services Mana		1
		eyor to have soured milk in			to food service employe		
		tainer. Three of the dietary			to ensure that floors are		
	food preparation.	heir hair in hairnets during			from spillage to include		
	rood preparation.				coolers and freezers and		
	On 01/23/18 beginnin	g at approximately 6:00				ior	
		companied by the dietary			all food service staff to		
		dietary department. When			ensure all hair is to be		
		ler the surveyor was able to			covered at all times.		
		tance resembling milk in the					
		Upon opening the cooler,	4) Corrective actions to				
		to smell a strong soured			ensure that the deficien	ıt İ	
		ervisor verbalized to the			practice will not recur.		
	•	smelled the odor and			Culinary Services Manage		
		substance in the bottom of			will complete kitchen	3	
	the cooler as being m contained one crate o				floor/hair net audits 3x		
:	contained one crate o	i itsik.			week for 2 months then		
	The milk cooler was n	echecked on 01/24/18 at					
	8:00 a.m. with no prot				monthly.	Ī	
					Audit information will be	;	
	On 01/24/18 at approx	kimately 1:00 p.m., the			reviewed monthly in the		
	surveyor observed thr	ee female dietary staff that			quality assurance and		
		preparation. These three			performance improvemen	1ţ	
		earing hairnets. However,			process for		
		completely cover the staff's			tracking/trending and any	ŗ	
		d with their hair uncovered			necessary additional		
	in the back and one st				interventions.		
	the attention of the die	sides. This was brought to			antor torrions.		
	acknowledged to the	* .			Date of compliance: 2/15/10		
		ot completely secured.			Date of compliance: 2/15/18		
	The administrator was	notified of the above					ŀ
	issues on 01/25/18 at	8:00 a.m.					Light of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state
	No further information	regarding this issue was					İ

provided to the surveyor team prior to the exit

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 /VA: 11 / D = /			OMB NO. 0938-0391
AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION   A. 5UILDING				ON	(X3) DATE SURVEY COMPLETED	
		495133	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER			STOREY ADDOC	00 000	01/26/2018
					SS, CITY, STATE, ZIP CODE	
VALLEY	HEALTH CARE CENTER		1	940 EAST LEE		
(Y4\ II)	CI MMSADV CT	ATELIEUT AT NECONOMIA		CHILHOWIE,	VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA	(XS) E COMPLETION ATE DATE
	•				DEFICIENCY)	
E 040						
F 812	Continued From page	42	F 812	2		
	conference.					
	Hospice Services		F 849	F849-L		
SS=D	. CFR(s): 483 70(o)(1)-	(4)		F047-1.	,	
	§483.70(o) Hospice se	nariana		_i 1)	Corrective Action for	
		term care (LTC) facility may		1)		4.
	do either of the followi				those residents found	
		vision of hospice services		1	be affected by the alle	ged
	through an agreement	t with one or more			deficient practice.	
	Medicare-certified hos					
	(ii) Not arrange for the				Contacted Hospice	
	services at the facility	through an agreement with			company and received	
	a Medicare-certified he	ospice and assist the			hospice notes for reside	nt i
	resident in transferring	to a facility that will			#95.	
	arrange for the provisi	on of hospice services				
	when a resident reque	sts a transfer,		2)	Like Residents	
	0.00 704 340 461		•	2)	Like Residents	
	9483.70(0)(2) It hospic	e care is furnished in an				
	LIC facility through an	agreement as specified in		•	Residents who receive	Į
	the LTC facility must me	his section with a hospice,			hospice services from	
	the LTC facility must m requirements:	leat the following			Southwest Home Health	1
	(i) Ensure that the hos	nice sandres most	-		and Hospice have the	
	professional standards	and principles that apply			potential to be affected.	I
	to individuals providing	services in the facility, and			-	
	to the timeliness of the	services.		3)	Systemic Changes put	
		ement with the hospice			into place to ensure the	. 1
	that is signed by an au	thorized representative of				
	the hospice and an aut	thorized representative of		-	alleged deficient practi	ce
	the LTC facility before !	hospice care is furnished to		į	does not recur.	
		en agreement must set out		į		
	at least the following:				Education completed by	the .
	(A) The services the ho	ospice will provide.			Director of	
	(B) The hospice's response	onsibilities for determining			Nursing/Designee to nur	rse
	the appropriate hospice	plan of care as specified			managers to ensure curre	ent
	in §418.112 (d) of this (	chapter.			hospice documentation i	
	(U) The services the LT	C facility will continue to			the resident chart weekly	
	provide based on each	residents plan of care.		!	•	1
				i	for CNA and nursing vis	iis.

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

		TOTAL SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTION OF SECTI					OWR M	<i>D.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		TRUCT	ion		SURVEY PLETED
		495133	B. WING			···		C /26/2018
NAME OF F	PROVIDER OR SUPPLIER	····		STREET	ADDRE	SS, CITY, STATE, ZIP CODE		
						HIGHWAY		
VALLEY	HEALTH CARE CENTER							
/ALDA 150	CUMMANYON	ATT 101.00		CIBER		VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(E/	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD I SS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 849	Continued From page	<del>2</del> 43	F 84	a	41	Corrective estimate	-	
		process, including how the		9	4)	Corrective actions to		
	communication will be	a documented between the				ensure that the deficie		
	LTC facility and the hi	ospice provider, to ensure				practice will not recur	<b>'</b> •	
	that the needs of the	resident are addressed and						
	met 24 hours per day			ĺ		Director of Nursing or		
	(E) A provision that the	e LTC facility immediately				designee will complete		
	notifies the hospice al	bout the following:		.		hospice chart audits we	ekly	•
	(1) A significant chang	ge in the resident's physical,				x 3 months to ensure th		
	mental, social, or emo	otional status.				hospice visit notes are o		
	(2) Clinical complication	ons that suggest a need to				the resident medical cha		
	alter the plan of care.	the regident form the facility		:				
	for any condition.	the resident from the facility				Audit findings will be		
	(4) The resident's dea	th.				reviewed monthly in the		
		that the hospice assumes				quality assurance and		
	responsibility for deter	mining the appropriate		•		performance improveme	nt	
	course of hospice care	e, including the				process for		
	determination to change	ge the level of services			•	tracking/trending and an	V	
	provided.					necessary additional	,	
	(G) An agreement tha	t it is the LTC facility's				interventions.		
	responsibility to furnish	h 24-hour room and board						
	care, meet the resider	it's personal care and		Dat	r of c	compliance: 2/23/18		
	nursing needs in coord	dination with the hospice		22 111		отфиансе, 2/23/16		
	representative, and er	sure that the level of care						
	resident's needs.	ely based on the individual						
		e hospice's responsibilities,						
	including but not limite	d to, providing medical						
	direction and manager	ment of the patient; nursing;						
	counseling (including s	spiritual dietanz and						·
	bereavement); social v	vork; providing medical						
	supplies, durable med	ical equipment, and drugs						
	necessary for the pallia	ation of pain and symptoms						
	associated with the ter	minal illness and related						
	conditions; and all other	er hospice services that are						
	necessary for the care	of the resident's terminal						
	illness and related con	ditions.						
	(I) A provision that who	en the LTC facility						

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES		-		FORM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						OMB NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BU:LO		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	8 WING_			C
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE. ZIP CODE	01/26/2018
VALLEY	HEALTH CARE CENTER		I		AST LEE HIGHWAY	
*********	CALL ONAL CERTER		ļ		.HOWIE, VA 24319	
(X4) 1D	SUMMARY ST	ATEMENT OF DEFICIENCIES	l			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 849	Continued From page	<del>2</del> 44	F8			
		sible for the administration	, ,	40		
	of prescribed therapie	s, including those therapies				
	determined appropria	te by the bosnics and				
	delineated in the hose	pice plan of care, the LTC				
	facility personnel may	administer the therapies				
	where permitted by St	tate law and as specified by				!
	the LTC facility.	ate law and as specified by				
		that the LTC facility must				
	report all alleged viola	tions involving				
	mistreatment, neglect	, or verbal, mental, sexual,		-		
	and physical abuse, in	cluding injuries of unknown				
	source, and misappror	priation of patient property				
	by hospice personnel,	to the hospice				
	administrator immedia	tely when the LTC facility				
	becomes aware of the	alleged violation				
	(K) A delineation of th	e responsibilities of the				
	hospice and the LTC fa	acility to provide				
	bereavement services	to LTC facility staff.		:		
	§483.70(o)(3) Each LT	C facility arranging for the				
	provision of hospice ca	are under a written				
	agreement must design	nate a member of the		-		1
	facility's interdisciplinar	ry team who is responsible				İ
	for working with hospic	e representatives to				ļ
	coordinate care to the	resident provided by the				
	LTC facility staff and ho	ospice staff. The				
	interdisciplinary team n	nember must have a				
	clinical background, fur	nction within their State				
	scope of practice act, a	and have the ability to				
	assess the resident or	have access to someone				
		capabilities to assess the				
	resident.					
	i ne designated interdis	sciplinary team member is				
	responsible for the follo					
(	(i) Collaborating with h	ospice representatives				
•	and coordinating LTC fa	acility staff participation in				
1	he hospice care planni	ng process for those				
1	esidents receiving thes	se services.				į

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	8. WING			С
MAKE OF D	PROVIDER OR SUPPLIER	970100	9.78.0_	1070		01/26/2018
NAME OF	ROVIDER OR SUFFEEN				EET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY H	HEALTH CARE CENTER	•			EAST LEE HIGHWAY	
	~			Chic	LHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<u>(                                    </u>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD S CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 849	Continued From page	ge 45	F£	349		
		with hospice representatives	•	-20-		
-		providers participating in the				
		the terminal illness, related				
		r conditions, to ensure quality				
	of care for the patient	•				
		e LTC facility communicates				
		dical director, the patient's		-		
		and other practitioners				
		rovision of care to the patient	•	•		
		nate the hospice care with the				
		ed by other physicians.  Iowing information from the				
	hospice:	Owing intomission non-me		•		
		t hospice plan of care specific				
	to each patient.	mapice plan or one oposition				
	(B) Hospice election	ı form.				
,	, , ,	cation and recertification of	:			
•		pecific to each patient.				
	•	tact information for hospice				
		n hospice care of each				
	patient.					
		now to access the hospice's				
	24-hour on-call system					
	· • -	tion information specific to				
-	<ul> <li>each patient.</li> <li>(G) Hospice physicia</li> </ul>	and attending shupining /if				
	any) orders specific to	an and attending physician (if				
	• • • • • • • • • • • • • • • • • • • •	LTC facility staff provides				
	` '	icies and procedures of the				
		ient rights, appropriate forms,				
		requirements, to hospice staff				:
	furnishing care to LTC					
		LTC facility providing hospice				
		agreement must ensure that				
		en plan of care includes both				
	the most recent nosp	pice plan of care and a				Į.

description of the services furnished by the LTC

DEPARTMENT	OF	<b>HEALTH AND</b>	HUMAN	SERVICES

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CENTE	RS FOR MEDICARE &	MEDICAID SERVICES	-		FORM APPROVED
1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	495133	8. WNG		C 01/26/2018
	HEALTH CARE CENTER		940	REET ADDRESS, CITY, STATE, ZIP CODE DEAST LEE HIGHWAY IILHOWIE, VA 24319	
IX4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TRE COMPLETION
	facility to attain or mai practicable physical, r well-being, as required. This REQUIREMENT by:  Based on staff intervirue review, the facility staff Hospice Services for 1 survey sample (Resident Fredility staff failed Services for Resident Fredility Services for Resident Fredility Services for Resident Fredility Services for Resident Fredility Services on and chronic disease. On the signification of 12/coded as having short memory problems with impaired in daily decision Resident Fredility Services and by Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Services on the surveyor conducter Fredility Ser	intain the resident's highest mental, and psychosocial d at §483.24. is not met as evidenced ew and clinical record of failed to coordinate of 31 residents in the ent #95).  It o coordinate Hospice #95.  It of 31 residents in the ent #95).  It o coordinate Hospice #95.  It of an existency on g diagnoses of, but not exheimer's disease, cobstructive pulmonary icant change MDS ith an ARD (Assessment 21/17; the resident was term and long-term being moderately on-making process. coded as being totally ember for dressing, pathing.  It are resident existency of the resident existency on the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the resident entry of the res	F 849		

the time of the review.

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

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

		T OCKAIOCO	<del></del>				OWR M	O. 0938-0391
		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			N	(X3) DATE SURVEY COMPLETED	
		495133	B. WING					C
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS	S, CITY, STATE, ZIP CODE	1 07	1/26/2018
					EAST LEE H			
VALLEY	HEALTH CARE CENTER							
	610000			C)	ILHOWIE, V	A 24319		
1X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	id Prefi Tag	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(XS) COMPLETION DATE	
F 849	Continued From page	± 47						
	· -	urveyor "I have to call the	F 849					
	hospice agency and o	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							
	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 880	Infection Prevention 8		F 8	80	F880-E	1	i	
SS≃D	CFR(s): 483.80(a)(1)(	2)(4)(e)(f)			1 000-2	,		
	§483.80 Infection Con	itrol			1)	Corrective Action for		
	The facility must estab				those residents found	to		
	infection prevention as	nd control program				be affected by the alle	ged	1
	designed to provide a	safe, sanitary and				deficient practice.	_	
	comfortable environme	ent and to help prevent the						
		smission of communicable				CNA #1 received		I
	diseases and infection	IS.				immediate education or	a the	l
	RADO ON/m) Infantion							
	§483.80(a) Infection program.	revention and control				proper seating arrangen		}
		lish an infection prevention				when providing feeding	3	ł
	and control program (	PCP) that must include, at				assistance to residents.	•	1
	a minimum, the followi	nn elements:						
	with the following	ay cichichts.			2)	Like Residents		
	§483.80(a)(1) A system	n for preventing, identifying,						
	reporting, investigating	, and controlling infections				Residents who receive		İ
	and communicable dis				feeding assistance have	the :	.	
	staff, volunteers, visito	rs, and other individuals				potential to be affected.	,	
i	providing services und	er a contractual				potential to oc attected.	•	
	arrangement based up	on the facility assessment			-	Contact Classes		
	conducted according to			[ 5)	Systemic Changes put			
	accepted national stan	dards;			ļ	into place to ensure th	3	
	**************************************				]	alleged deficient pract	tice	
	§483.80(a)(2) Written sprocedures for the pro-	standards, policies and gram, which must include,				does not recur.	1	
		7, 1111001 111031 1110HUGE,						. 1

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

STALEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIP	LE CONSTRUCTION	OMB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		A. BUILDING		COMPLETED		
	495133 E. WING			С		
NAME OF PROVIDER OR SUPPLIER				DYDCET ACCOUNT	01/26/2018	
			•	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	HEALTH CARE CENTER			940 EAST LEE HIGHWAY		
				CHILHOWIE, VA 24319		
(X4) ID PREFIX	SUMMARY ST/ (FACH OSSICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B	RE COMO! ETION	
		,	170	CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE DATE	
F 880	Continued From page	48	F 004		1	
	but are not limited to:		F 880	Education completed by	the	
·		lance designed to identify		Director of		
	possible communicab	le diseases or		Nursing/Designee with		
	infections before they	Can spread to other		nursing staff on proper	:	
	persons in the facility;			seating arrangement who	en Í	
	(ii) When and to whon			providing feeding		
	communicable diseas	e or infections should be				
	reported;			assistance per policy.		
	(iii) Standard and trans	smission-based precautions		4) Corrective actions to	1	
	to be followed to preve	ent spread of infections:		ensure that the deficien		
	(iv)When and how isol	ation should be used for a				
	resident; including but not limited to:			practice will not recur.		
	(A) The type and durat	tion of the isolation,		This A Chi		
	depending upon the in	fectious agent or organism		Director of Nursing or		
	involved, and	<b>n</b>		designee will complete		
	(b) A requirement that	the isolation should be the	÷	audits of meal observation	ns	
	circumstances.	le for the resident under the		3x week x 3 months.		
		under which the facility			į	
	must prohibit employee	es with a communicable		Audit findings will be		
	disease or infected ski	n lesions from direct		reviewed in the quality		
	contact with residents	or their food if direct		assurance and performan		
	contact will transmit the	e disease: and				
	(vi)The hand hygiene p	procedures to be followed		improvement process for		
	by staff involved in dire	ct resident contact.		tracking/trending and any	<i>'</i>	
				necessary additional		
	§483.80(a)(4) A system	n for recording incidents		interventions.		
	identified under the fac	ility's IPCP and the			İ	
	corrective actions takes	n by the facility.		Date of compliance: 2/23/18		
	\$492 90(a) Limama					
	§483.80(e) Linens.					
Personnel must handle, store, process, a transport linens so as to prevent the spre		, store, process, and				
	infection.	headur me sblesg of			İ	
	modern,					
	§483.80(f) Annual revie	NA.				
	The facility will conduct	an angual review of He			ĺ	
	IPCP and update their	MONAT AS DECASSAN				
IPCP and update their program, as necessary.		a.u., us nocessary.				

CENTERS FOR MEDICARE &	MEDICAID SERVICES	····		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
	495133	B. WING		C 01/26/2018
NAME OF PROVIDER OR SUPPLIER VALLEY HEALTH CARE CENTER		94	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST LEE HIGHWAY HILHOWIE, VA 24319	1 01120/2016
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
by: Based on observation document review the find established infection of Residents, Resident # The findings included: For Resident #123 the established infection of on Resident's bed while eating.  Resident #123 was add 07/09/13 and readmitted included but not limited vascular disease, hyperhemiplegia, depression pulmonary disease.  The most recent MDS an ARD (assessment in coded the Resident as cognitive status. Section coded the Resident as equivalent of extensive physical assist. This is  The surveyor observed breakfast on 01/24/18 and Resident with eating. Resident with eating. Resident with eating. Resident with eating. Resident at side of between the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at side of the resident at	is not met as evidenced  n, staff interview and facility facility staff failed to follow control guidelines for 1 of 31  2123.  It facility staff failed to follow control guidelines by sitting le assisting Resident with  mitted to the facility on ad on 10/23/17. Diagnoses d to anemia, peripheral erlipidemia, aphasia, an and chronic obstructive  (minimum data set) with eference date) of 01/08/18 15 of 15 in section C, on G, functional status, 3 of 2 in eating. This is the e assistance, one-person a quarterly MDS.  Resident #123 eating at approximately 0835. aide) #1 was assisting desident was seated in	F 880		

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STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIO IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED
		495133	B. WING_		c
NAME OF	PROVIDER OR SUPPLIER				01/26/2018
			1	STREET ADDRESS, CITY, STATE, ZIP CO	OOE
VALLEY	HEALTH CARE CENTER		I	940 EAST LEE HIGHWAY	
YATA	CLIBSIADY CT			CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 880	Continued From page	e 50	F8	len	
	Resident's bed. Surve normally sat on Resid him with eating and C	eyor asked CNA #1 if she dent's bed while assisting CNA #1 stated that she asks sit, "I don't just sit down".	1 <b>.</b>	au	
	01/25/18 at approxima sitting on Residents be feeding. Surveyor aske	DON (director of nursing) on ately 0925 regarding CNAs bed while assisting with sed DON if this should be d that CNA's should not be beeds.			
	and feeding assistance with policy entitled "As	colicies on infection control ce. DON provided surveyor ssistance with Meals" which			
	<ol><li>Residents who cannel fed with attention to sa</li></ol>	is requiring full assistance: not feed themselves will be afety, comfort and provided surveyor with a	•		

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.

diseases and infection".

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

No further information was provided prior to exit.