PRINTED: 06/21/2019 **FORM APPROVED** OMB NO. 0938-0391

	ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	G	COMPLETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			04/16/2019	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) PLETION DATE	
E 000	Initial Comments		E 00				
F 000	survey was condu 04/16/19. The fac compliance with 4 Requirement for L	Emergency Preparedness cted 04/14/19 through illity was in substantial 2 CFR Part 483.73, ong-Term Care Facilities.	F 00				
	survey was condu Corrections are re CFR Part 483 Fed requirements. Co	Medicare/Medicaid standard cted 4/14/19 through 4/16/19. quired for compliance with 42 leral Long Term Care mplaints were investigated of the survey. The Life Safety of will follow.					
F 550 SS=E	163 at the time of sample consisted and 3 closed recorned Resident Rights/E	xercise of Rights	F 55		6/20	/19	
	self-determination access to persons	ent Rights. a right to a dignified existence, , and communication with and and services inside and , including those specified in					
	with respect and d resident in a mann promotes mainten her quality of life, r	cility must treat each resident ignity and care for each ner and in an environment that ance or enhancement of his or recognizing each resident's acility must protect and of the resident.					
POBATOR	V DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) D/	ATE	

Electronically Signed

05/26/2019

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.

Facility ID: VA0251

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 495133 B WING 04/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 550 Continued From page 1 F 550 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced Corrective Action for those residents Based on observation, staff interview and clinical found to be affected by the alleged record review, the facility staff failed to provide a dignified dining experience for 4 of 36 residents in deficient practice. the survey sample (Resident #111, 127, 11, and Resident #111 and #13 has since been discharged from the facility. Resident 13). #127 and #11 are eating their meals in the The findings included: dining room. The facility staff failed to provide a dignified Like Residents- Residents who need assistance with feeding have the potential dining experience for Resident #111.

Resident #111 was admitted to the facility on

12/17/18 with the following diagnoses of, but not

to be affected. Audit completed by the

require feeding assistance to ensure they

Director of Nurses on residents that

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495133	B. WING			C 16/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
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F 550	limited to high blo disorder, depress Schizophrenia and MDS (Minimum D) (Assessment Referesident was code Interview or Mentapossible score of coded as requiring member for dress extensive assistant bathing. During the initial to on 4/14/19 at 12:3 unit manager and (certified nursing a unit manager to "Trooms for lunch to team leader survet that was standing dining room and a unit manager state regulation for having dining room as othe So they will have a saked the unit manager stated, "rooms for now, the and eat in the dining them back and fersurveyors that we observing staff referooms. Three of taken out of the distance of the surveyors that we observing staff referooms. Three of taken out of the distance of the surveyors that we observing staff referooms. Three of taken out of the distance of the surveyors that we observing staff referooms. Three of taken out of the distance of the surveyors that we observing staff referooms. Three of taken out of the distance of the surveyors that we observed the surveyo	od pressure, diabetes, anxiety ion, manic depression, d asthma. On the quarterly lata Set) with an ARD erence Date) of 3/25/19, the ed as having a BIMS (Brief al Status) score of 5 out of a 15. Resident #111 was also g limited assistance of 1 staffing, personal hygiene and nice of 1 staff member for lour of the 3rd wing in the facility 80 pm, the surveyor heard the several other nurses and CNA assistants) being directed by the Take the feeders back to their loday." This surveyor and the leaver went to the unit manager in the hallway outside of the lasked what was going on. The led, "We got into trouble with a ling the feeders in the same her residents that were eating to be taken back to their rooms staff there." This surveyor langer that if a resident lev wanted to remain in the trouble to be taken to their length of the lasken lask	F 550	are being given the option to recome als in the dining room. Systemic Changes put into place ensure the alleged deficient praction trecur. Education completed to the nurs department to ensure residents regardless of assistance needed feeding are able to eat in the faci rooms. Corrective Actions taken for residential to be affected by alleged deficient practice. Director of Nursing will audit dinit room(s) 3x week x 4 and monthly ensure residents who need assist present in the dining room(s). Plan of correction information an will be reviewed in the quality assand performance improvement protectional interventions. Date of compliance: 6/20/19	to tice does ing for lity dining dents with day x 2 to stance are daudits surance rocess	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495133		A. BUILDING B. WING	LE CONSTRUCTION	COMPLETED C 04/16/2019		
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F 550	telling the resident from the dining room and lunch. Resident #111 was of 3/25/19 as need encouragement or physical assistance. On 4/15/19 at 12:3 resident sitting at the the twere eating, helper why this resident sitting the wing helper stated after all the resident. The surveyor notifithe above documed 4:45 pm in the control No further informa surveyor prior to the control of the testident #127 rea 6/30/15 with the folimited to anemia, dementia and psycony problems impaired in making impaired in making in the control of the resident as has memory problems impaired in making in the control of the	s observed the facility staff is, that were being removed om, they could come back in the everyone has been fed as coded on the MDS with ARD ding "supervision, oversight, or cueing of 1 staff member for the in eating. 30 pm, the surveyor observed 1 the table with 2 other residents. The surveyor asked the wing sident was still in the dining of other residents eating. The providents have finished eating." 31 it is determined to the administrative team of the entermined findings on 4/16 19 at a ference room. 32 it is observed the facility staff failed to provide a dignified and staff failed to provi	F 550			

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 550	being totally depering personal hygiene. During the initial toon 4/14/19 at 12:3 unit manager and (certified nursing unit manager to "rooms for lunch to team leader surve that was standing dining room and a unit manager state regulation for have dining room as of So they will have and be fed by the asked the unit may verbalized that the dining room to ear manager stated, "rooms for now, the and eat in the dining them back and fe surveyors that we observing staff re rooms. Three of taken out of the distaff that they was eat. The surveyor telling the resident from the dining room a lunch. On 4/15/19 at 12: resident sitting at	aff member for eating, and endent on 1-2 staff members for	F 5	50		

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dent was still in the dining other residents eating. The "She is usually fed in here is have finished eating." In the administrative team of sted findings on 4/16 19 at erence room. In was provided to the exist conference on 4/16/19. If failed to provide a dignified or Resident #11. In the admitted to the facility on allowing diagnoses of, but not ip fracture, dementia, chotic disorder. On the mum Data Set) with an ARD ence Date) of 1/16/19, the eas having a BIMS (Brief Status) score of 9 out of a status) score of 9 out of a status as extensive assistance of 1-2 ressing, personal hygiene and dent on 1 staff member for a control of the 3rd wing in the facility pm, the surveyor heard the everal other nurses and CNA extensive being directed by the face the feeders back to their ay." This surveyor and the or went to the unit manager the hallway outside of the	F 58	50			
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	### A BUILDI ### A	A BUILDING 495133 B. WING STREET ADDRESS, CITY, STATE, ZIP- 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319 TEMENT OF DEFICIENCIES TRUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TO DEFICIENCY) TO DEFICIENCY TAG PREFIX TAG PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY) TO DEFICIENCY) TO DEFICIENCY TO DEFICIENCY TO DEFICIENCY TO DEFICIENCY TO DEFICIENCY F 550 F 55	A BUILDING 495133 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TO PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 dent was still in the dining other residents eating. The "She is usually fed in here ts have finished eating." and the administrative team of ited findings on 4/16 19 at erence room. On was provided to the exit conference on 4/16/19. If failed to provide a dignified or Resident #11. Beadmitted to the facility on llowing diagnoses of, but not ip fracture, dementia, chotic disorder. On the mum Data Set) with an ARD ence Date) of 1/16/19, the as having a BIMS (Brief Status) score of 9 out of a is. Resident #11 was also extensive assistance of 1-2 ressing, personal hygiene and lent on 1 staff member for or of the 3rd wing in the facility pm, the surveyor heard the everal other nurses and CNA sistants) being directed by the wether feeders back to their ay. "This surveyor and the or went to the unit manager the hallway outside of the event what was going on. The	

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F 550	regulation for have dining room as of So they will have and be fed by the asked the unit may verbalized that the dining room to ear manager stated, rooms for now, the and eat in the dinity them back and fe surveyors that we observing staff rerooms. Three of taken out of the distaff that they was eat. The surveyor telling the resident from the dining room the dining room and lunch. On 4/15/19 at 12: resident sitting at that were eating, helper why this reroom watching the wing helper states after all the resident the above documed: 4:45 pm in the colon of the facility site. The facility site of the dinity of the surveyor prior to the above documed: 4:45 pm in the colon of the facility site.	the residents that were eating. The same ther residents that were eating. The staff there. This surveyor anager that if a resident ey wanted to remain in the theorem to be taken to their en if they want to come back ing room, the staff will bring ed them in there. The 2 are present in the hallway and moving the "feeders" to their the residents that was being lining room verbalized to the ented to stay in the dining room to be sobserved the facility staff that were being removed from, they could come back in the table with 2 other residents. The surveyor asked the wing esident was still in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating. The drift in the dining e other residents eating.	F 5	50		

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F 550	7/17/18 with the follimited to anemia, I disorder, depression Schizophrenia. Or Data Set) with an ADate) of 1/16/19, the having a BIMS (Briscore of 5 out of a #13 was also code assistance of 1 stapersonal hygiene at 1 staff member for During the initial to on 4/14/19 at 12:30 unit manager and second (certified nursing as unit manager to "Tarooms for lunch took team leader survey that was standing in dining room and as unit manager state regulation for having dining room as other so they will have to and be fed by the saked the unit man verbalized that they dining room to eat, manager stated, "Trooms for now, there and eat in the dining them back and feed surveyors that were observing staff rem	admitted to the facility on llowing diagnoses of, but not pneumonia, dementia, seizure on, psychotic disorder and in the quarterly MDS (Minimum ARD (Assessment Reference he resident was coded as ef Interview for Mental Status) possible score of 15. Resident d as requiring extensive ff member for dressing, eating, and being totally dependent on	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE A. BUILDING 495133 B. WING		G		OMPLETED C 04/16/2019			
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F 550	taken out of the distaff that they wan eat. The surveyors telling the resident from the dining room at lunch. On 4/15/19 at 12:3 resident sitting at that were eating, helper why this resoom watching the wing helper stated after all the reside. The surveyor notifithe above documed 4:45 pm in the corresponding to the surveyor of the corresponding to the surveyor of the surveyor of the surveyor notifithe above documed 4:45 pm in the corresponding to the surveyor of the surveyor of the surveyor notifithe above documed 4:45 pm in the corresponding to the surveyor of the surveyor of the surveyor notifithe above documed 4:45 pm in the corresponding to the surveyor of the surveyor of the surveyor notifithe above documed 4:45 pm in the corresponding to the surveyor of the survey	ning room verbalized to the ted to stay in the dining room to sobserved the facility staff is, that were being removed om, they could come back in the everyone has been fed. 30 pm, the surveyor observed 1 the table with 2 other residents. The surveyor asked the wing sident was still in the dining e other residents eating. The is usually fed in here into have finished eating." ited the administrative team of ented findings on 4/16 19 at inference room.	F 55	0			
F 578 SS=D	surveyor prior to the Request/Refuse/ECFR(s): 483.10(c) §483.10(c) (6) The discontinue treatment to participate in experiment of the provision of measured as the reservices deemed in inappropriate.	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	F 57	8		6/20/19	

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ B. WING 495133 04/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

F 578 Continued From page 9 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

- legally responsible for ensuring that the requirements of this section are met.

 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance
- (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

This REQUIREMENT is not met as evidenced by:

Based on Resident interview, staff interview, and clinical record review, the facility staff failed to ensure an accurate DDNR form for 2 of 36 Residents in the survey sample, Resident # 56, and Resident # 89.

The findings included:

1. The facility staff failed to ensure that the information documented on the DDNR (durable do not resuscitate) was accurate for Resident

F 578

F578-D

Corrective Action for those residents found to be affected by the alleged deficient practice
Resident #68 physician order sheet was updated to reflect the code sheet in the resident record.

Like Residents
Residents with advance directives have

with State Law.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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F 578	#56. The facility s 56 executed a wr appointed a persibehalf with autho procedures be wi fact Resident # 5 desired full code Resident # 56 wa originally admittee readmission date but were not limit type 2 diabetes in failure. The clinical recor reviewed on 4/15 MDS (minimum of quarterly assessive reference date) of assesses hearing B0700, the ability assessed. The fat Resident # 56 wa communicating is but is able if prom B0800 assesses The facility staff of "Understands-cle the MDS assesses C0500, the facility # 56 had a BIMS status) score of 1 Resident # 56's of impaired. The current plant reviewed and reviewed and reviewed and reviewed.	staff documented that Resident # itten advanced directive, which on to consent on Resident # 56's rity that life-prolonging thdrawn or withheld, when in 6 did not wish to be a DNR and	F 578	the potential to be affected. completed to ensure physic sheets and the advance dir match as applicable. Systemic changes put into ensure the alleged deficient not recur. Education completed by the Nursing to licensed nurses department of social service the physician order sheet an advance directive sheet match and the physician order sheet and advance directive sheet match and the physician order sheet and corrective Actions taken for potential to be affected by a deficient practice. Director of Nursing will audit order sheets and 3x week monthly x 2 months. Plan of correction information will be reviewed in the quality and performance improvement for tracking/trending and an additional interventions. Date of compliance-6/20/19	place to t practice does e Director of and the es on ensuring atch. r residents with alleged it physician x 4 weeks and on and audits ity assurance nent process ny necessary	

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F 578	"Advanced Direction The goal for this for "Resident's advante through next reviewere not limited to section of chart," a directives with patterpresentative at a section of chart, and directives with patterpresentative at a section of chart, and directives with patterpresentative at a section of chart, and directives with patterpresentative at a section of the DDNR form declinical record. The handwritten check following statement is INCAPAI decision about prowithdrawing a specifical decision, of the risks and be decision." The surhandwritten check following statement capable of making patient has execut which appoints a section of the Patient's Bethat life-prolonging withdrawn." The siguardian for Resid of the DDNR form The surveyor further surv	res DNR (do not resuscitate)." recus area was documented as, ce directives will be honored w." Interventions included but proposed ent, family, or legal admission and quarterly." recian's orders for Resident # 56 exphysician on 4/6/19. Orders not limited to, "Code status do a mark documented next to the ent of alternatives to that weyor also observed a mark documented next to the ent on the DDNR form, "2. The entered and informed widing, withholding or confice medical treatment because of understand the nature, extent quences of the proposed or to make a rational evaluation nefits of alternatives to that weyor also observed a mark documented next to the ent on the DDNR form, "B. While an informed decision, the end a written advanced directive Person Authorized to Consent enalf" with the authority to direct procedures be withheld or urveyor observed that the ent # 56 had signed the back authorizing the DDNR status. For reviewed the clinical record and did not locate a written	F 5	78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/16/2019		
NAME OF PROVIDE		R		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		04/10/2019	
1 1 1 1 1 1 1	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
author The self-control which Reside hands follow resus my/m breatt Resu follow form, the all the widraws hands by the On 4/ Reside surves to bris Reside Reside fisher he stated stops back. On 4/ the fa and a income	nced directive orized to consurveyor did liopulmonar was dated lent # 56. The written check ing statement of the citation direction." The physician of the citation of the physician	we that appointed a person asent on Resident # 56's behalf. observe a facility y Resuscitation Directive" form, 6/23/08 in the clinical record for the surveyor observed a skmark documented next to the ent of the cardiopulmonary ective form, "B. In the event that it's heart stops beating and/or I DO WANT Cardiopulmonary the surveyor observed the entation at the bottom of the ician of Resident # 56 agree with on. The surveyor observed that ad a single handwritten line and the word disagree was the it. This document was signed	F 578				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/16/2019	
	PROVIDER OR SUPPLIE	R	940	REET ADDRESS, CITY, STATE, ZIP COD EAST LEE HIGHWAY ILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	requested to see 56 incompetent. On 4/16/19 at 8:0 approached by the provided the survey papers for Reside informed the survey paperwork that sied been declared in nursing stated, "Verticular funeral wear a red dress the director of nursing stated, "A "But there is a dostated that she did the surveyor information that the document in stated that Resid resuscitated. The cardiopulmonary Resident # 56 alc director of nursing documentation the resuscitated. The observed the document of nursing along with the word agree in drawn thorough if the word agree in the	page 13 paperwork declaring Resident # 3 am, the surveyor was e director of nursing who eyor with a copy of guardianship ent # 56. The director of nursing reyor that she did not locate any rated that Resident # 56 had competent. The director of While I was going through her learned a lot of things that I did ad a paper in her chart that Resident # 56) wanted to go to a home and that she wanted to "The surveyor then informed ring that she did not locate an e in Resident # 56's clinical NR form stated that an advance n executed. The director of All we have is the DNR form." cument in her chart where she d not want to be resuscitated." ormed the director of nursing that Resident # 56's clinical record ent # 56 did want to be director of nursing reviewed the resuscitation directive form for ong with the surveyor and the g agreed that the form contained at Resident # 56 wished to be director of nursing also cumentation at the bottom of the d as, "I, the physician of Resident he above decision." The director with the surveyor observed that and a single handwritten line and the word "disagree" was e it. The surveyor asked the	F 578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		495133	B. WING _		04	/16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		128
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	director of nursing appropriate to dissexpressed as her even though Resicode. The director surveyor asked th # 56 was able to ea daily basis. The "Yes." The director contact the guardishe can get more On 4/16/19 at 12:: provided the surve 56's DDNR that hof Resident # 56's The director of nushe had been una Resident # 56 and else in the office to information and the tothe facility from the facility social with facility social with facility social with facility social with the facility social with facility social	regard what Resident # 56 had wishes and initiate a DNR order dent # 56 desired to be a full of nursing stated, "No." The edirector of nursing if Resident express her wants and needs on director of nursing stated, or of nursing stated, or of nursing stated she would fan for Resident # 56 to see if information. 23 pm, the director of nursing eyor with a copy of Resident # ad been faxed from the agency of court appointed guardians. The resident has been faxed from the surveyor that a she had spoken to someone of try to obtain additional the DDNR was all that was sent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495133	B. WING		04	/16/2019
	PROVIDER OR SUPPLIE		94	REET ADDRESS, CITY, STATE, ZIP CODE 0 EAST LEE HIGHWAY HILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	appropriate that the decision to mafter she had expresuscitated. The understand what look into this." On 4/16/19 at 3:1 the facility social facility social wormeetings for Resworker stated that meetings for Resworker stated that meetings for Resulter care plan meinvited, but she dasked the social Resident # 56 att The social worker guardians for Replan meetings and the staff commur Resident # 56 by the social worker during the care pland determined it continued, revise stated that the guardians for Resident # 56 hay lan of care. The "No." The survey had offered to discare with her in him and the staff commur Resident # 56 hay lan of care. The "No." The survey had offered to discare with her in him and the same convould be able to	page 15 he physician and guardian made ake Resident # 56 a DNR even pressed that she wanted to be a facility social worker stated, "I you mean and we will definitely on pm, the surveyor spoke with worker. The surveyor asked the ker if she attended care plan ident # 56. The facility social at she did attend the care plan ident # 56. The surveyor asked worker if Resident # 56 attended etings. The stated, "She is one not come." The surveyor worker if the guardians for ended the care plan meetings. Informed the surveyors that sident # 56 attended her care diff they were unable to attend incated with the guardians for telephone. The surveyor asked who reviewed the plan of care lan meetings for Resident # 56 for the focus areas needed to be do resolved. The social worker ardians and facility staff are areas and determined what be continued, revised, or reveyor asked the social worker if d any input with regard to her facility social worker stated, or asked the social worker if she is the social worker	F 578			

PRINTED: 06/21/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED		
		495133	B. WING		04	C I/16/2019	
	PROVIDER OR SUPPLIER		1527	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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 578	On 4/16/19 at 4:30 was made aware of the surconference on 4/16/2. The facility staff expressed wishes Resident #89 was 12/5/18 with the folimited to heart failuanxiety disorder ar quarterly MDS (Mir (Assessment Referesident was coder assistance of 2 stapersonal hygiene a staff members for During the clinical surveyor noted tha 1/5/19 with both the representative's significant was of Marenessent and Marenessent and Marenessent at the months of Marenessent aware of Marenessent according to the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of Marenessent aware of the surveyor reviewed the months of the surveyor reviewed the months of the surveyor reviewed the months of the surveyor reviewed the surveyor revi	pm, the administrative team of the findings as stated above. It ion regarding this issue was every team prior to the exit 6/18. If alled to ensure Resident #89 for end of life were honored. If admitted to the facility on the diagnoses of, but not the ure, diabetes, dementia, and depression. On the nimum Data Set) with an ARD rence Date) of 3/13/19, the diagnoses for dressing, and was totally dependent on 2	F 578				
	at 2 pm. She review findings and stated	ed unit manager #1 on 4/15/19 wed the above documented d, "The code status doesn't Full Code and the other is					
		ed the administrative team of nted findings on 4/16/19 at ference room.					
OPM CMS 2	567(02-99) Previous Version	s Obsolete Event ID: 4PGJ1:	1 F	acility ID: VA0251 If cor	itinuation shee	et Page 17 of 65	

FORM CMS-2567(02-99) Previous Versions Obsolete

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	surveyor prior to the Reporting of Alleg CFR(s): 483.12(c) In respondent to the Reporting of Alleg CFR(s): 483.12(c) In respondent to the Report of Alleg Repo	ation was provided to the he exit conference on 4/16/19. ed Violations of 1)(1)(4) conse to allegations of abuse, on, or mistreatment, the facility on, or mistreatment, the facility of the facility and to other to the State Survey Agency and the facility and to other to the State Survey Agency and the facilities of the facilities of the facilities of the facility and to other to the state Survey Agency and the facilities of the facilities of the facilities of the facility and to other the state survey Agency and the facilities of the facilities of the facilities of the facility of the facilities of the facilities of the facility of the facilities of the facilitie	F 5			6/20/19
	designated repres accordance with S Survey Agency, w incident, and if the appropriate correc This REQUIREMI by: Based on staff in facility document	the administrator or his or her sentative and to other officials in State law, including to the State within 5 working days of the alleged violation is verified ctive action must be taken. ENT is not met as evidenced terview, clinical record review, review and in the course of a the facility staff failed to report		Corrective Action for those found to be affected by the deficient practice.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING		COMPLETED COMPLETED COMPLETED
	PROVIDER OR SUPPLIE		9	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
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F 609	an injury of unknown Resident #363. The findings inclusion of the findings inclusion of the findings inclusion of the findings inclusion of the findings included for the finding fin	own origin for 1 of 36 Residents,	F 609	Resident #363 has since been discharge from the facility. Like Residents- Residents admitting into the facility have the potential to be affected. Audit completed on grievances and SBARs to identify any situations that need reporting and addressed as applicable. Systemic Changes put into place to ensure the alleged deficient practice do not recur. Education to nursing leadership on reporting injuries on unknown origin according the policy and procedures. Corrective Actions taken for residents we potential to be affected by alleged deficient practice. Director of Nursing will complete audits SBAR forms and progress notes and report situations according to the policy weekly x 3 months and then monthly. Plan of correction information and audit will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance-6/20/19	e g g es with on

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	C C C C C C C C C C C C C C C C C C C	
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1.00.000-0-0-0	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
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F 609	repeatedly trying to family to come an continues to be not (initiated 08/09/18 visual checks (inition 03/04/19), freque assist to restroom revised 03/04/19) reach of Resident height (initiated 05 keep remote to replace to where reconstituted 01/28/18 Resident #363's cond/15/19. It containdicated the Resident #363's condicated the Resident #363's conference of February 2019 precautions. Resident #363's conference of February 2019 precautions.	co stand or get up by self, notify d stay with Resident if con-compliant with instructions is, revised 03/04/19) frequent ciated 02/27/17, revised ently assess toileting needs and if needed (initiated 08/07/16, keep lift chair controller out of prevent from lifting it to max 5/07/16, revised 02/14/19), and ecliner in reach of Resident, mote will not fall to floor in revised 02/14/19)." Clinical record was reviewed on ined a fall risk evaluation, which ident was at high risk for falls. Sinical record also contained a corder summary for the month which read in part "fall clinical record contained nurse's which read in part "fall clinical record also contained on the clinical record of the month of the clinical record of		9		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURV COMPLETED		
		495133	B. WING	<u> </u>	04	/16/2019	
	NAME OF PROVIDER OR SUPPLIER VALLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		710/2010	
(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 ADDEDLY (IENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	Continued From pa	age 20	F 6	09		100	
	right eye red and s	wollen. Skin tear to left ring ished button to recliner said he					
	emergency room read in part "Admis complaint: Fall and (history of present male with past med disease, pacemake prostate, GERD, go hypothyroidism pretransfer form (face neurosurgery constance) The patient is a Rename/address omi patient's family as family reports that chair daily. When the motor is supposed cannot lift himself commotor was not turn was able to raise the of the chair, striking patient has a small forehead. Patient and ecchymosis. Homitted) for evalual indicated intracrani was transferred to neurosurgical evaluations or the subdural hematom Dementia, hyperter Subarachnoid hem right orbit, fall, closs.	inical record contained an eport dated 01/03/19, which is sion date: 1/3/2019 Chief dintracranial hemorrhage HPI illness): This is 99-year old dical history of coronary artery er, dementia, enlarged out, hyperlipidemia, esents to ER today as a cility name omitted) for ult for intracranial hemorrhage. Esident at(facility tted). HPI is obtained from the patient has dementia. The the patient gets of (sic) in a lift he patient is in the lift chair, the to be turned off so that he out of the chair. Apparently, the ed off today, and the patient ed off today, and the patient ed on the floor. The laceration of the middle frontal also has right periorbital edema le was taken to(facility name tion. A CT scan of the head al hemorrhage and the patient(facility name omitted) for uationPrinciple Problem: It is a. Active Problems: It i					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495133	B. WING		04	/16/2019	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
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F 609	regarding Resident's treatment at approx LPN #1 stated that power recliner chair the chair LPN #1 st the CNA (certified rome to Resident's when she entered to lying on his right side chair. Surveyor spoke with approximately 090s entered the Reside meal and told anoth Resident #363 with after assisting Resident #363 with after assisting Resident #363 with after assisting upright in Surveyor asked CN the chair, and CNA so". CNA #1 also to plugged into a power she left the room. Surveyor spoke with 04/16/19 at approximately 090s entered the Resident and CNA so". CNA #1 also to plugged into a power she left the room. Surveyor spoke with 04/16/19 at approximately of the chair of the chai	age 21 ##363. LPN #1 stated she had room to administer a breathing kimately 1200 on 01/0319. Resident was sitting up in his r. LPN #1 stated that the was kept in the side pocket of stated that approximately 1345, nurse's aide) called for her to a room. LPN #1 stated that the room, Resident #363 was de, in the floor in front of the h. CNA #1 on 04/16/19 at 5. CNA #1 stated that she had nt's room during the lunch her CNA that she would assist his meal. CNA #1 stated that dent with his meal, she left in his power recliner chair. IA if Resident could operate #1 responded, "I don't think old surveyor that the chair was er strip, which was off when the N #1 (registered nurse) on mately 0910. RN #1 stated do to come to Resident's room stated that Resident was in the was raised to the highest asked RN #1 if anyone saw the RN #1 responded, "Not that I asked RN #1 if Resident #363 and RN #1 responded, if he said what happened or the DON (director of the DON (director of the look).	F 6	09			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495133	B. WING		04/16/2019		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
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F 609	nursing) on 04/16 regarding Resider through her invess she determined the chair to the higher out into the floor. Surveyor requests of the facility policing and Reporting with Resident abuse, misappropriation mistreatment and ("abuse") shall be state and federal regulations) and the management. Firm will also be reported. The failure of the fall with major injuries.	nt #363. DON stated that tigation of the Resident's fall, nat the Resident had raised his st position, causing him to fall ed and the DON provided copy by, entitled "Abuse Investigation hich read in part "All reports of neglect, exploitation, of Resident property, for injuries of unknown source promptly reported to local, agencies (as defined by current thoroughly investigated by facility adings of abuse investigations red." facility to report an unwitnessed ury was discussed with the am during a meeting on 04/16/19	F 609				
F 641 SS=D	This is a complaint Accuracy of Asse CFR(s): 483.20(g) Accurate The assessment resident's status. This REQUIREM by: Based on staff in review, the facility	ssments	F 64	Corrective Action for those resider found to be affected by the alleged deficient practice.			

		IDENTIFICATION NUMBER.		X2) MULTIPLE CONSTRUCTION BUILDING		C C	
		495133	B. WING		A13950	6/2019	
	DER OR SUPPLIER		*	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
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in the The Res hosp Res was incluseiz fraction of a beer form beer again risks Discowith 2/2/2 Discowith a cut on a MDS the I surviving surviving the I surviving surviving the I surviving survivin	findings included facility staff incident # 164 was bital on the discident # 164 was admitted to the ded but were ures, major decure. 1/16/19 at 12:4 wing Against Mansigned by Resident # 164 was admitted to the ded but were ures, major decure. 1/16/19 at 12:4 wing Against Mansigned by Resident # 164 wing ARD (asset 19), the surveyor harge status, Resident # 164 wing a 12:5 wing a 16-4	ded: correctly documented that as discharged to an acute charge assessment. as a 7year-old female who e facility on 1/15/19. Diagnoses not limited to, anxiety disorder, pressive disorder, and closed by pm, the surveyor observed a Medical Advice" form that had esident # 164 on 2/2/19. The cumentation that stated, "I have he risks of leaving the facility dvice and understand those who of the "Nursing Home minimum data set) assessment reference date) of the facility staff documented a had been discharged to an according the discharge status of the MDS nurse #1 along with the Section A2100 on the ment for Resident # 164. MDS hat discharge status listed on nospital. MDS nurse #1 stated,	F 64	Resident #164 has since been diffrom the facility. Like Residents- Residents discharging from the facility to be affected. reimbursement coordinator compaudit on residents who have disc from the facility to ensure proper and changed a applicable. Systemic Changes put into place ensure the alleged deficient pract not recur. Education to the clinical reimbursteam to ensure correct coding for transfers by the Director of Nursi. Corrective Actions taken for residence potential to be affected by alleged deficient practice. Clinical reimbursement coordinate audit coding for resident transfers x 4 weeks and monthly x 2. Plan of correction information and will be reviewed in the quality assured performance improvement proton tracking/trending and any necessary and performance improvement proton tracking/trending and any necessary and performance: 6/20/19	acility Clinical bleted harged coding to tice does sement r resident ng. dents with d tor will s weekly d audits surance rocess		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	COMPLETED		
	3	495133	B. WING		04/16/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319				
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F 641	Continued From pa	age 24	F 641				
	was marked in error it corrected."	or. Stated "I'm sorry we will get					
		pm, the administrative team of the findings as stated above.					
		tion regarding this issue was vey team prior to the exit 6/18.					
	Care Plan Timing a CFR(s): 483.21(b)		F 657		6/20/19		
	§483.21(b) Compr §483.21(b)(2) A co be-	ehensive Care Plans Imprehensive care plan must					
	the comprehensive	interdisciplinary team, that					
	(A) The attending						
	resident. (D) A member of for	with responsibility for the cood and nutrition services staff.					
	the resident and the An explanation mu	practicable, the participation of the resident's representative(s). List be included in a resident's					
	and their resident not practicable for	he participation of the resident representative is determined the development of the					
		ate staff or professionals in ermined by the resident's needs					
	(iii)Reviewed and team after each as	revised by the interdisciplinary ssessment, including both the ad quarterly review					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495133	B. WING _			C 16/2019	
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY	HEALTH CARE CE	NTER		940 EAST LEE HIGHWAY			
VALLET	HEALTH CARE CE	NIEK		CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 657	assessments. This REQUIREMI by: Based on staff in review the facility a CCP (comprehe Residents, Reside The findings inclu For Resident #363 and revise the car Resident #363 wa 06/01/15 and read included but not li depression, coron hypothyroidism, g benign prostatic h The most recent N an ARD (assessm coded the Reside cognitive status. S coded the Reside two-person physic ((how Resident m including to or from standing position) standing position standing position wa Resident #363's C was reviewed and risk for falls due to coordination, and	terview and clinical record staff failed to review and revise ensive care plan) for 1 of 36 ent #363. ded: 3 the facility staff failed to review re plan for risk of falls. as admitted to the facility on dmitted on 01/11/19. Diagnoses mited to anemia, pneumonia, arry artery disease, astroesophageal reflux disease, yperplasia and insomnia. MDS (minimum data set) with nent reference date) of 12/14/18 nt as 7 out of 15 in section C, Section G, functional status, nt as needing extensive with eal assist in the area of transfer oves between surfaces m: bed, chair, wheelchair, . Moving from a seated to was coded as not steady, only ith staff assistance. CCP (comprehensive care plan) I contained a care plan for "At or impaired balance/poor unsteady gait and confusion at	F 65	Corrective Action for those reside found to be affected by the alleg deficient practice. Resident #363 has since been of from the facility. Like Residents- Residents admitting into the facilithe potential to be affected. Dire nursing completed an audit on the resident careplans to ensure the duplicate interventions and addresplicable. Systemic Changes put into place ensure the alleged deficient practice. Education to licensed nurses on interventions on the comprehensicare plans that are not duplicating other. Corrective Actions taken for resident practice. Director of Nursing will complete 10 comprehensive careplans we and 20 monthly x 2 for duplicate interventions. Plan of correction information and will be reviewed in the quality assuand performance improvement process.	lity have ctor of the current re are not essed as choosing sive g of each dents with d audits of ekly x 4		
	times". This care planterventions for the	plan was initiated on 02/27/15. his care plan included, "keep lift to freach of Resident, prevent		for tracking/trending and any neo additional interventions.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495133	B. WING		04/16/2019
	PROVIDER OR SUPPLIE		9-	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY HILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 657	revised 02/14/19) reach of Resident fall to floor (initiate Both interventions period. Surveyor spoke wapproximately 11 CCP. Surveyor pointerventions, whi another, were both DON responded, jacked-up". The concern of fatthe Resident's CC administrative stars.	ax height (initiated 05/07/16, , and keep remote to recliner in t, place to where remote will not ed 01/28/18, revised 02/14/19)." Is were in place during the same with the DON on 04/16/19 at 10 regarding Resident #363's pointed out to DON that the two ch were contradictory to one thin place during the same time. "Yeah, I know, that care plan is accility staff to review and revise CP was discussed with the iff during a meeting on 04/16/19	F 657	Date of compliance: 6/20/19	
F 658 SS=D	Services Provided CFR(s): 483.21(b)(3) Co The services provas outlined by the must- (i) Meet profession This REQUIREM by: Based on observe record review, factor practice for LPNs the State of Virgin staff failed to follow	ation was provided prior to exit. d Meet Professional Standards o)(3)(i) mprehensive Care Plans yided or arranged by the facility, comprehensive care plan, anal standards of quality. ENT is not met as evidenced ration, staff interview, clinical cility policy and scope of nursing of (licensed practical nurses) in hia it was determined the facility ow current professional etice while caring for 1 of 33	F 658	Corrective Action for those resider found to be affected by the alleged deficient practice. Residents #82 has been added to podiatrist list to be seen for foot callike Residents-	the

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Facility ID: VA0251

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	СОМІ	E SURVEY PLETED
		495133	B. WING		04/	16/2019
	PROVIDER OR SUPPLIER	rer	,	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 658	standards of practitoenails. The resident reviewed on 4-15-1 Resident #82 was 8-27-13. Her currediabetes, hypertens The latest MDS (m 3-11-19 coded the impairment. The reassistance to accoof daily living). Resident #82's CC reviewed and revision resident had a self-physical limitations processes. The stall "Assist with daily hybrid oral care, eating and Resident #82's physthe resident as an inshe received 8 unit bedtime. The resident "off loading boots to when in bed, as toll 04/14/19 at 04:50 CNA I repositioning I pulled the resident surveyor could obstoenails were overgone."	to follow current professional ce while cutting Resident #82's ent's clinical record was 9. admitted to the facility on the diagnoses included sion and dementia. Inimum data set) dated resident with severe cognitive esident required facility staff emplish all the ADLs (activities) P (comprehensive care plan) ed on 3/12/19 indicated the deficit in ADL care related to and altered thought efficitely included regione, grooming, dressing, and nail care as needed". Sician's orders documented insulin-dependent diabetic. Its of Levemir every evening at each had a physician order for the bilateral lower extremities	F 658	Residents who admit into the fact foot or nail deficits have the pote affected. A skin sweep was compourrent residents and addressed concerns as necessary. Systemic Changes put into place ensure the alleged deficient practice. Education completed by the Dire Nursing to the nursing departme provide proper foot care and nail residents per policy and procedured Corrective Actions taken for residential to be affected by alleged deficient practice. Director of Nursing will audit foot 10 residents weekly x 4 weeks a residents monthly x 2. Plan of correction information and will be reviewed in the quality assand performance improvement profortracking/trending and any necessity and performance in the contraction of the compliance: 6/20/19	e to etice does ector of eare to eare to eare on eare on eare double daudits surance erocess	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		495133	B. WING		04	/16/2019
	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 BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	Continued From p	age 28	F 658	3		
	appeared to have points on both feet	pressure areas at various :				
	of pain when CNA putting the boots b	ation the resident complained I was moving her feet and ack on her. CNA I said she t the resident's discomfort to				
	to look at her feet complained of bac	neck on the resident's pain and with the surveyor. Resident #84 k pain to LPN I. The LPN said get the resident something for				
	observe the reside great toe on her le needed to get a wa maybe "it" will com and feet). RN I rub the red spot just fe	ger (RN I) entered the room to int's feet. She looked at the ft foot and said she thought she ash cloth and clean it off and he off (darkened debris on toes bed a spot on the left foot and all off. RN I said it just looked the feet and toes and stated, "It to be cleaned."				
	falling away as RN RN I stated, "She	nd some lotion. Her toenails				
	clean her feet and long and curving/u	going to get a wash cloth and clip her toenails. "They are all nkempt. The CNAs should put lotion on her feet."				
	see that the CNA's	d who's responsibility it was to s provided foot care. Both LPN I				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			С	
		495133	B. WING			/16/2019	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	TER	940	EET ADDRESS, CITY, STATE, ZIP COL EAST LEE HIGHWAY ILHOWIE, VA 24319	ΣE		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	sure the CNAs clear agreed it should be manager that oversures. LPN I had a pair of clip the resident's to LPNs were allowed resident was diabed could do it—but the RNs to do that and LPN I and resumed to enails. RN I said she would policy to determine to enails at the facing do—but I will have to the could policy to determine to enails at the facing do—but I will have to the cut a diabetic's to stated it was not with the cut a diabetic's to stated it was not with the cut a diabetic's to stated it was not with the cut and could perform that the DON provided of finger and to enaincluded the following. Nail care included trimming. 2. Unless otherwise nails of diabetic rescirculatory impairments.	aned the resident's feet. They a the charge nurses and unit see what the CNAs do. I toenail clippers and started to oenails. The surveyor asked if it to cut her toenails since the tic. LPN said she thought she unit manager said they prefer she took the clippers from d trimming the resident's Id have to check the facility of the LPN's could cut a diabetic's lity. She stated, "I think they to check and see for you." In AM the facility DON was reveyor's findings. She was in the LPN's scope of practice oenails at the facility. She ithin an LPN's scope of iabetic's toenails, only RNs task. I the facility's policy on the care ills at the facility. The policy ing: as daily cleaning and regular the permitted, do not trim the sidents or residents with itents.	F 658				
F 677	the survey team ex	mation was provided prior to kit. If for Dependent Residents	F 677			6/20/19	

PRINTED: 06/21/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION	СОМІ	E SURVEY PLETED C 16/2019
	PROVIDER OR SUPPLIER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	out activities of daiservices to maintapersonal and oral This REQUIREME by: Based on observarecord review and determined the facresidents (Resident toenail care. Findings: Facility staff failed standards of pract toenails. The resident was 8-27-13. Her currediabetes, hypertent The latest MDS (m3-11-19 coded the impairment. The reassistance to accord daily living). Resident #82's Coreviewed and revisites dent had a self physical limitations processes. The stallar and control of the stallar and the stallar and the self physical limitations processes. The stallar and the stallar and the stallar and the self physical limitations processes. The stallar and the stal	sident who is unable to carry fly living receives the necessary in good nutrition, grooming, and hygiene; ENT is not met as evidenced ation, staff interview, clinical facility document review, it was facility staff failed to assist 1 of 33 at #82) with sufficient foot and to follow current professional face while cutting Resident #82's ent's clinical record was 19. admitted to the facility on and diagnoses included sion and dementia. Ininimum data set) dated resident with severe cognitive esident required facility staff amplish all the ADLs (activities) and altered thought aff interventions included bygiene, grooming, dressing,	F 677	Corrective Action for those resident found to be affected by the alleged deficient practice. Resident #82 is receiving foot and recare per policy and procedure and been added to the podiatry list for frassessment. Like Residents- Residents who need nail and foot chave the potential to be affected. Director of nursing completed an authorized the current resident careplans to enthere are not duplicate interventions addressed as applicable Systemic Changes put into place to ensure the alleged deficient practication recur. Education completed by the Director Nursing to the nursing department of provide proper foot care and nail caresidents per policy and procedures. Corrective Actions taken for resider potential to be affected by alleged deficient practice. Director of Nursing will audit foot care in a careful to the process of the potential to the affected by alleged deficient practice. Director of Nursing will audit foot care in a careful to the provide the potential to the affected by alleged deficient practice.	nail has urther are udit on a sure s and e does or of to are to s. are to s.	
	"Assist with daily h					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VA0251

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 495133 B. WING 04/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 677 Continued From page 31 F 677 Plan of correction information and audits Resident #82's physician's orders documented will be reviewed in the quality assurance the resident as an insulin-dependent diabetic. and performance improvement process She received 8 units of Levemir every evening at for tracking/trending and any necessary bedtime. The resident had a physician order for additional interventions. "off loading boots to the bilateral lower extremities when in bed, as tolerated". Date of compliance: 6/20/19 04/14/19 at 04:50 PM the surveyor observed CNA I repositioning Resident #82 in her bed. CNA I pulled the resident's boots off her feet so the surveyor could observe her feet. The resident's toenails were overgrown and curling. The resident's toes were brownish black and appeared to have pressure areas at various points on both feet. During this observation the resident complained of pain when CNA I was moving her feet and putting the boots back on her. CNA I said she was going to report the resident's discomfort to the nurse. LPN I came into check on the resident's pain and to look at her feet with the surveyor. Resident #84 complained of back pain to LPN I. The LPN said she was going to get the resident something for pain. The RN unit manager (RN I) entered the room to observe the resident's feet. She looked at the great toe on her left foot and said she thought she needed to get a wash cloth and clean it off and maybe "it" will come off (darkened debris on toes

and feet). RN I rubbed a spot on the left foot and the red spot just fell off. RN I said it just looked like dead skin on the feet and toes and stated. "It

The resident's right foot had a lot of dead skin

looks like it needs to be cleaned."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495133	B. WING _		04	/16/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	falling away as RI RN I stated, "She washing/soaking need clipping too. RN I said she was clean her feet and long and curving/wash her feet and long and resure the CNAs cleagreed it should the manager that over clip the resident's LPN I had a pair of clip the resident's LPNs were allowere resident was diable could do itbut the RNs to do that and LPN I and resume toenails. RN I said she worpolicy to determine toe nails at the fadobut I will have long finger and toen included the following resident was diable to have a long to the said she worpolicy to determine toenails at the fadobut I will have long finger and toen included the following long the provided of the said long the	N I proceeded the examination. needs a good foot and some lotion. Her toenails " s going to get a wash cloth and d clip her toenails. "They are all unkempt. The CNAs should I put lotion on her feet." ed who's responsibility it was to see sprovided foot care. Both LPN I have their responsibility to make eaned the resident's feet. They be the charge nurses and unit be toenails. The surveyor asked if the docut her toenails since the etic. LPN said she thought she et unit manager said they prefer d she took the clippers from the drimming the resident's solid have to check the facility the if LPNs could cut a diabetic's cility. She stated, "I think they to check and see for you." On AM the facility DON was surveyor's findings. In the facility's policy on the care ails at the facility. The policy	F 67	7		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	COM	TE SURVEY MPLETED C
		495133	B. WING	04	/16/2019
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL 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 677	Continued From p	page 33	F 677		
		se permitted, do not trim the esidents or residents with ments.			
	No additional info	rmation was provided prior to			
F 679 SS=D	•	erest/Needs Each Resident	F 679		6/20/19
	the comprehensive and the preference program to suppose activities, both fact individual activities designed to meet physical, mental, each resident, end interaction in This REQUIREMINDS: Based on observe interview, clinical document review, with activities profit diversional activities urvey sample (Recomprehensions)	e facility must provide, based on the assessment and care plan these of each resident, an ongoing out residents in their choice of cility-sponsored group and is and independent activities, the interests of and support the and psychosocial well-being of couraging both independence the community. ENT is not met as evidenced action, physician interview, staff record review, and facility facility staff failed to consult fessionals for individualized the sident #11).		Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #11 is receiving diversional activities with appropriate documentation in the resident record.	
	professionals for for Resident #11. Resident #11 was 11/15/18 with the	ded: ailed to consult with activities individualized diversional activity readmitted to the facility on following diagnoses of, but not hip fracture, dementia,		Like Residents- Residents requiring diversional activities have the potential to be affected. Director of nursing completed an audit of residents with diversional activities ordered to ensure the activities are being offered and documented. Systemic Changes put into place to	3

PRINTED: 06/21/2019 FORM APPROVED OMB NO. 0938-0391

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		495133	B. WING		04/	16/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 679	MDS (Minimum D (Assessment Ref resident was code Interview for Men possible score of During the clinical 4/16/19, the survey dated for 11/8/18, Activities for diversing) of the above the surveyor requested the activities that 4/16/19 at approximate a stated, "Activities department of the surveyor receive activities with the facility. The resident #11 with physician had or stated, "Activities activities with the facility. The resident #10 something the surveyor requested activities department of the conference room documentation the consulted due to	notic disorder. On the quarterly data Set) with an ARD erence Date) of 1/16/19, the ed as having a BIMS (Brief stal Status) score of 9 out of 15. I record review on 4/15 and eyor noted a progress note which read in part, "Consult resional activity" fied the DON (director of love physician order on 4/15/19, uested copies of the activities	F 679	ensure the alleged deficient protocur. Education completed by the DNursing to the activities deparensure to offer and document activities to residents that have activities ordered. Corrective Actions taken for repotential to be affected by alle deficient practice. Director of activities will audit activities week x 3 months and monthly x 2 for documentation. Plan of correction information will be reviewed in the quality and performance improvement for tracking/trending and any radditional interventions. Date of compliance: 6/20/19	irector of tment to diversional e diversional esidents with ged diversional dithen and audits assurance at process	

Facility ID: VA0251

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495133	B. WING _		04	C //16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 679	The surveyor spoke physician) via pho The surveyor read #11 in which the pactivities for diverse physician saw the resident had continually had been sated, was doing was not anxiety that the resident might gray that the resident might find decrease his anxiest that if he collisten to 40's and sea better answere sident for this. The surveyor notification in the surveyor notification in the surveyor notification.	ke with (name of ne this afternoon at 4:05 pm. If the progress note for Resident hysician had written to consult sional activities. On 11/8/18, the resident at which time the nued with wandering in grid through the garbage. The sident was experiencing with the issue but rather the sident was experiencing with the issue. I wanted a consult the if an individual patient based one for this the resident farmer most of his life. I here was anything that the sident was experiencing with the interest was anything that the sident was experiencing with the sident was experiencing with the interest was anything that the sident was experiencing to him to eatly of feeling." The MD also would listen to sires radio and so's music to relax him it would be that the addition to the line several different times on this everal different times on this everal different times on this everal findings on 4/16/19 at	F 67	9		
F 684 SS=D	surveyor prior to the Quality of Care CFR(s): 483.25	tion was provided to the ne exit conference on 4/16/19.	F 684	4		6/20/19
		f care a fundamental principle that ment and care provided to				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING B. WING		X3) DATE SURVEY COMPLETED C 04/16/2019
AND PLAN OF CORRECTION 495133 NAME OF PROVIDER OR SUPPLIER VALLEY HEALTH CARE CENTER (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 36 facility residents. Based on the comprehensive assessment of a resident, the facility must ensur that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to administer an antibiotic medication as ordered for 1 of 36 residents in the survey sample (Resident #145). Resident #145 was admitted to the facility on			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION DATE
F 684	facility residents. assessment of a that residents recordance with practice, the comcare plan, and the This REQUIREM by: Based on staff in review, facility state antibiotic medical residents in the stantibiotic medical residents and walking, failure, and esser admission Minimal assessment refersored 15/15 on status and was adelirium, psychoston 00 04/14/19 during resident reported resident had an is The nurse reported resident had an is The resident wound to the vac, so no precauplan to touch any During clinical recompleted late; revance trough 30 m. The resident was order for vancom	Based on the comprehensive resident, the facility must ensure eive treatment and care in professional standards of prehensive person-centered e residents' choices. ENT is not met as evidenced aff failed to administer and tion as ordered for 1 of 36 arrows ample (Resident #145). Bas admitted to the facility on moses including pressure ulcer, kidney failure, respiratory intial hypertension. On the aum Data Set assessment with the price of the treview for mental assessed as without symptoms of this, or behaviors affecting others. Ing a preliminary interview, the having MRSA in a wound. The solation cart outside the room. The solation cart outside the room. Based on the facility must ensure the resident of the price of the facility of the price of t	F 684	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #145 has since been disch from the facility. Like Residents- Residents on antibiotic therapy have potential to be affected. Director of nursing completed audit on resident receiving antibiotic therapy to ensure correct administration times according hysician schedule. Systemic Changes put into place to ensure the alleged deficient practice not recur. Education completed by the Director Nursing to licensed nurses to admin antibiotic medications according to the physician order. Corrective Actions taken for resident potential to be affected by alleged deficient practice. Director of Nursing will complete audinatibiotic according to the physician 3 x week x 4 weeks and monthly x 2. Plan of correction information and a will be reviewed in the quality assura	e the see the see ng to e does r of ister he ts with dits of order dits

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (.	COMPLETED
		495133	B. WING		04/16/2019
	PROVIDER OR SUPPLIER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	administration recresident received: AM, 4/2 at 4 PM, 4/9 at 11:30 AM, 4AM, and 4/13 at 1. The surveyor asked nursing about the administration school of nursing reveale of IV anomy at 11 no dose was schefinished running at administration on unavailability of the pharmacy had sent the next doses did administration. Easinformed and the rescheduled. The administrator	ord (MAR) documented the a the medication on 4/1/19 at 4 4/6/19 8 AM and 4/7 at 8 PM, 4/10 at 11:30 PM, 4/12 at 11:30 PM, and 4/14 at 11:30 PM. ed the nurse and director of	F 684	and performance improvement proof for tracking/trending and any necess additional interventions. Date of compliance: 6/20/19	
	the intravenous ar summary meeting Respiratory/Trache CFR(s): 483.25(i) \$ 483.25(i) Respiratracheostomy care. The facility must eneeds respiratory care and tracheal care, consistent w practice, the compare plan, the resi and 483.65 of this	atibiotic as ordered during a on 4/15/19. eostomy Care and Suctioning atory care, including and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such ith professional standards of orehensive person-centered dents' goals and preferences,	F 695		6/20/19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		495133	B. WING			C 16/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	Based on observe record review, fact delivery of oxyger residents in the state of the findings included the fi	vation, staff interview, and clinical cility staff failed to provide for a per physician orders for 1 of 36 urvey sample (Resident #56). Ided: ailed to provide for delivery of cian orders for Resident #111. as admitted to the facility on following diagnoses of, but not lood pressure, diabetes, anxiety sion, manic depression, at asthma. On the quarterly Data Set) with an ARD reference Date) of 3/25/19, the led as having a BIMS (Brief lat Status) score of 5 out of a 15. Resident #111 was also g limited assistance of 1 staff ling, personal hygiene and lince of 1 staff member for line or a staff member for line or a staff member for line or a staff was receiving oxygen by	F 695	Corrective Action for those restound to be affected by the alled deficient practice. Resident #111 has since been from the facility. Like Residents-Residents receiving oxygen the the potential to be affected. Dir nursing completed an audit on receiving oxygen therapy to en oxygen is being administered at the physicians order. Systemic Changes put into placensure the alleged deficient pranot recur. Education completed by the Di Nursing to licensed nurses to e residents receiving oxygen the receiving oxygen through the confadministration. Corrective Actions taken for respotential to be affected by alleged deficient practice. Director of Nursing will audit rewho receive oxygen therapy we and then monthly x 2 to ensure administration according to the order. Plan of correction information a will be reviewed in the quality and performance improvement for tracking/trending and any nadditional interventions. Date of compliance: 6/20/19	ged discharged erapy have ector of residents sure according to ce to actice does rector of ensure rapy are orrect route sidents with ged sidents eckly x 4 a proper physician and audits assurance a process	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		A STATE OF THE PARTY OF THE PAR	(X3) DATE SURVEY COMPLETED		
		495133	B. WING			16/2019
	PROVIDER OR SUPPLIER	TER	muse Li	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	practical nurse) #1 to write the orders in now, but I will check way he prefers for I The surveyor notified 4/16/19 at 4:43 pm findings. No further informat surveyor prior to the Provision of Medical CFR(s): 483.40(d) §483.40(d) The fact medically-related so maintain the highest and psychosocial with the REQUIREMENT by: Based on Resident clinical record reviet provide appropriate needs of 1 of 36 resident # 56. The findings included The facility staff fail with Resident # 56 regarding resuscitate arrest, resulting in Fedonot resuscitate of expressed that she measures implement.	stated, "I bet someone forgot for that. She has pneumonia k with the doctor to see which her to get her oxygen." ed the administrative team on of the above documented ion was provided to the exit conference on 4/16/19. Ally Related Social Service illity must provide ocial services to attain or st practicable physical, mental well-being of each resident. NT is not met as evidenced it interview, staff interview, and w, the facility staff failed to esocial services to meet the sidents in the survey sample,	F 745		s er was	6/20/19
	arrest. Resident # 56 was	a 76-year-old-female who was		Systemic Changes put into place to ensure the alleged deficient practice	does	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second	LE CONSTRUCTION	COMI	E SURVEY PLETED
		495133	B. WING		04/	16/2019
	PROVIDER OR SUPPLIE	R	9	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 745	originally admitted readmission date but were not limit type 2 diabetes or failure. The clinical recorreviewed on 4/15 MDS (minimum of quarterly assessor reference date) or assesses hearing B0700, the ability assessed. The farm Resident # 56 was communicating so but is able if prom B0800 assesses. The facility staff of "Understands-cle the MDS assesses C0500, the facility # 56 had a BIMS status) score of 1 Resident # 56's compaired. The current plan of reviewed and r	d to the facility on 6/23/08, with a of 9/25/15. Diagnoses included ed to, bipolar disorder, anxiety, nellitus, and congestive heart of for Resident # 56 was /19 at 4:40 pm. The most recent lata set) assessment was a ment, with an ARD (assessment f 2/22/19. Section B of the MDS of the speech, and vision. In Section to express ideas and wants was cility staff documented that is "Usually understood-difficulty ome words or finishing thoughts in the ability to understand others. In Section the ability to understand others. In Section of the scognitive patterns. In Section of the scognitive patterns. In Section of staff documented that Resident (brief interview for mental 0 out of 15, which indicated that orgitive status was moderately of care for Resident # 56 was used on 2/22/19. The facility staff caus area for Resident # 56 as, inves DNR (do not resuscitate). If the facility staff caus area was documented as, ince directives will be honored ew." Interventions included but to, "Copy of living will in legal and "Discuss advanced tient, family, or legal admission and quarterly." The sorders for Resident # 56 were	F 745	not recur. Education completed by the adto the director of social services that the advance directives door the medical record are an adecreflection of their wishes. Corrective Actions taken for response potential to be affected by alleg deficient practice. Director of social services will a advance directives for adequate weekly x 4 weeks and monthly. Plan of correction information a will be reviewed in the quality a and performance improvement for tracking/trending and any neadditional interventions. Date of compliance: 6/20/19	s to ensure cumented in quate sidents with led audit e reflection x 2. and audits ssurance process	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		MPLETED
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(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 745	included but were not resuscitate." On 4/15/19 at 4:50 the DDNR form da clinical record. The handwritten check following statement patient is INCAPAI decision about prowithdrawing a specific helps is unable to or probable consermedical decision, of the risks and be decision." The surhandwritten check following statement capable of making patient has execut which appoints a "on the Patient's Bethat life-prolonging withdrawn." The surguardian for Resident # 56 advanced directive authorized to constitute to constitute the surveyor did of "Cardiopulmonary which was dated 6 Resident # 56. The handwritten check	sician on 4/6/19. Orders not limited to, "Code status do a person and limited	F 74			
	resuscitation direc	tive form, "B. In the event that heart stops beating and/or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		495133	B. WING		04	/16/2019
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COL 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 745	Resuscitation." The following docume form, "I, the physical the above decision the word agree had drawn thorough it handwritten above by the physician of the physician of the facility and asked if she wanted CPF her heart and breastated, "Yes Resident # 56 and if she wanted CPF her heart and breastated, "Yes Resident, I when the facility administrated asked if Resident and asked incompetent. The "She's been here been declared increquested to see 56 incompetent. On 4/16/19 at 8:03 approached by the provided the survey papers for Reside informed the survey paperwork that states.	DO WANT Cardiopulmonary ne surveyor observed the ntation at the bottom of the cian of Resident # 56 agree with n. The surveyor observed that ad a single handwritten line and the word disagree was e it. This document was signed	F 7-	45		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495133		IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _ B. WING			(X3) DATE SURVEY COMPLETED C 04/16/2019	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			110/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 745	nursing stated, "V chart last night, I not know." "I foun stated that she (R particular funeral wear a red dress. the director of nur advance directive record as the DDI directive had been nursing stated, "A "But there is a dostated that she director of nursing stated that Resideresuscitated. The cardiopulmonary Resident # 56 alo director of nursing documentation the resuscitated. The observed the documented # 56 agree with the form documented # 56 agree with the form document with andwritten above director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dis expressed as her even though Resi code. The director surveyor asked the # 56 was able to a daily basis. The "Yes." The director of nursing appropriate to dispersion of the word and the word appropriate to dispersion of	While I was going through her learned a lot of things that I did d a paper in her chart that desident # 56) wanted to go to a home and that she wanted to "The surveyor then informed ring that she did not locate an in Resident # 56's clinical NR form stated that an advance in executed. The director of all we have is the DNR form." cument in her chart were she do not want to be resuscitated." It wanted the director of nursing that Resident # 56's clinical record and the director of nursing reviewed the resuscitation directive form for ng with the surveyor and the director of nursing also sumentation at the bottom of the as, "I, the physician of Resident and a single handwritten line and the word "disagree" was as it. The surveyor asked the diff she felt that it was regard what Resident # 56 had wishes and initiate a DNR order dent # 56 desired to be a full of nursing stated, "No." The director of nursing if Resident express her wants and needs on director of nursing stated, or of nursing stated she would fain for Resident # 56 to see if	F 745				

		IDENTIFICATION NUMBER: A. BU		LE CONSTRUCTION	COMPLETED	
	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 040 EAST LEE HIGHWAY CHILHOWIE, VA 24319	04/16/2019	
(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 APPROPE DEFICIENCY)	BE COMPLETION	
F 745	She can get more On 4/16/19 at 12:2 provided the surve 56's DDNR that had of Resident # 56's The director of nu she had been una Resident # 56 and else in the office to information and the to the facility from On 4/16/19 at 1:56 the facility social we cardiopulmonary in Resident # 56. The documentation on resuscitation direct 56 wished to be re breathing stopped documented that in 56's decision. The social worker if Re express her needs worker agreed that express her needs worker agreed that express her needs asked the facility is appropriate that the the decision to ma after she had express resuscitated. The understand what y look into this." On 4/16/19 at 3:10 the facility social we	information. 23 pm, the director of nursing eyor with a copy of Resident # ad been faxed from the agency court appointed guardians. rsing informed the surveyor that ble to reach the guardians for I she had spoken to someone of try to obtain additional e DDNR was all that was sent	F 745			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER HEALTH CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
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F 745	meetings for Resid worker stated that a meetings for Resid the facility social was her care plan meet invited, but she doe asked the social worker it guardians for Resid plan meetings and the staff communic Resident # 56 by the social worker with worker with the social worker with the social worker with the social worker with the social worker with the care plan and determined if the continued, revised stated that the guardiscussed the care areas needed to be resolved. The surveyor had offered to discussed the care with her in her may be more comfounded be able to profit the social worker w	ent # 56. The facility social she did attend the care plan ent # 56. The surveyor asked orker if Resident # 56 attended ings. The stated, "She is as not come." The surveyor orker if the guardians for nded the care plan meetings. Informed the surveyors that dent # 56 attended her care if they were unable to attend ated with the guardians for elephone. The surveyor asked ho reviewed the plan of care in meetings for Resident # 56 he focus areas needed to be or resolved. The social worker rdians and facility staff areas and determined what a continued, revised, or eyor asked the social worker if any input with regard to her icility social worker stated, asked the social worker if she asked the social worker	F 74	5		
F 755 SS=D	Pharmacy Srvcs/Pr CFR(s): 483.45(a)(l	ocedures/Pharmacist/Records b)(1)-(3)	F 75	5		6/20/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	COI	TE SURVEY MPLETED C /16/2019
	PROVIDER OR SUPPLIE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 40 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 755	§483.45 (b) (2) Es receipt and disposufficient detail to reconciliation; and \$483.45(b)(2) Es receipt and disposufficient detail to reconciliation; and \$483.45(b)(3) De order and that an is maintained and This REQUIREM by: Based on staff in review, facility stamedications were	cy Services provide routine and emergency icals to its residents, or obtain greement described in facility may permit unlicensed hinister drugs if State law under the general supervision of edures. A facility must provide fervices (including procedures focurate acquiring, receiving, fadministering of all drugs and feet the needs of each resident. The facility fobtain the services of a licensed covides consultation on all fovision of pharmacy services in tablishes a system of records of fisition of all controlled drugs in forenable an accurate	F 755	Corrective Action for those reside found to be affected by the allege deficient practice. Resident #122/145 have since be discharged from the facility.	ed	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUF	
		495133	B. WING		C	040
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	04/16/2	019
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F 755	ensure Intravenous administration. Resident #145 wa 3/30/19 with diagrid difficulty walking, failure, and essent admission Minimus assessment refersored 15/15 on the status and was as delirium, psychosis. On 04/14/19 during resident reported resident had an isomore and the following order the wound to the following order to touch anyto the following order to touch anyto the following order to make the following at 11 ml/hr Q 36 hours. The infusion order record (MAR) door the medication on 4/6/19 8 AM and 4/10 at 11:30 PM, 11:30 PM, and 4/11:30 P	distance to the facility on the series admitted to the facility on the series including pressure ulcer, kidney failure, respiratory that hypertension. On the series as without symptoms of its, or behaviors affecting others. In a preliminary interview, the having MRSA in a wound. The olation cart outside the room. It is just on contact isolation for foot. It's contained to the wound tions are necessary if you don't hing". In a preliminary interview, the having MRSA in a wound. The olation cart outside the room. It's contained to the wound tions are necessary if you don't hing". In a preliminary interview, the wound the series is a contained to the wound the series is a contained to the wound the pharmacy, restart Vancomycin have dosing of 36 hours" and the pharmacy to dose, - restart is 30 AM Vanc 1750 mg IV @ 15	F 755	Like Residents-Residents receiving antibiotic theraphave the potential to be affected. Director of nursing completed an audit on residents that are currently on antibition to ensure medications were available house and being administered. Systemic Changes put into place to ensure the alleged deficient practice not recur. Education completed by the Director Nursing to licensed nursing staff on ensuring medications are available administration or contacting the physic receive a substitution. Corrective Actions taken for resident potential to be affected by alleged deficient practice. Director of Nursing will complete and therapy audits 3x week x 4 weeks all then monthly x 2. Plan of correction information and a will be reviewed in the quality assuration and performance improvement proof or tracking/trending and any necess additional interventions. Date of compliance: 6/20/19	rector fotics le in does r of for sician ts with tibiotic nd udits ance ess	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMPLETED C
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				STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 755	irregular antibiotic 4/15/19. They rep on 4/4 and 4/9 wer the medication bed two doses per ship not arrive in time for Each time, the phy remaining doses where the administrator notified of the condition the intravenous and summary meeting. 2. For Resident 12 gentamycin was as Resident #122 was 4/8/19. Diagnoses neurogenic bladde anxiety, depression On the quarterly movith assessment reresident scored 15 mental status and of delirium, psychological status and of delirium, psychologi	administration schedule on orted the gaps in administration see the result of unavailability of cause the pharmacy had sent oment and the next doses did or scheduled administration. Sician was informed and the were rescheduled. and director of nursing were evern with failure to administer tibiotic as ordered during a on 4/15/19. 22, facility staff failed to ensure vailable for administration. 3 readmitted to the facility on included hypertension, r, diabetes mellitus, paraplegia, n, and gastroesophageal reflux. Inimum data set assessment reference date 3/28/19, the	F 75	5	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	The surveyor disc availability of the nursing. The dire had been unable the antibiotic for a	cussed the concern with lack of antibiotic with the director of ector of nursing stated that they to get the pharmacy to provide administration. The and director of nursing were oncern during a summary	F 755			
F 758 SS=D	Free from Unnec CFR(s): 483.45(c) §483.45(e) Psych §483.45(c)(3) A paffects brain active processes and be but are not limited categories: (i) Anti-psychotic; (ii) Anti-depressa; (iii) Anti-depressa; (iii) Anti-anxiety; (iv) Hypnotic Based on a compresident, the facil §483.45(e)(1) Repsychotropic drugunless the medic specific condition in the clinical receive graph shavioral interverse.	Psychotropic Meds/PRN Use (2)(3)(e)(1)-(5) notropic Drugs. psychotropic drug is any drug that vities associated with mental ehavior. These drugs include, d to, drugs in the following Int; and prehensive assessment of a green ity must ensure that esidents who have not used green as a residence and documented	F 758			6/20/19

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED		
		495133	B. WING	Contract of the contract of th	04/	16/2019
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 758	§483.45(e)(3) Repsychotropic drug unless that mediciagnosed specifin the clinical reconstruction of the clinical reconstruct	sidents do not receive gs pursuant to a PRN order cation is necessary to treat a condition that is documented ord; and N orders for psychotropic drugs days. Except as provided in the attending physician or tioner believes that it is e PRN order to be extended the or she should document their sident's medical record and ion for the PRN order. N orders for anti-psychotic to 14 days and cannot be the attending physician or tioner evaluates the resident for the ess of that medication. ENT is not met as evidenced terview and clinical record off failed to monitor targeted (36 residents in the survey (489)).	F 758	Corrective Action for those reside found to be affected by the allegate deficient practice. Resident #89 is having specific to documentation completed in the medical record. Like Residents- Residents who are on psychotromedications have the potential to affected. Director of nursing commandit of residents on psychotropiensure specific behaviors are be documented according to specific medications.	ed behavior resident oic be pleted an cs to ing	

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ B WING 495133 04/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 758 Continued From page 51 F 758 ensure the alleged deficient practice does resident was coded as requiring extensive assistance of 2 staff members for dressing, not recur. Education completed by the Director of personal hygiene and was totally dependent on 2 Nursing with licensed nurses to ensure staff members for bathing. specific behavior documentation is in each resident record. During the clinical record review on Resident #89's medical record on 4/15 and 4/16/19, the Corrective Actions taken for residents with surveyor noted the physician had ordered the

" Lorazepam (Ativan) 0.5 mg (milligram) twice a day for anxiety/agitation

following medications for the resident to receive:

" Risperidone 0.5 mg once a day for dementia with behaviors

" Sertraline (Zoloft) 50 mg daily for depression

Trazodone 50 mg at bedtime for insomnia

The surveyor also reviewed the behavioral monitoring sheets for March and April 2019 for Resident #89. For the medication, Risperidone, the monitoring sheet had behaviors and psychosis listed for the specific targeted behaviors to be monitored while the resident was receiving this medication. For the medication, Zoloft, the monitoring sheets had depression for the specific targeted behaviors while the resident was receiving this medication. For the medication, Ativan, the monitoring sheet had the behavior of anxiety for the specific targeted behaviors to be monitored while the resident was receiving this medication. In addition, for Trazodone, the monitoring sheet had the behavior of not sleeping as a specific targeted behavior to be monitored while the resident was receiving this medication.

The surveyor notified the DON (director of nursing) of the above documented findings on 4/16/19 at 1 pm. The DON stated, "They just

Corrective Actions taken for residents with potential to be affected by alleged deficient practice.

Director of Nursing or designee will complete audits of psychotropic associated behavior documentation 3x week x 4 weeks and monthly x2.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date of compliance: 6/20/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		MPLETED C
		495133	B. WING	04	/16/2019
	PROVIDER OR SUPPLIER	TER	,	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	wrote depression li	age 52 ke for this one but they didn't nt acts when depressed."	F 758	3	
	The surveyor notific	ed the administrative team of nted findings on 4/16/19 at			
F 807 SS=E	surveyor prior to th Drinks Avail to Mee	ion was provided to the e exit conference on 4/16/19. et Needs/Prefs/Hydration 6)	F 807	7	6/20/19
	§483.60(d)(6) Drinl liquids consistent w preferences and su hydration.	nd drink ives and the facility provides- ixs, including water and other ivith resident needs and ifficient to maintain resident NT is not met as evidenced			
	Based on observa staff failed to ensur available at the bed			Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #111, 136, and 13 have since been discharged from the facility. Resident #84, 67, 127, 15, 11, and 13 have fresh water each shift.	
	was readily availab #84. Resident #84 was 12/5/18 with the fol	f failed to ensure fresh water le at the bedside of Resident readmitted to the facility on lowing diagnoses of, but not high blood pressure, peripheral esychotic disorder,		Like Residents- Residents who admit into the facility have the potential to be affected. Director of nursing completed audit with the staffing scheduler to ensure that there is a staff member assigned to pass ice and fresh water each ice.	
		respiratory failure. On the		Systemic Changes put into place to	

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495133 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 807 Continued From page 53 F 807 quarterly MDS (Minimum Data Set) with an ARD ensure the alleged deficient practice does of 3/12/19 coded the resident as having a BIMS not recur. (Brief Interview for Mental Status) score of 14 out Education completed by the Director of of a possible score of 15. Resident #84 was also Nursing to staffing scheduler and nursing coded as requiring extensive assistance of 1-2 department to ensure that staff are passing ice and fresh water on each shift. staff members for dressing, personal hygiene and is totally dependent on 2 staff members for Corrective Actions taken for residents with bathing. potential to be affected by alleged deficient practice. During the initial tour on 4/14/19 at 12 noon, the surveyor observed the water cup that the facility Director of Nursing will complete fresh water and ice audits each shift 2x week x has for each resident was empty and the outside 4 weeks and monthly x2. of it was not wet from the ice melting in the cup. On the lid of the cup, there was a date of "4/13/19". The surveyor asked the resident how Plan of correction information and audits will be reviewed in the quality assurance often he gets fresh water. The resident stated, "I and performance improvement process don't know, maybe yesterday." for tracking/trending and any necessary additional interventions. At 1 pm on 4/14/19, the surveyor asked CNA (certified nursing assistant) #1 how often they put Date of compliance: 6/20/19 fresh water by the bedside of the resident. CNA #1 stated, "once a shift. That is the wing helper's job. This morning there was a call in by another CNA and I stayed over this morning to help them out. We have just been so busy and we haven't had help so we haven't had time to give out fresh water this morning." The surveyor notified the administrative staff of the above documented findings on 4/16/19 at 4:45 pm in the conference room.

#111.

No further information was provided to the surveyor prior to the exit conference on 4/16/19.

The facility staff failed to ensure fresh water was readily available at the bedside of Resident

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION NG		MPLETED C
		495133	B. WING		04	/16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 807	Resident #111 was 12/17/18 with the folimited to high blood disorder, depression Schizophrenia and MDS (Minimum Data (Assessment Referesident was coded Interview or Mentar possible score of 1 coded as requiring member for dressing extensive assistant bathing. During the initial to surveyor observed has for each reside of it was not wet frought on the lid of the curulation. At 1 pm on 4/14/19 (certified nursing as fresh water by the 1/4/13/19". At 1 pm on 4/14/19 (certified nursing as fresh water by the 1/4/13/19". The surveyor notified the above document water this morning. The surveyor notified the above document was not wet frought. We have just had help so we have water this morning. The surveyor notified the above document was not wet frought. We have just had help so we have water this morning. The surveyor notified the above document was not wet frought. We have just had help so we have water this morning.	admitted to the facility on collowing diagnoses of, but not of pressure, diabetes, anxiety on, manic depression, asthma. On the quarterly ata Set) with an ARD rence Date) of 3/25/19, the das having a BIMS (Brief I Status) score of 5 out of a 5. Resident #111 was also limited assistance of 1 staffing, personal hygiene and ce of 1 staff member for ur on 4/14/19 at 12 noon, the the water cup that the facility ent was empty and the outside om the ice melting in the cup. In there was a date of the resident. CNA shift. That is the wing helper's there was a call in by another over this morning to help them been so busy and we haven't en't had time to give out fresh in the diagram of the diagram	F 80			

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 04/16/2019 495133 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PRFFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 807 F 807 Continued From page 55 The facility staff failed to ensure fresh water was readily available at the bedside of Resident #136. Resident #136 was readmitted to the facility on 12/6/16 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, dementia, seizure disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/4/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and being totally dependent on 2 staff members for bathing. During the initial tour on 4/14/19 at 12 noon, the surveyor observed the water cup that the facility has for each resident was empty and the outside of it was not wet from the ice melting in the cup. On the lid of the cup, there was a date of "4/13/19". At 1 pm on 4/14/19, the surveyor asked CNA (certified nursing assistant) #1 how often they put fresh water by the bedside of the resident. CNA #1 stated, "once a shift. That is the wing helper's job. This morning there was a call in by another CNA and I stayed over this morning to help them out. We have just been so busy and we haven't had help so we haven't had time to give out fresh water this morning." The surveyor notified the administrative staff of

Event ID: 4PGJ11

the above documented findings on 4/16/19 at

No further information was provided to the surveyor prior to the exit conference on 4/16/19.

4:45 pm in the conference room.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _ B. WING _	CONSTRUCTION	COM	TE SURVEY MPLETED C /16/2019
	PROVIDER OR SUPPLIE	R	940	REET ADDRESS, CITY, STATE, ZIP COD DEAST LEE HIGHWAY HILHOWIE, VA 24319		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 807	4. The facility s was readily availa #67. Resident #67 was 2/4/19 with the folimited to coronar pressure, dementhe significant chawith an ARD (Ass 2/11/19; the resid BIMS (Brief Internation 3 out of a possible also coded as restaff members fobeing totally dependently dependently as for each resident of it was not wet from the lid of the control of the lid of t	page 56 staff failed to ensure fresh water able at the bedside of Resident as readmitted to the facility on allowing diagnoses of, but not by artery disease, high blood tia, depression and asthma. On ange MDS (Minimum Data Set) are sessment Reference Date) of tent was coded as having a view for Mental Status) score of the escore of 15. Resident #67 was a quiring extensive assistance of 2 or dressing, personal hygiene and tendent on 2 staff members for the water cup that the facility dent was empty and the outside from the ice melting in the cup. The surveyor asked CNA assistant) #1 how often they put the bedside of the resident. CNA as shift. That is the wing helper's a there was a call in by another over this morning to help them	F 807			
	had help so we had water this morning. The surveyor notion	fied the administrative staff of ented findings on 4/16/19 at				

	OF CORRECTION	IDENTIFICATION NUMBER:		G		TE SURVEY MPLETED C
		495133	B. WING _			/16/2019
	PROVIDER OR SUPPLIER HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP COD 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 807	Continued From pa	age 57	F 80	7	CODE ORRECTION N SHOULD BE E APPROPRIATE	
	No further informal surveyor prior to the surveyor problems. The following the surveyor problems in the surveyor problems in the surveyor problems.	tion was provided to the se exit conference on 4/16/19. aff failed to ensure fresh water ole at the bedside of Resident dmitted to the facility on llowing diagnoses of, but not peripheral vascular disease, chotic disorder. On the nimum Data Set) with an ARD grence Date) OF 4/1/19, coded ving short and long-term with being moderately				
	#127 was also cod assistance of 1 sta	g daily decisions. Resident led as requiring extensive aff member for eating, and adent on 1-2 staff members for and bathing.				
	surveyor observed has for each reside of it was not wet fr	our on 4/14/19 at 12 noon, the the water cup that the facility ent was empty and the outside om the ice melting in the cup. up, there was a date of				
	(certified nursing a fresh water by the #1 stated, "once a job. This morning CNA and I stayed out. We have just had help so we ha water this morning	9, the surveyor asked CNA assistant) #1 how often they put bedside of the resident. CNA shift. That is the wing helper's there was a call in by another over this morning to help them been so busy and we haven't ven't had time to give out fresh"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _		00	C
		495133	B. WING		04	/16/2019
	PROVIDER OR SUPPLIER		94	REET ADDRESS, CITY, STATE, ZIP 0 EAST LEE HIGHWAY HILHOWIE, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 807	the above docume 4:45 pm in the con No further informa surveyor prior to th 6. The facility sta was readily availab #15. Resident #15 was 1/1/17 with the folk limited to anemia, blood pressure, dia On the annual MD ARD (Assessment the resident was co assistance of 2 sta personal hygiene a 2 staff members for During the initial to surveyor observed has for each reside of it was not wet fro On the lid of the cu "4/13/19". At 1 pm on 4/14/19 (certified nursing a fresh water by the #1 stated, "once a job. This morning CNA and I stayed o out. We have just had help so we hav water this morning	ented findings on 4/16/19 at a ference room. Ition was provided to the se exit conference on 4/16/19. If failed to ensure fresh water ole at the bedside of Resident areadmitted to the facility on owing diagnoses of, but not coronary artery disease, high abetes, arthritis, and dementia. S (Minimum Data Set) with an Reference Date) of 1/18/19, oded as requiring extensive aff members for dressing, and being totally dependent on or bathing. For a 1/14/19 at 12 noon, the the water cup that the facility ent was empty and the outside om the ice melting in the cup. Ip, there was a date of It is the surveyor asked CNA ssistant) #1 how often they put bedside of the resident. CNA shift. That is the wing helper's there was a call in by another over this morning to help them been so busy and we haven't ven't had time to give out fresh	F 807			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	co	TE SURVEY MPLETED C	
	ALLEY HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP COD 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		04/16/2019 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 807	the above docume 4:45 pm in the con No further informa surveyor prior to th 7. The facility sta was readily availab #11. Resident #11 was 11/15/18 with the folimited to anemia, depression and ps quarterly MDS (Min (Assessment Referesident was code Interview for Menta possible score of 1 coded as requiring staff members for being totally dependently de	anted findings on 4/16/19 at ference room. Ition was provided to the se exit conference on 4/16/19. If failed to ensure fresh water ole at the bedside of Resident Ireadmitted to the facility on collowing diagnoses of, but not hip fracture, dementia, ychotic disorder. On the nimum Data Set) with an ARD rence Date) of 1/16/19, the das having a BIMS (Brief al Status) score of 9 out of a 15. Resident #11 was also extensive assistance of 1-2 dressing, personal hygiene and orden on 1 staff member for the water cup that the facility ent was empty and the outside om the ice melting in the cup.	F 807				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
ANDILANC	ST CONNECTION	495133	B. WING	G		C 04/16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319	CODE	04/10/2013
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT	
F 807	The surveyor notifithe above documed 4:45 pm in the corn. No further information surveyor prior to the surveyor depression of 17/18 with the following a BIMS (Brusche of 5 out of a surveyor and surveyor and surveyor depression of 1 states and surveyor observed that for each reside of it was not wet from the lid of the curicular to the surveyor observed that the surveyor observed the surveyor observed that the surveyor observed the	ied the administrative staff of ented findings on 4/16/19 at afference room. Ition was provided to the ne exit conference on 4/16/19. If failed to ensure fresh water ole at the bedside of Resident Identification of the facility on admitted to the facility on the facility of the faci	F 80	7		

PRINTED: 06/21/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 495133 B WING 04/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 940 EAST LEE HIGHWAY VALLEY HEALTH CARE CENTER CHILHOWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 807 Continued From page 61 F 807 CNA and I stayed over this morning to help them out. We have just been so busy and we haven't had help so we haven't had time to give out fresh water this morning." The surveyor notified the administrative staff of the above documented findings on 4/16/19 at 4:45 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 4/16/19. 6/20/19 F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 SS=D 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

This REQUIREMENT is not met as evidenced

Based on observation, staff interview, clinical

record review and facility document review it was

determined the facility staff failed to provide clean

standards for food service safety.

deficient practice.

Corrective Action for those residents

found to be affected by the alleged

The state of the s	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G	COMPLETED
		495133	B. WING		04/16/2019
	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 BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	DATE
F 812	residents (Resider failed to don glove resideglovgnt's real Findings: 1. Facility staff faile food service to Reclinical record was AM. Resident #25 was 7-18-18. Her diagrate hypertension, aner The latest MDS (modated 1-30-19, cool unimpaired. The reassistance for all tilliving) and a set-up one staff member Resident #25's CO reviewed and revisite resident required a interventions including hygiene, grooming as needed. On 4-14-19 at 12:5 the resident's mea (wing helper I) brount on the room and for the resident. W	service to 2 of 33 facility ats #25 and #140). Facility staff is when handling the ady made foods. ed to provide clean and sanitary sident #25. The resident's reviewed on 4-16-19 at 9:00 admitted to the facility on loses included diabetes, mia and depression. sinimum data set) assessment, led the resident as cognitively esident required staff the ADLs (activities of daily of and physical assistance of	F 81:	CNA 1 and WH 1 received immediate education on infection control practice when assisting residents with food. Like Residents- Residents who require assistance wifeeding or feeding setup have the potential to be affected. Director of nursing completed an audit of feeding assistance to ensure infection contropractices are being adhered to as applicable. Systemic Changes put into place to ensure the alleged deficient practice not recur. Education completed by the Director Nursing with the nursing department ensure infection control practices are followed during meal service according policy and procedures. Corrective Actions taken for resident potential to be affected by alleged deficient practice. Director of Nursing will complete auditional transfer infection control practices week x 4 weeks and monthly x2. Plan of correction information and auditional interventions.	does of to eng to s with lit of 3x ddits nce ess
		with her bare hands. 5 AM this observation was		Date of compliance: 6/20/19	

		E & MEDICAID SERVICES					
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	IPLETED
		495133	B. WING				16/2019
	PROVIDER OR SUPPLIER			940	COMPLET C 04/16/2 ADDRESS, CITY, STATE, ZIP CODE ST LEE HIGHWAY OWIE, VA 24319 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
F 812	reported to the factor surveyor the staff of practices and said ANY food was a part of the facility policy of addressed employ providing meal asset that staff would be demonstrate complete food borne illnessed and safe food hand. No additional informatively team exit. 2. Facility staff failed food service to Reclinical record was AM. Resident #140 was	ility DON. The DON told the were trained in safe food wearing gloves when handling art of that training. If the surveyor with a copy of meal assistance. The policy ee training for staff members sistance. The policy included trained and would betency in the prevention of es, "including hygiene practices dling". In the surveyor with a copy of meal assistance. The policy included trained and would be provided and would be provided and would be provided and survey in cluding hygiene practices dling". In the surveyor with a copy of meal assistance. The policy included trained and would be provided and would be provided and surveyor the provided clean and sanitary sident #140. The resident's reviewed on 4-16-19 at 9:15 and mitted to the facility on	F8	12			
	The latest MDS (m dated 4-5-19, code impaired. The resifor all the ADLs (ac	noses included dementia, depression. ninimum data set) assessment, ed the resident as cognitively dent required staff assistance ctivities of daily living) and the e of one staff member to eat.					
	Resident #140's C reviewed and revis resident required a interventions inclu-	CP (comprehensive care plan) sed on 1-10-19 indicated the assistance with ADLs. Staff ded assisting with daily dressing, nail care, oral care					

PRINTED: 06/21/2019

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
		495133	B. WING _		0/	C 4/16/2019
NAME OF PROVIDER OR SUPPLIER VALLEY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 940 EAST LEE HIGHWAY CHILHOWIE, VA 24319		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 812	resident's meal se brought the reside and set it up on the CNA I did not don and was observed the paper wrapper plate with her bare. On 4-16-19 at 10: reported to the factorices and said ANY food was a part of the facility policy of addressed employ providing meal assist that staff would be demonstrate completed food borne illnessed and safe food hand.	4 PM the surveyor observed the rivice in her room. CNA I ent's lunch tray into her room e overbid table for the resident. gloves during the tray set-up to remove a sandwich from and place it on the resident's hands. 15 AM this observation was sility DON. The DON told the were trained in safe food wearing gloves when handling art of that training. If the surveyor with a copy of a meal assistance. The policy ree training for staff members sistance. The policy included trained and would betency in the prevention of es, "including hygiene practices	F 87			