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	495133	A. BUILDING _____ B. WING _____	C 04/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/14/19 through 04/16/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/14/19 through 4/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Complaints were investigated during the course of the survey. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 163 at the time of the survey. The final survey sample consisted of 33 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/20/19

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

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.

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F 550	Continued From page 1 §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 by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a dignified dining experience for 4 of 36 residents in the survey sample (Resident #111, 127, 11, and 13). The findings included: 1. The facility staff failed to provide a dignified dining experience for Resident #111. Resident #111 was admitted to the facility on 12/17/18 with the following diagnoses of, but not	F 550	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #111 and #13 has since been discharged from the facility. Resident #127 and #11 are eating their meals in the dining room. Like Residents- Residents who need assistance with feeding have the potential to be affected. Audit completed by the Director of Nurses on residents that require feeding assistance to ensure they	

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F 550	Continued From page 2 limited to high blood pressure, diabetes, anxiety disorder, depression, manic depression, Schizophrenia and asthma. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/25/19, the resident was coded as having a BIMS (Brief Interview or Mental Status) score of 5 out of a possible score of 15. Resident #111 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and extensive assistance of 1 staff member for bathing. During the initial tour of the 3rd wing in the facility on 4/14/19 at 12:30 pm, the surveyor heard the unit manager and several other nurses and CNA (certified nursing assistants) being directed by the unit manager to "Take the feeders back to their rooms for lunch today." This surveyor and the team leader surveyor went to the unit manager that was standing in the hallway outside of the dining room and asked what was going on. The unit manager stated, "We got into trouble with a regulation for having the feeders in the same dining room as other residents that were eating. So they will have to be taken back to their rooms and be fed by the staff there." This surveyor asked the unit manager that if a resident verbalized that they wanted to remain in the dining room to eat, could they not stay. The unit manager stated, "They have to be taken to their rooms for now, then if they want to come back and eat in the dining room, the staff will bring them back and feed them in there." The 2 surveyors that were present in the hallway and observing staff removing the "feeders" to their rooms. Three of the residents that was being taken out of the dining room verbalized to the staff that they wanted to stay in the dining room to	F 550	are being given the option to receive meals in the dining room. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed to the nursing department to ensure residents regardless of assistance needed for feeding are able to eat in the facility dining rooms. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit dining room(s) 3x week x 4 and monthly x 2 to ensure residents who need assistance are present in the dining room(s). 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	

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F 550	Continued From page 3	F 550		

eat. The surveyors observed the facility staff telling the residents, that were being removed from the dining room, they could come back in the dining room after everyone has been fed lunch.

Resident #111 was coded on the MDS with ARD of 3/25/19 as needing "supervision, oversight, encouragement or cueing of 1 staff member for physical assistance in eating.

On 4/15/19 at 12:30 pm, the surveyor observed 1 resident sitting at the table with 2 other residents that were eating. The surveyor asked the wing helper why this resident was still in the dining room watching the other residents eating. The wing helper stated, "She is usually fed in here after all the residents have finished eating."

The surveyor notified the administrative team 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.

2. The facility staff failed to provide a dignified dining experience for Resident #127.

Resident #127 readmitted to the facility on 6/30/15 with the following diagnoses of, but not limited to anemia, peripheral vascular disease, dementia and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) OF 4/1/19, coded the resident as having short and long-term memory problems with being moderately impaired in making daily decisions. Resident #127 was also coded as requiring extensive

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F 550	Continued From page 4	F 550		

assistance of 1 staff member for eating, and being totally dependent on 1-2 staff members for personal hygiene and bathing.

During the initial tour of the 3rd wing in the facility on 4/14/19 at 12:30 pm, the surveyor heard the unit manager and several other nurses and CNA (certified nursing assistants) being directed by the unit manager to "Take the feeders back to their rooms for lunch today." This surveyor and the team leader surveyor went to the unit manager that was standing in the hallway outside of the dining room and asked what was going on. The unit manager stated, "We got into trouble with a regulation for having the feeders in the same dining room as other residents that were eating. So they will have to be taken back to their rooms and be fed by the staff there." This surveyor asked the unit manager that if a resident verbalized that they wanted to remain in the dining room to eat, could they not stay. The unit manager stated, "They have to be taken to their rooms for now, then if they want to come back and eat in the dining room, the staff will bring them back and feed them in there." The 2 surveyors that were present in the hallway and observing staff removing the "feeders" to their rooms. Three of the residents that was being taken out of the dining room verbalized to the staff that they wanted to stay in the dining room to eat. The surveyors observed the facility staff telling the residents, that were being removed from the dining room, they could come back in the dining room after everyone has been fed lunch.

On 4/15/19 at 12:30 pm, the surveyor observed 1 resident sitting at the table with 2 other residents that were eating. The surveyor asked the wing

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F 550	Continued From page 5	F 550		

helper why this resident was still in the dining room watching the other residents eating. The wing helper stated, "She is usually fed in here after all the residents have finished eating."

The surveyor notified the administrative team 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.

3. The facility staff failed to provide a dignified dining experience for Resident #11.

Resident #11 was readmitted to the facility on 11/15/18 with the following diagnoses of, but not limited to anemia, hip fracture, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #11 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and being totally dependent on 1 staff member for bathing and eating.

During the initial tour of the 3rd wing in the facility on 4/14/19 at 12:30 pm, the surveyor heard the unit manager and several other nurses and CNA (certified nursing assistants) being directed by the unit manager to "Take the feeders back to their rooms for lunch today." This surveyor and the team leader surveyor went to the unit manager that was standing in the hallway outside of the dining room and asked what was going on. The unit manager stated, "We got into trouble with a

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F 550	Continued From page 6	F 550		

regulation for having the feeders in the same dining room as other residents that were eating. So they will have to be taken back to their rooms and be fed by the staff there." This surveyor asked the unit manager that if a resident verbalized that they wanted to remain in the dining room to eat, could they not stay. The unit manager stated, "They have to be taken to their rooms for now, then if they want to come back and eat in the dining room, the staff will bring them back and feed them in there." The 2 surveyors that were present in the hallway and observing staff removing the "feeders" to their rooms. Three of the residents that was being taken out of the dining room verbalized to the staff that they wanted to stay in the dining room to eat. The surveyors observed the facility staff telling the residents, that were being removed from the dining room, they could come back in the dining room after everyone has been fed lunch.

On 4/15/19 at 12:30 pm, the surveyor observed 1 resident sitting at the table with 2 other residents that were eating. The surveyor asked the wing helper why this resident was still in the dining room watching the other residents eating. The wing helper stated, "She is usually fed in here after all the residents have finished eating."

The surveyor notified the administrative team 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.

4. The facility staff failed to provide a dignified dining experience for Resident #13.

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F 550	Continued From page 7	F 550		

Resident #13 was admitted to the facility on 7/17/18 with the following diagnoses of, but not limited to anemia, pneumonia, dementia, seizure disorder, depression, psychotic disorder and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of 1 staff member for dressing, eating, personal hygiene and being totally dependent on 1 staff member for bathing.

During the initial tour of the 3rd wing in the facility on 4/14/19 at 12:30 pm, the surveyor heard the unit manager and several other nurses and CNA (certified nursing assistants) being directed by the unit manager to "Take the feeders back to their rooms for lunch today." This surveyor and the team leader surveyor went to the unit manager that was standing in the hallway outside of the dining room and asked what was going on. The unit manager stated, "We got into trouble with a regulation for having the feeders in the same dining room as other residents that were eating. So they will have to be taken back to their rooms and be fed by the staff there." This surveyor asked the unit manager that if a resident verbalized that they wanted to remain in the dining room to eat, could they not stay. The unit manager stated, "They have to be taken to their rooms for now, then if they want to come back and eat in the dining room, the staff will bring them back and feed them in there." The 2 surveyors that were present in the hallway and observing staff removing the "feeders" to their rooms. Three of the residents that was being

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F 550	Continued From page 8 taken out of the dining room verbalized to the staff that they wanted to stay in the dining room to eat. The surveyors observed the facility staff telling the residents, that were being removed from the dining room, they could come back in the dining room after everyone has been fed lunch. On 4/15/19 at 12:30 pm, the surveyor observed 1 resident sitting at the table with 2 other residents that were eating. The surveyor asked the wing helper why this resident was still in the dining room watching the other residents eating. The wing helper stated, "She is usually fed in here after all the residents have finished eating." The surveyor notified the administrative team 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.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		6/20/19

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

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F 578	Continued From page 10 #56. The facility staff documented that Resident # 56 executed a written advanced directive, which appointed a person to consent on Resident # 56's behalf with authority that life-prolonging procedures be withdrawn or withheld, when in fact Resident # 56 did not wish to be a DNR and desired full code status. Resident # 56 was a 76-year-old-female who was originally admitted to the facility on 6/23/08, with a readmission date of 9/25/15. Diagnoses included but were not limited to, bipolar disorder, anxiety, type 2 diabetes mellitus, and congestive heart failure. The clinical record for Resident # 56 was reviewed on 4/15/19 at 4:40 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment, with an ARD (assessment reference date) of 2/22/19. Section B of the MDS assesses hearing, speech, and vision. In Section B0700, the ability to express ideas and wants was assessed. The facility staff documented that Resident # 56 was "Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." Section B0800 assesses the ability to understand others. The facility staff documented that Resident # 56 "Understands-clear comprehension." Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 56 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated that Resident # 56's cognitive status was moderately impaired. The current plan of care for Resident # 56 was reviewed and revised on 2/22/19. The facility staff documented a focus area for Resident # 56 as,	F 578	the potential to be affected. Audit completed to ensure physician order sheets and the advance directive form match as applicable. Systemic changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses and the department of social services on ensuring the physician order sheet and the advance directive sheet match. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit physician order sheets and 3x week x 4 weeks and monthly x 2 months. 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	

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"Advanced Directives DNR (do not resuscitate)." The goal for this focus area was documented as, "Resident's advance directives will be honored through next review." Interventions included but were not limited to, "Copy of living will in legal section of chart," and "Discuss advanced directives with patient, family, or legal representative at admission and quarterly."

The current physician's orders for Resident # 56 were signed by the physician on 4/6/19. Orders included but were not limited to, "Code status do not resuscitate."

On 4/15/19 at 4:50, pm, the surveyor reviewed the DDNR form dated 3/26/12 in Resident # 56's clinical record. The surveyor observed a handwritten check mark documented next to the following statement on the DDNR form, "2. The patient is INCAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." The surveyor also observed a handwritten checkmark documented next to the following statement on the DDNR form, "B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with the authority to direct that life-prolonging procedures be withheld or withdrawn." The surveyor observed that the guardian for Resident # 56 had signed the back of the DDNR form authorizing the DDNR status. The surveyor further reviewed the clinical record for Resident # 56 and did not locate a written

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advanced directive that appointed a person authorized to consent on Resident # 56's behalf. The surveyor did observe a facility "Cardiopulmonary Resuscitation Directive" form, which was dated 6/23/08 in the clinical record for Resident # 56. The surveyor observed a handwritten checkmark documented next to the following statement of the cardiopulmonary resuscitation directive form, "B. In the event that my/my loved one's heart stops beating and/or breathing stops, I DO WANT Cardiopulmonary Resuscitation." The surveyor observed the following documentation at the bottom of the form, "I, the physician of Resident # 56 agree with the above decision. The surveyor observed that the word agree had a single handwritten line drawn through it and the word disagree was handwritten above it. This document was signed by the physician on 6/23/08.

On 4/15/19 at 4:57 pm, the surveyor conducted a Resident interview with Resident # 56. The surveyor asked Resident # 56 if she wanted CPR to bring her back if her heart stops beating. Resident # 56 stated "Yes." The surveyor asked Resident # 56 again for clarification to ensure that Resident # 56 understood what was being asked if she wanted CPR to try to bring her back to life if her heart and breathing stops. Resident # 56 stated, "Yes Resident # 56 does." If my heart stops beating, I want them to try to bring me back."

On 4/15/19 at 6:00 pm, the surveyor spoke with the facility administrator and director of nursing and asked if Resident # 56 had been declared incompetent. The facility administrator stated, "She's been here a long time, I believe she has been declared incompetent." The surveyor

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F 578	Continued From page 13 requested to see paperwork declaring Resident # 56 incompetent. On 4/16/19 at 8:03 am, the surveyor was approached by the director of nursing who provided the surveyor with a copy of guardianship papers for Resident # 56. The director of nursing informed the surveyor that she did not locate any paperwork that stated that Resident # 56 had been declared incompetent. The director of nursing stated, "While I was going through her chart last night, I learned a lot of things that I did not know." "I found a paper in her chart that stated that she (Resident # 56) wanted to go to a particular funeral home and that she wanted to wear a red dress." The surveyor then informed the director of nursing that she did not locate an advance directive in Resident # 56's clinical record as the DDNR form stated that an advance directive had been executed. The director of nursing stated, "All we have is the DNR form." "But there is a document in her chart where she stated that she did not want to be resuscitated." The surveyor informed the director of nursing that the document in Resident # 56's clinical record stated that Resident # 56 did want to be resuscitated. The director of nursing reviewed the cardiopulmonary resuscitation directive form for Resident # 56 along with the surveyor and the director of nursing agreed that the form contained documentation that Resident # 56 wished to be resuscitated. The director of nursing also observed the documentation at the bottom of the form documented as, "I, the physician of Resident # 56 agree with the above decision." The director of nursing along with the surveyor observed that the word agree had a single handwritten line drawn thorough it and the word "disagree" was handwritten above it. The surveyor asked the	F 578		

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director of nursing if she felt that it was appropriate to disregard what Resident # 56 had expressed as her wishes and initiate a DNR order even though Resident # 56 desired to be a full code. The director of nursing stated, "No." The surveyor asked the director of nursing if Resident # 56 was able to express her wants and needs on a daily basis. The director of nursing stated, "Yes." The director of nursing stated she would contact the guardian for Resident # 56 to see if she can get more information.

On 4/16/19 at 12:23 pm, the director of nursing provided the surveyor with a copy of Resident # 56's DDNR that had been faxed from the agency of Resident # 56's court appointed guardians. The director of nursing informed the surveyor that she had been unable to reach the guardians for Resident # 56 and she had spoken to someone else in the office to try to obtain additional information and the DDNR was all that was sent to the facility from the agency.

On 4/16/19 at 1:58 pm, the surveyor interviewed the facility social worker. The surveyor along with the facility social worker reviewed the cardiopulmonary resuscitation directive for Resident # 56. The facility social worker observed documentation on the cardiopulmonary resuscitation directive that stated that Resident # 56 wished to be resuscitated if her heart or breathing stopped, and that physician documented that he disagreed with Resident # 56's decision. The surveyor asked the facility social worker if Resident # 56 was able to express her needs and wants. The facility social worker agreed that Resident # 56 was able to express her needs and wants. The surveyor asked the facility social worker if she felt it was

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appropriate that the physician and guardian made the decision to make Resident # 56 a DNR even after she had expressed that she wanted to be resuscitated. The facility social worker stated, "I understand what you mean and we will definitely look into this."

On 4/16/19 at 3:10 pm, the surveyor spoke with the facility social worker. The surveyor asked the facility social worker if she attended care plan meetings for Resident # 56. The facility social worker stated that she did attend the care plan meetings for Resident # 56. The surveyor asked the facility social worker if Resident # 56 attended her care plan meetings. The stated, "She is invited, but she does not come." The surveyor asked the social worker if the guardians for Resident # 56 attended the care plan meetings. The social worker informed the surveyors that guardians for Resident # 56 attended her care plan meetings and if they were unable to attend the staff communicated with the guardians for Resident # 56 by telephone. The surveyor asked the social worker who reviewed the plan of care during the care plan meetings for Resident # 56 and determined if the focus areas needed to be continued, revised or resolved. The social worker stated that the guardians and facility staff discussed the care areas and determined what areas needed to be continued, revised, or resolved. The surveyor asked the social worker if Resident # 56 had any input with regard to her plan of care. The facility social worker stated, "No." The surveyor asked the social worker if she had offered to discuss Resident # 56's plan of care with her in her room in an environment that may be more comfortable to her so that she would be able to provide input in her plan of care. The social worker stated, "I have not."

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F 578	Continued From page 16 On 4/16/19 at 4:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/16/18. 2. The facility staff failed to ensure Resident #89 expressed wishes for end of life were honored. Resident #89 was admitted to the facility on 12/5/18 with the following diagnoses of, but not limited to heart failure, diabetes, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/13/19, the resident was coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and was totally dependent on 2 staff members for bathing. During the clinical record review on 4/15/19, the surveyor noted that a signed DDNR was dated for 1/5/19 with both the physician's and resident representative's signatures present. The surveyor reviewed the physician orders sheets for the months of March and April 2019 and the resident's code status was "Full Code". The surveyor notified unit manager #1 on 4/15/19 at 2 pm. She reviewed the above documented findings and stated, "The code status doesn't match. One is for Full Code and the other is DDNR." The surveyor notified the administrative team of the above documented findings on 4/16/19 at 4:43 pm in the conference room.	F 578		

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F 578	Continued From page 17 No further information was provided to the surveyor prior to the exit conference on 4/16/19.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint survey the facility staff failed to report	F 609	Corrective Action for those residents found to be affected by the alleged deficient practice.	6/20/19

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F 609	Continued From page 18 an injury of unknown origin for 1 of 36 Residents, Resident #363. The findings included: For Resident #363 the facility staff failed to report an unwitnessed fall resulting in an injury. Resident #363 was admitted to the facility on 06/01/15 and readmitted on 01/11/19. Diagnoses included but not limited to anemia, pneumonia, depression, coronary artery disease, hypothyroidism, gastroesophageal reflux disease, benign prostatic hyperplasia and insomnia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/14/18 coded the Resident as 7 out of 15 in section C, cognitive status. Section G, functional status, coded the Resident as needing extensive with two-person physical assist in the area of transfer ((how Resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). Moving from a seated to standing position was coded as not steady, only able to stabilize with staff assistance. Resident #363's CCP (comprehensive care plan) was reviewed and contained a care plan for "At risk for falls due to impaired balance/poor coordination, and unsteady gait and confusion at times". This care plan was initiated on 02/27/15. Interventions for this care plan included, "assist of 2 staff member to bathroom (initiated 02/21/17, revised 03/04/19), assist Resident to be up in w/chair and out at desk when repeatedly tries to get up without help , and has no family present (initiated 12/09/17, revised 03/04/19), assist to chair and take to nsg desk to monitor when	F 609	Resident #363 has since been discharged 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 does not recur. Education to nursing leadership on reporting injuries on unknown origin according the policy and procedures. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete audits on SBAR forms and progress notes and report situations according to the policy weekly x 3 months and then monthly. 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	

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F 609	Continued From page 19 repeatedly trying to stand or get up by self, notify family to come and stay with Resident if continues to be non-compliant with instructions (initiated 08/09/18, revised 03/04/19) frequent visual checks (initiated 02/27/17, revised 03/04/19), frequently assess toileting needs and assist to restroom if needed (initiated 08/07/16, revised 03/04/19), keep lift chair controller out of reach of Resident, prevent from lifting it to max height (initiated 05/07/16, revised 02/14/19), and keep remote to recliner in reach of Resident, place to where remote will not fall to floor (initiated 01/28/18, revised 02/14/19)." Resident #363's clinical record was reviewed on 04/15/19. It contained a fall risk evaluation, which indicated the Resident was at high risk for falls. Resident #363's clinical record also contained a signed physician's order summary for the month of February 2019, which read in part "fall precautions". Resident #363's clinical record contained nurse's progress notes, which read in part "12/20/2018 22:53 Resident has mac'e multiple attempts to get out of bed unassisted. attempts at redirection are only successful for a short time before Resident is attempting to get up unassisted again. call light and PO (by mouth) fluids at bedside", "12/24/2018 03:31 12/24/18 1900-2330 Resident has been awake majority of shift since 2200...12/25/18 0001-315 repeatedly attempted to get out of bed since 0200 redirected every few minutes unsuccessful. has gotten crossways of bed x 2. assisted up to his chair at this x (time)", and "1/3/2019 14:00 Change in condition noted related to Called into room by staff observed Resident laying on right side on floor hit head with v shaped laceration to right side of forehead and	F 609		

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right eye red and swollen. Skin tear to left ring finger. Resident pushed button to recliner said he had...".

Resident #363's clinical record contained an emergency room report dated 01/03/19, which read in part "Admission date: 1/3/2019 Chief complaint: Fall and intracranial hemorrhage HPI (history of present illness): This is 99-year old male with past medical history of coronary artery disease, pacemaker, dementia, enlarged prostate, GERD, gout, hyperlipidemia, hypothyroidism presents to ER today as a transfer form ...(facility name omitted) for neurosurgery consult for intracranial hemorrhage. The patient is a Resident at ....(facility name/address omitted). HPI is obtained from patient's family as the patient has dementia. The family reports that the patient gets of (sic) in a lift chair daily. When the patient is in the lift chair, the motor is supposed to be turned off so that he cannot lift himself out of the chair. Apparently, the motor was not turned off today, and the patient was able to raise the chair up and fell forward out of the chair, striking his head on the floor. The patient has a small laceration of the middle frontal forehead. Patient also has right periorbital edema and ecchymosis. He was taken to ...(facility name omitted) for evaluation. A CT scan of the head indicated intracranial hemorrhage and the patient was transferred to ...(facility name omitted) for neurosurgical evaluation....Principle Problem: Subdural hematoma. Active Problems: Dementia, hypertension, HLD (hyperlipidemia) Subarachnoid hemorrhage, closed fracture of right orbit, fall, closed fracture of frontal sinus."

Surveyor spoke with LPN #1 (licensed practical nurse) on 04/16/19 at approximately 0900

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regarding Resident #363. LPN #1 stated she had been in Resident's room to administer a breathing treatment at approximately 1200 on 01/0319. LPN #1 stated that Resident was sitting up in his power recliner chair. LPN #1 stated that the remote to the chair was kept in the side pocket of the chair LPN #1 stated that approximately 1345, the CNA (certified nurse's aide) called for her to come to Resident's room. LPN #1 stated that when she entered the room, Resident #363 was lying on his right side, in the floor in front of the chair.

Surveyor spoke with CNA #1 on 04/16/19 at approximately 0905. CNA #1 stated that she had entered the Resident's room during the lunch meal and told another CNA that she would assist Resident #363 with his meal. CNA #1 stated that after assisting Resident with his meal, she left him sitting upright in his power recliner chair. Surveyor asked CNA if Resident could operate the chair, and CNA #1 responded, "I don't think so". CNA #1 also told surveyor that the chair was plugged into a power strip, which was off when she left the room.

Surveyor spoke with RN #1 (registered nurse) on 04/16/19 at approximately 0910. RN #1 stated that had been called to come to Resident's room on 01/03/19. She stated that Resident was in the floor and the chair was raised to the highest position. Surveyor asked RN #1 if anyone saw the Resident fall, and RN #1 responded, "Not that I know of". Surveyor asked RN #1 if Resident #363 said what had happened, and RN #1 responded, "I don't remember if he said what happened or not".

Surveyor spoke with the DON (director of

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F 609	Continued From page 22 nursing) on 04/16/19 at approximately 1110 regarding Resident #363. DON stated that through her investigation of the Resident's fall, she determined that the Resident had raised his chair to the highest position, causing him to fall out into the floor. Surveyor requested and the DON provided copy of the facility policy, entitled "Abuse Investigation and Reporting" which read in part "All reports of Resident abuse, neglect, exploitation, misappropriation of Resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local , state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported." The failure of the facility to report an unwitnessed fall with major injury was discussed with the administrative team during a meeting on 04/16/19 at approximately 1645. No further information was provided prior to exit. This is a complaint deficiency.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS assessment for 1 of 36 residents	F 641	Corrective Action for those residents found to be affected by the alleged deficient practice.	6/20/19

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F 641	Continued From page 23 in the survey sample, Resident #164. The findings included: The facility staff incorrectly documented that Resident # 164 was discharged to an acute hospital on the discharge assessment. Resident # 164 was a 7[illegible]-year-old female who was admitted to the facility on 1/15/19. Diagnoses included but were not limited to, anxiety disorder, seizures, major depressive disorder, and closed fracture. On 4/16/19 at 12:45 pm, the surveyor observed a "Leaving Against Medical Advice" form that had been signed by Resident # 164 on 2/2/19. The form contained documentation that stated, "I have been informed of the risks of leaving the facility against medical advice and understand those risks." Upon review of the "Nursing Home Discharge" MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/2/19, the surveyor observed in Section A2100 Discharge status, the facility staff documented that Resident # 164 had been discharged to an acute hospital. On 4/16/19 at 12:57 pm, the surveyor interviewed MDS nurse # 1 regarding the discharge status of the Resident # 164. MDS nurse #1 along with the surveyor reviewed Section A2100 on the discharge assessment for Resident # 164. MDS nurse # 1 agreed that discharge status listed on the MDS is acute hospital. MDS nurse # 1 stated, "Let me look into that." On 4/16/19 at 1:01 pm, MDS nurse # 1 spoke with the surveyor and agreed that acute hospital	F 641	Resident #164 has since been discharged from the facility. Like Residents- Residents discharging from the facility have the potential to be affected. Clinical reimbursement coordinator completed audit on residents who have discharged from the facility to ensure proper coding and changed a applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education to the clinical reimbursement team to ensure correct coding for resident transfers by the Director of Nursing. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Clinical reimbursement coordinator will audit coding for resident transfers weekly x 4 weeks and monthly x 2. 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	

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F 641	Continued From page 24 was marked in error. Stated "I'm sorry we will get it corrected." On 4/16/19 at 4:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/16/18.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		6/20/19

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F 657	Continued From page 25 assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to review and revise a CCP (comprehensive care plan) for 1 of 36 Residents, Resident #363. The findings included: For Resident #363 the facility staff failed to review and revise the care plan for risk of falls. Resident #363 was admitted to the facility on 06/01/15 and readmitted on 01/11/19. Diagnoses included but not limited to anemia, pneumonia, depression, coronary artery disease, hypothyroidism, gastroesophageal reflux disease, benign prostatic hyperplasia and insomnia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/14/18 coded the Resident as 7 out of 15 in section C, cognitive status. Section G, functional status, coded the Resident as needing extensive with two-person physical assist in the area of transfer ((how Resident moves between surfaces including to or from: bed, chair, wheelchair, standing position). Moving from a seated to standing position was coded as not steady, only able to stabilize with staff assistance. Resident #363's CCP (comprehensive care plan) was reviewed and contained a care plan for "At risk for falls due to impaired balance/poor coordination, and unsteady gait and confusion at times". This care plan was initiated on 02/27/15. Interventions for this care plan included, "keep lift chair controller out of reach of Resident, prevent	F 657	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #363 has since been discharged from the facility. Like Residents- Residents admitting into the facility have the potential to be affected. Director of nursing completed an audit on the current resident careplans to ensure there are not duplicate interventions and addressed as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education to licensed nurses on choosing interventions on the comprehensive careplans that are not duplicating of each other. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete audits of 10 comprehensive careplans weekly x 4 and 20 monthly x 2 for duplicate interventions. 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.	

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F 657	Continued From page 26 from lifting it to max height (initiated 05/07/16, revised 02/14/19), and keep remote to recliner in reach of Resident, place to where remote will not fall to floor (initiated 01/28/18, revised 02/14/19)." Both interventions were in place during the same period. Surveyor spoke with the DON on 04/16/19 at approximately 1110 regarding Resident #363's CCP. Surveyor pointed out to DON that the two interventions, which were contradictory to one another, were both in place during the same time. DON responded, "Yeah, I know, that care plan is jacked-up". The concern of facility staff to review and revise the Resident's CCP was discussed with the administrative staff during a meeting on 04/16/19 at approximately 1645. No further information was provided prior to exit.	F 657	Date of compliance: 6/20/19	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility policy and scope of nursing practice for LPNs (licensed practical nurses) in the State of Virginia it was determined the facility staff failed to follow current professional standards of practice while caring for 1 of 33 residents (Resident #82).	F 658	Corrective Action for those residents found to be affected by the alleged deficient practice. Residents #82 has been added to the podiatrist list to be seen for foot care. Like Residents-	6/20/19

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F 658	Continued From page 27 Findings: Facility staff failed to follow current professional standards of practice while cutting Resident #82's toenails. The resident's clinical record was reviewed on 4-15-19. Resident #82 was admitted to the facility on 8-27-13. Her current diagnoses included diabetes, hypertension and dementia. The latest MDS (minimum data set) dated 3-11-19 coded the resident with severe cognitive impairment. The resident required facility staff assistance to accomplish all the ADLs (activities of daily living). Resident #82's CCP (comprehensive care plan) reviewed and revised on 3/12/19 indicated the resident had a self-deficit in ADL care related to physical limitations and altered thought processes. The staff interventions included "Assist with daily hygiene, grooming, dressing, oral care, eating and nail care as needed". Resident #82's physician's orders documented the resident as an insulin-dependent diabetic. She received 8 units of Levemir every evening at bedtime. The resident had a physician order for "off loading boots to the bilateral lower extremities when in bed, as tolerated". 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	F 658	Residents who admit into the facility have foot or nail deficits have the potential to be affected. A skin sweep was completed on current residents and addressed skin concerns as necessary. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to the nursing department to provide proper foot care and nail care to residents per policy and procedures. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit foot care on 10 residents weekly x 4 weeks and 20 residents monthly x 2. 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	

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F 658	Continued From page 28 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 looks like it needs to be cleaned." The resident's right foot had a lot of dead skin falling away as RN I proceeded the examination. RN I stated, "She needs a good foot washing/soaking and some lotion. Her toenails need clipping too." RN I said she was going to get a wash cloth and clean her feet and clip her toenails. "They are all long and curving/unkempt. The CNAs should wash her feet and put lotion on her feet." The surveyor asked who's responsibility it was to see that the CNA's provided foot care. Both LPN I and RN I said it was their responsibility to make	F 658		

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F 658	Continued From page 29 sure the CNAs cleaned the resident's feet. They agreed it should be the charge nurses and unit manager that oversee what the CNAs do. LPN I had a pair of toenail clippers and started to clip the resident's toenails. The surveyor asked if LPNs were allowed to cut her toenails since the resident was diabetic. LPN said she thought she could do it--but the unit manager said they prefer RNs to do that and she took the clippers from LPN I and resumed trimming the resident's toenails. RN I said she would have to check the facility policy to determine if LPNs could cut a diabetic's toe nails at the facility. She stated, "I think they do--but I will have to check and see for you." On 4-16-19 at 10:00 AM the facility DON was informed of the surveyor's findings. She was asked if it was within the LPN's scope of practice to cut a diabetic's toenails at the facility. She stated it was not within an LPN's scope of practice to trim a diabetic's toenails, only RNs could perform that task. The DON provided the facility's policy on the care of finger and toenails at the facility. The policy included the following: 1. Nail care includes daily cleaning and regular trimming. 2. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. No additional information was provided prior to the survey team exit.	F 658		
F 677	ADL Care Provided for Dependent Residents	F 677		6/20/19

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F 677 SS=D	Continued From page 30 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to assist 1 of 33 residents (Resident #82) with sufficient foot and toenail care. Findings: Facility staff failed to follow current professional standards of practice while cutting Resident #82's toenails. The resident's clinical record was reviewed on 4-15-19. Resident #82 was admitted to the facility on 8-27-13. Her current diagnoses included diabetes, hypertension and dementia. The latest MDS (minimum data set) dated 3-11-19 coded the resident with severe cognitive impairment. The resident required facility staff assistance to accomplish all the ADLs (activities of daily living). Resident #82's CCP (comprehensive care plan) reviewed and revised on 3/12/19 indicated the resident had a self-deficit in ADL care related to physical limitations and altered thought processes. The staff interventions included "Assist with daily hygiene, grooming, dressing, oral care, eating and nail care as needed".	F 677	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #82 is receiving foot and nail care per policy and procedure and has been added to the podiatry list for further assessment. Like Residents- Residents who need nail and foot care have the potential to be affected. Director of nursing completed an audit on the current resident careplans to ensure there are not duplicate interventions and addressed as applicable Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to the nursing department to provide proper foot care and nail care to residents per policy and procedures. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit foot care on 10 residents weekly x 4 weeks and 20 residents monthly x 2.	

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F 677	Continued From page 31 Resident #82's physician's orders documented the resident as an insulin-dependent diabetic. She received 8 units of Levemir every evening at bedtime. The resident had a physician order for "off loading boots to the bilateral lower extremities when in bed, as tolerated". 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 looks like it needs to be cleaned." The resident's right foot had a lot of dead skin	F 677	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	

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F 677	Continued From page 32 falling away as RN I proceeded the examination. RN I stated, "She needs a good foot washing/soaking and some lotion. Her toenails need clipping too." RN I said she was going to get a wash cloth and clean her feet and clip her toenails. "They are all long and curving/unkempt. The CNAs should wash her feet and put lotion on her feet." The surveyor asked who's responsibility it was to see that the CNA's provided foot care. Both LPN I and RN I said it was their responsibility to make sure the CNAs cleaned the resident's feet. They agreed it should be the charge nurses and unit manager that oversee what the CNAs do. LPN I had a pair of toenail clippers and started to clip the resident's toenails. The surveyor asked if LPNs were allowed to cut her toenails since the resident was diabetic. LPN said she thought she could do it--but the unit manager said they prefer RNs to do that and she took the clippers from LPN I and resumed trimming the resident's toenails. RN I said she would have to check the facility policy to determine if LPNs could cut a diabetic's toe nails at the facility. She stated, "I think they do--but I will have to check and see for you." On 4-16-19 at 10:00 AM the facility DON was informed of the surveyor's findings. The DON provided the facility's policy on the care of finger and toenails at the facility. The policy included the following: 1. Nail care includes daily cleaning and regular trimming.	F 677		

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F 677	Continued From page 33 2. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. No additional information was provided prior to the survey team exit.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, physician interview, staff interview, clinical record review, and facility document review, facility staff failed to consult with activities professionals for individualized diversional activities for 1 of 36 residents in the survey sample (Resident #11). The findings included: The facility staff failed to consult with activities professionals for individualized diversional activity for Resident #11. Resident #11 was readmitted to the facility on 11/15/18 with the following diagnoses of, but not limited to anemia, hip fracture, dementia,	F 679	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. 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	6/20/19

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F 679	Continued From page 34 depression, psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of possible score of 15. During the clinical record review on 4/15 and 4/16/19, the surveyor noted a progress note dated for 11/8/18, which read in part, "Consult Activities for diversional activity ..." The surveyor notified the DON (director of nursing) of the above physician order on 4/15/19. The surveyor requested copies of the activities that Resident #11 participates in. The surveyor received the requested copies of the activities that Resident #11 participates in on 4/16/19 at approximately 11 pm. The surveyor asked the DON where is the documentation from the activities department that they provided Resident #11 with diversional activities as the physician had ordered on 11/8/19. The DON stated, "Activities department are always doing activities with the residents on the 3rd wing of the facility. The resident has the right to not participate in the activities. We can't make them do something that they don't want to do." The surveyor requested any documentation of the activities department since 11/8/18 when the physician wrote to consult activities for diversional activities. At 1 pm, the DON returned to the surveyor in the conference room and stated, "I don't have any documentation that the activities department was consulted due to the physician order on 11/8/18 or what extra activities they had provided."	F 679	ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to the activities department to ensure to offer and document diversional activities to residents that have diversional activities ordered. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of activities will audit diversional activities week x 3 months and then monthly x 2 for documentation. 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	

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F 679	Continued From page 35 The surveyor spoke with ____ (name of physician) via phone this afternoon at 4:05 pm. The surveyor read the progress note for Resident #11 in which the physician had written to consult activities for diversional activities. On 11/8/18, the physician saw the resident at which time the resident had continued with wandering in hallways and going through the garbage. The physician stated, " ... the walking that the resident was doing was not the issue but rather the anxiety that the resident was experiencing with the walking was the issue. I wanted a consult with activities to see if an individual patient based activity could be done for this the resident because he was a farmer most of his life. I wanted to see if there was anything that the resident might find more relaxing to him to decrease his anxiety of feeling." The MD also stated that if he could listen to sires radio and listen to 40's and 50's music to relax him it would be a better answer than to add medication to the resident for this. "I have spoken to ____ (name of administrator) on several different times on this and just don't believe that we are where we should be with all of this occurring." The surveyor notified the administrative team 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.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		6/20/19

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F 684	Continued From page 36 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure 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 3/30/19 with diagnoses including pressure ulcer, difficulty walking, kidney failure, respiratory failure, and essential hypertension. On the admission Minimum Data Set assessment with assessment reference date 4/6/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others. On 04/14/19 during a preliminary interview, the resident reported having MRSA in a wound. The resident had an isolation cart outside the room. The nurse reported "is just on contact isolation for the wound to the foot. It's contained to the wound vac, so no precautions are necessary if you don't plan to touch anything". During clinical record review, the surveyor noted the following order dated 4/15: 'hold dose of IV Vancomycin for 11:30 today due to previous dose completed late; restart on 4/16 at 11:00; draw vanc trough 30 min prior to start dose on 11/16'. The resident was admitted on 3/30/19 with an order for vancomycin 1750 grams intravenous every 36 hours. The infusion order medication	F 684	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #145 has since been discharged from the facility. Like Residents- Residents on antibiotic therapy have the potential to be affected. Director of nursing completed audit on residents receiving antibiotic therapy to ensure correct administration times according to physician schedule. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses to administer antibiotic medications according to the physician order. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete audits of antibiotic according to the physician order 3 x week x 4 weeks and monthly x 2. Plan of correction information and audits will be reviewed in the quality assurance	

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F 684	Continued From page 37 administration record (MAR) documented the resident received a the medication on 4/1/19 at 4 AM, 4/2 at 4 PM, 4/6/19 8 AM and 4/7 at 8 PM, 4/9 at 11:30 AM, 4/10 at 11:30 PM, 4/12 at 11:30 AM, and 4/13 at 11:30 PM, and 4/14 at 11:30 PM. The surveyor asked the nurse and director of nursing about the irregular antibiotic administration schedule on 4/15/19. The director of nursing revealed the resident received a dose of IV anomy at 11 PM last night (4/14/19) when no dose was scheduled, which the resident said finished running at 4:30 AM. The gaps in administration on 4/4 and 4/9 were the result of unavailability of the medication because the pharmacy had sent two doses per shipment and the next doses did not arrive in time for scheduled administration. Each time, the physician was informed and the remaining doses were rescheduled. The administrator and d.rector of nursing were notified of the concern with failure to administer the intravenous antibiotic as ordered during a summary meeting on 4/15/19.	F 684	and performance improvement process for tracking/trending and any necessary additional interventions. Date of compliance: 6/20/19	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		6/20/19

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F 695	Continued From page 38 Based on observation, staff interview, and clinical record review, facility staff failed to provide for delivery of oxygen per physician orders for 1 of 36 residents in the survey sample (Resident #56). The findings included: The facility staff failed to provide for delivery of oxygen per physician orders for Resident #111. Resident #111 was admitted to the facility on 12/17/18 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression, manic depression, Schizophrenia and asthma. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/25/19, the resident was coded as having a BIMS (Brief Interview or Mental Status) score of 5 out of a possible score of 15. Resident #111 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and extensive assistance of 1 staff member for bathing. On 4/15/19 at approximately 11 am, the surveyor observed the resident lying in bed with eyes closed. The resident was receiving oxygen by facemask at 2 l/min (liter/minute). The surveyor reviewed the clinical record of Resident #111 on 4/15/19. It was noted that the physician's order for oxygen was to be delivered to resident by nasal cannula and not the facemask as the surveyor observed. At 11:30 am on 4/15/19, the surveyor notified Resident #111's nurse on dayshift (LPN #1) of the above documented findings. LPN (licensed	F 695	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #111 has since been discharged from the facility. Like Residents- Residents receiving oxygen therapy have the potential to be affected. Director of nursing completed an audit on residents receiving oxygen therapy to ensure oxygen is being administered according to the physicians order. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nurses to ensure residents receiving oxygen therapy are receiving oxygen through the correct route of administration. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will audit residents who receive oxygen therapy weekly x 4 and then monthly x 2 to ensure proper administration according to the physician order. 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	

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F 695	Continued From page 39 practical nurse) #1 stated, "I bet someone forgot to write the orders for that. She has pneumonia now, but I will check with the doctor to see which way he prefers for her to get her oxygen." The surveyor notified the administrative team on 4/16/19 at 4:43 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/16/19.	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to provide appropriate social services to meet the needs of 1 of 36 residents in the survey sample, Resident # 56. The findings included: The facility staff failed to assist and communicate with Resident # 56 regarding her wishes regarding resuscitation in the event of cardiac arrest, resulting in Resident # 56 having an active do not resuscitate order when she had in fact expressed that she did want resuscitation measures implemented in the event of cardiac arrest. Resident # 56 was a 76-year-old-female who was	F 745	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #56 advance directive order was updated according to the recommendations of the resident. Like Residents- Residents admitting into the facility have the potential to be affected. Audit completed by the Director of Social Services to ensure adequate reflection of resident advance directive status according to their wishes and addressed as applicable. Systemic Changes put into place to ensure the alleged deficient practice does	6/20/19

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F 745	Continued From page 40 originally admitted to the facility on 6/23/08, with a readmission date of 9/25/15. Diagnoses included but were not limited to, bipolar disorder, anxiety, type 2 diabetes mellitus, and congestive heart failure. The clinical record for Resident # 56 was reviewed on 4/15/19 at 4:40 pm. The most recent MDS (minimum data set) assessment was a quarterly assessment, with an ARD (assessment reference date) of 2/22/19. Section B of the MDS assesses hearing, speech, and vision. In Section B0700, the ability to express ideas and wants was assessed. The facility staff documented that Resident # 56 was "Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." Section B0800 assesses the ability to understand others. The facility staff documented that Resident # 56 "Understands-clear comprehension." Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 56 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated that Resident # 56's cognitive status was moderately impaired. The current plan of care for Resident # 56 was reviewed and revised on 2/22/19. The facility staff documented a focus area for Resident # 56 as, "Advanced Directives DNR (do not resuscitate)." The goal for this focus area was documented as, "Resident's advance directives will be honored through next review." Interventions included but were not limited to, "Copy of living will in legal section of chart," and "Discuss advanced directives with patient, family, or legal representative at admission and quarterly." The current physician's orders for Resident # 56 were	F 745	not recur. Education completed by the administrator to the director of social services to ensure that the advance directives documented in the medical record are an adequate reflection of their wishes. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of social services will audit advance directives for adequate reflection weekly x 4 weeks and monthly x 2. 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	

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F 745	Continued From page 41 signed by the physician on 4/6/19. Orders included but were not limited to, "Code status do not resuscitate." On 4/15/19 at 4:50, pm, the surveyor reviewed the DDNR form dated 3/26/12 in Resident # 56's clinical record. The surveyor observed a handwritten check mark documented next to the following statement on the DDNR form, "2. The patient is INCAPABLE of making an informed decision about providing, withholding or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." The surveyor also observed a handwritten checkmark documented next to the following statement on the DDNR form, "B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with the authority to direct that life-prolonging procedures be withheld or withdrawn." The surveyor observed that the guardian for Resident # 56 had signed the back of the DDNR form authorizing the DDNR status. The surveyor further reviewed the clinical record for Resident # 56 and did not locate a written advanced directive that appointed a person authorized to consent on Resident # 56's behalf. The surveyor did observe a facility "Cardiopulmonary Resuscitation Directive" form, which was dated 6/23/08 in the clinical record for Resident # 56. The surveyor observed a handwritten checkmark documented next to the following statement of the cardiopulmonary resuscitation directive form, "B. In the event that my/my loved one's heart stops beating and/or	F 745		

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breathing stops, I DO WANT Cardiopulmonary Resuscitation." The surveyor observed the following documentation at the bottom of the form, "I, the physician of Resident # 56 agree with the above decision. The surveyor observed that the word agree had a single handwritten line drawn thorough it and the word disagree was handwritten above it. This document was signed by the physician on 6/23/08.

On 4/15/19 at 4:57 pm, the surveyor conducted a Resident interview with Resident # 56. The surveyor asked Resident # 56 if she wanted CPR to bring her back if her heart stops beating. Resident # 56 stated "Yes." The surveyor asked Resident # 56 again for clarification to ensure that Resident # 56 understood what was being asked if she wanted CPR to try to bring her back to life if her heart and breathing stops. Resident # 56 stated, "Yes Resident # 56 does." If my heart stops beating, I want them to try to bring me back."

On 4/15/19 at 6:00 pm, the surveyor spoke with the facility administrator and director of nursing and asked if Resident # 56 had been declared incompetent. The facility administrator stated, "She's been here a long time, I believe she has been declared incompetent." The surveyor requested to see paperwork declaring Resident # 56 incompetent.

On 4/16/19 at 8:03 am, the surveyor was approached by the director of nursing who provided the surveyor with a copy of guardianship papers for Resident # 56. The director of nursing informed the surveyor that she did not locate any paperwork that stated that Resident # 56 had been declared incompetent. The director of

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nursing stated, "While I was going through her chart last night, I learned a lot of things that I did not know." "I found a paper in her chart that stated that she (Resident # 56) wanted to go to a particular funeral home and that she wanted to wear a red dress." The surveyor then informed the director of nursing that she did not locate an advance directive in Resident # 56's clinical record as the DDNR form stated that an advance directive had been executed. The director of nursing stated, "All we have is the DNR form." "But there is a document in her chart were she stated that she did not want to be resuscitated." The surveyor informed the director of nursing that the document in Resident # 56's clinical record stated that Resident # 56 did want to be resuscitated. The director of nursing reviewed the cardiopulmonary resuscitation directive form for Resident # 56 along with the surveyor and the director of nursing agreed that the form contained documentation that Resident # 56 wished to be resuscitated. The director of nursing also observed the documentation at the bottom of the form documented as, "I, the physician of Resident # 56 agree with the above decision." The director of nursing along with the surveyor observed that the word agree had a single handwritten line drawn thorough it and the word "disagree" was handwritten above it. The surveyor asked the director of nursing if she felt that it was appropriate to disregard what Resident # 56 had expressed as her wishes and initiate a DNR order even though Resident # 56 desired to be a full code. The director of nursing stated, "No." The surveyor asked the director of nursing if Resident # 56 was able to express her wants and needs on a daily basis. The director of nursing stated, "Yes." The director of nursing stated she would contact the guardian for Resident # 56 to see if

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F 745	Continued From page 44 she can get more information. On 4/16/19 at 12:23 pm, the director of nursing provided the surveyor with a copy of Resident # 56's DDNR that had been faxed from the agency of Resident # 56's court appointed guardians. The director of nursing informed the surveyor that she had been unable to reach the guardians for Resident # 56 and she had spoken to someone else in the office to try to obtain additional information and the DDNR was all that was sent to the facility from the agency. On 4/16/19 at 1:58 pm, the surveyor interviewed the facility social worker. The surveyor along with the facility social worker reviewed the cardiopulmonary resuscitation directive for Resident # 56. The facility social worker observed documentation on the cardiopulmonary resuscitation directive that stated that Resident # 56 wished to be resuscitated if her heart or breathing stopped, and that physician documented that he disagreed with Resident # 56's decision. The surveyor asked the facility social worker if Resident # 56 was able to express her needs and wants. The facility social worker agreed that Resident # 56 was able to express her needs and wants. The surveyor asked the facility social worker if she felt it was appropriate that the physician and guardian made the decision to make Resident # 56 a DNR even after she had expressed that she wanted to be resuscitated. The facility social worker stated, "I understand what you mean and we will definitely look into this." On 4/16/19 at 3:10 pm, the surveyor spoke with the facility social worker. The surveyor asked the facility social worker if she attended care plan	F 745		

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F 745	Continued From page 45 meetings for Resident # 56. The facility social worker stated that she did attend the care plan meetings for Resident # 56. The surveyor asked the facility social worker if Resident # 56 attended her care plan meetings. The stated, "She is invited, but she does not come." The surveyor asked the social worker if the guardians for Resident # 56 attended the care plan meetings. The social worker informed the surveyors that guardians for Resident # 56 attended her care plan meetings and if they were unable to attend the staff communicated with the guardians for Resident # 56 by telephone. The surveyor asked the social worker who reviewed the plan of care during the care plan meetings for Resident # 56 and determined if the focus areas needed to be continued, revised or resolved. The social worker stated that the guardians and facility staff discussed the care areas and determined what areas needed to be continued, revised, or resolved. The surveyor asked the social worker if Resident # 56 had any input with regard to her plan of care. The facility social worker stated, "No." The surveyor asked the social worker if she had offered to discuss Resident # 56's plan of care with her in her room in an environment that may be more comfortable to her so that she would be able to provide input in her plan of care. The social worker stated, "I have not." On 4/16/19 at 4:30 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/16/18.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		6/20/19

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F 755	Continued From page 46 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure antibiotic medications were available for administration for 2 of 36 residents in the survey sample (Residents #122 and 145).	F 755	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #122/145 have since been discharged from the facility.	

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F 755	Continued From page 47 1. For Resident #145, facility staff failed to ensure Intravenous vancomycin was available for administration. Resident #145 was admitted to the facility on 3/30/19 with diagnoses including pressure ulcer, difficulty walking, kidney failure, respiratory failure, and essential hypertension. On the admission Minimum Data Set assessment with assessment reference date 4/6/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others. On 04/14/19 during a preliminary interview, the resident reported having MRSA in a wound. The resident had an isolation cart outside the room. The nurse reported "is just on contact isolation for the wound to the foot. It's contained to the wound vac, so no precautions are necessary if you don't plan to touch anything". During clinical record review, the surveyor noted the following orders: "4/4/19 -hold Vancomycin 1750 mg until received from the pharmacy, -when received from the pharmacy, restart Vancomycin 1750 mg IV pharmacy dosing of 36 hours" and "4/9/19 - hold vanc pharmacy to dose, - restart Vanc dosing at 11:30 AM Vanc 1750 mg IV @ 15 ml/hr Q 36 hours". The infusion order medication administration record (MAR) documented the resident received the medication on 4/1/19 at 4 AM, 4/2 at 4 PM, 4/6/19 8 AM and 4/7 at 8 PM, 4/9 at 11:30 AM, 4/10 at 11:30 PM, 4/12 at 11:30 AM, and 4/13 at 11:30 PM, and 4/14 at 11:30 PM. The surveyor asked the nurse and director of nursing about the	F 755	Like Residents- Residents receiving antibiotic therapy have the potential to be affected. Director of nursing completed an audit on residents that are currently on antibiotics to ensure medications were available in house and being administered. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing staff on ensuring medications are available for administration or contacting the physician to receive a substitution. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete antibiotic therapy audits 3x week x 4 weeks and then monthly x 2. 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	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 48 irregular antibiotic administration schedule on 4/15/19. They reported the gaps in administration on 4/4 and 4/9 were the result of unavailability of the medication because the pharmacy had sent two doses per shipment and the next doses did not arrive in time for scheduled administration. Each time, the physician was informed and the remaining doses were rescheduled. The administrator and director of nursing were notified of the concern with failure to administer the intravenous antibiotic as ordered during a summary meeting on 4/15/19. 2. For Resident 122, facility staff failed to ensure gentamycin was available for administration. Resident #122 was readmitted to the facility on 4/8/19. Diagnoses included hypertension, neurogenic bladder, diabetes mellitus, paraplegia, anxiety, depression, and gastroesophageal reflux. On the quarterly minimum data set assessment with assessment reference date 3/28/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During clinical record review on 4/16/19, the surveyor noted an order dated 4/8/19 for gentamycin 240 milligram /100 ml(milliliter) normal saline 60 ml via supra catch into bladder & clamp off for 30 min then allow to drain QED (daily). A verbal order was written on 4/14/19 to hold the entrancing until available from the pharmacy. The treatment administration record documented administration 4/10-4/13.	F 755		

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F 755	Continued From page 49 The surveyor discussed the concern with lack of availability of the antibiotic with the director of nursing. The director of nursing stated that they had been unable to get the pharmacy to provide the antibiotic for administration. The administrator and director of nursing were informed of the concern during a summary meeting on 4/16/19.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		6/20/19

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F 758	Continued From page 50 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to monitor targeted behaviors for 1 of 36 residents in the survey sample (Resident #89). The findings included: The facility staff failed to monitor specific targeted behaviors while Resident #89 was taking Zoloft, Ativan, Risperidone and Trazodone. Resident #89 was admitted to the facility on 12/5/18 with the following diagnoses of, but not limited to heart failure, diabetes, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/13/19, the	F 758	Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #89 is having specific behavior documentation completed in the resident medical record. Like Residents- Residents who are on psychotropic medications have the potential to be affected. Director of nursing completed an audit of residents on psychotropics to ensure specific behaviors are being documented according to specific ordered medications. Systemic Changes put into place to	

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F 758	Continued From page 51 resident was coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and was totally dependent on 2 staff members for bathing. During the clinical record review on Resident #89's medical record on 4/15 and 4/16/19, the surveyor noted the physician had ordered the following medications for the resident to receive: " Lorazepam (Ativan) 0.5 mg (milligram) twice a day for anxiety/agitation " 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	F 758	ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing with licensed nurses to ensure specific behavior documentation is in each resident record. 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	

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F 758	Continued From page 52 wrote depression like for this one but they didn't put how the resident acts when depressed." The surveyor notified the administrative team 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.	F 758		
F 807 SS=E	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to ensure fresh water was readily available at the bedside for 8 of 36 residents in the survey sample (Resident #84, #111, #136, #67, #127, #15, #11 and #13). The findings included: 1. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #84. Resident #84 was readmitted to the facility on 12/5/18 with the following diagnoses of, but not limited to anemia, high blood pressure, peripheral vascular disease, psychotic disorder, Schizophrenia and respiratory failure. On the	F 807	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. 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. Systemic Changes put into place to	6/20/19

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F 807	Continued From page 53 quarterly MDS (Minimum Data Set) with an ARD of 3/12/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #84 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and is 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". The surveyor asked the resident how often he gets fresh water. The resident stated, "I don't know, maybe yesterday." 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 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. 2. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #111.	F 807	ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to staffing scheduler and nursing department to ensure that staff are passing ice and fresh water on each shift. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete fresh water and ice audits each shift 2x 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	

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F 807	Continued From page 54 Resident #111 was admitted to the facility on 12/17/18 with the following diagnoses of, but not limited to high blood pressure, diabetes, anxiety disorder, depression, manic depression, Schizophrenia and asthma. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/25/19, the resident was coded as having a BIMS (Brief Interview or Mental Status) score of 5 out of a possible score of 15. Resident #111 was also coded as requiring limited assistance of 1 staff member for dressing, personal hygiene and extensive assistance of 1 staff member 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 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.	F 807		

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F 807	Continued From page 55 3. 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 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.	F 807		

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F 807	Continued From page 56 4. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #67. Resident #67 was readmitted to the facility on 2/4/19 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, dementia, depression and asthma. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/11/19; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #67 was also 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 the above documented findings on 4/16/19 at 4:45 pm in the conference room.	F 807		

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F 807	Continued From page 57 No further information was provided to the surveyor prior to the exit conference on 4/16/19. 5. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #127. Resident #127 readmitted to the facility on 6/30/15 with the following diagnoses of, but not limited to anemia, peripheral vascular disease, dementia and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) OF 4/1/19, coded the resident as having short and long-term memory problems with being moderately impaired in making daily decisions. Resident #127 was also coded as requiring extensive assistance of 1 staff member for eating, and being totally dependent on 1-2 staff members for personal hygiene and 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	F 807		

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F 807	Continued From page 58	F 807		

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. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #15.

Resident #15 was readmitted to the facility on 1/1/17 with the following diagnoses of, but not limited to anemia, coronary artery disease, high blood pressure, diabetes, arthritis, and dementia. On the annual MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/18/19, 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

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F 807	Continued From page 59	F 807		

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.

7. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #11.

Resident #11 was readmitted to the facility on 11/15/18 with the following diagnoses of, but not limited to anemia, hip fracture, dementia, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #11 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and being totally dependent on 1 staff member for bathing and eating.

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

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F 807	Continued From page 60	F 807		

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.

8. The facility staff failed to ensure fresh water was readily available at the bedside of Resident #13.

Resident #13 was admitted to the facility on 7/17/18 with the following diagnoses of, but not limited to anemia, pneumonia, dementia, seizure disorder, depression, psychotic disorder and Schizophrenia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of 1 staff member for dressing, eating, personal hygiene and being totally dependent on 1 staff member 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

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	495133	A. BUILDING _____ B. WING _____	C 04/16/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 807	Continued From page 61 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.	F 807		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review it was determined the facility staff failed to provide clean	F 812	Corrective Action for those residents found to be affected by the alleged deficient practice.	6/20/19

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F 812	Continued From page 62 and sanitary food service to 2 of 33 facility residents (Residents #25 and #140). Facility staff failed to don gloves when handling the resideglovgnt's ready made foods. Findings: 1. Facility staff failed to provide clean and sanitary food service to Resident #25. The resident's clinical record was reviewed on 4-16-19 at 9:00 AM. Resident #25 was admitted to the facility on 7-18-18. Her diagnoses included diabetes, hypertension, anemia and depression. The latest MDS (minimum data set) assessment, dated 1-30-19, coded the resident as cognitively unimpaired. The resident required staff assistance for all the ADLs (activities of daily living) and a set-up and physical assistance of one staff member to eat. Resident #25's CCP (comprehensive care plan) reviewed and revised on 11-6-18 indicated the resident required assistance with ADLs. Staff interventions included assisting with daily hygiene, grooming, dressing, oral care and eating as needed. On 4-14-19 at 12:57 PM the surveyor observed the resident's meal service in her room. WH I (wing helper I) brought the resident's lunch tray into her room and set it up on the overbed table for the resident. WH I was observed to remove a sandwich from the paper wrapper and place it on the resident's plate with her bare hands. On 4-16-19 at 10:15 AM this observation was	F 812	CNA 1 and WH 1 received immediate education on infection control practices when assisting residents with food. Like Residents- Residents who require assistance with feeding or feeding setup have the potential to be affected. Director of nursing completed an audit of feeding assistance to ensure infection control practices are being adhered to as applicable. Systemic Changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing with the nursing department to ensure infection control practices are followed during meal service according to policy and procedures. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Director of Nursing will complete audit of setup of resident tray and feeding assistance infection control practices 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	

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F 812	Continued From page 63	F 812		

reported to the facility DON. The DON told the surveyor the staff were trained in safe food practices and said wearing gloves when handling ANY food was a part of that training.

The DON provided the surveyor with a copy of the facility policy on meal assistance. The policy addressed employee training for staff members providing meal assistance. The policy included that staff would be trained and would demonstrate competency in the prevention of food borne illnesses, "including hygiene practices and safe food handling".

No additional information was provide prior to the survey team exit.

2. Facility staff failed to provide clean and sanitary food service to Resident #140. The resident's clinical record was reviewed on 4-16-19 at 9:15 AM.

Resident #140 was admitted to the facility on 2-14-18. Her diagnoses included dementia, hypertension, and depression.

The latest MDS (minimum data set) assessment, dated 4-5-19, coded the resident as cognitively impaired. The resident required staff assistance for all the ADLs (activities of daily living) and the physical assistance of one staff member to eat.

Resident #140's CCP (comprehensive care plan) reviewed and revised on 1-10-19 indicated the resident required assistance with ADLs. Staff interventions included assisting with daily hygiene, grooming, dressing, nail care, oral care and eating as needed.

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F 812	Continued From page 64 On 4-14-19 at 1:04 PM the surveyor observed the resident's meal service in her room. CNA I brought the resident's lunch tray into her room and set it up on the overbid table for the resident. CNA I did not don gloves during the tray set-up and was observed to remove a sandwich from the paper wrapper and place it on the resident's plate with her bare hands. On 4-16-19 at 10:15 AM this observation was reported to the facility DON. The DON told the surveyor the staff were trained in safe food practices and said wearing gloves when handling ANY food was a part of that training. The DON provided the surveyor with a copy of the facility policy on meal assistance. The policy addressed employee training for staff members providing meal assistance. The policy included that staff would be trained and would demonstrate competency in the prevention of food borne illnesses, "including hygiene practices and safe food handling". No additional information was provide prior to the survey team exit.	F 812		