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 06/30/2023

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 onsite on 6/27/23 through 6/30/23. The facility was in substantial compliance with 42 CFR Part 483.73 Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 06/27/23 through 06/30/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirement(s) and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. Eight complaints were investigated during the survey: VA00055284-compliant with regulations VA00055440-compliant with regulations VA00056759-compliant with regulations VA00055773-compliant with regulations VA00056652-compliant with regulations VA00058135-compliant with regulations VA00058356-compliant with regulations VA00058986-compliant with regulations The census in this 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 7 closed record reviews.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical	F 583		7/27/23

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

Electronically Signed | 07/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583	Continued From page 1 records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to safeguard resident private information on 1 of 4 units, 2 front. The findings included:	F 583	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged	

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F 583	Continued From page 2 Facility staff failed to close the narcotic book or the computer screen when leaving the medication cart unattended on the hallway. 06/28/23 8:35 a.m., the surveyor observed a medication pass and pour observation with Licensed Practical Nurse (LPN) #1. Upon approaching the medication cart the surveyor observed LPN #1 to walk away from their medication cart and enter a residents room. LPN #1 left the computer screen up and running and the narcotic book was observed to be open exposing resident information. A male visitor and several staff were observed to be in the vicinity of the medication cart. LPN #1 returned to their medication cart and prepared a residents medication for administration. After preparing the medication LPN #1 again left their computer screen and the narcotic book open. Walked away from the cart and entered a residents room to administer the medications. Upon returning to the medication cart the surveyor observed that the computer screen and narcotic book remained open and in full view of anyone that walked by. 06/29/23 9:00 a.m., the Director of Nursing (DON) stated they were providing education in regard to privacy of residents information. 06/29/23 9:25 a.m., DON provided the survey team with their policy titled, "Confidentiality of Patient Information/HIPAA." This policy read in part, "...Employees are expected to protect the confidentiality of all patient and employee information...Employees are expected to protect documents and computer screens from inadvertent access by unauthorized parties..." 06/30/23 11:50 a.m., this issue was reviewed with	F 583	deficiencies cited have been or will be corrected by the date or dates indicated. F583 1.DON/ADON/SDC/Designee will give education to LPN#1 regarding privacy of residents by 7/27/2023. 2.On 6/28/2023 Unit Managers/ADON and designee rounded facility med carts to ensure that no other patient information was left unattended. 3.DON/ADON/SDC/Designee will provide education to current licensed staff regarding privacy of resident information by 7/27/2023. 4.DON/ADON/Unit Manager/Designee will audit med carts 2-3x weekly for 1 month to ensure that computer screens and narcotic books are closed when med cart is unattended. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 5. Date of compliance 7/27/2023	

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F 583	Continued From page 3 the Administrator, Assistant Administrator, DON, and Nurse Consultant. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 583		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, and staff interview, the facility staff failed	F 657	F657 1.On 6/30/2022 resident # 145 CP was	7/27/23

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F 657	Continued From page 4 to review and revise the residents Comprehensive Care Plan (CCP) for 1 of 39 residents, Resident #145. The findings included: The facility staff failed to review and revise the residents CCP when they fell and fractured their left distal fibula. Resident #145's diagnoses included, but were not limited to, fracture of the left distal fibula, muscle weakness and difficulty in walking. Section C (cognitive patterns) of Resident #145's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/06/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Section G (functional status) was coded to indicate the resident required minimal assistance of one person for transfers. Walk in room/corridor was coded to indicate the resident required extensive assistance of one person. Resident #145 was coded as using a walker for mobility. 06/27/23 1:10 p.m., Resident #145 stated their leg had given out when they were trying to get into their closet, they had fallen and broken their ankle. The clinical record included an X ray report dated 06/15/23 indicating Resident #145 had a "Nondisplaced fracture distal fibula with mark associated soft tissue swelling." A review of Resident #145's CCP revealed that the CCP had not been revised to capture the	F 657	updated to capture the fracture. 2.ADON/DON/SDC or designee will educate MDS coordinators regarding the updating CP when a resident has a fracture by 7/27/2023 3.MDS coordinators will complete an audit of current residents with fractures to ensure CP are updated by 7/27/2023. 4.MDS coordinator/designee will audit CP 1-2x weekly to ensure that any resident with a fracture CP is updated for 1 month. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 5. Date of compliance: 7/27/2023	

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F 657	Continued From page 5 fracture. 06/29/23 4:30 p.m., during an end of day meeting with the Administrator, Director of Nursing, and Nurse Consultant the issue with the missing CCP information regarding the fracture was reviewed. 06/30/23 10:05 a.m., Licensed Practical Nurse (LPN) #2 stated the CCP had been updated to reflect the fracture. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 657		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were two errors in 25 opportunities for a medication error rate of 8%. These errors effected Resident's #106 and #149. The findings included: For Resident #149, the facility nursing staff administered a whole tablet of Quetiapine (25 mg) when the order was for one half a tablet (12.5 mg) of Quetiapine. For Resident #106 the	F 759	F759 1. A medication error was completed on resident #149 and the physician was made aware on 6/30/2023. A medication error was also completed for resident #106 on 6/30/2023. 2.LPN #1 and RN #2 received education on 6/30/2023 regarding medication administration. 3. SDC/ADON/Designee will provide education to current licensed staff regarding medication administration by 7/27/2023. 4. DON/ADON/Unit Manager/Designee	7/27/23

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F 759	Continued From page 6 facility nursing staff failed to shake the residents liquid Carafate prior to administering. During a medication pass and pour observation on 06/28/23 8:35 a.m., the surveyor observed Licensed Practical Nurse (LPN) #1 prepare and administer Resident #149's medication. LPN #1 pulled a card of Quetiapine (Seroquel) from the medication cart and popped one full pill into the medication cup and handed the medication card to the surveyor. This card read, give 1 tablet by mouth at bedtime for delusional disorder. The surveyor stated to LPN #1 that the card read to administer at night. LPN #1 reviewed the medication card label and stated that sometimes the labels are incorrect. The surveyor reconciled the medication using Resident #149's clinical record. The clinical record included two orders for the medication Quetiapine. One that read, Quetiapine oral tablet 25 mg give 0.5 tablet by mouth one time a day. The time on the medication administration record (MAR) was documented as 9:00 a.m. The second order read Quetiapine 25 mg give 1 tablet by mouth at bedtime. The time on the MAR read 9:00 p.m. Both orders included the order date of 06/06/23. 06/28/23 9:45 a.m., LPN #1 pulled two cards of Quetiapine from the medication drawer one card contained a whole tab and read to administer at night. One medication card contained tablets that were cut in half and read to give 0.5 tablet by mouth one time a day. Indicating LPN #1 had administered the bedtime dosage in the morning.	F 759	will audit medication administration pass with a licensed nurse 2-3x weekly for 1 month. Above audits will be reviewed in QA any noncompliance will be addressed and result in education and or corrective action. 5. Date of compliance: 7/27/2023	

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F 759	Continued From page 7	F 759		

06/28/23 8:50 a.m., the surveyor observed Registered Nurse (RN) #2 prepare and administer Resident #106's morning medications to include Carafate. RN #2 pulled the liquid Carafate from the medication drawer and poured 10 ml's into a clear medication cup. RN #2 did not shake this medication prior to pouring the medication into the medication cup. After the medication administration the surveyor and RN #2 checked the Carafate medication bottle this bottle read "SHAKE WELL BEFORE USE." RN #2 was asked if they should have shaken the medication and stated most definitely, they should have.

The facility staff provided the surveyor with a copy of their policy titled, Administration Procedures for All Medications. This policy read in part, "...Check the MAR ...for the order...Check the label against the order on the MAR...Note any supplemental labeling that applies (fractional tablet ...shake well ...etc.)..."

06/28/23 4:15 p.m., during a meeting with the Director of Nursing (DON), Nurse Consultant, Administrator, and Assistant Administrator the issue regarding the medication errors were reviewed. The administrative staff were made aware that their medication error rate was 8%.

06/30/23 10:00 a.m., DON provided the surveyor with a copies of medication error/disciplinary action reports regarding these two medications.

No further information regarding this issue was provided to the survey team prior to the exit conference.