DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(OMB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345426	B. WING			06/	12/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		NTED		5	51 KENT STREET		
VALLET	IEW CARE & REHAB CE	INTER		A	NDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 242 SS=D	483.15(b) SELF-DET MAKE CHOICES	ERMINATION - RIGHT TO	F	242			7/9/14
	schedules, and health her interests, assess interact with members inside and outside the	right to choose activities, in care consistent with his or ments, and plans of care; is of the community both e facility; and make choices or her life in the facility that resident.					
	by: Based on resident ar record reviews, the fa residents for the freque preferred each week food preferences for 2 choices. (Resident #4 The findings included 1. Resident #6 was diagnosis including ca disorder, mental retar affective disorder and Resident #6's admiss (MDS) dated 04/09/14 moderately impaired of make herself understa assessed Resident #4 assistance with bed mand hygiene. Resident #6's most re 04/09/14 indicated sh activities of daily living	and failed to honor specific 2 of 3 residents reviewed for 6 and Resident #75). admitted on 03/31/14 with erebral palsy, schizoaffective dation, major depressive high blood pressure. ion Minimum Data Set 4 assessed her as having cognition and the ability to bood. The MDS further 6 as needing extensive nobility, transfer, dressing ecent care plan dated e required assistance with g (ADL's).			 Resident #6 was not injured related this citation. Resident # 6 was interview by the Licensed Nurse on 6/16/2014 to determine her bath/shower preference a well as frequency. Resident #6 care pla and kardex were updated to reflect resident stated preference. Resident #75 was not injured related to this citation. Resident # 75 was interviewed by the Food Service Directo on 6/13/2014 to learn food preferences. Resident # 75 care plan and meal tray card were updated to reflect resident preferences. All residents have the potential to be affected by this citation. The interdisciplinary team asked residents and/or their responsible party about the type and frequency of shower/bath they prefer. Then the residents' care plan and kardex were updated. On 6/13/2014-6/20/2014, the interdisciplinary team asked residents and/or responsible party about the interdisciplinary team asked residents and/or responsible party about the 	ed as n or	
	During an interview o	n 06/11/14 at 11:59 AM			residents' food preferences. Then the		
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

Electronically Signed

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.

07/04/2014

S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
	345426	B. WING		06/12/2014
ROVIDER OR SUPPLIER	·	5	STREET ADDRESS, CITY, STATE, ZIP CODE	
IEW CARE & REHAB CE	INTER			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
Continued From page	e 1	F 242		
Resident #6 revealed baths/showers a wee baths/showers a wee baths/showers a wee "Buring an interview of #3 revealed Resident baths/showers week NA #3 further stated baths/showers a wee schedule. The show and room number. N understood when to g she was on the show the residents Kardex asked for additional b to accommodate ther During an interview of Nurse#7 revealed res a week and if a reside baths/showers a wee accommodated. This assessed the resider frequency of baths/showers	I she would prefer to have 3 k instead of the 2 k offered by the facility. In 06/11/14 at 12:11 PM, NA t #6 was assigned to get 2 y on Monday and Thursday. each resident received 2 k based on the shower er schedule is divided by hall IA#3 also explained she give the showers because er team and by looking at . NA#3 stated if residents baths/showers they would try n. In 06/11/14 at 3:04 PM, sidents get 2 baths/showers ent requested more than 2 k they would be nurse did not know who its for there preference on nowers per week.		residents' care plans and meal tra- were updated. New admissions to facility will be a their preference for bath/shower b frequency, and time by Admission Coordinator and/or Nursing Super The Food Service Director will inte new admissions for food preference 3. Licensed Nurses and Certified N Assistants, were in-serviced by the Director of Clinical Services and/o Nursing Supervisor between the d 6/13/2014-6/20/2014. The facility r inquire about each resident's prefe for the frequency and type of bath/showers for each week, and i information must be transcribed to resident's care plan and kardex accordingly. On 6/12/2014, the Food Service D was in-serviced by the Corporate Regional Dietician regarding obtai residents' preferences and updatir care plans and meal tray cards.	asked y day, s visor. erview ces. Nursing e r lates of must erences this o the Director
baths/showers a wee requested additional were accommodated further stated she did on frequency of baths activity director did.	k. Some residents baths/showers and they . The MDS Coordinator not assess for preference s/showers per week but the n 06/11/14 at 3:24 PM,		residents' bathing preferences will conducted 3 times a week for 2 m times a week for 2 months, and th time a week for 2 months and/or u substantial compliance is obtained The Food Service Director will per Quality Improvement Monitoring o residents' food preferences 3 time week for 1 month, 2 times a week months, and then 1 time a week for	onths, 2 en 1 intil d. form f 10 is a for 3
	ROVIDER OR SUPPLIER IEW CARE & REHAB CE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Resident #6 revealed baths/showers a wee baths/showers a wee baths/showers a wee baths/showers weekl NA #3 further stated of baths/showers a wee schedule. The show and room number. N understood when to g she was on the show the residents Kardex: asked for additional b to accommodate ther During an interview of Nurse#7 revealed resident baths/showers a wee a week and if a reside baths/showers a wee a week and if a resident baths/showers a wee a week and if a resident baths/showers a wee a commodated. This assessed the resident frequency of baths/sh During an interview of Coordinator revealed baths/showers a wee requested additional were accommodated ditional were accommodated further stated she did on frequency of baths activity director revealed During an interview of Activity Director revealed	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426 ROVIDER OR SUPPLIER IEW CARE & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Resident #6 revealed she would prefer to have 3 baths/showers a week instead of the 2 baths/showers a week offered by the facility. During an interview on 06/11/14 at 12:11 PM, NA #3 revealed Resident #6 was assigned to get 2 baths/showers a week based on the shower schedule. The shower schedule is divided by hall and room number. NA#3 also explained she understood when to give the showers because she was on the shower team and by looking at the residents Kardex. NA#3 stated if residents asked for additional baths/showers they would try to accommodate them. During an interview on 06/11/14 at 3:04 PM, Nurse#7 revealed resident requested more than 2 baths/showers a week they would be accommodated. This nurse did not know who assessed the residents for there preference on frequency of baths/showers per week. During an interview on 06/11/14 at 3:14 PM, MDS Coordinator revealed every resident gets 2 baths/showers a week. Some residents requested additional baths/showers and they were accommodated. The MDS Coordinator further stated she did not assess for preference on frequency of baths/showers per week but the	CORRECTION IDENTIFICATION NUMBER: A. BUILDING. 345426 B. WING ROVIDER OR SUPPLIER B. WING IEW CARE & REHAB CENTER D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 1 F 242 Resident #6 revealed she would prefer to have 3 baths/showers a week instead of the 2 baths/showers a week offered by the facility. F 242 During an interview on 06/11/14 at 12:11 PM, NA #3 revealed Resident #6 was assigned to get 2 baths/showers a week based on the shower schedule. The shower schedule is divided by hall and room number. NA#3 also explained she understood when to give the showers because she was on the shower team and by looking at the residents Kardex. NA#3 stated if residents asked for additional baths/showers they would try to accommodate them. During an interview on 06/11/14 at 3:04 PM, Nurse#7 revealed resident requested more than 2 baths/showers a week. Some residents a week and if a resident requested more than 2 baths/showers a week. Some residents requested additional baths/showers and they were accommodated. This nurse did not know who assessed the residents for there preference on frequency of baths/showers per week. During an interview on 06/11/14 at 3:14 PM, MDS Coordinator revealed every resident gets 2 baths/showers a week. Some residents requested additional baths/showers and they were accommodated. The MDS Coordinator further stated she did not assess for preference on frequency of baths/showers per week but the activity director revealed she assessed how	FERCENCIES (X1) PROVIDERSUPPLIERCUAN (X2) MULTIPLE CONSTRUCTION SOUDER OR SUPPLIER 345426 BUILDING BUILDING IEW CARE & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES IN REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX Continued From page 1 F 242 Resident #6 revealed she would prefer to have 3 bath/showers a week offered by the facility. F 242 During an interview on 06/11/14 at 12:11 PM, NA #3 further stated each resident received 2 bath/showers a week based on the shower schedule is divided by hall and room number. NA#3 also explained she understood when to give the shower baccuse she was on the shower team and by looking at the residents for there preference on frequency of bath/showers a week there would be accommodate. This nurse did not know who assessed the residents for there preference on frequency of bath/showers a week. Some residents to three preference on frequency of bath/showers a week. Some residents for there preference on frequency of bath/showers a meek. Some residents to three preference on frequency of bath/showers and they would be accommodated. This nurse did not know who assessed the residents for there preference on frequency of bath/showers per week. Quality Improvement monitoring or residents' food preferences 3 time a week for 2 months, and they were accommodated. The MR MDS Coordinator further stated she did not assess for preference on frequency of bath/showers are week based on they word assess for preference on frequency of bath/showers per weekb. Quality Improvement Monitoring or resi

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345426	B. WING			06/	12/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				5	51 KENT STREET		
VALLEY V	IEW CARE & REHAB CE	NTER		A	NDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 242	preference on frequer week but the social w During an interview of Social Worker reveale residents would like a Residents were given morning or evening. revealed she did not a frequency of baths/sh During an interview of the Director of Nursin get offered 2 baths/sh	ncy of baths/showers per orker did. n 06/11/14 at 3:46 PM, ed she assessed when bath/shower to be given. the preference between The Social Worker further assess for preference on	F	242	4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but no limited to the Executive Director, Direct of Clinical Services, Assistant Director Nursing, Medical Director, Social Services, Activities Director, Maintenau Director, and Minimum Data Assessme Nurse.	t tor of nce	
	02/11/14 with diagnost depression, anxiety a Physician orders on a diet with fruit for dess through the time of th The 05/10/14 Minimu noted Resident #75 w Review of the care pla Resident #75 (since a documentation related During observations of	m Data Set assessment vas cognitively intact. an and dietary notes for admission) revealed no d to food preferences.					

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 07/31/2014 FORM APPROVEI MB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION		X3) DATE SURVEY COMPLETED
		345426	B. WING _				06/12/2014
NAME OF P	ROVIDER OR SUPPLIER	I		STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
VALLEY V	VIEW CARE & REHAB CE	INTER			KENT STREET DREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
F 242	did not like the carrot: a mixed vegetable ble communicated this di he told the nursing as meal to him in his roc carrots and also wrot the paper tray card th Resident #75 stated I talking to him since a preferences. Resider served often, especia In a follow-up intervie Resident #75 stated I he did not like cream Resident #75 stated I all hot cereal with the delivered meal trays f #75 stated he was not the food dislikes with issues, he could not to oatmeal or cream of that every time he is a nursing assistants he he had received them that day. Review of t carrots had been service vegetable blend for lu On 06/11/14 at 5:15 F Director (FSD) looked record and noted she dislikes recorded for list stated because of this receive all food items including carrots, creat grits. The FSD stated	s that were served as part of end and had repeatedly slike. Resident #75 stated asistants that served his own that he did not like e the dislike for carrots on nat came with the meal. he did not recall anyone ever dmission about food int #75 stated carrots were ally in mixed vegetables. w on 06/11/14 at 5:00 PM that in addition to the carrots of wheat, oatmeal or grits. he had shared the dislike of nursing assistants that to him in his room. Resident aware of who else to share and, because of stomach olerate carrots, grits, wheat. Resident #75 stated served carrots he tells the doesn't like them; noting, n on the lunch meal earlier he facility menus noted ved as part of a mixed unch on 06/11/14.	F2	242			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/31/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345426	B. WING		06/12/2014
NAME OF PF	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
VALLEY V	IEW CARE & REHAB CE	ENTER		51 KENT STREET NDREWS, NC 28901	
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F 242	the time of the intervi the dislikes of Reside carrots, cream of whe On 06/12/14 at 10:35 he received a bowl of tray that morning. On 06/12/14 at 12:00	e 4 dislikes for Resident #75. At ew the FSD was informed of ent #75 which included eat, grits and oatmeal. AM Resident #75 reported f oatmeal with his breakfast	F 242		
F 309 SS=E	and reported there w Resident #75. The c oatmeal was part of t because there were r electronic system it h breakfast to Resident at the time of the inter explanation why the c wheat, oatmeal and c the electronic tray ca been reported to her 483.25 PROVIDE CA	ere no dislikes entered for orporate dietitian reported he preplanned menu and no designated dislikes in the ad been served for t #75. The FSD was present rview and could offer no dislikes of carrots, cream of grits had not been entered in rd system after they had on 06/11/14. NRE/SERVICES FOR	F 309		7/9/14
	provide the necessar or maintain the highe mental, and psychose	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment			
	by: Based on record rev	└ is not met as evidenced iew and staff interviews the or blood pressure and		 Resident #79 suffered no injury related to this citation. Resident #79 was 	35

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		ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 07/31/201 DRM APPROVE NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345426	B. WING _				06/12/2014
NAME OF PI	ROVIDER OR SUPPLIER	•	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				55	1 KENT STREET		
VALLET	IEW CARE & REHAB CI	ENTER		A	NDREWS, NC 28901		
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F 309	Continued From page	e 5	F 3	200			
1 000		pertensive medication as		09	assessed by the physician on 06/26	/2014	
		cian for 1 of 5 sampled			with no new orders.	2011	
		or unnecessary medications			Resident #31 suffered no injury relation	ted to	
		e facility also failed to monitor			this citation. Resident #31 was asse		
	2 of 8 sampled reside	ents bowel movements			by the physician on 07/02/2014 with	no	
	(Resident #31 and R	esident #3).			new orders.		
					Resident #3 suffered no injury relate		
	The findings included	d:			this citation. Resident #3 was asses	,	
	1 a Booidont #70 y	as admitted on 03/19/14			the physician on 07/02/2014 with no orders.	new	
	with diagnoses include				On 6/12/2014, Nurse #1 was in-serv	iced	
	-	coronary artery disease.			by the Director of Clinical Services of		
					following physician orders, notifying		
	Review of a Physicia	n's telephone order dated			physician of vital signs outside of sta		
	04/17/14 revealed in:				perimeter, and recording vital signs	in the	
		blood pressure) twice a day			medical record.		
		onidine (medication used to			On 6/13/2014Nurse #3 was in-servic	ced by	
		sure) 0.1 mg (milligrams)			the Director of Clinical Services on		
	every 12 nours as ne 150/90.	eded for BP greater than			following physician orders, notifying		
	150/90.				physician of vital signs outside of sta perimeter, and recording vital signs		
	A care plan for self c	are deficit dated 03/28/14			medical record.		
		h dated 04/17/14 to monitor			On 6/16/2014Nurse #4 was in-servio	ced by	
		vice a day and to administer			the Director of Clinical Services on	J	
		ery 12 hours as needed for			following physician orders, notifying	the	
	BP greater than 150/	90.			physician of vital signs outside of sta	ated	
					perimeter, and recording vital signs	in the	
		#79's vital signs and weight			medical record.		
		through 06/11/14 revealed			On 6/16/2014, Nurse #5 was in-serv		
		wice a day from 04/17/14 esident #79's BP was			by the Director of Clinical Services of following physician orders, notifying		
		/24/14, 05/01/14, 05/08/14,			physician of vital signs outside of sta		
	05/22/14, and 05/29/				perimeter, and recording vital signs medical record.		
	An interview was cor	nducted with the Director of					
	Nursing (DON) on 06	6/11/14 at 3:45 PM after she			2. All residents have the potential to	be	
		ent #79's medical record			affected by this citation.		
	-	Administration Records			On 06/17/14, the Director of Clinical		
	(MARs). The DON c	onfirmed she could not			Services and/or Nursing Supervisor		

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		MEDICAID SERVICES			OMB NO.	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		345426	B. WING		06/12	2/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP (CODE	
VALLEY V	IEW CARE & REHAB CE	INTER		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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 309	Continued From page	2 6	F 30	9		
	locate any additional #79 other than the BF signs and weight reco would expect BPs to the Physician and do	BP monitoring for Resident Ps documented on the vital ord. The DON stated she be monitored as ordered by cumented on the residents a ordered to be monitored		monitored residents requir signs and residents requiri anti-hypertensive medicati On 6/17/14, the Director of Services and/or Nursing S reviewed/audited the bowe current residents.	ng ons. f Clinical upervisor	
	#2 (while she was on PM. During the intern Resident #79's medic had signed off on the for his BP to be monif on 04/17/14. Nurse # placed this order on t notify the nurse aides the acute vital sign sh	was conducted with Nurse duty) on 06/11/14 at 8:25 view Nurse #2 reviewed cal record and confirmed she Physician's telephone order tored twice a day beginning #2 stated she would have he acute vital sign sheet to c. Nurse #2 further stated neets were not saved after ecorded and as a result she		 3. On 6/16/2014-6/30/2014 of Clinical Services and/or Supervisor in-serviced lice following physician orders, physician of vital signs out perimeters, and recording the medical record and/or System. On 6/16/2014-6/30/2014, t Clinical Services and/or No Supervisor in-serviced Cer 	Nursing nsed nurses on notifying side set vital signs in Care Tracker he Director of ursing	
	not monitored twice a	-		Assistants on recording rea movements in the medical Care Tracker.	record, using	
	PM the Physician sta of her visits Resident monitored frequently order for BP monitorin elevated BPs. The P reviewed Resident #7 not notice how freque monitored. The Phys written an order to dis Resident #79's BP tw his BP to be checked 04/17/14.	sician indicated she had not scontinue the monitoring of rice a day and would expect per the order written on		Utilizing data recorded in the record and/or Care Tracket of Nursing and/or Nursing perform Quality Improvement of 10 residents receiving a medications and daily vital monitoring will occur 3 times months, 2 times a week for then 1 time a week for 2 m until substantial compliance The Director of Nursing an Supervisor will perform Qual Improvement monitoring of movements utilizing the No	r, the Director Supervisor will ent monitoring nti-hypertensive signs. The es a week for 2 r 2 months, and onths and/or e is obtained. d/or Nursing uality f bowel o BM Report	
		admitted on 03/19/14 with hypertensive cardiomyopathy lisease.		from Care Tracker 3 times months and/or until substa compliance is obtained.		

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 07/31/2014 ORM APPROVED NO. 0938-0391
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F 309	Continued From page	27	F	309			
	04/17/14 revealed ins Resident #79's BP (b and to administer Clo treat high blood press every 12 hours as ne 150/90. A care plan for self ca included an approach Resident #79's BP tw Clonidine 0.1 mg by r needed for BP greate Review of Resident # Medication Administra revealed documentat being given as ordere 04/17/14, 04/19/14, 0 and 04/29/14. Contir and May MARs revea needed Clonidine 0.1 Resident #79 on 04/17 Review of Resident # record from 04/17/14 the following docume above the parameters There were no nurse the MAR regarding th - 04/18/14 during f Nurse #3 documente (millimeters of mercu completed with a mar a BP reading of 180/8 monitored later on 04	lood pressure) twice a day inidine (medication used to sure) 0.1 mg (milligrams) eded for BP greater than are deficit dated 03/28/14 in dated 04/17/14 to monitor rice a day and to administer mouth every 12 hours as er than 150/90. 79's April and May 2014 ation Records (MARs) ion for Clonidine 0.1 mg ed for elevated BP on 4/20/14, 04/22/14, 04/24/14, hued review of the 2014 April aled no documentation of as mg administered to 8/14, 04/23/14, or 05/08/14. 79's vital signs and weight through 05/29/14 revealed nted BPs were elevated as specified by the Physician. as notes or documentation on the elevated BPs. the 7:00 AM to 3:00 PM shift- d a BP of 182/107 mmHg			4. The results of these audits will be reported to the Quality Assurance Performance Improvement Committe 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but no limited to the Executive Director, Dire of Clinical Services, Assistant Director Nursing, Medical Director, Social Services, Activities Director, Maintena Director, and Minimum Data Assession Nurse.	t ot ctor r of ance	

						IO. 0938-039	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
VALLEY V	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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 309	Continued From page		F 30	9			
	shift- Nurse #4 docur mmHg. - 05/08/14 during t shift- Nurse #1 docur	the 11:00 PM to 7:00 AM nented a BP of 189/104 the 3:00 PM to 11:00 PM nented a BP of 166/91					
	mmHg. An interview was conducted with the Director of Nursing (DON) on 06/11/14 at 3:45 PM after she had reviewed Resident #79's medical record including Medication Administration Records (MARs). The DON confirmed she could not locate any additional nurse's notes or documentation to verify Resident #79 had received the as needed Clonidine 0.1 mg on 04/18/14, 04/23/14, or 05/08/14. The DON stated she expected nurses to administer as needed medication as ordered by the Physician and						
	or in a nurse's note. During a telephone in PM Nurse #2 (while s she was the charge n 11:00PM shift on 05/0 Resident #79's BP or record. Nurse #2 rev medical record during she would have notifi nurse for Resident #7 #2 reviewed Residen	R and the back of the MAR aterview on 06/11/14 at 8:25 she was on duty) confirmed burse on the 3:00 PM to 08/14 and documented in the vital signs and weight iewed Resident #79's g the interview and stated ed Nurse #5 who was the 79's hall that evening. Nurse t #79's May 2014 MAR and documentation to verify the 0.1 mg had been					
	#3 on 06/12/14 at 8:2 nurse aide (NA) woul	/ was conducted with Nurse 3 AM. Nurse #3 stated the d have brought Resident 4/18/14 to record in the					

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345426	B. WING			06/	12/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		-
VALLEY V	IEW CARE & REHAB CE	NTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	medical record. Nurs typically have written the hall nurse of the e recall if she had done Nurse #5 was intervie at 9:05 AM. Nurse #8 as needed Clonidine not recall if she had a for an elevated BP on explained the NAs tal and report the results each hall. Attempts to contact N 04/23/14, were not su During a telephone in PM the Physician stat #79 to receive the as any time his BP was e 2. Review of signed medical record of Res following: "Milk of Magnesia (or centimeters) orally ev constipation. If no res in 8 hours, insert Dulo equivalent of). If no re physician". Resident #31 was add with diagnoses which disease. A significant (MDS) assessment da completed due to initi	e #3 stated she would a nurse's note and informed elevated BP but could not so on 04/18/14. weed by phone on 06/12/14 order for elevated BP but did diministered this medication 0.05/08/14. Nurse #5 further we the residents vital signs to the nurse assigned to urse #4, who worked on accessful. terview on 06/12/14 at 1:49 ted she expected Resident needed Clonidine 0.1 mg elevated above 150/90. standing orders in the sident #31 included the equivalent of) 30 cc (cubic ery day as needed for sults from Milk of Magnesia colax suppository (or esults from suppository in 8 ema. If no results, call mitted to the facility 09/24/12 included Alzheimer's t change Minimum Data Set	F	309			

Facility ID: 923155

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/31/2014 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345426	B. WING		01	6/12/2014
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CC		
VALLEY V	VIEW CARE & REHAB CE	INTER		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	transfers and toileting Assessment (CAA) a included review of the issues including cons assessment noted the Incontinence was trig #31 was incontinent of needs extensive-max Contributing factors in Alzheimer's disease, behavioral disturband oriented to person on decline in condition a caseload. Staff will of routinely/as needed a occur. The 05/05/14 care pla the following problem -Bowel and bladder in approach to monitor I -Risk for constipation with approaches to m pattern every shift, m signs/symptoms of co abdominal pain, abdo etc and report to physic Resident #31 was ho readmitted to the faci the facility and initiatin medications (taken by hospitalization 04/24/ including Miralax and Resident #31 was no readmission to the faci on readmission including	and dependence on staff for g. The 05/05/14 Care Area ssociated with the MDS e area "Incontinence" due to stipation/impaction. The CAA e following: gered because Resident of bladder and bowel and timum assist with toileting. Included advanced delirium and confusion with ces. Resident alert and ly. She has had a recent nd is now on Hospice ontinue to provide assist as incontinent episodes an for Resident #31 included a areas: noontinence with an bowel pattern and risk for dehydration nonitor bowel elimination onitor for any onstipation such as pominal distention, nausea,	F 30	γ		

Facility ID: 923155

If continuation sheet Page 11 of 31

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/31/2014 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345426	B. WING			06	/12/2014
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
VALLEY	/IEW CARE & REHAB CE	INTER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	order on readmission puree with honey thic effect at the time of the Review of the facility Resident #31 from 03 following: 04/30/14-05/05/14-a recorded for bowels fo 05/23/14-06/04/14-a recorded for bowels fo 06/05/14-06/11/14-a recorded for bowels fo Review of the 2014 A Medication Administra the only medication g one dose of 30 cc of 0 05/26/14 and 06/11/1 nurses notes and hos readmission to the fac address administratio Dulcolax or Fleets en impaction. On 06/12/14 at 10:15 typically pulled the "n on her shift to show w greater than 72 hours Nurse #1 stated she w #31 and routinely wor verified Resident #31 hospitalization 04/24/ had noticed a change since her return to the there had been times Magnesia to residents	to the facility 04/28/14 was k liquids; which remained in he survey. electronic bowel records of 3/13/14-06/11/14 noted the seven day period with "0" or all three shifts thirteen day period with "0" or all three shifts six day period with "0" or all three shifts six day period with "0" or all three shifts april, May and June ation Records (MARs) noted iven for constipation was Milk of Magnesia on 4. Review of Resident #31s spice notes since cility 04/24/14 did not on of Milk of Magnesia, ema or any issues with AM Nurse #1 stated she o bowel movement" report which residents had gone a without a bowel movement. was familiar with Resident rked with her. Nurse #1 was taking laxatives prior to 14-04/28/14 and stated she a with her bowel movements e facility. Nurse #1 stated she had given Milk of s and had forgotten to chart any specifics regarding	F	309			

Facility ID: 923155

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	S FOR MEDICARE 8	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G		OMPLETED
		345426	B. WING			06/12/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	TY, STATE, ZIP CODE	
VALLEY V	IEW CARE & REHAB C	ENTER		551 KENT STREET ANDREWS, NC 28	001	
						0(5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
F 309	Continued From page	ge 12	F 30	09		
		ent standing orders for				
		ot had a bowel movement in				
		h she could not recall any				
		Resident #31, Nurse #1 stated s she identified residents had				
		after talking with nursing				
	assistants) and it wa	asn't recorded in the				
	,	Nurse #1 stated she did				
		agnesia to Resident #31 on esults. Nurse #1 could offer				
	-	e extended times recorded in				
		at Resident #31 had gone				
	without a bowel mov	vement.				
		0 PM the Director of Nursing				
		ses were responsible to				
		the start of every shift from o determine any residents				
		er than three days without a				
	bowel movement. T	•				
		t standing orders would be				
		corded on the MAR for any				
		one three days without a The DON stated any issues				
		nts should be reported to the				
	oncoming shift in rep	port so appropriate follow-up				
		DON stated there was not a				
	0 ,	n in place to monitor bowel				
		lents with the expectation that be addressing any concerns.				
	•	e was not aware Resident #31				
	had gone extended	times without a bowel				
		N stated if the Milk of				
	•	administered (as on				
		as not effective then a y should have been given.				
	3. Review of signed					

Facility ID: 923155

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PRINTED: 07/31/2014 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345426	B. WING			06/	12/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
VALLEY V	/IEW CARE & REHAB CE	INTER			51 KENT STREET NDREWS, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	following: "Milk of Magnesia (or centimeters) orally ev constipation. If no res in 8 hours, insert Dulo equivalent of). If no re- hours, give Fleets energy physician". Resident #3 was adm with diagnoses includ and chronic pain. The Set (MDS) dated 03/2 as dependent on staff The 05/27/14 care plather the following problem -Urinary elimination a monitor bowel pattern Review of physician co of Resident #3 noted and Senna (two laxatiseveral years. Review of the facility Resident #3 from 03/7 following: 03/22/14-03/25/14-a frecorded for bowels for 05/04/14-05/12/14-a r recorded for bowels for 05/17/14-05/24/14-a r recorded for bowels for 05/17/14-05/24/14-a r	equivalent of) 30 cc (cubic very day as needed for sults from Milk of Magnesia colax suppository (or esults from suppository in 8 ema. If no results, call hitted to the facility 03/23/06 ling T1-T6 spinal fracture e quarterly Minimum Data 24/14 assessed Resident #3 f for toileting. an for Resident #3 included area: litered with an approach to n. orders in the medical record she had been taking Miralax ives) on a daily basis for electronic bowel records of 13/14-06/11/14 noted the four day period with "0" or all three shifts nine day period with "0"	F	309			

Facility ID: 923155

If continuation sheet Page 14 of 31

		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 07/31/20 ² ORM APPROVE 3 NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345426	B. WING				06/12/2014
NAME OF PI	ROVIDER OR SUPPLIER	l		STR	EET ADDRESS, CITY, STATE, ZIP CO	DDE .	
	IEW CARE & REHAB CI			551	KENT STREET		
VALLET	IEW CARE & REHAD CI	ENTER		ANI	DREWS, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Medication Administr Resident #3 noted th constipation was one Magnesia on 03/18/1 06/09/14 and a Dulco On 06/12/14 at 10:15 typically pulled the "n on her shift to show w greater than 72 hours Nurse #1 stated she #3 and routinely work stated Resident #3 st the time, was incontin to change incontinent there had been times Magnesia to resident it but could not recall Resident #3. Nurse as supposed to implement residents that had not three days. Although specifics related to R there had been times a bowel movement (a assistants) and it was	March, April, May and June ation Records (MARs) for e only medication given for dose of 30 cc of Milk of 4, 04/21/14, 05/09/14 and blax suppository on 04/13/14. AM Nurse #1 stated she o bowel movement" report which residents had gone is without a bowel movement. was familiar with Resident ked with her. Nurse #1 tayed in bed the majority of nent and dependent on staff t briefs. Nurse #1 stated is she had given Milk of s and had forgotten to chart any specifics regarding #1 stated nurses are ent standing orders for t had a bowel movement in in she could not recall any esident #3, Nurse #1 stated is she identified residents had after talking with nursing	F	309			
	the facility record tha without a bowel move On 06/11/14 at 12:00 (DON) reported nurse generate a report at t electronic charting to that had gone greate bowel movement. Th	PM the Director of Nursing es were responsible to he start of every shift from determine any residents r than three days without a					

Facility ID: 923155

If continuation sheet Page 15 of 31

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		MB NO. 0938-03 X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345426	B. WING		06/12/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY V	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 309	Continued From page	e 15	F 309		
		orded on the MAR for any			
	•	ne an extended time without			
		The DON stated any issues			
		ts should be reported to the ort so appropriate follow-up			
		DON stated there was not a			
	management system	in place to monitor bowel			
		ents with the expectation that			
	•	e addressing any concerns.			
	had gone extended ti	was not aware Resident #3			
	movement. The DOM				
	Magnesia had been a				
	05/09/14) and if it wa				
		should have been given.			
F 312 SS=D	483.25(a)(3) ADL CA DEPENDENT RESID		F 312		7/9/14
		able to carry out activities of			
		he necessary services to			
		on, grooming, and personal			
	and oral hygiene.				
		is not met as evidenced			
	by: Based on observatio	n record review and staff		1. Resident #87 was not injured relate	d
		n, record review and staff failed to provide correct		to this citation.	u
		sident who was incontinent		On 6/12/2014, Certified Nursing Assistar	nt
	and dependent on sta	aff for 1 of 2 residents		#1 was in-serviced by the Director of	
	observed for incontin	ence care (Resident #87).		Clinical Services regarding providing	
	The findings included	:		proper peri care and notifying the Licensed Nurse when a dressing becomes soiled.	
		mitted to the facility on		On 6/12/2014, Certified Nursing Assistan	nt
	11/29/13 with diagnos	ses which included diabetes		#2 was in-serviced by the Director of Clinical Services regarding providing	
	mellitus, hypertensior				

Event ID: YYS911

Facility ID: 923155

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PIEC	CONSTRUCTION	T	O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			1 Y /	IPLETED
		345426	B. WING			0	6/12/2014
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
VALLEY	VIEW CARE & REHAB CE	INTER	551 KENT STREET ANDREWS, NC 28901				
				7.1.1			0(5)
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 312	Continued From page	e 16	F 3 ⁻	12			
	10	arterly Minimum Data Set			proper peri care and notifying the		
		4 assessed her as having			Licensed Nurse when a dressing		
		airment. The MDS further			becomes soiled.		
	assessed Resident #				2. All residents have the potential to	be	
	assistance of 2 staff f	or toileting and personal			affected by this citation.		
	hygiene. The MDS in	dicated she was			Director of Clinical Services and/or		
		ent of bladder and always			Nursing Supervisor observed 12 Certif	ied	
	continent of bowel.				Nurse Assistants on 6/12/14.		
					On 06/13/2014 through 06/30/2014, th	е	
		ontinence care was made			Director of Clinical Services and/or		
		PM. Nursing Assistants (NA)			Nursing Supervisor in-serviced Certifie		
		ne care for Resident #87. ng on her right side in bed			Nursing Assistants on proper peri care 3. The Director of Nursing and/or	•	
	when NA #1 checked				Nursing Supervisor will perform Qualit		
		served to be dependent on			Improvement monitoring of 2 Certified	у	
		is wearing fleece jogging			Nurse Assistant providing peri care ea	ch	
		t across the back and a			shift 5 times a week for 1 month, 3 tim		
		s present on the bed sheets.			a week for 1 month, 2 times a week fo		
		d the jogging pants, there			month and 1 time a week for 2 months	5	
	was liquid, yellow sto	ol on the inside of the pants			and/or until substantial compliance is		
	and on the bottom of	Resident #87's shirt. The			obtained.		
		s saturated with yellow,					
		A #1 requested assistance			4. The results of these audits will be		
		nence care to Resident #87			reported to the Quality Assurance		
		was resistive to being			Performance Improvement Committee	for	
	-	red the room with 2 wet			6 months and/or until substantial		
		Ind NA #2 removed the			compliance is obtained. The Quality		
	linen from underneath	dent #87 and the soiled			Assurance Performance Improvement Committee members consist of but no		
		cks and anal area washing			limited to the Executive Director, Director		
		hen placed a clean sheet on			of Clinical Services, Assistant Director		
		n incontinence brief under			Nursing, Medical Director, Social		
		and NA #2 then rolled			Services, Activities Director, Maintena	nce	
		r back, pulled the front of			Director, and Minimum Data Assessme		
		ed to fasten the brief. When			Nurse.		
		r to check Resident #87's					
		A #2, pulled the front of the					
		ed Resident #87's front					
	perineal area using d	isposable washcloths. NA #2					

Facility ID: 923155

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345426	B. WING		06/12/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
VALLEY V	IEW CARE & REHAB C	ENTER		551 KENT STREET ANDREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 312	Continued From pag	e 17	F 31	2	
		viping from front to back.		-	
		served on the washcloths			
		d NA #2 then placed an			
		n Resident #87. When asked the dressing on Resident			
		and NA#2 loosened the			
		d checked the dressing			
		one edge and soiled with			
		then notified the wound			
	nurse that the dressi	ng needed changed.			
	An interview was cor	nducted with NA #2 on			
	06/11/14 at 12:24 PN	A. When asked how she was			
		sidents who were incontinent			
		she should clean the front			
		ea washing from front to bout not washing Resident			
		area until requested by			
	surveyor, NA #2 stat	ed she got in a hurry			
		t was upset and she forgot to			
	-	eal area. When asked what			
		do when a dressing was fecal matter, she stated she			
	should notify the nur				
	An interview on 06/1	1/14 at 5:32 PM was			
		Director of Nursing (DON).			
		expected nurse aides to			
		ront and back perineal area			
		nt to back, using multiple			
	•	remove fecal matter. The she expected staff to notify			
		charge nurse if a dressing			
	was loose or soiled v	. .			
F 329 SS=D	483.25(I) DRUG REO UNNECESSARY DF	GIMEN IS FREE FROM RUGS	F 32	29	7/9/14
	1		1	1	

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/31/201 RM APPROVE NO. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345426	B. WING		0	6/12/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
VALLEY V	VIEW CARE & REHAB CI	ENTER		551 KENT STREET ANDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 329	unnecessary drugs. drug when used in ex duplicate therapy); of without adequate mo indications for its use adverse consequence should be reduced on combinations of the r Based on a compreh resident, the facility r who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventio	An unnecessary drug is any excessive dose (including r for excessive duration; or unitoring; or without adequate e; or in the presence of res which indicate the dose r discontinued; or any reasons above. ensive assessment of a must ensure that residents ntipsychotic drugs are not eless antipsychotic drug to treat a specific condition ocumented in the clinical s who use antipsychotic al dose reductions, and	F3	29		
	by: Based on record rev facility failed to monit reactions (tardive dys residents who were p medications (Residen The findings included 1. Resident #70 was diagnoses including psychosis. The adm	T is not met as evidenced riew and staff interviews the tor residents for adverse skinesia) for 3 of 3 sampled prescribed antipsychotic nt #70, #55, and #78). d: s admitted on 04/17/14 with vascular dementia and ission Minimum Data Set 4 revealed Resident #70 had		1. Resident #70 suffered n related to this citation. Resid assessed by the physician of with no new orders. An Abno Involuntary Movement Scale performed on resident by the Clinical Services on 6/16/207 Resident # 55 suffered no inj this citation. An Abnormal Inv Movement Scale was perforr resident by the Director of Cl Services on 6/16/2014.	ent #70 was n 07/02/2014 ormal was e Director of 14. jury related to voluntary med on	

Event ID: YYS911

Facility ID: 923155

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/31/20 ⁻ RM APPROVE IO. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345426	B. WING		0	6/12/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				551 KENT STREET		
VALLET	IEW CARE & REHAB C	ENTER		ANDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 329	Continued From pag	e 19	F 32	29		
	severely impaired co antipsychotic medica the facility. The Care Area Asses psychotropic drug us Resident #70 receive medication due to a o AA summary noted th administer medicatio	ignition and received an ation since her admission to ssment (AA) Summary for se dated 04/24/14 stated ed a routine antipsychotic diagnoses of psychosis. The he nurses would continue to on as ordered and monitor for ctiveness of medication and	1 32	Resident #78 suffered no injur this citation. Resident #78 was by the physician on 06/19/2014 new orders. An Abnormal Invo Movement Scale was performe resident by the Director of Clin Services on 6/16/2014. Nurse#6 was in-serviced by th of Clinical Services on 6/17/20 completion of Abnormal Involu Movement Scale upon admiss quarterly.	a assessed 4 with no luntary ed on iical e Director 14 on ntary	
	had the potential for psychotropic medica included to evaluate effects of medication elimination of psycho Review of Resident # orders revealed an o Resident #70 to rece medication) 2 mg (m daily and Trilafon 2 n needed for psychosis Continued review of record revealed no A Movement Scale) ha admission. The AIM detect tardive dyskin	tion use. Interventions the effectiveness and side is for possible decrease or otropic drugs. #70's June 2014 Physician's order dated 04/17/14 for sive Trilafon (antipsychotic illigrams) by mouth twice mg every six hours as		 2. Residents receiving anti-psy medication have the potential a affected by this citation. On 06/16/2014, the Director of Services completed an audit o residents receiving anti-psycho medications for Abnormal Invo Movement Scale. The Director of Clinical Services Nursing Supervisor in-services nurses, on 06/16/2014 through 06/30/2014, regarding complet Abnormal Involuntary Movemer residents with anti-psychotic m upon admission and quarterly. On admission and quarterly, re have an Abnormal Involuntary Scale assessment completed for Director of Clinical Services on Supervisor. 	to be f Clinical f current otic oluntary es and/or d licensed tion of ent Scale on nedications esidents will Movement by the	
	Nursing (DON) on 06 the interview the DO assessments to be c	nducted with the Director of 6/11/14 at 3:45 PM. During N stated she expected AIMS ompleted on admission and is for any resident who was		3. The Director of Nursing and Supervisor will perform Quality Improvement monitoring of 10 for completion of Abnormal Inv Movement Scale on admissior	/ residents /oluntary	

Facility ID: 923155

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	S FOR MEDICARE &					D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	· · · ·	E SURVEY PLETED
		345426	B. WING		06	/12/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	/IEW CARE & REHAB CE	INTER		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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	prescribed an antipsy DON further stated th AIMS assessments u months ago when Nu responsibility for the a reviewed Resident #7 could not locate an Ai A telephone interview at 3:15 PM revealed s an AIMS assessment suggested it may hav nurse who admitted h 2. Resident #55 was diagnoses including b admission Minimum I revealed Resident #5 medication 7 days du period. The Care Area Assess behavioral symptoms Resident #55 was ad diagnoses including o received antipsychoti A care plan dated 10/ had episodes of yellir including administerir ordered by the Physio Review of Resident # orders revealed an or Resident #55 to recei antipsychotic medication	Achotic medication. The ne MDS nurse completed the ntil approximately six rse #6 assumed assessments. The DON 70's medical record and IMS assessment. With Nurse #6 on 06/12/14 she did not recall completing for Resident #70 and re been completed by the ner on 04/17/14. As admitted on 10/25/13 with Dipolar disorder. The Data Set dated 10/25/13 75 received an antipsychotic ring the 7 day look back Assent Summary for a dated 10/25/13 revealed mitted from the hospital with dementia with agitation and c medications. Action (25/13) noted Resident #55 ng with interventions and behavior medications as cian. Action (25/14) Physician's refer dated 01/06/14 for the Seroquel (atypical tion used for the treatment D mg (milligrams) twice daily	F 32	 quarterly assessments three time for 2 months, two times a week for months, 1 time a week for two mo and/or until substantial compliance obtained. 4. The results of these audits will reported to the Quality Assurance Performance Improvement Comr 6 months and/or until substantial compliance is obtained. The Qua Assurance Performance Improve Committee members consist of b limited to the Executive Director, of Clinical Services, Assistant Dir Nursing, Medical Director, Social Services, Activities Director, Mair Director, and Minimum Data Asse Nurse. 	or 2 onths ce is be nittee for lity ment ut not Director ector of ntenance	

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		D HUMAN SERVICES					FORM	D: 07/31/2014
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345426	B. WING _			_	06/	12/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VALLEY V	IEW CARE & REHAB CE	NTER			51 KENT STREET NDREWS, NC 28901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued review of the Resident #55's last All completed on 10/25/14 An interview was completed on 10/25/14 An interview was completed on 10/25/14 An interview the DON assessments to be contract the interview the DON assessments to be contract the every six months grescribed an antipsy DON further stated the AIMS assessments up months ago when Nuresponsibility for the arreviewed Resident #55 could not locate an All since 10/25/13. The lassessment should he 2014. A telephone interview at 3:15 PM revealed as completed Resident # her last MDS assessment should her are placed it in the responsibility for the arreviewed Resident # her last MDS assessment should her are placed it in the responsibility for the arreviewed Resident # her last MDS assess for the care Area Assess and the specified (Noroluntary movement Minimum Data Set (Norevealed Resident #7 received an antipsych during the 7 day look The Care Area Assess the completed Area Assess and the care Area Asses and the c	he medical record revealed IMS assessment was 3. ducted with the Director of /11/14 at 3:45 PM. During V stated she expected AIMS ompleted on admission and a for any resident who was chotic medication. The e MDS nurse completed the ntil approximately six rse #6 assumed assessments. The DON i5's medical record and MS assessment completed DON confirmed an AIMS ave been completed in April with Nurse #6 on 06/12/14 she thought she had t55's AIMS assessment with nent (05/30/14) and would nedical record. s admitted on 03/07/14 with ded mental disorder not NOS) and abnormal ts. The most recent IDS) dated 04/03/14 8 was cognitively intact and notic medication 7 days	F 3	329				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345426	B. WING			06/	12/2014
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
VALLEY V	VIEW CARE & REHAB CE	INTER			551 KENT STREET ANDREWS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 329	Resident #78 receive medications due to di anxiety, and insomnia would continue to adr ordered and monitor f and update the Physi note further stated ps made as indicated an continue on hospice of cancer. A care plan dated 04/ had potential for side medication use. The have no evidence of s psychotropic medicat Interventions included monitor side effects of decrease/elimination A review of Resident revealed an order for Seroquel 50mg (millig evening for depressiv and recurring depressiv and recurring depressiv completed since adm assessment is used to which is a common ad antipsychotic medicate An interview was con Nursing (DON) on 06 the interview the DON assessments to be com	d routine antipsychotic agnosis for depression, a. The CAA noted nursing minister medications as for side effects/effectiveness cian as indicated. The CAA ychiatric consults would be d Resident #78 would caseload for metastatic 03/14 stated Resident #78 effects from psychotropic care plan goals were to side effects from ion through next review. d evaluate effectiveness and f medication for possible of psychotropic medications. #78's Physician's orders Resident #78 to receive grams) by mouth every e disorder, anxiety disorder, sion. Resident #78's medical MS (Abnormal Involuntary sessment had been ission. The AIMS o detect tardive dyskinesia dverse side effect of	F	329			

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		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY
		345426	B. WING			06/12/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
VALLEY V	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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 329	DON reviewed Resid	e 23 /chotic medication. The ent #78's medical record an AIMS assessment.	F 32	9		
F 371 SS=E		OCURE,	F 37	1		7/9/14
	considered satisfacto authorities; and	a sources approved or ry by Federal, State or local stribute and serve food ions				
	by: Based on observatio	is not met as evidenced		1. No residents were injured		
	facility failed to clean nozzles and discard e The findings included	expired food.		this citation. The two spray no to dispense beverages were of the Food Service Director on The out of date Cottage chee	cleaned by 6/9/2014.	
		of the facility on 06/09/14 PM the following concerns		chocolate milk were discarded 6/9/2014 by the Food Service The Food Service Director wa in-serviced on 06/12/14 by the Director regarding cleaning th	e Director. as e Executive	
	dispense multiple bev	spray nozzles used to verages was observed. A		nozzles and discarding expire	ed foods.	
	-	cream colored build-up was lozzles which came in erages dispensed.		 All residents have the pote affected by this citation. On 6 audit of all food was complete Food Service Director, checki 	/9/2014, an ed by the	
	cheese was stored re	ainer of low fat cottage ady for use in the walk in nufacturer expiration date		expiration dates. On 6/13/14, the Food Service in-serviced the Dietary Aides	Director	

Event ID: YYS911

Facility ID: 923155

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					E SURVEY
ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 345426					COMPLETED	
		B. WING			06/12/2014	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EAG	CH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
Continued From pag	e 24	F 37	1			
				ig daily the spray nozzles u	sed	
remained inside the	container.				card	
			foods that	have reached expiration.		
-			e evitive Director and/or Fee	-		
-						
nourishment pantry.					onth,	
On 06/09/14 at 1:00	PM the Food Service		and/or unt	til substantial compliance is		
					l/or	
	•			-		
	-				DOG	
					and	
	•		time a wee	ek for 1 month and/or until		
				-	ny	
	-					
FSD checked the kite	chen cleaning schedule and				nd/or	
had been inadverten	tly left off the cleaning					
				-	e for	
	· ·		complianc	e is obtained. The Quality		
				-		
for removing any foo	d past the expiration date.					
			-		ance	
	CORRECTION ROVIDER OR SUPPLIER IEW CARE & REHAB C SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From pag stamped on the cont Approximately 1/4 of remained inside the 3. Nine, single serve with a manufacturer were stored ready for cartons were in the r shelving in the walk was inside a cooler s nourishment pantry. On 06/09/14 at 1:00 Director (FSD) obset The FSD removed th dispensing units. The should be removed a week. The interior of formed cream colorer measuring approxim removed intact by th other nozzle had a th which encompassed FSD checked the kit noted cleaning the b had been inadvertent schedule. The FSD the dispensing nozzl and cleaned. The FSD milk and cottage che from service and not	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345426 ROVIDER OR SUPPLIER IEW CARE & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 stamped on the container was 05/18/14. Approximately 1/4 of the cottage cheese remained inside the container. 3. Nine, single serve containers of chocolate milk with a manufacturer expiration date of 06/08/14 were stored ready for use. Seven of these cartons were in the milk box cooler and one on shelving in the walk in refrigerator. One carton was inside a cooler stored on a "snack cart" in the	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345426 B. WING	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345426 B. WING ROVIDER OR SUPPLIER STREET ADDRES SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. PREFIX CRO Continued From page 24 F 371 on cleanin to dispense remained inside the container. F 371 3. Nine, single serve containers of chocolate milk with a manufacturer expiration date of 06/08/14 were stored ready for use. Seven of these cartons were in the milk box cooler and one on shelving in the walk in refrigerator. One carton was inside a cooler stored on a "snack cart" in the nourishment pantry. Strevice M UT 2 Cool 2 Co	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345426 B: WING ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901 REW CARE & REHAB CENTER ID (EACH DEPICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTON SHOLD) Continued From page 24 stamped on the container. ID PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTON SHOLD) Continued From page 24 stamped on the container. F 371 on cleaning daily the spray nozzles us to dispense beverages and check da the expiration dates of foods and disk foods that have reached expiration. 3. Nine, single serve containers of chocolate milk with a manufacturer expiration date of 06/08/14 were stored ready for use. Seven of these remained inside the container. F 371 On 06/09/14 at 1:00 PM the Food Service Director (FSD) observed the above concerns. The FSD removed the nozzles from the beverage dispensing units. The FSD reported the nozzles should be removed and soaked/cleaned twice a threas uring approximately 1"X 1/4" which was formed cream colored buildup which encompassed the entire perimeter. The FSD checked the kitchen cleaning schedule. The FSD stated she dint know when the dispensing nozzles had last been removed and cleaned. The FSD could not explain why the milk and cottage cheese had not been removed for removing any food past the expiration date. 4. The results of these audits will be reported to the Quality Assurance Performance	CORRECTION IDENTIFICATION NUMBER: A BUILDING COM A BUILDING STREET ADDRESS. CITY, STATE, ZIP CODE BST KENT STREET ADDREWS, NC 23901 STREET ADDRESS. CITY, STATE, ZIP CODE BST KENT STREET ADDREWS, NC 23901 STREET ADDRESS. CITY, STATE, ZIP CODE BST KENT STREET ADDREWS, NC 23901 STREET ADDRESS. CITY, STATE, ZIP CODE BST KENT STREET ADDREWS, NC 23901 Image: Continued From page 24 stamped on the container was 05/18/14. Approximately 1/4 of the cottage cheese remained inside the container. Image: Continued From page 24 stamped on the container was 05/18/14. Approximately 1/4 of the cottage cheese remained inside the container. F 371 on cleaning daily the spray nozzles used to dispense beverages and check daily the expiration dates of foods and discard foods that have reached expiration. 3. Nine, single serve containers of chocolate milk with a manufacturer expiration date of 06/08/14 were stored ready for use. Seven of these cartons were in the milk box cooler and one on shelving in the walk in refigerator. One carton was inside a cooler stored on a "snack cart" in the nourishment pantry. 3. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of the spray nozzles used the nozzles from the beverage dispensing nuits. The FSD reported the nozzles shad a formed cream colored gelationus matter measuring approximately 1*X 14* which was removed intact by the FSD. The interior of the other nozzle had a thick cream colored buildup which encompassed the entire perimeter. The FSD checket he kitchen cleaning schedule and noted cleaning the beverage dispensing nozzles had last beer removed and cleaned. The FSD could not explain why the milt and cottage cheese had not been remo

Event ID: YYS911

Facility ID: 923155

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/31/2014 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345426	B. WING				06/	12/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE,	ZIP CODE		
VALLEY V	VIEW CARE & REHAB CE	NTER			51 KENT STREET NDREWS, NC 28901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 441	Continued From page	25	F.	441				
F 441 SS=D	483.65 INFECTION C	CONTROL, PREVENT		441				7/9/14
	The facility must estal Infection Control Prog safe, sanitary and cor to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contr in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection	gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions.						
	prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact with direct contact will tran (3) The facility must re hands after each direct hand washing is indic professional practice. (c) Linens Personnel must hand	infection, the facility must prohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which ated by accepted						

Facility ID: 923155

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		06/12/2014	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER			·	STREET ADDRESS, CITY, STATE, ZIP CODI	E
				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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 441	Continued From page	e 26	F 44	11	
	by: Based on observatio staff failed to use prop practices including ha and handling of soiled contamination and so surfaces during 1 of 4 The findings included An observation of inc on 06/11/14 at 12:08 #1 and #2 provided th Resident #87 was lyin when NA #1 checked Resident #87 was ob staff for care. She wa pants which were we brown circled ring wa When NA #1 removed was liquid, yellow sto and on the bottom of incontinence brief wa liquid fecal matter. N/ jogging pants on the #87's bed. NA #1 req providing incontinence because the resident changed. NA #2 ente hand towels. NA #1 a soiled shirt from Resi linen from underneath the floor with the jogg	and washing, glove usage d linens to prevent cross biling of environmental d observations of care. : ontinence care was made PM. Nursing Assistants (NA) ne care for Resident #87. Ing on her right side in bed her for incontinence. served to be dependent on is wearing fleece jogging t across the back and a s present on the bed sheets. d the jogging pants, there ol on the inside of the pants Resident #87's shirt. The s saturated with yellow, A #1 placed the soiled floor at the foot of Resident uested assistance with e care to Resident #87 was resistive to being red the room with 2 wet and NA #2 removed the dent #87 and the soiled in her and NA #1 placed it on jing pants. NA #2 washed		 Resident #87 suffered nothis citation. Resident #87 was by the physician on 06/19/201 orders. Certified Nursing Assistant#1 in-serviced by the Director of 0 Services on 6/11/2014 regardit washing, proper glove usage, handling of linens. Certified Nursing Assistant#2 in-serviced by the Director of 0 Services on 6/11/2014 regardit washing, proper glove usage, handling of linens. All current residents have the to be affected by this citation. The Director of Clinical Service Nursing Supervisor completed observations of hand washing glove usage, and linen handling 06/16/2014 through 06/20/201 The Director of Clinical Service Nursing Supervisor in-service Nursing Supervisor in-service Nursing Assistants and Licens on infection control practices f washing, proper glove usage, handling on 06/16/2014 throug 06/30/2014. The Director of Nursing and/o Supervisor will perform Quality 	s assessed 4 no new was Clinical ing hand and proper was Clinical ing hand and proper he potential es and/or d proper ng 14. vices and/or d Certified sed Nurses for hand and linen gh r Nursing y
	soiled shirt from Resi linen from underneath the floor with the jogg Resident #87's buttoo front to back. Without	dent #87 and the soiled n her and NA #1 placed it on		06/30/2014. The Director of Nursing and/o	r Nursing y Certified and

Facility ID: 923155

If continuation sheet Page 27 of 31

		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345426		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		B. WING		06/12/2014	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	
				551 KENT STREET ANDREWS, NC 28901	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 441	Continued From pag	e 27	F 441		
	incontinence brief un NA #2 then rolled Re pulled the front of the fasten the brief. Whe check Resident #87's pulled the front of the Resident #87's front disposable washclott wiping from front to b observed on the was changing gloves or w and NA #2 then place Resident #87. When the dressing on Resi and NA#2 loosened checked the dressing edge and soiled with notified the wound m needed changed. Will changing Resident # removed the soiled of floor of Resident #87 stain approximately 6 was the same color of visible on the floor w been. On 06/11/14 at 12:45 of Resident #87's roo stain remained uncha	hs. She used 3 washcloths, back, and fecal matter was shcloths each time. Without vashing their hands, NA #1 ed an incontinence brief on asked if they had checked dent #87's coccyx, NA #1 the incontinence brief and g which was loose on one fecal matter. NA # 1 then urse that the dressing hen the nurse was finished 87's dressing, NA #1 clothes and linen from the "'s room. A yellow circular 6 inches in diameter, which of the fecal matter, was here the soiled clothes had 5 PM observation of the floor om revealed the 6 inch yellow anged.		 linen each shift 5 times a week for month, 3 times a week for 1 month times a week for 2 month, and 1 ti- week for 2 months and/or until sub- compliance is obtained. 4. The results of these audits will reported to the Quality Assurance Performance Improvement Comm 6 months and/or until substantial compliance is obtained. The Qual Assurance Performance Improver Committee members consist of bu- limited to the Executive Director, I of Clinical Services, Assistant Direc Nursing, Medical Director, Social Services, Activities Director, Main Director, and Minimum Data Asse Nurse. 	h, 2 ime a ostantial be hittee for hittee for hittee for hittee for birector birector birector birector birector of birector

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/31/2014 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		345426	B. WING			-	06/	12/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VALLEY	VIEW CARE & REHAB CE	NTER			51 KENT STREET ANDREWS, NC 28901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	should have washed area before being ask NA #2 stated she got resident was upset ar front perineal area or wash her hands. Whe expected to do when soiled with fecal matter notify the nurse. An interview was com 06/11/14 at 12:35 PM not have placed the s the floor but she didn' An interview on 06/11 in Resident #87's root was from the liquid fe clothes and linens that floor. NA #1 stated I s housekeeping to clea An interview on 06/11 conducted with the Di The DON stated she wash the resident's fr and to wash from fror wipes as needed to re DON further stated sh the wound nurse or cl was loose or soiled w stated she expected s a bag and not be in d The DON further state change gloves and w removing soiled cloth incontinence care bef	ident. NA #2 stated she Resident #87's front perineal ked to do so by the surveyor. in a hurry because the hd she forgot to wash her change her gloves and en asked what she was a dressing was loose or er, she stated she should ducted with NA #1 on . NA #1 stated she should colled clothing and linen in thave a bag in her pocket. /14 at 12:55 PM with NA #1 m confirmed the yellow stain cal matter that was on the at had been placed in the should have called n it up. /14 at 5:32 PM was irrector of Nursing (DON). expected nurse aides to ont and back perineal area at to back, using multiple emove fecal matter. The he expected staff to notify harge nurse if a dressing rith fecal matter. The DON soiled linens to be placed in irrect contact with the floor. ed she expected staff to ash their hands after	F	441				

Facility ID: 923155

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/31/2014 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345426	B. WING			6/12/2014
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL		
VALLEY V	IEW CARE & REHAB CE	INTER		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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 441	about loose or soiled what staff were exper- visible contamination	e 29 nd nurse or charge nurse dressings. When asked cted to do when there was of environmental surfaces e stated staff should clean up	F 44	1		
F 520		d and notify housekeeping	F 52	0		7/9/14
SS=E	COMMITTEE-MEMB QUARTERLY/PLANS					
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the				
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.				
		ords of such committee h disclosure is related to the ommittee with the				
		by the committee to identify ficiencies will not be used as				
	This REQUIREMENT	is not met as evidenced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345426		. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		B. WING	06/12/2014		
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW CARE & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/12/2014
				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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 520	Based on records re the facility's Quality A monitor if effective sy regarding resident bo The findings included An interview was con Administrator on 06/1 interview the Adminis Quality Assessment a committee met on a r herself, the Medical D Nursing, all departme QA monitoring tools r effective monitoring p	views and staff interviews assurance process failed to stems were in place wel movements. I: ducted with the 2/14 at 5:50 PM. During the trator stated the facility's	F 52	 No residents were injured relate this citation. An audit of resident bowel movern was completed by the Director of Cli Services and/or Nursing Supervisor 6/20/2014. The Interdisciplinary team was re-educated on F520 and the Facility Policy and Procedure for Quality Assurance Performance Improvement the Regional Director of Clinical Ser on 6/24/2014. The Director of Nursing and/or Nurs Supervisor will perform Quality Improvement monitoring of bowel movements utilizing the No BM Rep from Care Tracker 3 times a week for months and/or until substantial compliance is obtained. The results of these audits will be reported to the Quality Assurance Performance Improvement Committ 6 months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee members consist of but to limited to the Executive Director, Dir of Clinical Services, Assistant Direct Nursing, Medical Director, Social Services, Activities Director, Mainter Director, and Minimum Data Assess Nurse. 	ee for ee for ent of ector or of hance

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