STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	04/08/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey and State Licensure survey were conducted 04/07/19 through 04/08/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 70 certified bed facility was 65 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for 1 of 19 Residents in the survey sample, Resident # 14. The findings included: The facility staff failed to ensure that Resident # 14 was wearing physician ordered TED hose. Resident # 14 was an 86-year-old- female who	F 684	F684 Resident #14 has had her TED hose applied and removed as per her MD orders since 4/7/19. The nurse who charted that the TEDS were applied on 4/7/19 was counseled regarding charting accurately and application of special garments. Any residents with TED orders are at risk	5/17/19

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

Electronically Signed | 05/02/2019

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F 684	Continued From page 1 was originally admitted to the facility on 9/20/18, with a readmission date of 3/26/19. Diagnoses included but were not limited to, congestive heart failure, type 2 diabetes mellitus, major depressive disorder, and hyperlipidemia. The clinical record for Resident # 14 was reviewed on 4/7/19 at 2:55 pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/2/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 14 had a BIMS (brief interview for mental status) score of 10 out of 15, which indicated that Resident # 15's cognitive status was moderately impaired. The current plan of care for Resident # 14 was reviewed and revised on 4/5/19. The facility staff documented a focus area as, "Self care deficit related to muscle weakness from long standing chronic medical conditions. Requires total assistance with: None Requires extensive assistance with: bed mobility, transfers, dressing, toileting, and personal hygiene and locomotion. Requires limited assistance with: eating at times. Requires set up assistance with: eating is independent with eating requires hands on assistance with: bathing Required 2 (#) staff members to assist with transfers and bed mobility." Interventions included but were not limited to, "TED hose on in am off in pm." Resident # 14 had current orders that included but were not limited to, "TED hose on in AM, off in PM," which was initiated by the physician on 3/26/19. On 4/7/19 at 11:06 am, the surveyor was in	F 684	for having them not applied. A 100% audit of the residents MD orders will be conducted by the DON or designee in order to identify those residents who should have TED hose applied every AM. Staff will be inserviced on the importance of applying TED hose. The DON, or designee will check those residents having TED orders daily for 4 weeks and then spot check monthly for 3 months to make sure the TEDS were applied. If it is discovered that the ordered TEDS were not applied, the certified nursing assistant assigned to provide care for that resident will receive counseling. The findings of the TED audit will be discussed at the weekly risk meeting for 4 weeks. Any findings of the deficient practice will be addressed and revisions made with an action plan. The audit will also be reviewed by the quarterly QA Committee.	

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F 684	Continued From page 2	F 684		

Resident # 14's room conducting a Resident interview. The surveyor observed that Resident # 14 was fully dressed and wearing nonskid socks. The surveyor did not observe and TED hose in place on Resident # 14.

On 4/7/19 at 2:51 pm, the surveyor observed Resident #14 sitting in her room in wheelchair her wheelchair. The surveyor observed that Resident # 14 was wearing nonskid socks and no TED hose were in place.

On 4/7/19 at 3:05 pm, the surveyor spoke with LPN #1 (licensed practical nurse) regarding the TED hose for Resident #14. The surveyor and LPN reviewed the physician's orders for Resident # 14 and LPN # 1 agreed that Resident # 14 had an active order for TED hose to be placed on in the AM off in PM. The surveyor informed LPN #1 that Resident # 14 was not wearing TED hose on 4/7/19 during observations. LPN # 1 along with the surveyor went into Resident # 14's room and observed that Resident # 14 was not wearing TED hose. LPN # 1 asked Resident # 14 where her TED hose were. Resident # 14 stated, "They are in the drawer." LPN # 1 asked Resident # 14 if she would like to put on her TED hose. Resident # 14 stated, "I don't see any point in putting them on, they haven't been on all day and I would be putting them on and have to take them right back off." The surveyor and LPN # 1 reviewed the treatment administration history for Resident # 14 and observed documentation that TED hose had been applied at 3:18 am in 4/7/19.

On 4/8/19 at 3:24 pm, the administrator and director of nursing were made aware of the findings as stated above.

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F 684	Continued From page 3 No further information regarding this issue was presented to the survey team prior to the exit conference on 4/8/18.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		5/17/19

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F 690	Continued From page 4 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to provide services to prevent urinary tract infections for 1 of 19 Residents in the survey sample, Resident # 52. The findings included: The facility staff failed to ensure that Resident # 52 Foley catheter was secure with a leg strap. Resident # 52 was an 84-year-old-female who was originally admitted to the facility on 4/7/16, with a readmission date of 5/25/17. Diagnoses included but were not limited to, obstructive and reflux uropathy, type 2 diabetes mellitus, dementia with behavioral disturbance, and hypertension. The most recent MDS (minimum data set) assessment for Resident # 52 was an annual assessment with an ARD (assessment reference date) of 3/16/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 52 had a BIMS (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 52's cognitive status was severely impaired. Section H of the MDS assesses bowel and bladder. In Section H0100, the facility staff documented that Resident # 52 had an indwelling catheter. The current plan of care for Resident # 52 was reviewed and revised on 4/1/19. The facility staff documented a focus area for Resident # 52 as,	F 690	F690 A foley leg strap was procured for resident #52. The foley leg strap is changed twice weekly or as needed. Placement of the leg strap is verified every shift. The nurse responsible for applying a leg strap was counseled regarding following physician orders. Residents who have foley catheter orders are at risk for not having leg strap applied to secure foley tubing. A 100% audit of physician orders will be conducted by the DON or designee to identify those residents with orders for a foley catheter. Staff will be inserviced on the policy for care of a foley catheter including the use of a leg strap to prevent the increased risk of infection. The DON or designee will check daily for 4 weeks, then weekly for 2 months to make sure that a leg strap was applied for each resident having a foley catheter. The audit results will be reviewed at the weekly risk meeting. Deficient findings will be addressed and an action plan initiated. The audit results will be discussed at the quarterly QA meeting.	

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F 690	Continued From page 5 "Resident # 52 is at risk for urinary tract infections due to chronic Foley cath use and disease process." Interventions included bit were not limited to, "Follow principles of infection control and universal precautions." Resident # 52 had current orders that included but was not limited to, "Check catheter strap placement q (every) shift." On 4/8/19 at 9:31 am, the surveyor was in Resident # 52's room conducting a Resident interview. During the interview, Resident showed the surveyor her Foley catheter. The surveyor observed that Resident # 52's catheter was not secured with a leg strap. On 4/8/19 at 10:06 am, the surveyor along with RN # 1 (registered nurse). The surveyor along with RN # 1 observed that Resident # 52's Foley catheter was not secured with a catheter strap. The surveyor asked RN # 1 if Resident # 52's Foley catheter should be secured with a strap. RN # 1 stated, "Yes she is supposed to have one on." On 4/8/19 at 3:26 pm, the administrator and director of nursing were made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/8/19.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		5/17/19

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F 761	Continued From page 6 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to securely store medication in 1 of 2 medication rooms. On 4/07/19, when the surveyors arrived to the facility at 7:45 AM, the door to the medication room behind the nurse's station on Sullivan hall was open. The treatment cart was unlocked. No nursing staff were present in the room or at the nurse's station nearby. Two nurses were working medication carts in the hall and the nursing supervisor was in the dining room. The medication refrigerator was unlocked. There were no controlled substances in the refrigerator. None	F 761	F761 There have been no reports or sightings of the medication room door being left open, any of the medication or treatment carts left unlocked and unattended, or of the medication room refrigerator being left unlocked. Any medication or treatment cart, medication room, and medication refrigerator are at risk for being left unsecured and unattended. Licensed nurses will be inserviced on the	

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F 761	Continued From page 7 of the stored medications were expired. The door to the medication room was closed by 8:15 AM. The medication rooms were not observed open and unattended again during the survey. The director of nursing was notified of the concern during a discussion on 4/8/19 at approximately 3 PM. The director of nursing stated she would address the issue with nursing staff.	F 761	section #25 in the Medication Administration policy regarding keeping the refrigerator locked to prevent a medication security policy breach when controlled substances require refrigeration. The DON or designee will conduct a review of the Medication Administration Policy, item #19 which addresses keeping the medication and treatment carts locked when unattended. Staff will receive an inservice reminder to keep the medication room door locked when no licensed nurse is physically present in that room. The facility administrator and other administrative personnel will daily inspect the medication and treatment carts, the medication room door and the med room refrigerator to make sure they are all locked when unattended. The findings of the administrative rounds will be discussed in the weekly risk meeting. Any deficient practice will be addressed at the time of discovery with the employee responsible for the security breach and the progressive disciplinary process will be applied. The audit results will be discussed at the quarterly QA meeting.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		5/17/19

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F 812	Continued From page 8 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review it was determined the kitchen staff failed prepare food in a clean and sanitary manner for facility residents. Findings: The facility kitchen staff failed to prepare foods in a clean and sanitary manner. The initial tour of the kitchen environment began 4/7/19 at 8:00 AM. The surveyor entered the second floor dining room. A kitchenette at the rear of the dining section contained a steam table and refrigerator. A kitchen employee was stirring the breakfast foods on the steam table. None of the foods were covered with lids or wrap of any sort. The surveyor asked to see the temperature log on the foods contained in the steam table. The employee did not understand what the surveyor was asking about. When asked if she had obtained the temperatures on the food, the	F 812	Food temps are being tested and logged at each meal by the dietary staff. Frozen foods are being thawed according to the policy. the finding was corrected when the inspector noted the chicken being thawed. Raw chicken was thrown away and all three sinks were washed out. Cooks have been educated and inserviced on policy and procedure. Unsanitary environments can affect residents and employees if not appropriately maintained. Any residents receiving meals being prepared at the facility are at risk with health being compromised with a breach in policy. Staff personal drinks are not being stored in the food prep area. Staff has been educated and inserviced on this issue. Food Service Director, or designee will	

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F 812	Continued From page 9	F 812		

kitchen employee held up her hands and shook her head. She did not understand when the surveyor asked if she had a thermometer to take the food temperatures.

At this point, another staff member called down to the kitchen to find someone to take the food temperatures of the steam table. Cook I appeared with alcohol swabs and a thermometer to take the temperatures of the foods ready to be served to the residents in the dining hall.

The temperatures on the steam table were obtained. The hot cereal/grits were 130 degrees; scrambled eggs were 130 degrees; baked apples were 140 degrees. Cook I said the food had to be kept at 145 degrees on the steam table and removed all the food and took it back downstairs to the kitchen to reheat.

The surveyor accompanied Cook I and the food cart downstairs to the regular kitchen. Cook I said the server had removed the plastic covers from the foods after placing them on the steam table and that is why they had cooled down so much.

Inside the kitchen the surveyor observed a three bay sink with two bays full of raw chicken in the bottom of the basins. Water was running from the faucets across the chicken and back washing onto the surface of the sink before returning to the sink or splashing onto the floor. The surface of the sink was observed to have food debris and used, unwashed dishes on the surface surrounding the basins. The back washing water was running through/around the dishes and back into the basin.

The surveyor asked Cook I about the facility monitor daily.

Wet baking pans are not being nested and are placed in the appropriate area to dry. Food Service Director or designee will continue to monitor daily with kitchen rounds.

The gas stove, kitchen floor, kitchen walls, and fire sprinkler above the stove have been cleaned. Food Service Director or designee will monitor daily to keep burners clean and maintenance will conduct monthly checks on sprinklers.

The sugar in the bin with trash on top and a liquid leaking into the bin was discarded. The bin was cleaned and refilled and was also relocated to another area in the kitchen to prevent debris near the sugar bin.

Dietary staff will be inserviced on the Dietary Policy for sanitation, food storage, food delivery, and the kitchen area and equipment cleaning schedule. The Food Service Director, or designee will audit the food temp and the cleaning schedule logs daily.

The Food Service Director, or designee will perform an inspection of the kitchen area daily to ascertain that trash is stored in the proper receptacles, pans are not wet nested, and the food prep area is free of staff's personal items.

Any deficient practice noted in these areas will be immediately corrected and

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F 812	Continued From page 10 policy for thawing out frozen chicken. Cook I said she was supposed to put the chicken into buckets and place it into the sink to thaw with water running over it. Cook I pointed out the two buckets that were to be used in this process. They were stored on a wire rack in the kitchen. Cook I said she was going to throw the chicken in the trash, since she had not followed the appropriate procedure to place in containers to thaw it under running water in the sink. The facility administrator was entering the kitchen and informed of the findings prior to the surveyor leaving the area. She said she would oversee the chicken being thrown in the trash. Other areas of concern in the kitchen included: 1. The staff use of styrofoam and refillable drink cups left in various areas of the food preparation area. Three white styrofoam cups with lids and one refillable mug-type cup were seen on the table tops in the food preparation area. They had staff names/initials on them. They were all moved back to one table in the rear of the kitchen out of the food preparation by the employees in the kitchen. 2. 36 baking pans were observed nested on wire racks for storage. All the pans were observed to have moisture between them and had been nested prior to drying, trapping the moisture inside. 3. Baking pans stored under food preparation tables were observed to have built-up food debris on them. Cook I said they had already been washed, and she removed them to run them back through the dishwasher. 4. The six burner gas stove top was crusted with built-up/blackened food debris. The eyes of the burners contained trash and food debris. Cook I	F 812	the responsible employees will be counseled and disciplined. The dietary audit results will be discussed at the weekly risk meeting. Action plans will be initiated or revised as needed. The results of the dietary audits will be discussed at the quarterly QA meetings.	

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said she didn't know what the schedule was to clean it.
5. The fire sprinkler system had four faucets over the cook stove top. The ends of the faucets were caked with dust and smut-taggles. A large open pan was placed on the stove top directly underneath the sprinkler system with food boiling in the pot.
6. The sugar bin on the floor was observed to have trash and debris on the lid which fell onto the surface of the sugar when the lid was opened. The inside of the sugar bin had what appeared to be splash marks on it. (Drops of something yellow had run down the inside.)
7. The kitchen floor was slippery with grease. This was pervasive throughout the kitchen and accumulated beside stoves, sinks and under countertops. Built-up food debris was observed throughout the kitchen at the base of the walls.

On 4/7/19 at 12:44 PM the DM (dietary manager) was interviewed. She was informed about the surveyor's findings. The DM said thawing the chicken in the sink was appropriate and they had measures in place to ensure the sink was sanitized prior to the procedure. The surveyor asked to the see the policy and procedure for the sanitation process and requested proof of inservices that the staff had been trained in the process. (The kitchen staff members spoke very little-to-no English and it could not be established what they actually understood by interviewing them about the process.)

The DM also told the surveyor the staff were not supposed to have their personal drinking cups in the food preparation area. They were provided with a table outside the food prep area for personal drinks and had to have their names and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	04/08/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 12 dates on them. The facility administrator provided a few pages of the facility dietary policy--which was computerized and over 200 pages long. On page 47 the policy referenced frozen foods being thawed under refrigeration or under cold running water. The policy did not reference the vessel the food should be contained in or the procedure for sanitizing the sink basins prior to water thawing food. There was no evidence presented that referred to any training the kitchen staff had to sanitize the basins and surround sink surface prior to placing food into it for thawing. No additional evidence was provided prior to the survey team exit.	F 812		