STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 06/08/2021 through 06/10/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	**The filing of this Plan of Correction does not constitute an admission that the alleged deficiencies did in fact exist. This plan of correction is filed as evidence to comply with the requirements of participation and continue to provide high quality resident centered care.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/08/21 through 06/10/21. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 145 at the time of the survey. The final survey sample consisted of 30 current resident reviews and 2 closed record reviews. Three complaints were investigated.	F 000		
F 607 SS=E	CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 607	**Develop/Implement Abuse/Neglect Policies** **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all remain within the facility and investigations have been completed for the incidents. Resident #115 has been discharged from the facility. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected.	

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

Administrator 7/1/21

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
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 06/08/2021 through 06/10/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	**The filing of this Plan of Correction does not constitute an admission that the alleged deficiencies did in fact exist. This plan of correction is filed as evidence to comply with the requirements of participation and continue to provide high quality resident centered care.**	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/08/21 through 06/10/21. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 145 at the time of the survey. The final survey sample consisted of 30 current resident reviews and 2 closed record reviews. Three complaints were investigated.	F 000		
F 607 SS=E	CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 607	**Develop/Implement Abuse/Neglect Policies** 1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all remain within the facility and investigations have been completed for the incidents. Resident #115 has been discharged from the facility. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected.	

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

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
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 1 a complaint investigation it was determined that the facility staff failed to implement facility policy and procedures in regards to reporting and investigating incidents for 10 of 30 Residents, Residents #72, #111, #108, #131, #28, #26, #140, #53, #134, and #115. The findings included: 1. For Resident #72 the facility staff failed to implement facility policy in regards to reporting/investigating resident to resident altercations Resident #72's face sheet listed diagnoses which included, but not limited to major depressive disorder, dementia with behavioral disturbance, anxiety, convulsions and gastroesophageal reflux disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15. This indicates that the resident is cognitively intact. Resident #72's comprehensive care plan was reviewed and contained a care plan for "Inappropriate behavior at times, history of verbal/physical agitation/aggression towards other residents related to Cognitive impairment, traumatic brain injury". The goal for this care plan is "to decrease/minimize episodes of verbal/physical abuse". Resident #72's clinical record was reviewed and contained nurse's progress notes, which read in part "09/19/2020 15:24 CNA (certified nurse's	F 607	3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Facility staff will be educated regarding facility policy and procedures regarding reporting and investigating alleged abuse in a timely manner. 4. **Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:** Director of Nursing or designee will audit alleged allegations to ensure facility policy is being followed weekly times 4 weeks and monthly times 2. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5. **Include dates when the corrective action will be completed:** Date of compliance: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 2	F 607		

aide) observed this resident slap her roommate because she was 'using her sink'. this resident turned the water off at the cutoff so other resident couldn't use it. Reminded this resident that roommate can use sink and other areas of the room as well", "09/20/2020 14:57 CNA reported to nurse that this resident 'slammed' another resident in to a chair. Reminded resident she shouldn't be putting her hands on other people", "09/20/2020 15:26 this resident hit another resident on the right side of the face. separated residents", "09/20/2020 15:34 Notified DON (director of nursing) of resident's behavior. Explained to resident that the police can be called if she hits anyone else. Room change to 323 B", "09/23/2020 18:20 Second floor staff called to tell this nurse that they observed ... (Resident #72) place her hand over another resident's face and nose. She then hit the other resident", "10/04/2020 18:52 Rsd (resident) found in room with curtain pulled hitting roommate. Writer was informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04 Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The residents were separated and unit manager notified", "4/7/2021 10:10 this nurse entered activity room, this resident walked over to another resident and smacked her twice to right side of face to point you heard the second slap. resident that was slapped was sitting in chair in corner with a drink in her hands. no injury noted. resident removed from area. when asked why she slapped other resident she stated 'she was staring at me'. MD and RP (responsible party) notified" and "4/9/2021 16:43 the nurses aides ([names omitted]) relayed to me that the resident pushed another resident ([name omitted]) three times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 3 resident did not sustain any injury or fall. .... (name omitted) stated 'He was going to hit her if she did not quit'. the two were separated, no further issues at this time. Will continue to monitor." Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 4 a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not implementing their policy for reporting/investigating incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 2. For Resident #111 the facility staff failed to implement facility policy in regards to report a resident to resident altercation. Resident #111's face sheet listed diagnoses which included, but limited to chronic obstructive pulmonary disease, bipolar disorder, Alzheimer's disease, hypothyroidism, and schizophrenia. The most recent quarterly MDS (minimum data	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 5 set) with an ARD (assessment reference date) of 05/13/21 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns. This indicates the resident is cognitively intact. Resident #111's comprehensive care plan was reviewed and contained a care plan for "At risk for behavior symptoms related to Alzheimer's disease/dementia, Bipolar; Resident will approach residents/others to hug and kiss in face, makes repetitive statements demanding pudding/food and hugs". Resident #111's clinical record was reviewed and contained nurse's progress notes, which read in part "9/23/2020 18:20 This nurse received a phone call from 2nd flood staff stating that staff saw another resident place her hand over ... (Resident #111) mouth and nose, and then hit ... (Resident #111). Unit manager and DON (director of nursing) notified, residents were separated and will be monitored", "10/4/2020 19:13 Rsd (resident) has been hit by roommate. Writer has completed head to toe assessment and no injuries noted at this time. Family and MD have been notified no new orders. Rsd is safe sitting at nurses station. Will continue to observe", and "4/7/2021 12:08 this nurse entered the activity room, when another resident walked over to this resident and smacked her twice to right side of face to point you heard the second slap. this resident was sitting in chair in corner with a drink in her hands when smacked. no injury noted. other resident removed from area. rp (responsible party) and md notified". Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 6 asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 7 Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not implementing their policy for reporting/investigating incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 3. For Resident #108 the facility staff failed to implement facility policy in regards to reporting resident to resident altercations. Resident #108's face sheet listed diagnoses which included, but not limited to Alzheimer's disease, psychosis, depressive disorder, chronic obstructive pulmonary disease, dementia, and insomnia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/12/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 8 Resident #108's comprehensive care plan was reviewed and contained a care plan for "Verbal/physical agitation/aggression related to Change in routine, Cognitive impairment, Communication disorder/visual impairment, sensory overload". Goal for this care plan is "Will not harm self or others" Resident #108's clinical record was reviewed and contained nurse's progress notes, which read in part "3/21/2021 20:34 Resident in hall cursing, another resident came out of his room and told resident to 'shut up'. The residents then locked their hands together and began pushing and pulling each other back and forth, resident received two skin tears to left fingers. Resident became aggressive and hit a staff member several times in the back, resident then hit this nurse and other female resident in the face." Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative,	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 9 friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not implementing their policy for reporting/investigating incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 10 No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 4. For Resident #131 the facility staff failed to implement facility policy in regards to reporting a resident to resident altercation. Resident #131's face sheet listed diagnoses which included, but limited to dementia with behavioral disturbance, hypertension, hypothyroidism, depression, psychotic disorder, and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/23/21 assigned the resident a BIMS (brief interview for mental status score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #131's comprehensive care plan was reviewed and contained a care plan for "Verbal/physical agitation/aggression related to dementia". Goals for this care plan are "Will not harm self or others". Resident #131's clinical record was reviewed and contained a nurse's progress note, which read in part "2/18/201 01:41 On rounds, other nurse called this to resident's room. Resident was seen hitting roommate with a knotted sock by other nurse. When this nurse entered the room, resident was in a rage, screaming loudly, swinging and hitting this nurse and other nurse. Resident threatened to 'beat the shit out of her', speaking of roommate. Resident attempted multiple times to go back over to roommate and	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 11 hit roommate. Other nurse and this nurse intervened and separated resident. Resident attempted multiple times to shut the door on this nurse and other nurse while separating residents. Resident continued to hit, scratch, and pinch this nurse and other nurse. Resident tied a knot in her sheet and swung and hit this nurse with it. This nurse was able to take sheet and attempted to redirect resident by lying down and rubbing shoulders. Resident continued to be in a rage, refused to lie down. Supervisor notified". Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 12 "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not implementing their policy for reporting/investigating incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 5. For Resident #28, the facility staff failed to implement facility policy regarding reporting and investigating a resident to resident altercation occurring on 3/15/21.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 13 Resident #28's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Essential Primary Hypertension, Anxiety Disorder Unspecified, Blindness One Eye Low Vision Other Eye, Muscle Weakness Generalized, and Difficulty in Walking. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/25/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. A review of Resident #28's clinical record revealed the following documentation: A "SBAR (Situation, Background, Appearance, Review) Communication Form" dated 3/15/21 at 11:43 am states in part, "Resident standing at nurses desk with walker, another resident came and shoved resident in the back. Resident fell, hitting right cheek on nurses desk as went down into the floor. Landed on (his/her) buttocks. Assessed from head to toe with red slightly raised area noted on right cheek. No other complaints voiced". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI report for the	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 14 aforementioned incident involving Resident #28 occurring on 3/15/21. The following day at 10:52 am, surveyor spoke with the DON who stated the incident was reported to them and they then reported it to the administrator but could not find an FRI for the incident. On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: Policy Statement 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. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record;	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 15 d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing), surveyor discussed the concern of the facility not implementing facility policy regarding an incident of a resident to resident altercation involving Resident #28. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 6. For Resident #26 and #134, the facility staff failed to implement facility policy regarding reporting a resident to resident altercation occurring on 6/03/21 to Adult Protective Services. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia without Behavioral Disturbance, Type 2 Diabetes Mellitus without Complications, Iron Deficiency Anemia Unspecified, and Muscle	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 16 Weakness Generalized. Resident #26's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/22/21 assigned the resident a BIMS (brief interview for mental status) score of 4 out of 15 in section C, Cognitive Patterns. Resident #134's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Schizophrenia Unspecified, Bipolar Disorder Unspecified, and Unstable Angina Pectoris. Resident #134's most recent quarterly MDS with an ARD of 5/24/21 assigned the resident a BIMS score of 15 out of 15 in section C, Cognitive Patterns. On 6/08/21 at 1:55 pm during initial rounds, surveyor observed Resident #26 with redness under the left eye and bruising to the left side of the face from the left eye down to the cheek area. Surveyor asked the resident what caused the bruising and the resident stated they hit their face on the door and then stated they must have fallen. At 2:08 pm, surveyor spoke with TCNA (temporary certified nursing assistant) #1 concerning the cause of the bruising and TCNA #1 stated it was reported to them that Resident #134 "punched" this resident. Surveyor spoke with the administrator and DON (director of nursing) on 6/09/21 at 11:42 am concerning the bruising on Resident #26's face and the DON stated a FRI (facility reported incident) was completed and they are working on the final report now.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 17 At 12:30 pm, the DON provided the initial and final FRI report to the surveyor. The follow-up to the FRI dated 6/04/21 for the incident date of 6/03/21 involving Resident #26 and #134 states in part, "Reported by staff that the residents mentioned above had a resident-to-resident altercation. It was reported that (Resident #26) wheeled (his/her) self into (Resident #134's) room and started going through (his/her) personal belongings. (Resident #134) asked (him/her) to leave (his/her) 'stuff' alone, (Resident #134) also asked (Resident #26) to leave (his/her) room due to this being (his/her) room and not (his/hers). (Resident #134) was unable to redirect (Resident #26) from (his/her) personal belongings. (Resident #134) stated, '(he/she) started cussing me and I hit (him/her)'. (Resident #26) was assessed, and staff observed a red area on the left side of the forehead. I, (name omitted), DON, upon entering the facility the next morning assessed (Resident #26) and I observed a discolored area to the left side of the forehead, staff was verbally instructed to continue to monitor for signa [sp] and symptoms of any distress". The FRI report did not include the date that APS (adult protective services) was notified of the resident to resident altercation. On 6/10/21 at 11:45 am, surveyor spoke with the DON and asked if APS was notified of the resident to resident altercation between Resident #26 and #134, the DON stated no because there was no injury. At 11:52 am, surveyor spoke with the administrator who stated APS was not notified and it was a team decision. Surveyor requested and received the facility	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 18	F 607		

policy entitled "Abuse Investigation and Reporting" which states in part:
"Reporting
1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
a. The State licensing/certification agency responsible for surveying/licensing the facility;
b. The local/State Ombudsman;
c. The Resident's Representative (Sponsor) of Record;
d. Adult Protective Services (where state law provides jurisdiction in long-term care);
e. Law enforcement officials;
f. The resident's Attending Physician; and
g. The facility Medical Director.

On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not implementing facility policy regarding reporting an incident of a resident to resident altercation involving Resident #26 and Resident #134 to APS.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.

7. For Resident #140, the facility staff failed to implement facility policy regarding reporting resident to resident altercations occurring on 3/21/21 and 4/05/21.

Resident # 140's diagnosis list indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 19	F 607		

diagnoses, which included, but not limited to Parkinson's Disease, Alzheimer's Disease Unspecified, Unspecified Dementia with Behavioral Disturbance, and Chronic Obstructive Pulmonary Disease Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/25/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns.

A review of Resident #140's clinical record revealed the following documentation:

A nursing progress note dated 3/21/21 19:55 (7:55 pm) states "This resident and another (male/female) resident locked hand [sp] together and with hands joined, pushed and shoved each other back and forth. Staff intervened and separated residents. Received two small (.5 cm) skin tears to right fingers".

A 4/05/21 09:45 (9:45 am) "eINTERACT SBAR Summary for Providers" note states in part, "resident entered another residents room and hit resident, denies pain no injuries noted staff immediately intervened and ensured both residents safety staff witnessed and stated 'As I entered the room another Resident was in this residents room hitting this resident, staff immediately moved both residents to safety".

On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 20 incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI reports for the aforementioned incidents involving Resident #140. On 6/09/21 at 12:30 pm, the DON provided the surveyor with a risk management form, "Incident #827" for Resident #140. Incident #827 form states in part, "This resident and another (male/female) resident locked hand [sp] together and with hands joined, pushed and shoved each other back and forth. Staff intervened and separated residents. Received two small (.5 cm) skin tears to right fingers". In the section "Resident Description", it is documented "I told (him/her) to shut up and quit cussing". On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 21 Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not implementing the facility policy regarding the reporting of two incidents of resident to resident altercations involving Resident #140. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 8. For Resident #53, the facility staff failed to implement facility policy regarding reporting and investigating a resident to resident altercation occurring on 6/08/21. Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease Unspecified, Major Depressive Disorder Recurrent	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 22 Unspecified, and Spinal Stenosis Site Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/13/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. On 6/08/21 at approximately 12:05 pm, surveyor #2 observed Resident #53 hit at another resident around the head and TCNA (temporary certified nursing assistant) #1 separated the two residents. At 2:08 pm, this surveyor spoke with TCNA #1 and asked if Resident #53 made contact with the other resident when they hit at them earlier and TCNA #1 stated yes, the resident made contact with the back of the other resident's head. TCNA #1 also stated that the nurse was "sitting right there" and saw it. A nursing progress noted dated 6/08/21 14:11 (2:11 pm) states in part, "Behavior episodes this day with resident attempting to hit other residents". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor spoke with the DON (director of nursing) concerning the above incident and progress note dated 6/08/21 14:11, DON stated "it should have been documented and reported to	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 23 me. We will do education on that and do what needs to be done". On 6/09/21 at 12:28 pm, the DON and TCNA #1 met with the survey team and TCNA #1 stated Resident #53 swatted the other resident's hat off from behind them and it was not a slap across the face. On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: Policy Statement 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. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record;	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 24 d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not implementing facility policy regarding reporting and investigating an incident of a resident to resident altercation involving Resident #53. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 9. For Resident #115, the facility staff failed to implement facility policy regarding reporting of resident to resident altercations occurring on 4/05/21 and 5/26/21. Resident #115's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease Unspecified, Unspecified Dementia with Behavioral Disturbance, Obsessive-Compulsive Disorder Unspecified,	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 25 Hypothyroidism Unspecified, and Essential Primary Hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/16/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, Cognitive Patterns. A review of Resident #115's clinical record revealed the following documentation: An "eInteract Change in Condition Evaluation" dated 4/05/21 09:45 (9:45 am) states in part, "resident entered this residents room and hit resident, discolored area to left eye, denies pain no injuries noted staff immediately intervened and ensured both residents safety". A nursing progress note dated 5/26/21 14:00 (2:00 pm) states "resident noted to have a discolored raised area with scratched area in the center. resident nonambulatory, bedbound. residents roommate has been witnessed standing over this resident's bed, cursing (him/her), hitting (his/her) fist into (his/her) hand in a threatening manner. upon interview with residents in this room with both having a BIMS score of 0, neither could voice any type of incident. roommate stated I didn't do anything, resident stated no I didn't roll out of bed. no other resident observed going in and out of room. rp (responsible party) and FNP (family nurse practitioner) notified. spoke with RP regarding move to another room, RP in agreeance to move resident up the hall to another room as a precaution/prevention". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 26 discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI reports for the incidents involving Resident #115 occurring on 4/05/21 and 5/26/21. At 12:30 pm, the DON provided risk management reports dated 4/05/21 and 5/26/21 and stated FRIs were not done. On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director.	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 607	Continued From page 27 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not implementing facility policy regarding reporting incidents of resident to resident altercations involving Resident #115 occurring on 4/05/21 and 5/26/21. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.	F 607		
F 609 SS=E	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	F 609	**Reporting of Alleged Violations** 1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents #72, #111, #108, #131, #28, #26, #140,#53, and #134 all re.main within the facility and reporting has been completed for the incidents. Resident #115 has been discharged from the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 28 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, facility document review, clinical record review and in the course of a complaint survey it was determined that the facility staff failed to report incidents for 10 of 30 Residents, Residents #72, #111, #108, #131, #28, #26, #140, #53, #134, and #115. The findings included: 1. For Resident #72 the facility staff failed to report incidents of resident to resident altercations. Resident #72's face sheet listed diagnoses which included, but not limited to major depressive disorder, dementia with behavioral disturbance, anxiety, convulsions and gastroesophageal reflux disease. The most recent quarterly MDS (minimum data	F 609	2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Facility staff will be educated regarding facility policy and procedures regarding reporting and investigating alleged abuse in a timely manner. 4. **Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:** Director of Nursing or designee will audit of alleged allegations to ensure facility policy is being followed weekly times 4 weeks and monthly times 2. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5. **Include dates when the corrective action will be completed:** Date of Compliance: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 29	F 609		

set) with an ARD (assessment reference date) of 04/26/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15. This indicates that the resident is cognitively intact.

Resident #72's comprehensive care plan was reviewed and contained a care plan for "Inappropriate behavior at times, history of verbal/physical agitation/aggression towards other residents related to Cognitive impairment, traumatic brain injury". The goal for this care plan is "to decrease/minimize episodes of verbal/physical abuse".

Resident #72's clinical record was reviewed and contained nurse's progress notes, which read in part "09/19/2020 15:24 CNA (certified nurse's aide) observed this resident slap her roommate because she was 'using her sink'. this resident turned the water off at the cutoff so other resident couldn't use it. Reminded this resident that roommate can use sink and other areas of the room as well", "09/20/2020 14:57 CNA reported to nurse that this resident 'slammed' another resident in to a chair. Reminded resident she shouldn't be putting her hands on other people", "09/20/2020 15:26 this resident hit another resident on the right side of the face. separated residents", "09/20/2020 15:34 Notified DON (director of nursing) of resident's behavior. Explained to resident that the police can be called if she hits anyone else. Room change to 323 B", "09/23/2020 18:20 Second floor staff called to tell this nurse that they observed ... (Resident #72) place her hand over another resident's face and nose. She then hit the other resident", "10/04/2020 18:52 Rsd (resident) found in room with curtain pulled hitting roommate. Writer was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 30 informed of what staff had observed. Will continue to observe.", "10/06/2020 11:04 Residents were up at nurse's station watching TV and talking. This resident smacked the resident beside her in the head for no apparent reason. The resident were separated and unit manager notified", 4/7/2021 10:10 this nurse entered activity room, this resident walked over to another resident and smacked her twice to right side of face to point you heard the second slap. resident was slapped was sitting in chair in corner with a drink in her hands. no injury noted. resident removed from area. when asked why she slapped other resident she stated 'she was staring at me'. MD and RP (responsible party) notified" and "4/9/2021 16:43 the nurses aides ([names omitted]) relayed to me that the resident pushed another resident ([name omitted]) three times. resident did not sustain any injury or fall. .... (name omitted) stated 'He was going to hit her if she did not quit'. the two were separated, no further issues at this time. Will continue to monitor." Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor asked the DON if the incidents should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done". Surveyor reviewed the facility policy entitled	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 31 "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury."	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 32 The concern of the facility not reporting incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 2. For Resident #111 the facility staff failed to report an incident of resident to resident altercation. Resident #111's face sheet listed diagnoses which included, but limited to chronic obstructive pulmonary disease, bipolar disorder, Alzheimer's disease, hypothyroidism, and schizophrenia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/13/21 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, cognitive patterns. This indicates the resident is cognitively intact. Resident #111's comprehensive care plan was reviewed and contained a care plan for "At risk for behavior symptoms related to Alzheimer's disease/dementia, Bipolar; Resident will approach residents/others to hug and kiss in face, makes repetitive statements demanding pudding/food and hugs". Resident #111's clinical record was reviewed and contained nurse's progress notes, which read in part "9/23/2020 18:20 This nurse received a phone call from 2nd flood staff stating that staff	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 33	F 609		

saw another resident place her hand over ... (Resident #111) mouth and nose, and then hit ... (Resident #111). Unit manager and DON (director of nursing) notified, residents were separated and will be monitored", "10/4/2020 19:13 Rsd (resident) has been hit by roommate. Writer has completed head to toe assessment and no injuries noted at this time. Family and MD have been notified no new orders. Rsd is safe sitting at nurses station. Will continue to observe", and "4/7/2021 12:08 this nurse entered the activity room, when another resident walked over to this resident and smacked her twice to right side of face to point you heard the second slap. this resident was sitting in chair in corner with a drink in her hands when smacked. no injury noted. other resident removed from area. rp (responsible party) and md notified".

Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor asked the DON if the incidents should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done".

Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 34 limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator , or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not reporting incidents of resident to resident altercations was discussed with the administrative team during a meeting on	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 35 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 3. For Resident #108 the facility staff failed to report an incident of resident to resident altercations. Resident #108's face sheet listed diagnoses which included, but not limited to Alzheimer's disease, psychosis, depressive disorder, chronic obstructive pulmonary disease, dementia, and insomnia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/12/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #108's comprehensive care plan was reviewed and contained a care plan for "Verbal/physical agitation/aggression related to Change in routine, Cognitive impairment, Communication disorder/visual impairment, sensory overload". Goal for this care plan is "Will not harm self or others" Resident #108's clinical record was reviewed and contained nurse's progress notes, which read in part "3/21/2021 20:34 Resident in hall cursing, another resident came out of his room and told resident to "shut up". The residents then locked their hands together and began pushing and pulling each other back and forth, resident	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 36 received two skin tears to left fingers. Resident became aggressive and hit a staff member several times in the back, resident then hit this nurse and other female resident in the face." Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor asked the DON if the incidents should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 37 mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator , or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not reporting incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 4. For Resident #131 the facility staff failed to report an incident of resident to resident altercation. Resident #131's face sheet listed diagnoses which included, but limited to dementia with behavioral disturbance, hypertension,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 38 hypothyroidism, depression, psychotic disorder, and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/23/21 assigned the resident a BIMS (brief interview for mental status score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #131's comprehensive care plan was reviewed and contained a care plan for "Verbal/physical agitation/aggression related to dementia". Goals for this care plan are "Will not harm self or others". Resident #131's clinical record was reviewed and contained a nurse's progress note, which read in part "2/18/201 01:41 On rounds, other nurse called this to resident's room. Resident was seen hitting roommate with a knotted sock by other nurse. When this nurse entered the room, resident was in a rage, screaming loudly, swinging and hitting this nurse and other nurse. Resident threatened to 'beat the shit out of her', speaking of roommate. Resident attempted multiple times to go back over to roommate and hit roommate. Other nurse and this nurse intervened and separated resident. Resident attempted multiple times to shut the door on this nurse and other nurse while separating residents. Resident continued to hit, scratch, and pinch this nurse and other nurse. Resident tied a knot in her sheet and swung and hit this nurse with it. This nurse was able to take sheet and attempted to redirect resident by lying down and rubbing shoulders. Resident continued to be in a rage, refused to lie down. Supervisor notified".	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 39 Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility submitted facility reported incidents for resident to resident altercations and DON stated "only if there is an injury". Surveyor asked the DON if the incidents should have been reported and DON stated, "They should have been documented and reported to me. We will do education on that and do what needs to be done". Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, which read in part "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator , or his/her designee, to the following persons or agencies: a. The State licensing/certification agency	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 40 responsible for surveying/licensing the facility; b. the local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." The concern of the facility not reporting incidents of resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 5. For Resident #28, the facility staff failed to report a resident to resident altercation occurring on 3/15/21. Resident #28's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Essential Primary Hypertension, Anxiety Disorder Unspecified, Blindness One Eye Low Vision Other Eye, Muscle Weakness Generalized, and Difficulty in Walking. The most recent quarterly MDS (minimum data	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 41 set) with an ARD (assessment reference date) of 3/25/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. A review of Resident #28's clinical record revealed the following documentation: A "SBAR (Situation, Background, Appearance, Review) Communication Form" dated 3/15/21 at 11:43 am states in part, "Resident standing at nurses desk with walker, another resident came and shoved resident in the back. Resident fell, hitting right cheek on nurses desk as went down into the floor. Landed on (his/her) buttocks. Assessed from head to toe with red slightly raised area noted on right cheek. No other complaints voiced". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI report for the aforementioned incident involving Resident #28 occurring on 3/15/21. The following day at 10:52 am, surveyor spoke with the DON who stated the incident was reported to them and they then reported it to the administrator but could not find an FRI for the incident. On 6/10/21 at 1:28 pm, surveyor team spoke with	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 42 the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 43 ADON (assistant director of nursing), surveyor discussed the concern of the facility not reporting an incident of a resident to resident altercation involving Resident #28. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 6. For Resident #26 and #134, the facility staff failed to report a resident to resident altercation occurring on 6/03/21 to Adult Protective Services. Resident #26's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia without Behavioral Disturbance, Type 2 Diabetes Mellitus without Complications, Iron Deficiency Anemia Unspecified, and Muscle Weakness Generalized. Resident #26's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/22/21 assigned the resident a BIMS (brief interview for mental status) score of 4 out of 15 in section C, Cognitive Patterns. Resident #134's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Schizophrenia Unspecified, Bipolar Disorder Unspecified, and Unstable Angina Pectoris. Resident #134's most recent quarterly MDS with an ARD of 5/24/21 assigned the resident a BIMS score of 15 out of 15 in section C, Cognitive Patterns. On 6/08/21 at 1:55 pm during initial rounds,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 44 surveyor observed Resident #26 with redness under the left eye and bruising to the left side of the face from the left eye down to the cheek area. Surveyor asked the resident what caused the bruising and the resident stated they hit their face on the door and then stated they must have fallen. At 2:08 pm, surveyor spoke with TCNA (temporary certified nursing assistant) #1 concerning the cause of the bruising and TCNA #1 stated it was reported to them that Resident #134 "punched" this resident. Surveyor spoke with the administrator and DON (director of nursing) on 6/09/21 at 11:42 am concerning the bruising on Resident #26's face and the DON stated a FRI (facility reported incident) was completed and they are working on the final report now. At 12:30 pm, the DON provided the initial and final FRI report to the surveyor. The follow-up to the FRI dated 6/04/21 for the incident date of 6/03/21 involving Resident #26 and #134 states in part, "Reported by staff that the residents mentioned above had a resident-to-resident altercation. It was reported that (Resident #26) wheeled (his/her) self into (Resident #134's) room and started going through (his/her) personal belongings. (Resident #134) asked (him/her) to leave (his/her) 'stuff' alone, (Resident #134) also asked (Resident #26) to leave (his/her) room due to this being (his/her) room and not (his/hers). (Resident #134) was unable to redirect (Resident #26) from (his/her) personal belongings. (Resident #134) stated, '(he/she) started cussing me and I hit (him/her)'. (Resident #26) was assessed, and staff observed a red area on the left side of the forehead. I, (name omitted), DON, upon entering the facility the next morning	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 45 assessed (Resident #26) and I observed a discolored area to the left side of the forehead, staff was verbally instructed to continue to monitor for signa [sp] and symptoms of any distress". The FRI report did not include the date that APS (adult protective services) was notified of the resident to resident altercation. On 6/10/21 at 11:45 am, surveyor spoke with the DON and asked if APS was notified of the resident to resident altercation between Resident #26 and #134, the DON stated no because there was no injury. At 11:52 am, surveyor spoke with the administrator who stated APS was not notified and it was a team decision. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect,	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 46 exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not reporting an incident of a resident to resident altercation involving Resident #26 and Resident #134 to APS. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 7. For Resident #140, the facility staff failed to report resident to resident altercations occurring on 3/21/21 and 4/05/21. Resident # 140's diagnosis list indicated diagnoses, which included, but not limited to Parkinson's Disease, Alzheimer's Disease Unspecified, Unspecified Dementia with Behavioral Disturbance, and Chronic Obstructive Pulmonary Disease Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/25/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 47 A review of Resident #140's clinical record revealed the following documentation: A nursing progress note dated 3/21/21 19:55 (7:55 pm) states "This resident and another (male/female) resident locked hand [sp] together and with hands joined, pushed and shoved each other back and forth. Staff intervened and separated residents. Received two small (.5 cm) skin tears to right fingers". A 4/05/21 09:45 (9:45 am) "eINTERACT SBAR Summary for Providers" note states in part, "resident entered another residents room and hit resident, denies pain no injuries noted staff immediately intervened and ensured both residents safety staff witnessed and stated 'As I entered the room another Resident was in this residents room hitting this resident, staff immediately moved both residents to safety". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI reports for the aforementioned incidents involving Resident #140. On 6/09/21 at 12:30 pm, the DON provided the surveyor with a risk management form, "Incident #827" for Resident #140. Incident #827 form states in part, "This resident and another (male/female) resident locked hand [sp] together and with hands joined, pushed and	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 48 shoved each other back and forth. Staff intervened and separated residents. Received two small (.5 cm) skin tears to right fingers". In the section "Resident Description", it is documented "I told (him/her) to shut up and quit cussing". On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 49 a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not reporting two incidents of resident to resident altercations involving Resident #140. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 8. For Resident #53, the facility staff failed to report a resident to resident altercation occurring on 6/08/21. Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease Unspecified, Major Depressive Disorder Recurrent Unspecified, and Spinal Stenosis Site Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/13/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. On 6/08/21 at approximately 12:05 pm, surveyor #2 observed Resident #53 hit at another resident around the head and TCNA (temporary certified nursing assistant) #1 separated the two residents. At 2:08 pm, this surveyor spoke with TCNA #1	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 50	F 609		

and asked if Resident #53 made contact with the other resident when they hit at them earlier and TCNA #1 stated yes, the resident made contact with the back of the other resident's head. TCNA #1 also stated that the nurse was "sitting right there" and saw it.

A nursing progress noted dated 6/08/21 14:11 (2:11 pm) states in part, "Behavior episodes this day with resident attempting to hit other residents".

On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor spoke with the DON (director of nursing) concerning the above incident and progress note dated 6/08/21 14:11, DON stated "it should have been documented and reported to me. We will do education on that and do what needs to be done".

On 6/09/21 at 12:28 pm, the DON and TCNA #1 met with the survey team and TCNA #1 stated Resident #53 swatted the other resident's hat off from behind them and it was not a slap across the face.

On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 51 Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not reporting an incident of a resident to resident altercation involving Resident #53.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 52 No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 9. For Resident #115, the facility staff failed to report resident to resident altercations occurring on 4/05/21 and 5/26/21. Resident #115's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease Unspecified, Unspecified Dementia with Behavioral Disturbance, Obsessive-Compulsive Disorder Unspecified, Hypothyroidism Unspecified, and Essential Primary Hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/16/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, Cognitive Patterns. A review of Resident #115's clinical record revealed the following documentation: An "eInteract Change in Condition Evaluation" dated 4/05/21 09:45 (9:45 am) states in part, "resident entered this residents room and hit resident, discolored area to left eye, denies pain no injuries noted staff immediately intervened and ensured both residents safety". A nursing progress note dated 5/26/21 14:00 (2:00 pm) states "resident noted to have a discolored raised area with scratched area in the center. resident nonambulatory, bedbound. residents roommate has been witnessed standing over this resident's bed, cursing (him/her), hitting	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 53 (his/her) fist into (his/her) hand in a threatening manner. upon interview with residents in this room with both having a BIMS score of 0, neither could voice any type of incident. roommate stated I didn't do anything, resident stated no I didn't roll out of bed. no other resident observed going in and out of room. rp (responsible party) and FNP (family nurse practitioner) notified. spoke with RP regarding move to another room, RP in agreeance to move resident up the hall to another room as a precaution/prevention". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor requested the FRI reports for the incidents involving Resident #115 occurring on 4/05/21 and 5/26/21. At 12:30 pm, the DON provided risk management reports dated 4/05/21 and 5/26/21 and stated FRIs were not done. On 6/10/21 at 1:28 pm, surveyor team spoke with the DON concerning resident to resident altercations. The DON stated that following altercations, residents are assessed and if there is not an injury, there is nothing to report. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: "Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 609	Continued From page 54 an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury." On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not reporting incidents of resident to resident altercations involving Resident #115 occurring on 4/05/21 and 5/26/21. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 55 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 investigation it was determined that the facility staff failed to investigate alleged incidents of abuse for 4 of 30 residents, Residents #72, #131, #28 and #53. The findings included: 1. For Resident #72 the faciltiy staff failed to investigate incidents of resident to resident altercations. Resident #72's face sheet listed diagnoses which included, but not limited to major depressive disorder, dementia with behavioral disturbance, anxiety, convulsions and gastroesophageal reflux	F 610	**Investigate/Prevent/Correct Alleged Violation** 1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** , Residents #72, #131, #28 and #53 remain in the facility and the investigation has been completed. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Facility staff will be educated regarding facility policy and procedures regarding reporting and investigating alleged abuse in a timely manner. 4. **Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:** Director of Nursing or designee will audit alleged allegations to ensure facility policy is being followed weekly times 4 weeks and monthly times 2. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5. **Include dates when the corrective action will be completed:** Date of compliance: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 56 disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 04/26/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15. This indicates that the resident is cognitively intact. Resident #72's comprehensive care plan was reviewed and contained a care plan for "Inappropriate behavior at times, history of verbal/physical agitation/aggression towards other residents related to Cognitive impairment, traumatic brain injury". The goal for this care plan is "to decrease/minimize episodes of verbal/physical abuse". Resident #72's clinical record was reviewed and contained nurse's progress notes, which read in part "09/19/2020 15:24 CNA (certified nurse's aide) observed this resident slap her roommate because she was 'using her sink'. this resident turned the water off at the cutoff so other resident couldn't use it. Reminded this resident that roommate can use sink and other areas of the room as well", "09/20/2020 14:57 CNA reported to nurse that this resident 'slammed' another resident in to a chair. Reminded resident she shouldn't be putting her hands on other people", "09/20/2020 15:26 this resident hit another resident on the right side of the face. separated residents", "09/20/2020 15:34 Notified DON (director of nursing) of resident's behavior. Explained to resident that the police can be called if she hits anyone else. Room change to 323 B", "09/23/2020 18:20 Second floor staff called to tell this nurse that they observed ... (Resident #72) place her hand over another resident's face and	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 57 nose. She then hit the other resident", and "4/9/2021 16:43 the nurses aides ([names omitted]) relayed to me that the resident pushed another resident ([name omitted]) three times. resident did not sustain any injury or fall. .... (name omitted) stated 'He was going to hit her if she did not quit'. the two were separated, no further issues at this time. Will continue to monitor." Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility investigated the incident of resident to resident altercation, and the DON stated, "We take it to risk management". Surveyor asked if these specific incidents had been investigated, and the facility could not provide any information to indicate that they had. Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 58 "Abuse Investigation and Reporting" policy, 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 concern of the facility not investigating resident to resident altercations was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 2. For Resident # 131 the facility staff failed to investigate incidents of resident to resident altercations. Resident #131's face sheet listed diagnoses which included, but limited to dementia with behavioral disturbance, hypertension, hypothyroidism, depression, psychotic disorder, and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/23/21 assigned the resident a BIMS (brief interview for mental status score of 0 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #131's comprehensive care plan was reviewed and contained a care plan for	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 59 "Verbal/physical agitation/aggression related to dementia". Goals for this care plan are "Will not harm self or others". Resident #131's clinical record was reviewed and contained a nurse's progress note, which read in part "2/18/201 01:41 On rounds, other nurse called this to resident's room. Resident was seen hitting roommate with a knotted sock by other nurse. When this nurse entered the room, resident was in a rage, screaming loudly, swinging and hitting this nurse and other nurse. Resident threatened to 'beat the shit out of her', speaking of roommate. Resident attempted multiple times to go back over to roommate and hit roommate. Other nurse and this nurse intervened and separated resident. Resident attempted multiple times to shut the door on this nurse and other nurse while separating residents. Resident continued to hit, scratch, and pinch this nurse and other nurse. Resident tied a knot in her sheet and swung and hit this nurse with it. This nurse was able to take sheet and attempted to redirect resident by lying down and rubbing shoulders. Resident continued to be in a rage, refused to lie down. Supervisor notified". Surveyor spoke with the administrator and DON on 06/09/21 at approximately 11:40 am. Surveyor asked the DON if resident to resident altercations were considered to be abuse, and DON stated they were "some form of abuse". The administrator stated the facility follows their policy on what is defined as abuse. Surveyor asked if the facility investigated the incident of resident to resident altercation, and the DON stated, "We take it to risk management". Surveyor asked if this specific incident had been investigated, and the facility could not provide any information to	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 60 indicate that is had. Surveyor reviewed the facility policy entitled "Abuse Prevention Program" which read in part, "As part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representative, friends, visitors, or any other individual. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements". Surveyor also reviewed the facility "Abuse Investigation and Reporting" policy, 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 concern of the facility not investigating a resident to resident altercation was discussed with the administrative team during a meeting on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. THIS IS A COMPLAINT DEFICIENCY 3. For Resident #28, the facility staff failed to investigate a resident to resident altercation	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 61 occurring on 3/15/21. Resident #28's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Essential Primary Hypertension, Anxiety Disorder Unspecified, Blindness One Eye Low Vision Other Eye, Muscle Weakness Generalized, and Difficulty in Walking. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 3/25/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. A review of Resident #28's clinical record revealed the following documentation: A "SBAR (Situation, Background, Appearance, Review) Communication Form" dated 3/15/21 at 11:43 am states in part, "Resident standing at nurses desk with walker, another resident came and shoved resident in the back. Resident fell, hitting right cheek on nurses desk as went down into the floor. Landed on (his/her) buttocks. Assessed from head to toe with red slightly raised area noted on right cheek. No other complaints voiced". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 62 Surveyor requested the FRI report for the aforementioned incident involving Resident #28 occurring on 3/15/21. The following day at 10:52 am, surveyor spoke with the DON who stated the incident was reported to them and they then reported it to the administrator but could not find an FRI for the incident. Surveyor then requested the facility investigation of the incident, however, none was provided prior to the survey exit. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: Policy Statement 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. Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 63 appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. 5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not investigating an incident of a resident to resident altercation involving Resident #28 occurring on 3/15/21. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21. 4. For Resident #53, the facility staff failed to investigate a resident to resident altercation occurring on 6/08/21. Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Chronic	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 64 Obstructive Pulmonary Disease Unspecified, Major Depressive Disorder Recurrent Unspecified, and Spinal Stenosis Site Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 4/13/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. On 6/08/21 at approximately 12:05 pm, surveyor #2 observed Resident #53 hit at another resident around the head and TCNA (temporary certified nursing assistant) #1 separated the two residents. At 2:08 pm, this surveyor spoke with TCNA #1 and asked if Resident #53 made contact with the other resident when they hit at them earlier and TCNA #1 stated yes, the resident made contact with the back of the other resident's head. TCNA #1 also stated that the nurse was "sitting right there" and saw it. A nursing progress noted dated 6/08/21 14:11 (2:11 pm) states in part, "Behavior episodes this day with resident attempting to hit other residents". On 6/09/21 at 11:42 am, survey team met with the administrator and DON (director of nursing) to discuss the facility process for resident to resident altercations. The DON stated resident to resident altercations can be a form of abuse. Surveyor asked if the facility submits FRIs (facility reported incidents) for resident to resident altercations and the DON stated "if there's an injury". The administrator stated they try to follow their policy. Surveyor spoke with the DON (director of nursing) concerning the above incident and	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 65 progress note dated 6/08/21 14:11, DON stated "it should have been documented and reported to me. We will do education on that and do what needs to be done". On 6/09/21 at 12:28 pm, the DON and TCNA #1 met with the survey team and TCNA #1 stated Resident #53 swatted the other resident's hat off from behind them and it was not a slap across the face. Surveyor requested and received the facility policy entitled "Abuse Investigation and Reporting" which states in part: Policy Statement 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. Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate);	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 610	Continued From page 66 f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. 5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. On 6/10/21 at 4:45 pm, during a meeting with the administrator, administrator in training, DON, and ADON (assistant director of nursing) surveyor discussed the concern of the facility not investigating an incident of a resident to resident altercation involving Resident #53. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/10/21.	F 610		
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	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 684	Continued From page 67 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 observations, interviews, and the review of documents, it was determined the facility staff failed ensure treatment and/or care was provided for a skin tear for one (1) of 30 sampled residents (Resident #47). The findings included: The facility staff failed to ensure Resident #47 received care/treatment for a skin tear according to the medical provider's orders. Resident #47 minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/8/21, was signed as completed on 4/9/21. Resident #47 was assessed as usually being able to make self understood and as usually being able to understand others. Resident #47's brief interview for mental status (BIMS) summary score was documented as 13 out of 15. Resident #47 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #47's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, dementia, and lung disease. On 6/9/21 at 09:50 a.m., Resident #47 was observed to have a dressing on the outer part of their left lower leg. The dressing was not dated and was not initialed. During an interview on 6/9/21 at 10:13 a.m., RN #21 reported they could not find a medical provider order for the dressing	F 684	**Quality of Care** 1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #47 remains in the facility and orders for skin tear treatment, documentation completed with measurements are in place. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have potential to be affected. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** Education to be completed with licensed nurses involving residents with skin tears in regard to documentation of description/measurements, orders, and treatments rer dered. 4. **Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:** Director of Nursing or designee will randomly audit Residents with any skin alterations weekly times 4 weeks and monthly times 2 for completion documentation of description of skin alteration measurements, orders for complete treatment, and treatment completed as ordered with dressing to be dated and initialed by nurse upon change. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5. **Include dates when the corrective action will be completed:** Date of completion: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 684	Continued From page 68	F 684		

to the left, lower leg. On 6/9/21 at 10:18 a.m., RN (registered nurse) #21 confirmed the dressing was neither dated nor initialed.

On 6/9/21 at 10:18 a.m., Resident #47's dressing and wound to left, outer, lower leg was assessed by NP (nurse practitioner) #22. On 6/9/21 at 10:28, NP #22 reported it did not appear as if the wound was approximated but indicated they were unsure if the wound was able to be reapproximated. The following information was found in a note documented by NP #22 on 6/9/21 at 10:29 a.m.: " ...Dimensions of left lower leg wound are as follows: 4x3x0.1 cm. Skin flap does not appear approximated today but wound appears stable." The following information was found in a note documented by NP #22 on 6/9/21 at 11:16 a.m.: "Wound appears to have possibly occurred from a trauma of the skin. Per staff report, patient picks at (their) skin often due to (their) diagnosis of dementia/(their) altered mental status. Appears to be a slight abrasion of skin/skin tear with no skin flap approximated noted. Wound is stable."

On 6/9/21 at 10:20 a.m., RN #23 (with RN #24 present) was asked about documentation of the aforementioned wound. RN #23 reported they found a note dated 4/7/21 of the initial wound care but did not see additional documentation related to wound care of this area.

Resident #47's documentation included a nursing note dated 4/7/21 at 3:17 p.m. This note indicated the resident received a skin tear on 4/7/21 while self transferring to their wheelchair. This documentation indicated the skin tear was 'cleaned and dressed'. A nursing note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 684	Continued From page 69 4/7/21 at 6:43 p.m. stated Resident #47's "dressing was reinforced (due to) bleeding." Resident #47's clinical record included the following medical provider order dated 8/16/19 at 4:44 p.m.: "May continue to use standing orders as signed upon admission, unless otherwise specified by physician". The following "standing order" was found in a document titled "NURSING HOME STANDING ORDERS": "Wound (skin abrasion/skin tear) -------[sic] Cleanse with (normal saline) reapproximate skin edges if intact and apply steri-strips. Apply triple antibiotic ointment and cover with dry dressing. Notify physician on rounds weekly." (Reapproximate, as related to wounds, means to bring the skin together to close a wound.) Documentation assessing the size of and providing a description of the skin tear Resident #47 received on 4/7/21 was neither found by nor provided to the surveyor (prior to documentation entered by NP #22 after being asked about the wound on 6/9/21). No documentation was found to address if the skin tear had been reapproximated at the time of the initial wound care. No documentation was found to address if the skin tear had had steri-strips applied or needed at the time of the initial wound care. The following information was found in a facility document titled "Skin Tears - Abrasions and Minor Breaks, Care of" (with a revised date of September 2013): ".... Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage ... Apply the ordered dressing and secure with tape	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 684	Continued From page 70 or bordered dressing per order ... Label with date and initials to top of dressing ..." The following information was found in a facility document titled "Dressing, Dry/Clean" (with a revised date of September 2013): "Verify that there is a physician's order for this procedure. (Note: This may be generated from a facility protocol.)" Resident #47's aforementioned skin tear was discussed during a survey team meeting on 6/9/21 at 5:19 p.m. The facility's Administrator, Director of Nursing (DON), and Nurse Consultant were present during this meeting. The following issues related to Resident #47's 4/7/21 skin tear was discussed: (a) an absence of measurements and/or description of the skin tear, (b) the absence of documentation addressing if steri-strips were needed or not, and (c) the failure to document dressing changes.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842	**Resident Records - Identifiable Information** 1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents #92 and #142 remain in the facility. Facility notified attending physician and residents' responsible parties regarding incomplete documentation. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 71 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842	3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur**: Education with licensed nurses regarding completion of EMAR and progress note if indicated on EMAR. 4. **Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained:** Director of Nursing or designee will randomly audit EMARs of resident weekly times 4 weeks and monthly times 2. Audit findings will be reviewed monthly in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. 5. **Include dates when the corrective action will be completed:** Date of compliance: 8/5/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 72 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility document review the facility staff failed to ensure a complete and accurate clinical record for 2 of 30 residents, Residents #142 and #92. The findings included: 1. For Resident #142 the facility staff failed to initial eMAR's (electronic medication administration record). Resident #142's face sheet listed diagnoses which included, but not limited to dementia, depression, anxiety, insomnia, encephalopathy and constipation. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 05/27/21 assigned the resident a BIMS (brief interview for mental status) score of 9 out of 15 is section C, cognitive patterns. Resident #142's clinical record was reviewed and contained a physician's order summary (POS) for the month of May 2021, which read in part "Abilify	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 73 Tablet 10 MG (ARIPiprazole) Give 1 tablet by mouth one time a day for dementia with behavioral disturbances", "Linzess Capsule 290 MCG (linaCLOtide) Give 1 capsule by mouth 1 time a day for IBS (irritable bowel syndrome)", "Increase fluids strain urine for stone every shift for Kidney stones increase fluids strain urine for stones", "Intrusive wandering: Insomnia-wandering unit in other residents rooms every shift (Provide any additional detail as needed in progress note)", "Pain score every shift... every shift for pain", "S/E (side effects) Tracking-ANTIDEPRESSANTS-Observation and documentation of potential side effects: Nausea, increased appetite and weight gain, Fatigue and drowsiness, insomnia, Dry mouth, Blurred vision, Constipation, Dizziness, Agitation, Irritability, Anxiety every shift related to OTHER RECURRENT DEPRESSIVE DISORDERS (Provide any additional detail in progress notes)" and "S/E Tracking-ANTIPSYCHOTICS-Observation and documentation of potential side effects: Blurred vision, Dry mouth, Drowsiness, Muscle spasms or tremors, Weight gain, Tardive dyskinesia every shift (Provide any additional detail in progress note)". Resident #142's eMAR's for the month of May were reviewed and contained entries as above. The entry for Abilify was coded as "9" on 05/01/21, 05/06-07/21, and 05/08-09/21. The entry for Linzess was coded as "9" on 05/01-02/21, 05/05-06/21 and 05/11/21. Chart code "9" is equivalent to "other/see nurses notes". Resident #142's nurse's notes were reviewed and there were no related notes. The other entries were not initialed on 05/15-16/21, evening shift and 05/30/21, day shift.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 74 Surveyor spoke with the DON (director of nursing) on 06/10/21 at approximately 1:30 pm. Surveyor asked DON if there should have been a note for the coding of "9" on the eMAR and DON stated that there should have been, because with a note there is no way to determine if the medication was given or not. DON also stated that blanks on the eMAR are "uncalled for". The concern of the incomplete documentation of the eMAR's was discussed with the administrative team (administrator, administrator in training, DON, ADON (assistant director of nursing) on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit. 2. For Resident #92 the facility staff failed to ensure eMAR's (electronic medication administration record) were complete. Resident #92's faced sheet listed diagnoses, which included but not limited to chronic obstructive pulmonary disease, psychosis, convulsions, anemia, dementia, hypertension, and chronic pain. The most recent significant change MDS (minimum data set) with an ARD (assessment reference date) of 05/06/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15 in section C, cognitive patterns. This indicates the resident is not cognitively intact. Resident #92's clinical record contained a physician's order summary for the month of May 2012, which read in part "Mighty Shake two times	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 75	F 842		

a day for wt loss prevention-w (with)/ L (lunch) & D (dinner) trays -start date- 05/08/2021 1200", "Fall mat every shift related to UNSPECIFIED FRACTURE OF RIGHT FEMUR, SUBSEQUENT ENTCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING", "Monitor for pain every shift related to UNSPECIFIED FRACTURE OF RIGHT FEMUR, SUBSEQUENT ENTCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING", "Pain Score every shift...every shift for pain", "Physically abusive: attempting to hit staff while providing every shift (Provide any additional detail as needed in progress note)", "Raised edge mattress every shift related to UNSPECIFIED FRACTURE OF RIGHT FEMUR, SUBSEQUENT ENTCOUNTER FOR CLOSED FRACTURE WITH ROUTINE HEALING", " S/E (side effects) Tracking-ANTIPSYCHOTICS-Observation and documentation of potential side effects: Blurred vision, Dry mouth, Drowsiness, Muscle spasms or tremors, Weight gain, Tardive dyskinesia every shift (Provide details in progress note).

Resident #92's eMAR's for the month of May 2021 were reviewed and contained entries as above. The entry for Mighty Shakes was not initialed on 05/06/21 at 5 pm, 05/07/21 at 12 pm and 05/24/21 at 5 pm. The other entries were not initialed on05/15/21, evening shift and 05/30/21, day shift.

Surveyor spoke with the DON (director of nursing) on 06/10/21 at approximately 1:30 pm regarding the eMAR's not being initialed. DON stated that blanks on the eMAR's are "uncalled for".

The concern of the incomplete documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY REHABILITATION AND NURSING 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 842	Continued From page 76 the eMAR's was discussed with the administrative team (administrator, administrator in training, DON, ADON (assistant director of nursing) on 06/10/21 at approximately 4:30 pm. No further information was provided prior to exit.	F 842		