DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 04/10/2013 FORM APPROVED

CENTER	S EOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING		03/28/2013
NAME OF PE	ROMDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY \	/IEW CARE & REHAB CE	ENTER		551 KENT STREET ANDREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPING DEFICIENCY)	D BE COMPLETION
	consult with the resid known, notify the resid or an interested family accident involving the injury and has the positive intervention; a signification physical, mental, or produced the deterioration in health status in either life the clinical complications significantly (i.e., a new interesting form of treatments); or a decist the resident from the §483.12(a). The facility must also and, if known, the resor interested family must also and, if known, the resor interested family must also and interested family must also and interested family must regulations as specifications as specifithis section. The facility must record the address and phorested family must record the address and p	attely inform the resident, ent's physician; and if dent's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., an, mental, or psychosocial eatening conditions or), a need to alter treatment due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative tember when there is a sommate assignment as	F 157	A. F157 Resident #39 bowel documentation was reviewed of 3/27/13 for any other indication of change in bowel habits to indicate constipation or risk of fecal impaction and none were noted B. An audit of all current facility residents for changes in bowel consistency was completed on 3/27/13 and no other resident were noted to have changes or presence of fecal impaction. C. All Licensed Nurses and C.N.A. were re-educated beginning 3/27/13 on the responsibility to report changes in bowel habits include changes in consistency curexpected results to treatment to the Licensed Nurses via the Stop And Watch INTERACT tool. The Licensed Nurses will evaluate the resident and notify the Physician of any changes in condition	4-25-5
	by: Based on staff and p	hysician interviews and v, the facility failed to notify			

'S OR PROVIDER/SOPPLIER REPRESENTATIVE'S SIGNATURE LABOR

Any periodency 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 replaced by the facility of deficiencies are cited, an approved plan of corrections are provided.

program participation.

Event ID CG7711

Facility ID 923155

tion sheet Page 1 of 36

by: PAN

Received

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(3		SURVEY PLETED
		345426	B WING				03/	28/2013
NAME OF PR	OVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
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VALLEY	TIEW CARE & REHAB CE	INTER		ANI	DREWS, NC 28901			
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F 157	Continued From page	s 1	E	157				
, ,,,,		ng resident response to	1	101				
		ation to prevent a fecal		47				
	impaction for 1 of 3 re				D. The ED/DCS/Unit Manager w	ill		
	notification of change	. (Resident #39)			audit a maximum of 5 residen	ts		
	The findings included				for bowel movement frequency ensure resident is not	10		
					experiencing a change in			
	Danidant #30 was ad	mitted to the facility 09/02/12			condition: and/or if they are			
		ing chronic constipation,			experiencing a change in condition, that the physician v			
		weakness, and dementia.			notified. Monitoring will be	, 43		8
	respondence from a sometime a				conducted 5 x weekly for 4			9
		11/12 documented Resident			weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4			
		of bowel and bladder. The			weeks and then 1 x monthly fo	r 7		
		keep the resident clean and			months. The results of the aud			
		number of incontinent view period. Interventions			will be reported monthly to Q1 Committee monthly x 10 mon			
		d monitor bowel pattern.			for continued substantial			
		and a second control of the second control o			compliance and/or revision.			
	A physician's progres	s note dated 01/04/13			E. 4/25/13			
		was seen by the physician		!	2			
		issues. The note specified						i
	그는 그리지 않아 있다면서 이 시간에 되었다. 그 그렇게	eived enemas but was still						
		t. The physician's physical the resident's abdomen						
	was soft and non tend							
		lication dosage, increasing						
	dosages of current la:	xatives with the addition of						
		and 3 laxative suppositories						
		this date. A review of						
		aled written orders dated						
	01/04/13 to support th	ie huysicians hian						
	A review of a bowel a	nd bladder detailed entry						
		hrough 01/10/13 revealed						
	documentation by nur	se aides regarding						
	frequency and consist	lency of bowel movements.						
		pose stool was documented						
	at 3 04 AM by NA #3	and 4 56 AM by NA #4, a						

Facility ID 923155

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		Commission and Commission (Commission Commission Commis		COMPLETED	
		345426	B. WING				02/20/2042	
NAME OF PE	ROVIDER OR SUPPLIER	U-10420	1 = 1	075	FET ADDDESS OFF STATE 322 0005		03/28/2013	
				1000	EET ADDRESS, CITY, STATE, ZIP CODE 51 KENT STREET			
VALLEY V	IEW CARE & REHAB CE	ENTER		4999	NDREWS, NC 28901			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETION DATE	
F 157	Continued From page	. 2	_	457				
1 107	70 (70)	:40 PM by NA #5, and a	F	157				
		:35 PM by NA #6. On						
8		e stool was documented at						
		nd at 2:32 PM by NA #5.						
		documented on 01/07/12 or						
l H		12 an extra-large loose stool						
	was documented at 2	::35 AM by NA #3 and a						
		umented at 5:01 AM by NA						
	#4. No stools were o	documented on 01/10/13.						
	An interview was con	ducted via phone with NA #3						
		M. She described Resident	İ	8			ı İ	
	#39's bowel moveme	nts on 01/05/13 and						
	01/09/13 as loose and	d runny and not dark in	-					
		he stools were so large,						
		s were required. She stated					l l	
	she reported the loos	e stools to the hall nurse.						
	An interview was con-	ducted via phone with NA #4						
	on 03/27/13 at 2:59 P		Į.					
		on 01/05/13 and 01/06/13						
		and not hard. She stated		1				
	she reported the loos	e stools to the hall nurse.						
	An interview was con-	ducted with NA #5 on						
	03/27/13 at 2:11 PM.	NA #5 stated she worked						
	01/05/13 and 01/06/1	3. She stated she did report					1	
	the stool to the hall nu	urse on 01/06/13 because it						
	was so large.							
į	An interview was cond	ducted via phone with NA #6						
	on 03/27/13 at 3:30 P							
	recalled Resident #39							
		ed change. She described	P.	8			92	
		nd not formed. NA #6						
	stated it was her norm							
		nurse but was unable to						

OLIVILIV	O TON WEDICANE &	WILDIOAID SERVICES				OIVIE	3 190. 0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CO	(X3) DATE SURVEY COMPLETED		
		345426	B. WING				03/28/2013
NAME OF PR	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	/IEW CARE & REHAB CI	ENTER			KENT STREET DREWS, NC 28901		
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F 157	Continued From page	. 3	F	157			
	to the hall nurse.	. 0	4	157			6
	An interview was con #3 on 03/27/13 at 3:0 worked 01/05/13 and Nurse #3 did not reca regarding Resident # first week in January a stomach virus and I A review of Resident 01/05/13 through 01/documentation of rep stool consistency and Review of a nursing management of the stool consistency and Review of a nursing management of the stool consistency and Review of a nursing management of the stool consistency and Review of a nursing management of the stool consistency and stool cons	#39's nursing notes from 10/13 revealed no orting laxative results or frequency to the physician. ote dated 01/10/13 at 9:00 intation that Resident #39 incute care facility for					
	01/10/13 and written I physician was conducted Resident #39 was ser treatment of bilateral I The resident started to assessments in the wincrease in pulse and pressure. The resident emergency department the ED Resident #39 distended abdomen a digital rectal examinat	ound clinic revealed an a decrease in blood on the was sent to the ont (ED) for evaluation. In was assessed with a ond no bowel sounds. A ion by the ED physician					
		f hard impacted stool. An ed a fecal impaction with colon.					
	Review of a Discharge	Summary dated 01/18/13					

CLITTLI	OT OTT MEDIO, THE G	WEDIO/ IID OLIVVIOLO					WID 110. 0000 0001	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		345426	B. WING				03/28/2013	
NAME OF PR	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY	IEW CARE & REHAB CE	ENTER		5	551 KENT STREET			
VALLET	IEW OAKE & KENAD OF	INTER		P	ANDREWS, NC 28901			
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F 157			F	157	Ti and the second secon			
		9 was sent back to the long						
0	term care facility with fecal impaction.	diagnoses including severe						
	An interview was con-	ducted via phone on						
		with the Medical Director						
		hysician for Resident #39.						
		he visited the facility on						
		ally informed by the nurses						
		ion of enemas and the	1					
	constipation problems	s exhibited by the resident.			100			
·	He stated he examine	ed Resident #39 and					If.	
	described his findings	in the physician's progress						
	notes of 01/04/13. Th	ne MD stated he changed						
	the resident's medica	tions as was also						
		ogress notes. He stated he						
	does not recall being							
	The state of the s	movements after his orders						
	were written on 01/04							
		ld the resident was having						
		he MD stated he wanted the						
		t not watery. If he had						
		y and frequency of the would have adjusted the						
		s, ordered an abdominal						
		nurses to perform a digital						
		check for impaction. The						
		owel movements could						
	The property of the second second second second second second second second second second second second second	ng around an impaction.						
	An interview with the	Director of Nursing on	18					
	03/28/13 at 2:25 PM r							
	nurses to notify the ph							
		cted results from laxatives.						
F 248	483.15(f)(1) ACTIVITI		F	248				
	INTERESTS/NEEDS				!			
200								
	The facility must provi	de for an ongoing program						

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		345426	B WING		03/28/2013	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER				STREET ADDRESS, CITY, STATE ZIP COD 551 KENT STREET ANDREWS, NC 28901		
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F 243 Continued From page 5

of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced

Based on observations, record review, review of activity interest assessments, and staff interviews, the facility failed to involve residents in preferred activities for 2 of 3 residents reviewed for activities. (Residents #3 and #12)

The findings included

 Resident #3 was admitted to the facility on 07/26/12 with diagnoses including dementia. congestive heart failure, and osteoarthritis. An admission Minimum Data Set (MDS) completed 03/07/12 included an interview for activity preferences. Resident #3 indicated listening to music, doing things with groups of people, going outside when the weather was good, and participating in religious practices were all very important to her. A quarterly MDS completed 01/13/13 revealed Resident #3 had short and long term memory problems, moderate difficulty with hearing, and was understood and usually understands. The quarterly MDS further revealed Resident #3 required extensive assistance with locomotion on the unit.

Review of Resident #3's most recent "Activity Interest Assessment" dated 11/13/12 stated her interests were music and TV (television) and the common settings for the resident's activities were in room and out of room. The assessment also

F 248 F

- A. Resident #3 and #12 whom are room mates, were provided a radio in their room for music on 4/3/13 by Activity Director. Resident #3 and #12 were given their baby dolls during the survey ands several residents were noted to have baby dolls under their blankets as the residents stated it was cold outside and they were keeping them warm.
- B. The Activity Director was inserviced on 4/3/13 by the Regional Director of Clinical services regarding activity assessments and documentation of preferences. documentation of activity participation, care planning the individual preferences of the resident and providing activities to residents according to their interest. An audit was completed by the Activity Director on 4/4/13 of all resident activity preferences and care plans reflecting the resident preferences, Care Plans were revised at the time of the audit

Facility ID 923155

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F 248	Continued From pag	e 6	F	248	
	Resident #3 had an allittle involvement in a thought process. The participate in at least next review. Interve passive activities and watching TV as exart Review of Resident for February 2013 reon two occasions, he attended two music special events. Duri Resident #3 observe had six one to one vactivities, and attendables.	ewed 01/2013 stated activity intolerance due to activities related to impaired be goal was for Resident #3 to two activities a week by the intions included providing disted listening to music and		C. The ED will audit 5 reper week for 4 weeks residents per week for then 5 residnets per reflect resident prefer activities, care plans the resident preferent that the resident is pactivities per resident preferences. D. the results of the audit reviewed monthly by Committee and adjumill be mad3e as need the Plan of Correction.	s, 3 or 4 weeks, month for it will erences for reflecting nces and provided it dits will be y the Q1 istment cessary t
	- 03/25/13 at 12:2 chair at a dining root wall to her right. The - 03/25/13 at 2:15 chair in the hallway Resident #3 had her a baby doll 03/26/13 at 10: chair just outside of baby doll was obserwas awake and the observed in the dining the chair in the dining the chair just outside of baby doll was obserwas awake and the observed in the dining the chair just outside of baby doll was observed in the dining the chair just outside of baby doll was observed in the dining the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside of the chair just outside outside of the chair just outside out	sident #3 were as follows. 25 PM- Sitting in her wheel m table with the TV on the e TV was on with no sound 5 PM- Sitting in her wheel across from her room. e eyes closed and was holding 15 AM- Sitting in her wheel the dining room doors. No ved at that time. Resident #3 Activity Director was no room reading to a group of vity Director was not observed prior to the activity.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
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F 248	- 03/26/13 at 3:35 chair in the hallway ac eyes closed. No baby time 03/26/13 at 6:30 chair at a dining room wall to her right. The - 03/27/13 at 8:15 chair at a dining room wall to her right. The - 03/27/13 at 9:30 chair in the hallway ac Talking with a staff me observed at that time 03/27/13 at 10:50 were noted on Reside - 03/27/13 at 2:15 chair in the hallway ac eyes closed. Bingo w room. Staff were note #3 to Bingo. No baby time 03/27/13 at 2:45 ft Resident #3 to her roor returned her to the hall No baby doll was obse - 03/28/13 at 8:20 ft chair in the hallway ac a day and the hallway ac a baby doll. An interview was cond Director on 03/28/13 at 8:dent #3's activity i assessment she comp	PM- Sitting in her wheel cross from her room with her y doll was observed at that PM- Sitting in her wheel table with the TV on the TV was not on. AM- Sitting in her wheel table with the TV on the TV was not on. AM- Sitting in her wheel table with the TV on the TV was not on. AM- Sitting in her wheel cross from her room. Ember. No baby doll was a AM- Several baby dolls not #3's bed. PM- Sitting in her wheel cross from her room with her as in progress in the dining observed inviting Resident doll was observed at that the PM- Nurse Aide took are and laway outside of her room. Envel at that time. AM- Sitting in her wheel table with her back to the table with her back to the table with the Activity the Sitting in her wheel tross from her room holding the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the table with the Activity the Sitting in the situation of the situation of the situation of the situation of the situation of the situation of the situation of the situation of the si	F	248				

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VALLEY	VIEW CARE & REHAB CI	ENTER		100000000000000000000000000000000000000	KENT STREET			
	THE WINE WILLIAMS OF			AND	PREWS, NC 28901			
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F 248	Continued From page	s 8	_	0.40				
2 37 1.5	11 1120		r	248				
		ne could bring to resident ovided this activity for						
		tivity Director felt Resident						
		s of music she enjoyed.						
		f the dining room TV being						
	off and/or with out so	und were shared with the						
		stated TV was marked daily		li li				
		ance log as a passive activity						
		n the dining room. The	1					
		er stated she was aware						
	Resident #3 enjoyed	holding a baby doll and tried						
	to give baby dolls to t	he residents when she was					10	
	able but thought the r	urse aides (NAs) assisted						
	with this as well. With	regards to the reading						
		ne Activity Director stated					3	
	she took as many res	idents to the activity as her					ř.	
	time allowed and she	did not take Resident #3.						
	An interview with Nurs	se Aide (NA) #7 on 03/28/13					2	
		she was aware Resident #3					25	
	enjoyed holding baby	dolls. When asked why						
	Resident #3 spent the	majority of her day in the					7	
	hallway NA #7 stated	Resident #3 was at risk for					ii .	
		s placed in the hallway so		ľ.				
	staff could keep an ey	e on her.						
1		03/28/13 at 11:15 AM the						
	Administrator stated s	he expect Resident #3 to					(4	
		referred activities including						
	music, TV, and baby of							
		tated Resident #3 was hard	N.				~	
	The state of the s	ly could not hear the TV in					1	
		s it was turned up very loud.					ı	
		evealed the NAs usually	il.					
		ir dolls when they got them	1	8			II.	
	up in the morning. At							
	interview the Administ			1				
	could do a petter Job W	rith activities and would						

F 248 Continued From page 9 correct the problem. 2. Resident #12 was readmitted to the facility on 11/28/09 with diagnoses including Alzheimer's Disease, dementia, coronary artery disease, and osteoarthritis. An annual Minimum Data Set (MDS) completed on 10/11/12 revealed Resident #12 had long and short term memory loss, was understood and could sometimes understand, and could not complete the interview for activity preference. Staff assessment for activities was completed and indicated Resident #12 liked to participate in religious activities. In addition, the annual MDS noted Resident #12 required extensive assistance with locomotion on the unit and had moderate difficulty with hearing. A Care Area Assessment (CAA) summary completed with the annual MDS stated activities triggered because Resident #12 was unable to complete the activity preference assessment.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
VALLEY VIEW CARE & REHAB CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 9 correct the problem. 2. Resident #12 was readmitted to the facility on 11/28/09 with diagnoses including Alzheimer's Disease, dementia, coronary artery disease, and osteoarthritis. An annual Minimum Data Set (MDS) completed on 10/11/12 revealed Resident #12 had long and short term memory loss, was understood and could sometimes understand, and could not complete the interview for activity preference. Staff assessment for activities was completed an indicated Resident #12 liked to participate in religious activities. In addition, the annual MDS noted Resident #12 required extensive assistance with locomotion on the unit and had moderate difficulty with hearing. A Care Area Assessment (CAA) summary completed with the annual MDS stated activities triggered because Resident #12 was unable to complete the activity preference assessment.			345426	B. WING		**************************************		03/28/2013	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 248 Continued From page 9 correct the problem. 2. Resident #12 was readmitted to the facility on 11/28/109 with diagnoses including Alzheimer's Disease, dementia, coronary artery disease, and osteoarthritis. An annual Minimum Data Set (MDS) completed on 10/11/12 revealed Resident #12 had long and short term memory loss, was understood and could sometimes understand, and could not complete the interview for activity preference. Staff assessment for activities was completed and indicated Resident #12 liked to participate in religious activities. In addition, the annual MDS noted Resident #12 required extensive assistance with locomotion on the unit and had moderate difficulty with hearing. A Care Area Assessment (CAA) summary completed with the annual MDS stated activities triggered because Resident #12 was unable to complete the activity preference assessment.			ENTER		551	KENT STREET			
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The CAA summary further stated Resident #12 had to be assisted to activities and seemed to enjoy church services and singing. The CAA summary revealed Resident #12 enjoyed sitting in the hall way watching staff and keeping her baby doll when she was up in her wheel chair and/or in bed. A care plan last reviewed 12/2012 stated Resident #12 had an activity intolerance due to little involvement in activities related to an impaired thought process. The goal was for Resident #12 to participate in at least two activities a week by the next review. Interventions included providing passive activities and listed listening to music, watching TV, books,		correct the problem. 2. Resident #12 was 11/28/09 with diagnost Disease, dementia, consteoarthritis. An annoted (MDS) completed on the work of the wo	readmitted to the facility on ses including Alzheimer's pronary artery disease, and sual Minimum Data Set 10/11/12 revealed Resident at term memory loss, was sometimes understand, the the interview for activity essment for activities was sed Resident #12 liked to activities. In addition, the esident #12 required with locomotion on the unit ficulty with hearing. Then (CAA) summary mual MDS stated activities sident #12 was unable to preference assessment. There stated Resident #12 activities and seemed to and singing. The CAA sident #12 enjoyed sitting in staff and keeping her baby in her wheel chair and/or in least. The goal was for pate in at least two anext review. providing passive activities	F	248				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345426	B. WING				03/28/2013
	ROVIDER OR SUPPLIER	ENTER		551	T ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901		30/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 248	Continued From name	10					4
1 240	plan noted Resident #	#12 should be provided with d a baby doll she enjoyed	F	248			
	Interest Assessment" interests were music	12's most recent "Activity dated 01/17/13 stated her and TV (television) and the he resident's activities were om.					
	for February 2013 rev on two occasions, had attended one music a During the month of M observed Bingo on the	ctivity, and had a manicure. Plarch 2013 Resident #12 Pree occasions, had three Pred two music activities. Pred daily as a passive					
	- 03/25/13 at 12:20 dining room with her bon with no sound 03/25/13 at 2:15 fichair in the hall way no had her eyes closed. at that time 03/26/13 at 10:10 chair just outside of the baby doll was observed #12 was awake and the observed in the dining residents. The Activity inviting Resident #12 p	room reading to a group of Director was not observed prior to the activity.					
	 03/26/13 at 3:35 F chair in the hall way ne 	PM- Sitting in her broda ear her room. Resident #12 No baby doll was observed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2011-000-000-00-00-00-00-00-00-00-00-00-0		ONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345426	B. WING				03/28/2013
	ROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901		KENT STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	
	room at a table. The #12 had her back to the order of their returned her to the returned her to the returned her to the returned her to the returned her to the order of their returned her to the returned her to the order of their returned her to the order of order of order or	AM- Sitting in the dining TV was not on and Resident the TV. AM- Staff member returned from to provide care and the hall way near her room. Ad at that time. AM- A baby doll was noted diside table. PM- Sitting in her broda the half was not on and Resident #12 No baby doll was observed that in progress in the dining TW was not on and Resident the TV. AM- Sitting in her broda the TV. AM- Sitting in the dining to be the dining to be the true true the true	F	248			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	N	(X3) DATE SURVEY COMPLETED	
		345426	B. WING			03/28/2013	
	ROVIDER OR SUPPLIER VIEW CARE & REHAB CI	ENTER		STREET ADDRESS, C 551 KENT STREE ANDREWS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC)	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 248	nurse aides (NAs) as regards to music Bing Director stated she to activity as her time al Resident #12. An interview with Nur at 10:50 AM revealed majority of her day in Resident #12 was at	vas able but thought the sisted with this as well. With go on 03/25/13 the Activity ook as many residents to the lowed and did not take se Aide (NA) #7 on 03/28/13 Resident #12 spent the the hallway NA #7 stated risk for falls and therefore loway so staff could keep an	F	248			
	Administrator stated as be provided with her provided with her provided. TV, and baby administrator further a hard of hearing and p TV in the dining room very loud. The interviusually gave the resid got them up in the mothe interview the Admicould do a better job accorrect the problem. 483.15(h)(2) HOUSEMAINTENANCE SER The facility must provimaintenance services sanitary, orderly, and	stated Resident #12 was robably could not hear the unless it was turned up ew further revealed the NAs lents their dolls when they rning. At the conclusion of inistrator stated the facility with activities and would CEEPING & VICES de housekeeping and necessary to maintain a	F 2	53			
	by:	is and staff interviews, the				я	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 100 MISSE 50 C		ONSTRUCTION	(X3) DATE COMP	SURVEY
		345426	B WING			03/	28/2013
NAME OF PR	OVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW CARE & REHAB CE	NTER		7,000,000,000	DREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	rooms in good repair of 1 shower rooms and The findings included On 03/28/13 at 8.26. A facility with the Mainte following environment as In Room 109, note to the wall unit for both not occupied and Becand oriented resident on the bedside tables. But In Room 115, a bilityer of drywall behin was observed, measured by 12 inches lon scrapes into the gyps the break. Drywall of the right of the bathrous approximately two feed metal corner support inside of the door frantoed scrapes and chelectrical outlet cover which the wall heating plugged was cracked of the cover missing a box. The lower metal observed covered in the cover missing a box. The lower metal observed covered in the cover missing a control of the cover metal observed covered in the cover metal observed covered in the cover missing a covered covered in the cover missing a covered covered in the cover metal covered in the cover metal covered in the cover metal covered in the cover	a shower room and resident and wheelchairs clean for 1 and 10 of 41 rooms observed. AM during a tour of the enance Director, the tal concerns were observed. Call bell cords were attached the A and B beds. Bed A was as Bed B was occupied by an alert. Cow bells were observed for both Beds A and B. Treak through the gypsum of the headboard of Bed B wring approximately 2 inches and the headboard of Bed B wring approximately 2 inches and with multiple deep for a corner section of wall to bom door was cracked bet up from floor, exposing a funder the drywall. On the me of the bathroom were hips in the paint. An to the right of and into grain conditioning unit was the upper right hand corner and exposing the electrical I frame of Bed A was	F	253 A	a. "Cow bell" was replaced with diff type of bell. Simplex Grinnell repaire bell system in 109 on 4/17/13. In the interim, a walkie talkie was given to resident to allow the resident access table to notify the nurses station. b. It is wall bed guards were installed, in corner guard, door frame was repain outlet cover was replaced, bed a was sprimed, and painted. c. Room #116 guard was installed. d. Room #116 guard was installed. d. Room #118 wheelchair was cleaned, door frame was replaced. resealed commode. e. Room wheel chair was cleaned, arm rest we replaced. f. #121 area was repainted light cover was replaced. g. Bathroo between #128 and #132 commode between #128 and #132 commode between #128 and hase board was repain Room #132 window has been orderewill be replaced by 4-19, arm rests heen replaced, and light cover replace of 136 light cover replaced. Shower room on D hall tiles were repaind ventilation cover in ceiling was of the facility acknowledges that all repair the potential to be affected by the deficient practices and corrective act accomplished by checking all rooms assure call bells are functioning, has checked all windows for obstruction to the outside, bed guards being instarooms identified having cracks, instructions in areas identified as them, all door frames have been repaall commodes have been regrouted, a chairs have been cleaned, all light co and outlet covers with cracks have breplaced, all armchair pads with crarips have been replaced.	the obe Room installed ted, sanded, corner was #119 re and m asse was red h. d and ave ced i. m 139 k. cleaned. Sidents in to the corner was it to the corner was it to the corner was red h. d and ave ced i. m 139 k. cleaned. Sidents in the corner was red h. d and ave ced i. m 139 k. cleaned cleaned. Sidents in the corner was red	
	observed along a cor- window, running from	ner wall in the vicinity of the floor to ceiling					

PRINTED: 04/10/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901		OF DEFICIENCIES CORRECTION	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
VALLEY VIEW CARE & REHAB CENTER 551 KENT STREET ANDREWS, NC 28901			345426	8 WNG		03/28/2013	
DOMADED DIAM DE CORRECTION DE			ENTER	s	551 KENT STREET ANDREWS, NC 28901		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION PROPERTY (EACH CORRECTION SHOULD BE COMPLETED FROM THE PROPERTY OF LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP	D BE COMPTE.	TION
F 253 Continued From page 14 a. In Room 115, the metal frame of a wheelichair was covered in dust and debris. On the inside and outside of the door frame of the bathroom were sorapes and chips in the paint. The bathroom floor at the base of the commode was discolored brown. E In Room 119, the metal frame of a wheelichair was covered in dust and debris with cracked armisess. Small pieces of vinyl covering were missing from the armrests exposing fabric covering underneath. I In Room 121, drywall on right nand side when entering the room near bed A was scraped. Brown stains were observed on the ceiling in the vicinity of the privacy curtain track between Beds. A and B In the bathroom, the wall to the right of the door upon entering the bathroom was scraped. The plastic light cover on the light over bed A was cracked and missing a piece measuring approximately 2 inches by 2 inches. g In the shared bathroom between Rooms 128 and 130, the floor and grout at the base of the commode, vinyl baseboard was observed pulling away from the wall. h In Room 132, the bottom half of the double-paned window was observed covered with a white opaque film, sandwiched between the layers of the glass, which obstructed approximately 2) percent of the vew to the outside. On the armrests of a wheelchair, small pieces of vinyl covering were missing, exposing fabric covering underneath.	F 253	d. In Room 118, the was covered in dust a and outside of the doc were scrapes and chi bathroom floor at the discolored brown e. In Room 119, the was covered in dust a armrests. Small piece missing from the arms covering underneath f. In Room 121, dryw entering the room nea Brown stains were ob vicinity of the privacy. A and B. In the bathrest the door upon entering scraped. The plastic bed A was cracked as measuring approximate. The floor and commode were discoof the commode, viny pulling away from the h. In Room 132, the double-paned window a white opaque film, slayers of the glass, whapproximately 50 percoutside. On the armrepieces of vinyl coverir	metal frame of a wheelchair and debris. On the inside or frame of the bathroom ps in the paint. The base of the commode was metal frame of a wheelchair and debris with cracked as of vinyl covering were rests exposing fabric. vall on right hand side when as bed A was scraped served on the ceiling in the curtain track between Beds dom, the wall to the right of g the bathroom was light cover on the light over and missing a piece stelly 2 inches by 2 inches throom between Rooms 128 d grout at the base of the lored brown. In the vicinity I baseboard was observed wall bottom half of the vicind was observed covered with sandwiched between the decit of the view to the lests of a wheelchair, smalling were missing, exposing	F 25	Monday thru Friday during "mock Su rounds for issues not in compliance. A "homework" sheet will be filled out and the person responsible for correcting th problem. Will be discussed daily Mond Friday at morning meeting. Once corremade, the homework sheets will be turn Administration. Mock Survey rounds a by all department managers with the exthe MDS Co-ordinator. D. Monitoring will be done daily Mon Friday during mock survey rounds of findings will be reported at mostand up meeting. Mock Survey rounds of done by department managers with exception of the MDS co-coordinat Results of monitoring will also be r to QI committee monthly for 4 mor	rvey" I given to ne lay thru ections are need in to nre done reception of Iday thru s. Results orning ounds are h the tor. reported	343

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID 923155

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		345426	B. WING		03/28/2013
	ROVIDER OR SUPPLIER	CENTER	551	T ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 253	light over Bed A wai irregular shaped pie 2 inches by 3 inches j. In Room 139, the of the commode we k. In the Shower R ceramic floor tiles, e inches and located tub, were loose with square metal ventilal entrance to the show substance, along the in the middle of the On 03/28/13 at 8:26 facility, the Maintenainterviewed. He state housekeeping staff maintenance concerthe problem was, or they would place as He stated the drywainches by 3 inches and 10 inches inches in the middle of the concertion of the problem was, or they would place as He stated the drywainches in the problem was, or they stated the drywainches in the problem was, or they stated the drywainches in the problem was, or they stated the drywainches in the problem was, or they stated the drywainches in the problem was, or they stated the drywainches in the problem was in the	cracked light cover on the wall is observed, with a missing one measuring approximately is a floor and grout at the base are discolored brown coom located on D Hall, 7 each measuring 2 inches by 2 between the shower and the rout surrounding grout. A sation cover in the ceiling by the over was covered in a black are sides facing the shower and cover.	F 253		
	equipment. In Roor Director showed wh was attached to the A to protect the wall would like to comple receipt of supplies a stated department h assigned to their own identifying and report meetings. The Mair nurse call bell system	n 113 the Maintenance ere a piece of painted wood wall behind the head of a Bed , stating this is a project he ete with painting, pending nd warmer weather. He eads walked through rooms ersight each morning, rting issues during morning intenance Director stated the m was tested daily with rooms per corporate policy. He			1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	(X3) DATE SURVEY			
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A BUILD		CON	MPLETED		
		345426	B. WING			03/28/2013		
	ROVIDER OR SUPPLIER			STEELS CONTRACT	ET ADDRESS, CITY, STATE, ZIP CODE KENT STREET			
VALLEY \	/IEW CARE & REHAB CI	ENTER		ANI	DREWS, NC 28901			
(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 253	Stated Room 109 had an electronic problem in the call bell wall box and had not been functioning for a couple of months. He stated he was awaiting approval for funding of another wall box. The Maintenance Director requested his assistant to immediately replace the electrical outlet cover in Room 115 during the facility tour. He stated he had a window specialist assess the condition of the window in Room 132 on an unspecified date and was told it would have to be replaced. He stated if replacement light covers over the beds could not be found on the Internet he would replace the entire fixture. The Maintenance Director stated loose floor tile in the shower room required repair to prevent accidents. He stated that he had no printed records of recent work requests or planned projects. He stated the Maintenance Department was responsible for wheelchair repairs and the Housekeeping Department was responsible for cleaning them.		F	253				
On 03/28/13 at 9:40 AM the Environment of the Environment was responsible for wheelchairs and she directed the to do this every Wednesday bases schedule. She stated this rotating should have resulted in each wheelcoked at every two weeks, but the dust and debris noted on tour was with the schedule. The Environment Manager stated if during the clear wheelchairs mechanical or repair noted, she expected Housekeeping these findings to the Maintenance She stated her expectation of House repair concerns in reside report these findings using a printer		as interviewed. She stated responsible for cleaning directed the floor technician mesday based on a rotating of this rotating schedule in each wheelchair being weeks, but the amount of don tour was not consistent the Environmental Services wing the cleaning of ical or repair concerns were Housekeeping staff to report Maintenance Department. Cotation of Housekeeping staff terns in resident rooms and				5		

PRINTED: 04/10/2013

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	80 (6)	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345426	B. WING			03/28/2013	
	OVIDER OR SUPPLIER EW CARE & REHAB CE	NTER		STREET ADDRESS. 551 KENT STRE ANDREWS, NO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX (EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309 4 SS=G +	interviewed. She state for warmer weather to painting where require maintenance assistant assist with facility conditions stated Department He Survey/Quality Assuration morning rounds of assuppon completion of more stated communicated to the Materian stated communication. Homework Sheet with description, a column to the stated approval was given a column to the stated approval was given a condition of the stated approval was given a condition of the stated approval was given a condition of the stated her expectation. Director and Environm develop plans address concerns. 483.25 PROVIDE CARALIGHEST WELL BEIN Each resident must record to the necessary or maintain the highest mental, and psychosocial accordance with the condition of care.	M the Administrator was eed the facility was waiting permit drywall repair and ed. She stated a transport was recently hired to beens. The Administrator ads used a Mock once form during their signed rooms. She stated bring rounds any facility of at morning meetings and Maintenance Director. She was facilitated by use of a room number, date, task for noting completion of the morning meetings and waintenance completion of the Maintenance went to purchase the parts wall bell in Room 109. She of the Maintenance ental Services Manager to ing the noted facility RE/SERVICES FOR G		253 I A. B.	Resident #39 bowel documentation was reviewed 3/27/13 for any other indicate of change in bowel habits to indicate constipation or risk of fecal impaction and none were noted. An audit of all current facility residents for changes in bowel consistency was completed on 3/27/13 and no other resident were noted to have changes or presence of fecal impaction. All Licensed Nurses and C.N., were re-educated beginning 3/27/13 on the responsibility to report changes in bowel habits include changes in consistency unexpected results to treatment to the Licensed Nurses via the Stop And Watch INTERACT tool. The Licensed Nurses will evaluate the resident and notifice Physician of any changes in condition.	A.'s s to or ots	

INMIE OF PROVIDER OR SUPPLIER VALLEY YIEW CARE & REHAB CENTER VALLEY YIEW CARE & REHAB CENTER VALUE YIEW CARE & REHAB CENTER VALUE YIEW CARE & REHAB CENTER SUMMAY STATEMENT OF DETICIONESS IN PROVIDER OR SUPPLIER SYNEST STREET ANDREWS, NC 28901 FREETX ARCOMERS PLANT CORRECTION (RAY) D REPORT RECORD SHOULD BE CANSESSEE REPORT WILL REGULATION ON ISC DESTIPMENT WORKMANDON FREETX ARCOMERS PLANT CORRECTION CANSESSEE RERECTION CANSESSEE REPORT WAS COMMENTED TO DETICIONES Based on staff and physician interviews, and medical record review, the facility failed to assess a resident regarding bowel movement frequency and consistency for 1 of 11 residents reviewed for bowel movements (Resident #39). The findings included: Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia. An admission Minimum Data Set (MDS) dated CO9/11/12 indicated impared cognition and dependence on extensive staff assistance for all care including eating. The MDS spain assessment noted Resident #39 reverted pain medications as needed and no signs of experienced pain were observed in the past 5 days. A quarterly MDS cated 12/03/12 was unchanged. A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel patterns. A care plan goal was to keep the resident clean and dry and decrease the number of mountment episodes over next amonths and other throughous the report of mountment episodes over next amonths included unsers would monitor bowel patterns. A care plan related to alteration in confort and cated 09/11/12 specified Resident #39 experienced acute pain episodes. The care plan goal was for the resident not to expenence unreleved pain. Interventions included unsers on the care plan goal was for the resident to the expenence unreleved pain interventions. Included	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER NAPID PRETTY REGULATORY OR LSC IDENTIFYING INFORMATION FROM CONSECUENCY IN THE APPROPRIATE PROVIDER SHALL OF CORRECTION PROVIDER SHALL OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION FROM CONSECUENCY IN THE PROPERTY IN THE P				2 2 5				
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. 2P CODE SSI KENT STREET ADDRESS. CITY. STATE. 2P CODE SIX KENT STREET. ADDRESS. CITY. STATE. 2P CODE SIX KENT STREET. ADDRESS. CITY. STATE. 2P CODE SIX KENT STREET. ADDRESS. CITY. STATE. 2P CODE SIX KENT STREET. ADDRESS. CITY. STATE. 2P CODE SIX KENT STREET. ADDRESS. CITY. STATE. 2P CODE SIX KENT STATE. 2P CODE SIX KENT SOULDED. COMMITTED ADDRESS. CITY. STATE. 2P CODE SIX KENT SOULDED. COMMITTED ADDRESS. CITY. STATE. 2P CODE SIX KENT SOULDED. COMMITTED ADDRESS. CITY. STATE. 2P CODE SIX KENT SOULDED. COMMITTED ADDRESS. CITY. STATE. 2P CODE SIX KENT SOULDED. COMMITTED ADDRESS. CITY. STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CODE SIX STATE. 2P CO								
An admission Minimum Data Set (MDS) dated O9/11/12 indicated impaired cognition and dependence on extensive staff assistance for all care including eating. The MDS specified the resident was incontinent of bowel always and no problems with constipation were identified. The MDS pair assessment noted Resident 12/39 received pain were observed in the past 5 days. A quarierly MDS dated 12/03/12 was unchanged. A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder. The care plan goal was for the resident in comfort and dated 09/11/12 potential or comfort and dated 09/11/			345426	B WING	_		03/28/2013	
INAID REWS, NC 28901 INAID SUMMARY STATEMENT OF DEFICIENCIES PRETEX TAG SEGUATORY OR LSC IDENTIFYING INFORMATION) FASTER TAG COntinued From page 18 by. Based on staff and physician interviews, and medical record review, the facility falled to assess a resident regarding bowel movement frequency and consistency for 1 of 11 residents reviewed for bowel movements (Resident #39). The findings included: Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia. An admission Minimum Data Set (MDS) dated 09/11/12 indicated impaired cognition and dependence on extensive staff assistance for all care including eating. The MDS pain assessment noted Resident #39 received pain medications as needed and no signs of experienced pain were observed in the past 5 days. A quarterly MDS dated 12/09/12 was unchanged. A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder. The care plan goal was to keep the resident clean and dry and decrease the number of incontinent episodes over next 3 months. Interventions included nurses would monitor bowel patterns. A care plan episodes cer next 3 months. Interventions included nurses would monitor bowel patterns. A care plan episodes cer next 3 months. Interventions included nurses would monitor bowel patterns. A care plan episodes. The care plan goal was for the resident not to experience unreleved pain. Interventions included urses would monitor bowel patterns. A care plan passed set patterns. A care plan episodes. The care plan goal was for the resident not to experience unreleved pain. Interventions included urses would monitor boxel patterns. A care plan passeds. The care plan goal was for the resident not to experience unreleved pain. Interventions included	NAME OF PR	OVIDER OR SUPPLIER						
PROJUD SUMMARY STATEMENT OF DEFICIENCIES FRETX REGULATION COLLECTION STOLLOGS FRETAX REGULATION COLLECTION STOLLOGS FRETAX REGULATION COLLECTION STOLLOGS FRETAX REGULATION COLLEGE FRETX TAG FROM COLLEGE FRETX REGULATION COLLEGE FRETX TAG FROM COLLEGE FRETX TAG FROM COLLEGE FRETX FAG FR FRETX FAG FRETX FAG FR FR FR FR FR FR FR FR FR FR FR FR FR	VALLEY V	IEW CARE & REHAB CE	ENTER					
FREIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) FOR CONTINUED FROM PROPERTIES COORDINATE RECOVERY TYPE OR INFORMATION TAG COORDINATE RECULATORY OR LSC IDENTIFYING INFORMATION) FOR CONTINUED FROM PROPERTIES COORDINATE REPROPERTIES APPROPRIATE DEFICIENCY FOR CONTINUED FROM PROPERTIES COORDINATE TO THE ED/IDCS/1 hit Manager will audit a maximum of 5 residuents for how ell movement frequency and consistency for 1 of 11 residents reviewed for bowel movements (Resident #39). The findings included: Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia. An admission Minimum Data Set (MDS) dated 09/11/12 indicated impared cognition and dependence on extensive staff assistance for all care including eating. The MDS specified the resident was incontinent of bladder frequently and bowel always and no problems with constipation were observed in the past 5 days. A quarterly MDS dated 12/09/12 was unchanged. A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder. The care plan goal was to keep the resident clean and dry and decrease the number of incontinent episodes over next 3 months. Interventions included nurses would monitor bowel patterns. A care plan related to alteration in comfort and dated 09/11/12 specified Resident #39 experienced acude pain episodes. The care plan goal was for the resident not to experience unreleved pain. Interventions included		CIRCIA POR CT	ATEMENT OF DEFICIENCIES			**************************************		(VE)
by: Based on staff and physician interviews, and medical record review, the facility failed to assess a resident regarding bowel movement frequency and consistency for 1 of 11 residents reviewed for bowel movements (Resident #39). The findings included: Resident #39 was admitted to the facility 09/02/12 with diagnoses including chronic constipation, chronic pain, muscle weakness, and dementia. An admission Minimum Data Set (MDS) dated 09/11/12 indicated impaired cognition and dependence on extensive staff assistance for all care including eating. The MDS specified the resident was incontinent of bladder frequently and bowel always and no problems with constipation were identified. The MDS pain assessment noted Resident #39 received pain medications as needed and no signs of experienced pain were observed in the past 5 days. A quarterly MDS dated 12/09/12 was unchanged. A care plan dated 09/11/12 documented Resident #39 was incontinent of bowel and bladder, The care plan goal was for the resident and dated 09/11/12 specified Resident #39 experienced acute pain eleted to alteration in comfort and dated 09/11/12 specified Resident #39 experienced acute pain episodes. The care plan goal was for the resident not to experience unrelieved pain. Interventions included	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
administer pain medication per physician's order and monitor effectiveness. There was no		by: Based on staff and p medical record review a resident regarding b and consistency for 1 bowel movements (Re included: Resident #39 was add with diagnoses includ chronic pain, muscle w An admission Minimul 09/11/12 indicated im dependence on exten care including eating, resident was incontine bowel always and no were identified. The M Resident #39 received needed and no signs observed in the past 5 dated 12/09/12 was u A care plan dated 09/ #39 was incontinent o care plan goal was to dry and decrease the episodes over next 3 in included nurses would care plan related to all dated 09/11/12 specifi experienced acute pai goal was for the reside unrelieved pain. Inter- administer pain medic	hysician interviews, and with the facility failed to assess a cowel movement frequency of 11 residents reviewed for resident #39). The findings mitted to the facility 09/02/12 ing chronic constipation, weakness, and dementia. In Data Set (MDS) dated paired cognition and sive staff assistance for all. The MDS specified the ent of bladder frequently and problems with constipation MDS pain assessment noted do pain medications as of experienced pain were of days. A quarterly MDS inchanged. 11/12 documented Resident of bowel and bladder. The keep the resident clean and number of incontinent months. Interventions of monitor bowel patterns. A teration in comfort and led Resident #39 in episodes. The care plan ent not to experience ventions included ation per physician's order	F	309	audit a maximum of 5 resider for bowel movement frequences resident is not experiencing a change in condition; and/or if they are experiencing a change in condition, that the physician notified. Monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks and then 1 x monthly for months. The results of the au will be reported monthly to Q Committee x 10 months for continued substantial complia and/or revision.	nts cy to was	4-25-13

	ATEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		ON	(X3) DATE SURVEY COMPLETED		
		345426	B. WING			03/28/2013
	ROVIDER OR SUPPLIER	ENTER	•	STREET ADDRESS, 551 KENT STRE ANDREWS, NO		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 309	addition of Chronular The physician also of suppositories to be a review of physician of dated 01/04/13 to sure A review of the 01/07 revealed the laxative the MAR but were not the MAR indicated the Senna-S and Miralar administered twice e added and initialed at An interview was corn#2 on 03/27/13 at 6:15 she worked nights at she administered the ordered by the physicinitial the MAR. Nurse documented by the Note that the detailed entry report.	to twice a day, and the c 30 mililiters (ml) at bedtime.	F	309		
	report reveled docum regarding frequency movements. On 12/3 bowel movements we formed and was docu 01/04/13 a medium for documented at 2:16 and a large loose sto An interview with Nur 03/28/13 at 8:29 AM, worked 01/03/13 and	nentation by nurse aides and consistency of bowel B1/12 through 01/03/12 no ere documented. A medium umented on 01/03/13. On ormed stool was PM by Nurse Aide (NA) # 1 ol by NA #2 at 10:16 PM. se #1 was conducted on Nurse #1 stated she				

CLITICIT	O I OIT MEDIO/ITE G	WEDIO/ IID OLIVVIOLO				ONID	10.0000001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		INSTRUCTION		TE SURVEY MPLETED
		345426	B. WING				3/28/2013
NAME OF PR	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW CARE & REHAB C	ENTER		0.0000000000000000000000000000000000000	REWS, NC 28901		
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F 309	medium amount of for #4 stated when the property around 3:00 PM on the property of the enemals o	the results as a small to brimed to loose stools. Nurse hysician made rounds 11/04/13, she reported the sto him. Nurse #1 explained to the enemas, results of the on of the physician. She we documented her she did regarding Resident the bowel and bladder revealed on 01/05/13 a large mented at 3:04 AM by NA #3 14, a small loose stool at 10 a large loose stool at 10 a large loose stool at 10 a large loose stool at 10 a large loose stool at 10 a large loose stool sizes AM by NA # 4 and at 10 a large loose stool was 10 a large loose stool was 10 a large loose stool was 10 a large loose stool was 10 a large loose stool was 11 a large loose stool was 12 a large loose stool was 13 a large loose stool was 14 a large loose stool was 15 a large loose stool was 16 a large loose stool was 17 a large loose stool was 18 a large loose stool was 18 a large loose stool was 19 a large loose loose stool was 19 a large	F	309	DEFINITION 1)		
	during the first of Jan Resident #39's stools	uary 2013. She described as runny and watery and she reported the loose					17 P

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/G		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DISTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING			03/28/2013
	OVIDER OR SUPPLIER	CENTER		551 H	I ADDRESS, CITY, STATE, ZIP CODE KENT STREET IREWS, NC 28901	
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F 300	Continued From pa	ao 22	1	200		
1 303			F	309		
	stools to the hall nu	irse.				
	An interview was as	and unted with NA 45 and				
		onducted with NA #5 on M. NA #5 stated she worked				
		i/13. She stated she did report				
		13 because it was so large.				
	NA #5 described Re					
		s of discomfort. NA #5 added				
		dent was having loose stools,				
		ne facility were doing the				
		here was a virus going around				
	involving residents	and the same of th				
		onducted via phone with NA #6				
		PM. NA #6 stated she				
		39 had large stools that		F.		
		e bed change. She described				
		and not formed. NA #6				
		rmal practice to report				
		he nurse but was unable to				
		d the loose stool on 01/06/13				
	to the hall nurse.					
	An intensional	and code of the above to the bloom	8			
		onducted via phone with Nurse :05 PM. She stated she				
		nd 01/06/13 at the facility.				
		call any reports of loose stools				
		#39. She stated during the				
		y several residents developed	19			
	a stomach virus and		Ï			
		nt #39's nursing notes from				
	12/31/12 through 01					
		nemas received or results of				
		assessments related to				
		tency of bowel movements or				
		ere documented. Continued				
	review of nursing no	otes revealed no				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		20 57	TIPLE CO	(X3) DATE SURVEY COMPLETED	
		345426	B. WING			03/28/2013
	ROVIDER OR SUPPLIER	ENTER		551 F	T ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 309	Continued From page 23		F	309		
	documentation of adr suppositories or resu suppositories.	ninistration of laxative Its produced by the				
	AM revealed docume Resident #39's attend specified the physicial	note dated 01/10/13 at 9:00 ntation of a phone call from ding physician. The note in notified the facility that the mitted to an acute care d clinic.				
	A review of a History and Physical (H&P) dated 01/10/13 and written by the acute care facility physician was conducted. The H&P specified Resident #39 was sent to the wound clinic for					
	The resident started to assessments in the waresident exhibited and decrease in blood pre-	lower extremity wounds. o vomit. Nursing round clinic revealed the increased in pulse and a essure. The resident was by department (ED) for		1		
	evaluation. In the ED assessed with a diste bowel sounds. A digit ED physician resulted	Resident #39 was nded abdomen and no tal rectal examination by the I in palpation of hard				
	fecal impaction with d	odominal x-ray showed a ilatation of the lower colon. e pain medication more than se constipation.				1
	01/18/13 revealed Re the long term care fac DS described the resi	ge Summary (DS) dated sident #39 was sent back to sility in stable condition. The dent's hospital course a fecal impaction that				11 15 1-
	included a variety of t diagnoses included se	reatments. Discharge evere fecal impaction and with distended lower bowel.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD	TIPLE CC	(X3)	(X3) DATE SURVEY COMPLETED		
		345426	B. WING				03/28/2013	
NAME OF PR	OVIDER OR SUPPLIER			STREET	FADDRESS, CITY, STATE, ZIP CODE			
VALLEY	IEW CARE & REHAB (ENTER		551 H	KENT STREET			
Charles and at				AND	PREWS, NC 28901			
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F 309	Continued France	- 04	1					
F 309	Continued From pag	Je 24	F	309				
	A review of Resident #39's medical record revealed when the resident returned to the long term care facility, the care plan was not updated to address constipation monitoring or treatment. An interview was conducted via phone on 03/27/13 at 5:49 PM with the Medical Director (MD) that was the attending physician for Resident #39. The MD stated when he visited the facility on 01/04/13 he was verbally informed by the nurses regarding administration of enemas and the constipation problems exhibited by the resident. He stated he examined Resident #39 and described his findings in the physician's progress notes of 01/04/13. The MD stated he changed the resident's medications as was also documented in the progress notes. He stated he does not recall being notified regarding							
	on 01/04/13. He adreports that the residence movements. The M to be loose, but not consistency and free movements, he wou resident's medicatio x-ray, and asked the rectal examination.	ld have adjusted the ns, ordered an abdominal nurses to perform a digital The MD explained loose ould mean stool was moving						
	Nursing (DON) on 0 stated she reviewed January and noted F bowel movements.	nducted with the Director of 3/27/13 at 6:21 PM. She a bowel movement report in Resident #39 was having This report did not specify stated she was unaware of					н	

Facility ID: 923155

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	20 00	X2) MULTIPLE CONSTRUCTION (X3) DATE COME				
		345426	B WNG				03/28	3/2013
	COVIDER OR SUPPLIER	NTER		551 KENT		TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 329 SS=E	she would have though stomach virus diagnost and staff at that time. An additional interview Nursing (DON) was considered and staff at that time. An additional interview Nursing (DON) was considered and staff at the DON additional interveals bowel reports for Resist through 01/10/13. She documentation reveals bowel movements were formed. The DON additional additional and the documented as hard, expected nurses to as concerns and to documented and medical 483 25(I) DRUG REGI UNNECESSARY DRUE. Each resident's drug runnecessary drugs. Adding when used in exclupilicate therapy); or without adequate monimications for its use; adverse consequences should be reduced or combinations of the resident, the facility must who have not used and given these drugs unless the staff at that time.	stools The DON loted the stools were loose, which the resident had the sed in many other residents In with the Director of conducted on 03/28/13 at stated she reviewed the dent #39 from 10/01/12 ereported the led 38% of the resident's reloose and 62% were ded no stools were. The DON stated she sees residents with bowel ment assessments ations administered liMEN IS FREE FROM JGS. Regimen must be free from an unnecessary drug is any dessive dose (including for excessive duration; or itoring; or without adequate or in the presence of swhich indicate the dose discontinued, or any asons above. Insive assessment of a just ensure that residents the stool of the s		329	F 329 a.	Resident # 43's Ph was notified on 3/2 upon notification of error by the State Surveyor. An order obtained to increas Wellbutrin to 150 a every morning and 3:00 pm. There was harm suffered by the resident.	6/13 of the er was se the mg daily at s no	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING			02/20/2042
	ROVIDER OR SUPPLIER	ENTER		551	ET ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901	03/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 309	the consistency of the explained if she had r she would have though		F	309	5	
	10:47 AM. The DON bowel reports for Resisthrough 01/10/13. She documentation reveal bowel movements we formed. The DON addocumented as hard. expected nurses to as concerns and to documented and medica 483.25(I) DRUG REG	onducted on 03/28/13 at stated she reviewed the ident #39 from 10/01/12 e reported the ed 38% of the resident's re loose and 62% were ded no stools were. The DON stated she sess residents with bowel ment assessments ations administered.	F	329		
	duplicate therapy); or it without adequate mon indications for its use; adverse consequences should be reduced or combinations of the re. Based on a comprehence resident, the facility months who have not used and given these drugs unle	for excessive duration; or itoring; or without adequate or in the presence of s which indicate the dose discontinued; or any asons above. Inside assessment of a just ensure that residents in the cipsychotic drugs are not seen antipsychotic drug of treat a specific condition amented in the clinical				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	WEDICAID SERVICES					IND DATE CI	IDVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		NSTRUCTION	-	COMPLE	
		345426	B WNG				03/28	3/2013
NAME OF PR	OVIDER OR SUPPLIER			COMMONWAY CONTRACTOR	ADDRESS, CITY, ST.	ATE, ZIP CODE		
VALLEY V	IEW CARE & REHAB C	ENTER			REWS, NC 28901			VACOUS .
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F 329	Continued From page	e 26	F	329	В.	DCS/Nurse Mana	iger	
1 020		Il dose reductions, and				reviewed all curre	ent	
	behavioral intervention	ons, unless clinically				residents medicat		
	contraindicated, in ar	n effort to discontinue these				ensure that the co		
	drugs					dosages are indic	ated on	
						Administration R	Record	
				1		(MAR) per the pl	hysicians'	
				1		orders. Inconsist	encies	
				l		were reported to	the	
	This REQUIREMENT	T is not met as evidenced		1		resident's physic	ian	
	by:	and sol social solutions		ĺ		medication error	report	
	Based on observation	ons, medical record reviews, acy personnel interviews, the		Ì		was completed by	vine	
	facility administered	an incorrect dosage of an		1	6	nurse. All Licensed Nu	rses were	
	antidepressant medi	cation for 45 doses to 1 of 7		1	C.	re-educated on N	1edication	
	residents reviewed d	uring medication				Administration t	o include	
		ent #43) The findings				ensuring the cor	rect dose	
	included:					was sent from th	e	
						pharmacy.		
	Resident #43 was ad	imitted to the facility 06/18/03		i	D.	The DCS / Unit	Manager	4-14
	with diagnoses inclu-	ding depression and mood				will observe med	ncation	7 60
	disorder.					pass on 5 resider week for 4 weeks	s then 3	
	A coulous of Posidon	#43's medical record				residents per we	ek for 4	
	revealed a physician	's order dated 02/01/12 for				weeks, then 4 re	sidents per	F.
	Wellbutrin (an antide	pressant medication) 100				month for 10 mg	onths. The	2
	milligrams (mg). The	e order specified the				results of the me	dication	
		e administered every morning				pass observation	is will be	
	and at 3.00 PM daily					reported to the	Al State of the St	
	A review of Resident	t #43's Medication				Committee mon months for cont	inued	
	Administration Reco	rds (MAR) dated February				substantial com	pliance	
İ	2013 and March 201	3 was conducted. The				and/or revision.		
	February 2013 MAR initials indicating We	contained facility nurses'			E.			
	administered twice a	day. The March 2013 MAR			L.	- 1944 (1944) - 1944 (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944) (1944)		
	contained facility nur	ses' initials indicating			<u> </u>			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING				03/28/2013
	ROVIDER OR SUPPLIER	ENTER		551	T ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From page	27	F	329			i B
	Wellbutrin 100 mg wa through 03/24/13 and	s administered twice a day once on 03/35/13.					
	03/08/13 indicated co resident required exter activities of daily living specified Resident #4 depression. A Care A	Data Set (MDS) dated gnition was intact and the ensive staff assistance for all gexcept eating. The MDS 3 acknowledged feelings of three Assessment stated the libutrin 100 mg twice a day					
	#43 at risk for potential antidepressant drug. specified the resident from the medication of the next 3 months. In monitoring the resident	The care plan goal would have no side effects rincreased depression for					
	Nurse #4 preparing m administered to Resid compared a blister pa physician's order on the Administration Record blister pack contained	ent #43. Nurse #4 ck of Wellbutrin to the ne March Medication I (MAR). She found the Wellbutrin 150 mg tablets					
	100 mg. Nurse #4 loc cart and was unable to for Resident #43 conta Nurse #4 reported the	MAR specified Wellbutrin ked through the medication of find another blister pack aining Wellbutrin 100 mg. discrepancy to the Director administer the medication		9			, [
	An interview with the A	Administrator was					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	000000000000000000000000000000000000000	TIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING			03/28/2013
	OVIDER OR SUPPLIER	ENTER		551 K	ADDRESS, CITY, STATE, ZIP CODE ENT STREET REWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 329	Continued From page conducted on 03/26/1/Administrator acknow had been administere instead of Wellbutrin physician. The Admi had been notified via order to Wellbutrin 15 3:00 PM daily. An interview with Resphysician on 03/28/13 resident was not harr dosages of Wellbutrin An interview via phor Manager was conducted faxed physician's ord #43 to have Wellbutriand at 3:00 PM every explained when the pethe medication into the system, the dosage via stated a blister pack of was sent to the facility added before the medicality nurse caught in notified the pharmacy blister pack of Wellbur resent the medication.	at 4:15 PM. The pledged Wellbutrin 150 mg and for a period of time 100 mg as ordered by the inistrator added the physician phone and he changed the 50 mg every morning and at sident #43's attending at 8:34 AM revealed the med due to the increased in she received. The with the facility Pharmacy steed 03/28/13 at 11:55 AM, the pharmacy received a per on 02/01/12 for Resident in 100 mg in the morning of day. The Manager sharmacy technician keyed are pharmacy computer was keyed as 150 mg. She containing 150 mg tablets by at that time. The Manager dication was administered, a the error in the dosage and of the facility returned the utrin 150 mg. The pharmacy in the correct dose of 100		329		
	the computer. The M 100 mg was sent to t when a refill was requ Manager stated the fa medication via compu 150 mg instead Wellk	re the 150 mg dosage from lanager stated Wellbutrin he facility until 02/14/13 uested by the facility. The acility nurse requested the uter and checked Wellbutrin butrin 100 mg. When the				

Facility ID: 923155

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG	(X3) DATE S COMPL	
		345426	B WING_		03/2	8/2013
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEVV	IEW CARE & REHAB CE	NITED		551 KENT STREET		
VALLETY	ILW CARE & REHAB CE	INTER		ANDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIMATE OF T		(X5) COMPLETION DATE
F 329	Continued From page	20				
. 020			10.5	723		
	package. The Manag packages containing	e on the Wellbutrin 150 mg er stated therefore blister Wellbutrin 150 mg were 02/14/13 and 03/11/13				
SS=D	Nursing (DON) on 03, stated her expectation desages on medication the dose to the order medication was admir On 03/28/13 at 2:37 F counting the Wellbutripackage sent to the fastated the blister pack Nurse #1 determined doses of Wellbutrin 15/483.35(e) THERAPEL BY PHYSICIAN	PM. Nurse #1 was observed in 150 mg left in the blister acility on 03/11/13. She is contained 30 tablets. Resident #43 received 45.	F 3	F 367 A. RD recommendation for resident # 39 faxed to physician and enriched was added order. MVI with Minerals and 60 ml. Med supplement was ordered and started. on 3-B. The facility acknowledges that a residents have the potential to be a by this deficient practice and correaction has been achieved by educat DM on the process for follow up of recommendations. On 4/9/13 all cuRD recommendations have been reto assure all current RD recommendations have been addressed.	to diet pass -28-13 all ffected ctive ing the RD irrent viewed	
	by Based on medical rec interviews, the facility physician received an dietary recommendati	nutrition (Resident #39) nitted to the facility nd added diagnoses		C. DM will keep a log of all recommendations each month to as they have been reviewed and responsive the physician. Regional Dieticial review monthly for compliance x 10 months. D.Regional Dietician will report resimonitoring to QI Committee month months for continued substantial compliance and/or revision. E. 4-25-13	nded to n will) ults of	Y-25-13

Facility ID 923155

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345426	B. WING			03/28/2013	
	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE ENT STREET	1 03/20/2013	
				AND	REWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 367	Continued From page	e 30	F	367			
	muscle weakness, dementia, and lower extremity wounds.						
		ım Data Set (MDS) dated esident #39 was severely					
	cognitively impaired a	and required extensive staff vities of daily living including					
	eating. The MDS assadmission weight at						
	Assessment (CAA) with this assessment specified Resident #39 was on a pureed enriched diet. The resident was tolerating the diet well and						
	Registered Dietician	le since admission. A (RD) consult would be					
	nutritional status.	d as needed to evaluate					
	A care plan dated 09/ #39 was at risk for we	/11/12 identified Resident					
	mechanically altered specified the resident	diet. The care plan goal would maintain adequate e more than 5% of her					
	present weight. Inter ordered as pureed wi	ventions included a diet th enriched foods and RD					
	consults as indicated						
		#39's medical record s order dated 09/19/12. The liliters (ml) of a nutritional					
	, and the setting the paper of the setting and the setting of the	administered 4 times daily					
		Resident #39's medical					
	care facility on 01/10/	vas admitted to an acute 13. A History and Physical he physician in the acute				a	
	care facility on 01/10/	he physician in the acute 13 was reviewed. The H&P agnoses included vomiting,				1	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345426	B. WING		03/28/2013			
	ROVIDER OR SUPPLIER	CENTER	551 1	T ADDRESS, CITY, STATE, ZIP CODE KENT STREET DREWS, NC 28901				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION			
F 367	H&P, the physician appearance as frail A review of discharge revealed the request regarding poor calor discharge was for pliquids. A review of weights to the long term fact resident's weight on The latest recorded 03/01/13. Additional medical of dietary nutrition review was dated 0 facility RD. The recincluded the following nutritional supplementation and enriched to current multivitamin with mit daily nutritional needs.	mild malnutrition. In the documented the resident's looking and very emaciated. ge instructions dated 01/18/13 st for a dietary consult rie intake. The diet order at ureed foods with regular after Resident #39 returned fility on 01/18/13 revealed the no1/22/13 was 99.5 pounds. weight was 109 pounds on record review revealed a few was completed. The 1/24/13 and signed by the ommendations on the review ng: (1) re-order 60 ml of a fent to be provided with all administrations, (2) add diet order, and (3) add a nerals every day to help meet	F 367					
	revealed a diet order liquids. No request foods, nutritional surnoted on the March. An interview with the at 9:39 AM. The RE completed a nutrition.	r for puree with regular for the addition of enriched pplement or multivitamin was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	95 6	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WNG		03/28/2013
	OVIDER OR SUPPLIER	ENTER	S	TREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 431	dietary nutrition reviee #38's attending phys with the RD revealed physician to indicate the recommendation completed nutritional verbal report to the E. An interview with the at 10.52 AM. The Diverbal report from the supplement recomm DM explained the province of the province of the DM containing The DM stated she for Resident #39's dischedularly and the province of the DM containing the DM stated she for Resident #39's dischedularly are commendations with the the three was no physician received a recommendation. Continued interview 11.10 AM revealed to system in place to veresponded to her received a feet of the there was no the three was no physician received a recommendation. Continued interview 11.10 AM revealed to the received a feet of the three was no physician received a recommendation. The facility must emial licensed pharmacie.	sulting Dietician form mendations as stated in the ew was faxed to Resident incian. Review of this form if a place was provided for the he agreed or disagreed with s. The RD added after she reviews, she provided a dietary Manager (DM). DIM was conducted 03/28/13 M verified she received a e RD regarding dietary endations on 01/24/13. The occess was the physician insulting Dietician important with fax. The nurses und write a physician's order uest and provide a dietary slip or changes to dietary orders and not received any change interpretated in the DM verified in the system in place to assure the not responded to the with the RD on 03/28/13 at the facility should have a early physicians received and commendations.	F 43	F 431 A. The identified bottle of insudiscarded immediately upon not the State Surveyor on 3/28/13, suffered no harm. B. All insulin vials were checked expiration on 3/28/13 and no of found out of date. C. All Licensed Nurses were reson the dating and expiration of Third shift Licensed Nurses will responsible to check their medito ensure no expired insulin remarks. D. The DCS/Unit Manager will review insulin vials 5 x weekly then 3 x weekly for 4 weeks, the for 4 weeks and then 1 x months. The results of the OL memory is the former of the old memory in the results of the OL memory is the former of the old memory in the results of the OL memory is the former of the old memory in the results of the OL memory is the old memory in the results of the OL memory is the old memory in the results of the OL memory is the old memory in the results of the OL memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory in the old memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory is the old memory in the old memory in the old memory is the old memory in the old memory is the old memory in the	ed for hers were e-educated insulin vials. If be cart nightly nains on the l QI monitor for 4 weeks, in 1 x weekly ly x 7 onitoring nittee ued

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345426	B. WING_		03/28/2013
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CC 551 KENT STREET ANDREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 431	accurate reconciliation records are in order a controlled drugs is mareconciled.	e 33 Ifficient detail to enable an on; and determines that drug and that an account of all aintained and periodically a used in the facility must be	F 4	31	
		e with currently accepted es, and include the y and cautionary			
	facility must store all locked compartments	tate and Federal laws, the drugs and biologicals in sunder proper temperature only authorized personnel to eys.			II B
	permanently affixed of controlled drugs listed Comprehensive Drug Control Act of 1976 a abuse, except when to package drug distribu	compartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can			
	by: Based on observatio	of 1 medication			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		345426	B. WING				03/28/2013
	ROVIDER OR SUPPLIER	ENTER		55	EET ADDRESS, CITY, STATE, ZIP CODE 11 KENT STREET NDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	Continued From page	: 34	F	431			
	2011, indicated after for up to 28 days. A refrigerator check she	log insulin, revised June opening a vial may be used eview of medication					
	medication refrigerator preparation room reversible open vials of insulin. insulin, 100 units per inside a plastic contain. On the plastic contain space for writing the contains of the plastic contains pace for writing the contains of the plastic contains pace for writing the contains of the plastic contains of the p	PM, an observation of the or in the facility's medication ealed a plastic basket with An open vial of Novolog milliliter, was observed ner with a prescription label. er, a yellow label with a late of the 28th day after eft blank. No written dates					* ************************************
	on 03/28/13 at 2:50 F interviewed. She stat noted on the prescript morning of 03/28/13 a which she obtained the	I. M, Nurse #1 was ed she gave the resident ion label Novolog insulin the nd this was the vial from e insulin. She stated per					1.
	vial should have writte after opening, either of container, on a sticker the vial or with ink on stated she should hav	e who originally opened the enthe date of the 28th day in the yellow label on the placed on the bottom of the vial itself. Nurse #1 e checked for the date of ning when she performed					n o
	administering the insu absence of the date o and based on the pha the 28th day after ope	before drawing up and lin. She stated in the f the 28th day after opening rmacy fill date of 02/15/13, ning could have been as rse #1 stated Monday night					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345426	B. WING			03/	28/2013
	OVIDER OR SUPPLIER	NTER			REET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
1			*		*		
F 431	shift nurses were to cl refrigerator for expired additional check. On 03/28/13 at 3:00 F	heck the medication d medications as an M, Nurse #1 was observed al of Novolog insulin in the	F	431			
	(DON) was interviewed expectation of nurses day after opening a viprovided for it on the pival itself. The DON s for this date before dra a dose of insulin as pacheck. She stated the Monday night shift for expiration dates or	noting the date of the 28th all of insulin, on the label plastic container or on the tated nurses are to check awing up and administering art of their medication at as an additional check, a nurse is expected to check a medications in the r but this is not to replace performed by nurses					