

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345247	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/18/2013
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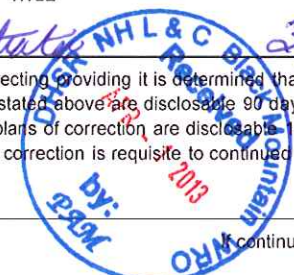
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HWY 16 SOUTH TAYLORSVILLE, NC 28681
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide toileting assistance for a resident who fell and broke his hip and failed to ensure the resident had nonskid footwear when he ambulated for 1 of 3 sampled residents (Resident #2).</p> <p>The findings include:</p> <p>Resident #2 was readmitted to the facility on 01/15/13 with diagnoses that included Alzheimer's disease, muscle weakness, lack of coordination, history of falls, and heart disease among others. The most recent Minimum Data Set (MDS) dated 01/22/13 specified the resident had moderately impaired cognition and required limited assistance with transfers and toilet use. The MDS also specified the resident was not steady with his balance and required use of a walker for mobility. According to the MDS, the resident was always continent of bowel and bladder and the resident had a history of falls that included a fracture.</p> <p>The resident's fall care plan dated 01/15/13</p>	F 323	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.</p> <p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p><b>Corrective actions taken for resident found to have been affected by alleged deficient practice as listed:</b></p> <p>Resident #2 is no longer at the facility. Nurse #1 and Nurse Aide #1 who cared for resident #2 in the early morning hours of 1/29/13 were both given one-on-one in-service education and re-training by the Director of Nursing on 3/26/13. This in-service training was concerning the facility protocols and expectations for the accurate exchange of information from the Nurses to the CNAs during the shift report huddle, providing non-skid footwear for residents who's plan of care indicates such, the location of care plan information, the location of resident transfer status, and the implementation of the newly revised bowel protocol, and the newly implemented Meal Intake / Transfer Status sheet.</p>	3/26/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Doreen B. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/28/13</i>
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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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NAME OF PROVIDER OR SUPPLIER  <b>VALLEY NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>581 NC HWY 16 SOUTH</b> <b>TAYLORSVILLE, NC 28681</b>		
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F 323	<p>Continued From page 2</p> <p>floor. The resident's right leg was rotated outward and appeared shorter than the left leg. The on-call physician was notified and ordered the resident to be sent to the Emergency Department for evaluation.</p> <p>The Emergency Department report dated 01/29/13 was reviewed and revealed the resident presented to the hospital and was diagnosed with a fractured right femur as a result of a fall while standing.</p> <p>On 03/18/13 at 10:30 AM Nurse #1 was interviewed on the telephone and reported that she was notified during the shift report that Resident #2 had received a suppository and had not experienced a bowel movement. She stated that it was usual procedure to notify the nurse aides of which residents had received a suppository so the nurse aides would be aware to monitor those residents more closely and to notify the nurse when the resident had a bowel movement. Nurse #1 could not recall who the nurse aide was on the night of 01/29/13 but stated she should have told the nurse aide that Resident #2 had received a suppository and would have expected the nurse aide to monitor him closely in the event he needed to go to the bathroom to have a bowel movement. Nurse #1 also reported the resident required assistance with toileting. She added Resident #2 was more confused than usual on the night of 01/29/13. She added that around 3:45 AM she was at the nurses' station and heard a loud noise. She stated she looked down the hall and saw Resident #2 in the floor. Nurse #1 stated Resident #2 appeared to have gotten out of bed unassisted, ambulated without his walker across</p>	F 323	<p>Continued from page 2</p> <p>regimen for Constipation. The "Standing Orders" now require that the medications for constipation be administered at earlier times during the day. This change was implemented with the intent to ensure that the medications / interventions had ample time to work prior to third (11p – 7a) shift. This is in effort to try to prevent the resident from being awakened during hours of sleep with the sudden need to have a bowel movement.</p> <p>2) The residents transfer status is now being listed on the newly created Meal Intake / Transfer Status sheet that is provided for all CNAs at the beginning of each shift. This new form was created so that the hall staff will know, at the start of each shift, the current transfer status for each resident without having to access the electronic resident records to locate this information. The Therapy Director or her designee will be responsible to ensure that the correct transfer status of each resident is listed. The Medical Records staff will print these forms to ensure that the current copies are available to hall staff at the beginning of each shift.</p> <p>3) The DON and RN Supervisors are providing in-service training to the Nurses and CNAs on the facility protocols and expectations for the exchange of pertinent information during the shift report huddles; ensuring the use of non-skid foot wear (shoes or skid resistant socks) as indicated by the care plan; the location of care plan information, the location of resident transfer status, ensuring residents are checked and monitored as necessary to prevent</p>	



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F 323	Continued From page 4 resident was able to ambulate but offered no explanation why she failed to change Resident #2's socks to non-skid socks.  On 03/18/13 at 12:20 PM the Director of Nursing (DON) was interviewed and stated that nurses were expected to notify nurse aides if a resident had been given a suppository so the nurse aide could monitor the resident and notify the nurse if the resident had a bowel movement. She stated she would expect the nurse aide to respond quickly to a resident's call bell request to go to the bathroom and continue to monitor residents at least every 2 hours for incontinence. The DON also stated residents were to have either non-skid socks or shoes on when out of bed. She added that nurse aides were expected to monitor a resident's footwear and change any footwear that was not appropriate. The DON stated she would have expected NA #1 to have changed Resident #2's socks to non-skid when she assisted him to bed the night he fell. The DON also stated she would have expected NA #1 to have known the resident had been given a suppository and provided him with the assistance he required with transfers and toileting. The DON provided additional information from the computer system used by the nurse aides that specified on 01/29/13 at 2:09 AM NA#1 documented in the computer that she had monitored Resident #2 but had not assisted him to the bathroom. The DON also provided a nurses' entry dated 01/29/13 at 1:10 AM made by Nurse #1 that specified the nurse had obtained vital signs on Resident #2.	F 323	Continued from page 4 for the care of any resident receiving a "NO" answer will receive one-on-one re-education by the RN Supervisor or DON.  <b>3) The Director of Nursing and/or her designee will monitor various shift report "huddles" to ensure the conveyance of pertinent information from the Nurses to the CNAs. The designated auditor will record the results "YES or NO" as to whether or not the Nurse satisfactorily informed the CNAs of pertinent information such as the use of laxatives or noted change in condition during "shift huddle". The huddle audit will be conducted 10 times weekly for 4 weeks, then continue at a rate of 4 times weekly for a minimum of 6 months.</b>  <b>The DON or her designee will compile collected data from the above stated audits and present the results to the Quality Assurance Committee monthly for a minimum of 6 months. To begin 3/28/13 and end with data collected through September 2013.</b>  <b>The QA committee will review the results of each audit, evaluate effectiveness, and recommend changes or extend monitoring if needed to assure compliance is sustained with F323.</b>	3/28/13	