PRINTED: 02/23/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	C 02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/8/16 through 2/10/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 70 certified bed facility was 68 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Resident #1 through Resident #13) and 3 closed record reviews (Resident #14, #15, and #16).	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 1 of 16 residents (Resident #4). The facility staff failed to obtain intake and output (I&O) for 1 week on Resident #4. The findings included: The facility staff failed to obtain intake and output (I&O) for 1 week on Resident #4 after her indwelling Foley catheter was removed 9/24/15. Resident #4's clinical record was reviewed 2/9/16	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Lynn Yost	Administrator	3/4/2016

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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and 2/10/16. Resident #4 was admitted to the facility 6/25/15 with diagnoses that included but not limited to urine retention, fractured femur, bipolar disorder, depressive disorder, hypertension, venous thrombosis, adult failure to thrive, chronic kidney disease, and repeated falls. Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/16 assessed the resident with a cognitive summary score of 15 out of 15.
A physician order dated 9/23/15 read "D/C (discontinue) foley. Replace if no void in 6 hours. Do a post void residual after 1st urine & replace foley if > (greater than) 300 cc (cubic centimeters) remain. I (intake) & O (output) x 1 wk (week) after foley removal."
The surveyor reviewed the electronic "Vitals Report" on 2/9/16. The vitals report included amount of fluids taken, percentage of meals consumed, percentage of snacks consumed, and amount of urine output.
There was no evidence intake was obtained on all three shifts on 9/24/15, 9/25/15, 9/26/15 and 9/29/15. There was no evidence of intake on 9/27/15 for breakfast or dinner. There was no evidence of intake on 9/28/15 for breakfast or lunch. There was no evidence of intake on 9/30/15 at dinner.
There was no evidence output was obtained 9/24/15 through 9/27/15 and 9/29/15 and 9/30/15 on all three shifts. There was no evidence of output on both day and night shift on 9/28/15.
The surveyor interviewed the director of nursing on 2/10/16 at 8:20 a.m. She stated "I think you got me. But I'll dig a little farther."
The surveyor informed the administrator and the director of nursing of the failure of the facility staff to obtain physician ordered intake and output on Resident #4 for 1 week in a meeting on 2/10/16 at

In-servicing of all staff on following MD orders.

Audits by Unit Coordinator or Designee weekly to ensure proper documentation for MD order is obtained.

Charge Nurse or Designee will monitor C.N.A. charting at end of each shift for accuracy.

Director of Nursing will monitor compliance monthly to ensure that all documentation is correct per MD order.

3/22/16

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F 309	Continued From page 2 11:25 a.m. The director of nursing stated she found no other intake and output results prior to the exit on 2/10/16.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to ensure a hazard free environment in the rehabilitation room. The rehab room was left open and unattended on 2/9/16. The facility hydrocollator was not secure and accessible to residents in the facility. The findings included: The facility hydrocollator was found unattended and unlocked in the rehab room on 2/9/16. The temperature of the hydrocollator unit was documented to be 158 degrees Fahrenheit. The room was accessible to facility residents; however, there were no residents in the immediate area at the time of the observation. During a walk-through of the facility on 2/9/16 at 1:20 p.m., the surveyor checked the rehabilitation room located on the 1st floor of the facility. The	F 323	In-servicing of all Rehab staff on safety of keeping the Hydrocollator secured in the Rehab gym. Hydrocollator will be locked at all times and Rehab gym door will be locked when no Rehab staff present. Audits will be conducted daily by Rehab Staff to ensure Hydrocollator is always locked.	3/8/16

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rehab area was unlocked and unattended. The surveyor observed the facility hydrocollator unsecured and positioned near the restroom. The temperature recorded in the log book on 2/9/16 was 158 degrees Fahrenheit. The surveyor opened the unsecured lid and several hot packs were found to be in the hydrocollator in the heated water.

The surveyor interviewed other #4 on 2/9/16 at 1:25 p.m. Other #4 stated the rehab room was kept unlocked during the day and usually there were staff in the area. Other #4 stated the room was locked when staff left for the day.

The surveyor interviewed the rehab manager other #2 on 2/9/16 at 1:30 p.m. She stated the room was left unlocked during the day and staff were usually there. Other #2 was asked if the unlocked/unattended rehab room with the temperature of the water in the hydrocollator at 158 degrees Fahrenheit would be a concern for safety Other #2 stated it would be a concern.

The surveyor informed the administrator and the director of nursing of the above concern on 2/9/16 at 3:40 p.m. and requested the facility policy on storage of the hydrocollator.

No further information regarding this issue was provided to the survey team prior to the exit conference on 2/10/16.

F 333 SS=D 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS — F 333

The facility must ensure that residents are free of any significant medication errors.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 16 residents was free of a significant medication error. Resident #14 did not receive physician ordered sliding scale insulin on 11/8/15.
The findings included:
Resident #14 did not receive sliding scale insulin on 11/8/15 as ordered by the physician.
The clinical record of Resident #14 was reviewed 2/10/16. Resident #14 was admitted to the facility 11/5/15 and readmitted 11/7/15 with diagnoses that included but not limited to diabetes mellitus, syncope and collapse, dementia without behavioral disturbance and atrial fibrillation.
Resident #14's admission minimum data set (MDS) with an assessment reference date (ARD) of 11/14/15 assessed the resident with a cognitive summary score of 8 out of 15.
Resident #14's readmission orders dated 11/7/15 read in part "Sliding Scale per Protocol." House Sliding Scale insulin orders read "Humulin R per sliding scale: 201-250 give 2 units; 251-300 give 4 units; 301-350 give 6 units; 351-400 give 8 units; > (greater than) 400 give 10 units and call physician."
The surveyor reviewed the November 2015, December 2015, and January 2016 electronic medication administration records (eMAR). The November 2015 eMAR revealed Resident #14's blood sugar result obtained 11/8/15 at 11:30 a.m. was 222. The units administered was 0. Based on the house sliding scale protocol, Resident #14 should have received 2 units of Humulin R insulin.
The surveyor reviewed the blood sugar result with the director of nursing on 2/10/16 at 9:00 a.m.

In-servicing of all staff on following MD orders in regards to Sliding Scale Insulin.

Audits by Unit Coordinator or Designee daily to ensure proper documentation for sliding scale is administered per MD order is obtained.

Charge Nurse or Designee will review any Resident with Diabetes diagnosis at end of each shift to ensure MD order is followed.

Director of Nursing or Designee will monitor compliance monthly to ensure that MD order for sliding scale is correct.

3/22/16

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F 333	Continued From page 5 The DON stated based on the blood sugar result. Resident #14 should have received 2 units of insulin. The DON reviewed the progress note for 11/8/15 and stated there was no documentation of the blood sugar or administration of insulin The surveyor informed the administrator and the director of nursing of the above finding on 2/10/16 at 11:25 a.m. No further information was provided prior to the exit conference on 2/10/16.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to prepare and serve food in the kitchen in a sanitary manner. The findings include: The kitchen area was observed on 2/9/16 at 11:00 a.m. to observe the food tray line preparation. The cook preparing the food items was observed to have a full beard without a beard protector in place.	F 371	In-servicing of all Dietary staff in regards to wearing Masks and Hair Nets while in Dining or Kitchen areas. In-Servicing of all Dietary staff in regards to Infection Control and good handwashing at all times. Beard protectors were purchased day of Inspection and instructed staff that anyone with facial hair will wear them.	3/10/16

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The cook also was observed during food preparation to use an ungloved hand to lift the lid of the garbage can and dispose of food from a 1/4 serving pan. The cook then replaced the lid on the garbage can and proceeded to the oven to remove food from the oven. The cook failed to wash hands after handling of the garbage can lid.

The cook and dietary director were informed of the observations. The dietary director then obtained a beard protector for the cook.

The administrator and director of nursing were informed of the findings during a meeting with the survey team on 2/9/16 at 4:00 p.m.

F 371

Food Service Director or Designee will monitor daily that all staff with facial hair is wearing Beard Protectors.

Food Service Director or Designee will monitor Staff daily to ensure proper hand washing occurs throughout the work day in the Kitchen and Dining Areas.

F 372 SS=C 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure the dumpster area was clean and free of debris.

The findings include:

The dumpster area was observed on 2/8/16 at 1:15 p.m. with the dietary director. The dumpster had food particles consisting of corn and bacon pieces spilled down the side of the dumpster and on the ground surrounding the dumpster in front and around the side of the dumpster.

The dietary director stated the dumpster had

F 372

In-servicing of all Dietary and Maintenance staff in regards sweeping the Dumpster area daily to ensure clean and debris free area.

The food particles on the side and in front of the dumpster from Trash disposal the day of Survey was cleaned, swept, and disposed on that day.

3/23/16

In-servicing by all Dietary and Maintenance staff on a dumpster Inspection Log will be notated daily and monthly

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been dumped that day and the spill resulted from the dumping and also stated the area would be cleaned.

The administrator and director of nursing were informed of the findings during a meeting with the survey team on 2/9/16 at 4:00 p.m.

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

F 372

The Assistant Administrator and/or designee will audit the dumpster area and inspect log on a monthly basis.

F 441

Addressed Infection Control with Charge Nurse immediately day of inspection.

In-servicing of all Nursing staff on Infection Control and good handwashing. 3/22/16

Audits daily and random by Unit Coordinator or Designee to ensure that all staff are using proper hand washing techniques at all times.

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professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on a medication pass and pour observation and staff interview, the facility staff failed to follow infection control policy and procedure for hand washing.

The findings include:

The staff nurse (LPN#2) failed to wash hands between resident contact during a medication pass and pour observation conducted on 2/9/16 at 7:38 a.m.

LPN#2 was observed to prepare medications for a resident seated in the dining room. LPN#2 administered the medications to the resident and returned to the medication cart. LPN#2 immediately began to prepare medications for the next resident. LPN#2 did not wash hands prior to preparation of the medications. LPN#2 then administered the medication to the next resident and again returned to the medication cart to prepare the next resident's medications and again failed to wash her hands.

The director of nursing was asked for the facility policy on handwashing. The policy for "Hand Hygiene was provided. The policy stated, "All personnel are required to cleanse their hands

Charge Nurse or Designee will monitor all Nursing Staff on washing hands between Resident care.

Director of Nursing or Designee will monitor weekly and randomly to ensure all staff are performing proper hand washing techniques.

Director of Nursing or Designee will also perform random and monthly Med Pass Observations to ensure Charge Nurses are performing proper handwashing techniques.

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F 441	Continued From page 9 after each resident contact for which hand hygiene is indicated by accepted professional practice". The administrator and director of nursing were informed of the findings during a meeting with the survey team on 2/9/16 at 4:00 p.m.	F 441		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 1 of 16 residents (Resident #4). The findings included: The facility staff obtained a BMP (basic metabolic panel) and a CBC (complete blood count) on Resident #4 without a physician order on 9/22/15. Resident #4's clinical record was reviewed 2/9/16 and 2/10/16. Resident #4 was admitted to the facility 6/25/15 and readmitted 9/16/15 with diagnoses that included but not limited to urine retention, fractured femur, bipolar disorder, depressive disorder, hypertension, venous thrombosis, adult failure to thrive, chronic kidney disease, and repeated falls. Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/16 assessed the resident with a cognitive summary score of 15 out of 15. During the review of Resident #4's laboratory	F 504	In-servicing of all staff on following MD orders in regards to Labs. Audits by Unit Coordinator or Designee weekly to ensure that all labs are being drawn per MD order. Charge Nurse or Designee will monitor orders for Labs during shift to ensure that Labs being drawn have MD order. Director of Nursing will monitor compliance monthly to ensure that all Labs are drawn per MD order.	3/22/16

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section, the surveyor was unable to locate a physician order for a BMP and CBC obtained 9/22/15. The surveyor requested the assistance of registered nurse #1 on 2/9/16 at 2:35 p.m. R.N. #1 was unable to locate the physician order for the labs obtained 9/22/15.

The surveyor interviewed the director of nursing on 2/9/16 at 3:00 p.m. She stated "Resident #4's physician ordered the BMP and CBC to be done every 4th Tuesday of the month beginning on 7/28/15. When Resident #4 was admitted to the hospital in September 2015 and then returned to the facility with new orders on 9/16/15, the lab book wasn't changed to reflect new physician orders. Resident #4 got an additional BMP and CBC. I'll have to eat this one."

The surveyor informed the administrator and the director of nursing of the above finding on 2/9/16 at 3:40 p.m.

No further information was provided prior to the exit conference on 2/10/16.

State of Virginia

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F 000	Initial Comments The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities The census in this 70 certified bed facility was 68 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Resident #1 through Resident #13) and 3 closed record reviews (Resident #14, #15, and #16).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements. This RULE is not met as evidenced by: A biennial State Licensure Inspection was conducted 01/05/16 through 01/07/16. The facility was not in compliance with the following Virginia Nursing Home Rules and Regulations 12 VAC 5-371-220. Quality of Care 12 VAC 5-371-220 (A THRU G) Cross reference to F-309 12 VAC 5-371-220. Quality of Care 12 VAC 5-371-220 (B) Cross reference to F-323 12 VAC 5-371-350 Dietary Services 12VAC 5-371- 350- (E) Cross reference to F-371,F-372 12 VAC 5-371-180. Infection Control 12 VAC 5-371-180 (A, B, C) Cross reference to F-441	F 001		

mary kim Lenart — Administrator — 3/4/2016

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