STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	C 04/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/13/21 through 4/15/21. Corrections are required for compliance with 42 CFR Part 483.73 Requirements for Long Term Care facilities.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain	E 004		

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

Executive Director | 5/19/21

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 004	Continued From page 1 an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interviews and the review of facility documents, it was determined the facility staff failed to ensure the facility's emergency preparedness plan was annually updated/reviewed. The findings included: Review of the facility's emergency preparedness documentation failed to include evidence of an annual review/update of the complete emergency preparedness plan during 2020. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. Evidence of an annual review/update, during 2020, of the facility emergency preparedness plan was not found. The facility staff was able to provide evidence of a policy and procedure review during 2020. On 4/15/21 at 1:57 p.m., the absence of a review/update of the facility's emergency preparedness plan during 2020 was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey	E 004	1. Emergency Prepardness documents annual review was conducted during quarterly QA on 4/20/21. 2. Staff need to know proper processes for emergencies that could take place in facility. 3. Emergency prepardness will be reviewed with all staff on annual basis. 4. Administrator/ Maintenance Director or designee will monitor for annual compliance.	4/20/21

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E 004	Continued From page 2 team prior to exit.	E 004		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency	E 006		

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E 006	Continued From page 3 events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and a review of facility documents, it was determined the facility staff failed to ensure the facility's emergency preparedness plan was developed based on an all hazards risk assessment. The findings included: Review of the facility's emergency preparedness documentation failed to reveal an all hazards risk assessment for the facility. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. Evidence of an all hazard assessment for the facility was not found during the review of the facility's emergency preparedness documents. On 4/15/21 at 1:57 p.m., the absence of a	E 006	1. The facility Risk Assessment Plan has been updated and reviewed. 2. All staff need to know proper processes for emergencies that could take place in the facility. 3. Risk assessment will be reviewed with staff on annual basis. 4. Administrator/Director of maintenance will monitor for annual compliance.	4/28/21

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E 006	Continued From page 4 facility's all hazard assessment was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit.	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interviews and the review of documents, it was determined the facility staff	E 007	1. The facility continuity of operations plan has been implemented and will be reviewed with all staff. 2. Resident could be effected by staff not knowing the plan for an emergency. 3. Continuity of operations plan will be educated to all staff. 4. Administrator/Director of maintenance will monitor for compliance.	5/20/21

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E 007	Continued From page 5 failed to ensure the facility's emergency preparedness plan included delegations of authority and succession details. The findings include: Review of the facility's emergency preparedness documentation failed to reveal guidance related to delegations of authority and succession details. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. Guidance related to delegations of authority and succession details were not found during the review of the facility's emergency preparedness documents. On 4/15/21 at 1:57 p.m., the absence of the aforementioned information was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:	E 015		

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E 015	Continued From page 6 (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and the review of	E 015	1. Emergency Prepardness policy review will be conducted no later than annually with staff to include, but not limited to: food, water, medical, temperatures, emergency lighting, fire detection, sewage/waste disposal. 2. Residents could be effected by staff not knowing proper processes for emergencies. 3. Emergency Prepardness plan will be reviewed with all staff on an annual basis. 4.Administrator/Designee will monitor for annual compliance.	5/25/21

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E 015	Continued From page 7 facility documents, it was determined the facility staff failed to develop an emergency preparedness plan that included policies and procedures to provide for sewage and non-biohazardous waste disposal. The findings included: The facility staff failed to include policies and procedures to provide for sewage and non-biohazardous waste disposal in the facility's emergency preparedness plan. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. The facility staff were able to provide evidence of a policy and procedure addressing disposal of biohazardous waste but was not able to provide a policy and procedure that addressed sewage and non-biohazardous waste disposal during a shelter-in-place emergency. On 4/15/21 at 1:57 p.m., the absence of an emergency preparedness policy and procedure to address sewage and non-biohazardous waste disposal was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit.	E 015		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 024		

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E 024	Continued From page 8 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interviews and a review of facility documents, it was determined the facility staff failed to ensure the facility's emergency preparedness plan included policies and procedures to address the use of volunteers. The findings included: The facility's emergency preparedness documentation failed to include policies and procedures to provide guidance addressing	E 024		

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E 024	Continued From page 9 volunteers. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. No policies and procedures addressing the use of volunteers during an emergency was found during the review of the facility's emergency preparedness documents. On 4/15/21 at 1:57 p.m., the absence of emergency preparedness policies and procedures addressing volunteers was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit.	E 024	1. All staff will be educated as to their assistance needed to evacuate current residents. Currently we do not utilize volunteers. 2. Residents and staff are at Risk if annual education is not conducted. 3. Emergency Prepardness will be reviewed with all staff annually. 4. Administrator/Designee will monitor for compliance.	5/25/21
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility]	E 039		

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E 039	Continued From page 10	E 039		

is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is

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E 039	Continued From page 11	E 039		

exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise

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E 039	Continued From page 12 that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or	E 039		

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E 039	Continued From page 13 and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the	E 039		

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E 039	Continued From page 14 following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based	E 039		

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E 039	Continued From page 15 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interviews and the review of facility documents, it was determined the facility staff failed to conduct exercises/drills to test the	E 039		

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E 039	Continued From page 16 facility's emergency preparedness program. The findings include: Review of the facility's emergency preparedness documentation failed to reveal evidence of the facility completing exercises/drills to test the facility's emergency preparedness program during 2020. The facility's emergency preparedness documents were reviewed with the facility's Administrator and Director of Maintenance on 4/15/21 at 10:31 a.m. and 1:11 p.m. Evidence of facility staff members involvement with exercises/drills to test the facility's emergency preparedness program was not found during the review of the facility's emergency preparedness documents. On 4/15/21 at 1:57 p.m., the failure of the facility to complete exercise/drills of its emergency preparedness program, during 2020, was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit.	E 039	1. Staff will participate in a mock Disaster Drill. 2. Residents could be effected by staff inability to properly respond to emergencies. 3. Mock disaster Drill will be conducted every two years. 4. Administrator/Designee will monitor for compliance.	5/25/21
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/13/21 through 04/15/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 70 certified bed facility was 53 at the time of the survey. The survey sample	F 000		

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F 000	Continued From page 17 consisted of 14 current Resident reviews and 2 closed record reviews.	F 000		
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 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 interviews, clinical record reviews, and in the course of a complaint investigation, the facility staff failed to ensure that residents receive treatment and care by not following physician's orders for one (1) of 16 sampled residents (Resident #105). The findings include: Facility staff members failed to ensure Resident #105's medical provider orders, for (a) a head CT and (b) the medication Zyprexa, were implemented in a timely manner. Resident #105's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/10/21, had the resident assessed as able to make self understood and as able to under others. Resident #105's Brief Interview for Mental Status (BIMS) summary score was assessed as 13 out of 15. Resident #105 was assessed as requiring assistance with bed	F 684	1. The CT scan for resident #105 was completed on 3/29/2021. Zyprexa for Resident #105 arrived on 2/11/2021 and administered as prescribed. 2. An audit will be conducted on all residents with consult orders to ensure orders have been completed. An audit will be conducted to ensure all medications for all residents are available for administration. 3. Education will be provided to Charge Nurse's to (schedule new orders for consults until consult appointment has been made.) Education will be provided to Charge Nurse's that if a medication is not available then DON/Designee shall be notified, and DON/Designee will contact pharmacy. Documentation will reflect MD/NP/PA notification. 4. The DON/Designee will monitor new orders 3x weekly x4 weeks to ensure consult orders have been scheduled on the EMAR and documentation to support consult appointment has been set up. DON/Designee will monitor new orders 3x weekly 4x weeks to ensure all new medications have been delivered to facility and proper documentation completed for any unavailable medications. DON/Designee will review and discuss in quarterly QA meeting.	5/12/21

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F 684	Continued From page 18	F 684		

mobility, dressing, toilet use, personal hygiene, and bathing. Resident #105's diagnoses included, but were not limited to: anemia, heart disease, high blood pressure, anxiety, and vision problems.

Resident #105 had a head CT scan ordered on 3/5/21 but this CT scan was not completed until 3/29/21. Resident #105's clinical record included an order for a "CT scan of head (without) contrast" entered on 3/5/21 at 12:44 p.m. This head CT scan was documented as being completed on 3/29/21. The facility's Director of Nursing (DON) was interviewed about this order on 4/14/21 at 11:10 a.m. The DON reported the order was entered on 3/5/21. The DON reported this order was revised on 3/8/21 to change how it was showing up in the facility's electronic records system so the nursing staff would be able to schedule the head CT scan. The DON reported the order was revised again on 3/16/21 when the head CT scan was scheduled. The DON reported that no evidence of provider communication related to the delay in scheduling and/or obtaining the head CT scan was found.

Resident #105's clinical record included an order for Zyprexa dated 2/9/21. The Zyprexa was not started until 2/11/21. On 4/15/21 at 8:40 a.m., the facility's Director of Nursing (DON) was interviewed about the delay in implementing this Zyprexa order. The DON confirmed the Zyprexa had been ordered at 8:40 p.m. and scheduled to be started at 9:00 p.m. on 2/9/21. The DON reported the Zyprexa was not available at the facility. The DON stated the order should have been clarified with the medical provider to see if it could be started the following day (2/10/21). The DON stated no documentation of such medical

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F 684	Continued From page 19 provider clarification was found. Resident #105's Zyprexa was still not available on 2/10/21. The DON stated the medical provider and the pharmacy should have been contacted about this medication not being available. The DON reported no such documentation, of medical provider and/or pharmacy, was found. The following information was found in a facility policy and procedure titled "Administration of Medications" (with a revised date of August 14, 2019): "All medications will be given per physician, Nurse Practitioner (NP) or Physician Assistant (PA) written, verbal or telephone order and shall not be started, changed or discontinued by the facility without an order from the physician, NP or PA ... Medication fills and refills shall be timely to avoid missed dosages. Medications should be reordered according to the pharmacy procedures or electronic record vendor procedures. If a medication that is ordered does not arrive as scheduled, the Director of Nursing or designee shall be notified so that the pharmacy can be contacted via telephone for a stat delivery or follow electronic record policy for checking status." On 4/15/21 at 1:57 p.m., the failure of the facility to appropriately implement the aforementioned medical provider orders was discussed for a final time with the facility's Administrator and Director of Nursing; no additional information related to this issue was provided to the survey team prior to exit. This is a complaint deficiency.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 20 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to safely store medications in 1 of 2 medication rooms. This medication room contained expired medications. The findings included: The facility staff failed to dispose of expired medications in medication room #1. On 04/13/2021 at 2:30 p.m., the (DON) director of	F 761	1. The STAT box with expired medications was returned to the contracted pharmacy, 4/14/21. 2. An audit for expired medications was conducted in both medication rooms on 4/14/2021. No other expired medication observed. 3. All nurses will be educated to check medication rooms during rounds for expired medications. 4. The DON/Designee will inspect medication room weekly for the next 30 days. DON/Designee will review and dicuss during quarterly QA.	5/12/21

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F 761	Continued From page 21 nursing accompanied the surveyor to medication room #1. This medication room contained an unlocked plastic box. Inside this box, the surveyor observed the following expired medications. 200 ml IV bag of Ciprofloxacin expiration date 03/2021, Cefepime 2-1 gram vials expiration date 10/2020, Ivanz 1 vial expiration date 04/2020, Vancomycin 1 gram expiration date 05/2020, Vancomycin 1 gram expiration date 04/2020, Gentamicin 80 mg/2 ml 8 vials expiration date 09/2020. The box was labeled with a different pharmacy name then the one currently being used by the facility. The DON stated they would take the box to their office and call the pharmacy. On 04/14/2021 at 3:08 p.m., the expired medication was reviewed with the DON and administrator. The DON stated the pharmacy had picked up the expired medications. No further information was provided to the survey team prior to the exit conference.	F 761		
F 812 SS=F	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.	F 812		

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F 812	Continued From page 22 (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 and facility document review the facility staff failed to store, prepare and serve food in a safe and sanitary manner. The findings included: The facility staff failed to ensure serving pans in the facility were dry and clean and failed to date an opened package of dried pasta. During initial tour of the facility kitchen, conducted on 04/13/21 at approximately 1:45 pm, surveyor observed an opened package of macaroni noodles located on a shelf in the dry storage area. Surveyor could not locate an "opened on" date on the package. Surveyor asked the dining services manager if there was a date on the package and dining services manager stated that there was not, and removed the package. While continuing initial tour of the kitchen, surveyor observed a rack containing metal serving pans, nested together. Surveyor asked the dining services manager to separate the pans to allow surveyor to observe inside of pans, and when dining services manager did so, water ran	F 812	1. Serving pans are being allowed to dry on the cambro shelf. Once dried they are placed in the dry area. All opened food packages are now being sealed with label and date. 2. Residents receiving meals being prepared at the facility are at risk with being compromised with a breach in policy. 3. Dietary staff has been educated and inserviced on these findings. 4. Food Service Director o Designee will monitor daily with rounds.	4/27/21

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F 812	Continued From page 23	F 812		

from between the pans. Dining services manager stated that should not happen. Surveyor also observed a dried yellowish debris on the inside of one of the pans. Dining services manager removed the pans from the rack, stating that the pans would be washed again.

Surveyor requested and was provided with a facility policy entitled "Food Service Infection Control", which read in part "Procedures. The following activities of food serviced personnel may involve or have an effect on the risk of infection for residents and personnel. Infection prevention and control measures are: 5. Thorough washing and drying of all utensils, food contact surfaces, and equipment between preparations of food items. 15. Cleaning and sanitization of equipment, dishes, utensils, etc.: a. thoroughly washing and drying all utensils, food contact surfaces, and equipment between preparation of food items g. allowing all food preparation equipment, dishes, and eating utensils to air dry".

The administrator and DON (director of nursing) were informed of the kitchen findings during a meeting on 04/14/21 at approximately 3:10 pm.

Facility administrator provided the surveyor with an "In-Service Record of Content and Attendance" on 04/14/21 at approximately 11:05 am, with a title of "Dishes-Properly Washing/Drying". Administrator stated that the dining services manager had started re-education of staff and would be providing training as staff come in to work.

The concern of wet/dirty serving pans and unlabeled open food was discussed during a

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F 812	Continued From page 24 meeting on 04/15/21 at approximately 2:00 PM. No further information provided prior to exit.	F 812		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review the facility staff failed to provided evidence that the facility QA (quality assurance) committee met at least quarterly for the last 2 quarters of 2020. The findings included: Surveyor reviewed the facility QA program on 04/15/21 at approximately 1:00 pm. The surveyor could not locate evidence that the facility QA committee had met during the last two quarters of 2020 (July-December). Surveyor informed the	F 868	1. The Q.A. meetings are on track for 2021, and being held quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	C 04/15/2021

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

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F 868	Continued From page 25 administrator that the information could not be located. On 04/14/21 at approximately 1:45 pm, the administrator stated the evidence of QA meetings could not be located. The concern of no having evidence of quarterly QA meetings was discussed with the administrator and director of nursing during a meeting on 04/15/21 at approximately 2:00 pm. No further evidence provided prior to exit.	F 868	2. The quarterly QA meetings cannot effectively identify and address issues if meetings are not being held. 3. All management team members will be educated on the importance of the QA meeting taking place quarterly. 4. QA meeting minutes will be audited quarterly by Administrator or Designee to ensure meetings are held quarterly.	4/20/21
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	1. On 4/13/2021, proper hand hygiene policy reviewed with Charge Nurse #1. 2. Residents are at risk due to proper hand hygiene not being followed per policy. 3. Education will be provided to charge nurses on proper hand hygiene. 4. DON/Designee will conduct treatment observation 3x weekly for 30 days. DON/Designee will review and discuss in quarterly QA meeting.	5/20/21

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F 880	Continued From page 26 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 27 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an effective infection prevention and control program for 1 of 16 residents, Resident #12. The findings included: The facility staff failed to complete hand hygiene during a wound care observation. The (EHR) electronic health record included the diagnoses, adult failure to thrive, diabetes, and chronic kidney disease. Section C (cognitive patterns) of Resident #12's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 01/17/2021 included a (BIMS) brief interview for mental status summary score of 5 out of a possible 15 points. Section M (skin conditions) was coded to indicate the resident did not have any pressure ulcers or wounds to the feet. On 02/05/2021, the facility staff identified a wound to the residents left heel. The resident was seen by a wound physician and this wound was classified as an arterial wound. On 04/13/2021 at 1:42 p.m., the surveyor observed (LPN) licensed practical nurse #1 complete wound care. LPN #1 cleaned the wound with normal saline changed their gloves and applied a new pair of clean gloves but did not	F 880		

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F 880	Continued From page 28 complete any hand hygiene. LPN #1 applied an alginate dressing (maxorb) and wrapped the wound with kerlix. On 04/13/2021 at 11:07 a.m., LPN #1 stated they should have hand sanitized. On 04/03/2021 at 4:11 p.m., the (IP) infection preventionist stated LPN #1 should have performed hand hygiene after removing their gloves and before applying a clean pair of gloves. The facility provided the surveyor with a copy of policy titled, "Infection Control." This policy read in part, "...In the absence of a true emergency, personnel should always wash their hands...after removing gloves..." On 04/14/2021 at 3:08 p.m., the administrator and (DON) director of nursing were made aware of the infection control issue regarding wound care and hand hygiene. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		