STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		4/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete Care Area Assessments that addressed the individual underlying causes, contributing factors and risk factors for 3 of 9 sampled residents. The areas not comprehensively assessed included pressure ulcers (Residents #5 & #6), activities of daily living (Resident #8) and falls (Resident #8). The findings included: 1. Resident #5 was admitted to the facility on 11/05/15. The most recent annual Minimum Data Set (MDS) dated 01/05/17 indicated Resident #5 had short and long term memory problems with diagnoses which included contractures. The MDS also indicated Resident #5 had a pressure reducing device for his bed. Review of the Care Area Triggers (CAT) for the annual MDS dated 01/05/17 indicated pressure ulcers triggered as an area of concern. The Care Area Assessment (CAA) for the annual MDS dated 01/05/17 under "analysis of findings" and "care plan considerations" there was no indication an assessment had been completed. Review of the most recent care plans indicated there was a care plan dated 01/19/17 addressing the risk of development of skin concerns including a	F 272	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of qualify of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings. 483.209(b)(1) COMPREHENSIVE ASSESSMENT A. Corrective actions taken for resident found to have been affected by alleged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 2 pressure areas for Resident #5. During an interview with the MDS Coordinator (MDSC) on 03/15/17 at 8:54 AM the MDSC reviewed the annual MDS dated 12/26/16 for Resident #5 and acknowledged a CAA should have been completed. The MDSC stated sometimes she gets distracted with some of her other work and forgets to go back and complete the CAA. The MDSC also stated she normally looked at the CAT for review of each area triggered and would use all that information for the analysis of findings. The MDSC further acknowledged the information from the CAA was supposed to be used to develop the care plan. During an interview with the Director of Nursing (DON) on 03/15/17 at 9:10 AM the DON stated her expectations were for the CAA's to be done for each area that was care planned. 2. Resident #6 was admitted to the facility on 06/11/08 with the most recent readmission from a hospitalization on 11/03/16. The most recent annual Minimum Data Set (MDS) dated 12/26/16 indicated Resident #6 had short and long term memory problems with diagnoses which included Alzheimer's disease and chronic lung disease with respiratory failure. The MDS also indicated Resident #6 had a Stage 2 pressure ulcer (a blister or a shallow crater on the skin), was receiving pressure ulcer care, and had a pressure reducing device to her bed and her chair. Review of the Care Area Triggers (CAT) for the annual MDS dated 12/26/16 indicated pressure ulcers triggered as an area of concern. The Care Area Assessment (CAA) for the annual MDS dated 12/26/16 under "analysis of findings" and	F 272	deficient practice: The Care Area Assessments (CAA□s) for Residents #5, #6, and #8 were completed on 3/16/17 by the MDS nurses. They include analysis, causes and contributing factors for the triggered areas on the MDS assessment. The Comprehensive Care Plans were also reviewed to ensure accuracy. B. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: The MDS nurses completed a review of all current residents most recent comprehensive MDS assessment on 3/22/17. This audit was conducted to ensure that Care Area Assessments had been completed for MDS care area triggers including pressure ulcers, activities of daily living, and falls. All current residents identified by this audit as needing modification to meet the requirement for Care Area Assessments will be completed to reflect comprehensive analysis of the individual underlying causes, contributing factors, and risk factors. This will be completed by the MDS nurses by or before 4/12/17. C. Measures taken and systems changed to prevent repeat of alleged deficient practice: The MDS staff responsible for completing the comprehensive MDS assessments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 3 "care plan considerations" there was no indication an assessment had been completed. Review of the most recent care plans indicated a care plan addressing Resident #6 having a pressure ulcer, and listing goals and interventions for maintenance and healing. During an interview with the MDS Coordinator (MDSC) on 03/15/17 at 8:54 AM the MDSC reviewed the annual MDS dated 12/26/16 for Resident #6 and acknowledged a CAA should have been completed. The MDSC stated sometimes she gets distracted with some of her other work and forgets to go back and complete the CAA. The MDSC also stated she normally looked at the CAT for review of each area triggered and would use all that information for the analysis of findings. The MDSC further acknowledged the information from the CAA was supposed to be used to develop the care plan. During an interview with the Director of Nursing (DON) on 03/15/17 at 9:10 AM the DON stated her expectations were for the CAA's to be done for each area that was care planned. 3. Resident #8 was admitted on 2/25/16 with diagnoses that included Alzheimer's disease, altered mental status, difficulty walking, lack of coordination, muscle weakness, osteoarthritis, and history of falls. The annual Minimum Data Set (MDS) dated 1/11/17 indicated Resident #8 had severe cognitive impairment and required the assistance of 1-2 staff persons for all activities of daily living (ADL) except eating. Further review revealed Resident #8 was not steady with balance during transitions or walking and had 2 falls with no	F 272	and CAA□ were provided directed in-service training by an outside professional MDS Registered Nurse Consultant on 03/31/17. This training was on the regulatory requirements and RAI Manual guidance on the process and timely completion of Care Area Assessments. The need to complete the CAA□s in their entirety following the completion of the comprehensive MDS assessment was a focus area of the in-service training. Performance Improvement Project initiated and a new MDS tracking tool was implemented on 4/3/17 to ensure total and timely completion of all areas of each required MDS assessment including the Care Area Assessments. The Director of Nursing (DON) will audit all completed comprehensive MDS assessments to assure triggered Care Area Assessments have been completed timely and reflect a comprehensive analysis of the individual underlying causes, contributing factors, and risk factors. This audit began the week of 4/1/17 and will be done weekly through the month of April, then every other week for one month, then monthly for two additional months for a minimum of 4 months. D. Facility plans to monitor its performance to make sure that solutions are sustained. The DON will conduct the audits of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 272	Continued From page 4 injuries since the prior MDS assessment. Review of Resident #8's Care Area Triggers (CAT) for the annual MDS dated 1/11/17 revealed both ADL and Falls triggered as areas of concern. Review of the Care Area Assessments (CAA) for the annual MDS dated 1/11/17 revealed no indication an analysis of findings or care area considerations had been completed for either ADL or Falls. Review of Resident #8's care plans dated 2/25/16 revealed an active plan in place for ADL which included goals and interventions addressing her need for staff assistance with all daily care needs. Further review revealed an active plan in place for Falls, most recently updated 1/3/17, that included goals and interventions for preventing falls. During an interview with the MDS Coordinator (MDSC) on 3/15/17 at 8:54 AM she reviewed the annual MDS dated 1/11/17 for Resident #8 and confirmed the CAA for both ADL and Falls should have been completed. The MDSC indicated she normally looked at the CAT to review each triggered area and would use that information for the analysis of findings. The MDSC acknowledged the information from the CAA was supposed to be used to develop the care plan. During an interview with the Director of Nursing on 3/1/17 at 9:10 AM she stated it was her expectation CAA's would be completed for each area that was care planned.	F 272	comprehensive assessments to assure timely CAA completion beginning week of on 4/1/17 and will be done weekly through the month of April, then every other week for one month, then monthly for two additional months for a minimum of 4 months. The DON will compile the results of these audits and present them to the QAPI committee monthly. The results of these audits to ensure the timely and full completion of the CAA will be reviewed and discussed by the committee in the monthly Quality Assurance Performance Improvement Committee meetings. The QAPI committee will assess and modify this performance improvement action plan as needed to ensure timely completion of CAA and maintain continual compliance with F272.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS (c) Quarterly Review Assessment. A facility must	F 276		4/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 276	Continued From page 5 assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 9 residents reviewed (Resident #3). Findings included: Resident #3 was readmitted on 12/30/16 with diagnoses that included chronic obstructive pulmonary disease (difficulty breathing), dysphagia, diabetes, hypertension, depression, and oxygen dependence. A review of Resident #3's MDS assessment history revealed the most recent quarterly assessment dated 1/30/17 was marked as "open." During an interview on 3/15/17 at 8:54 AM with the MDS Coordinator (MDSC) she reviewed the MDS assessment history for Resident #3 and stated she was unaware the quarterly MDS dated 1/30/17 was still open. The MDSC indicated it had been an oversight and should have been done in February 2017. The MDSC explained sometimes she gets distracted with some of her other work and forgets to go back to complete what she had been working on at the time. The MDSC confirmed she had not fully completed or submitted the MDS assessment within the required time frame.	F 276	483.20(c) Quarterly Review Assessments A. Corrective actions taken for resident found to have been affected by alleged deficient practice: The Quarterly MDS assessment for Resident # 3 was completed on 3/18/17 by the MDS nurse. B. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: The MDS Nurses completed an audit of all other residents currently residing in the facility on 03/18/17 to determine if Quarterly MDS assessments had been completed for all residents requiring a quarterly review assessment. MDS nurses completed all required quarterly review assessments for any current resident due by or before 3/31/17. C. Measures taken and systems changed to prevent repeat of alleged deficient practice: The MDS nurses responsible for completing the Quarterly Review Assessments were in-serviced by professional Nurse Consultant on 03/31/17 on the regulatory requirements and RAI Manual guidance on timely	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 276	Continued From page 6 During an interview with the Director of Nursing on 3/15/17 at 9:10 AM she stated it was her expectation for MDS assessments to be completed and submitted on time.	F 276	completion of Quarterly Review Assessments and the use of a tracking tool to ensure quarterly reviews are not missed. New Performance Improvement Project and MDS tracking tool implemented on 4/3/17 to ensure timely completion of all elements of each required assessment. The Director of Nursing (DON) will conduct an audit to review and monitor all required Quarterly Review Assessments to assure timely completion. This Quarterly Review QAPI audit will be done weekly for one month beginning 4/3/17, then every other week for one month, then monthly for two additional months, for a minimum of 4 months. D. Facility plans to monitor its performance to make sure that solutions are sustained: The DON began the Quality Assurance Performance Improvement audits of the Quarterly Review Assessments to ensure timely completion on 4/3/17. The audits will be done weekly for one month, then every other week for one month, then monthly for two additional months, for a minimum of 4 months. The results of these performance improvement audits of the Quarterly Review assessments will be presented by the DON for reviewed and discussion in the monthly Quality Assurance Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 276	Continued From page 7	F 276	meetings. The QAPI committee will assess and modify this performance improvement action plan as needed to ensure timely completion of MDS Quarterly Review Assessments and to maintain continual compliance with F276.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 309	Continued From page 8 (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and physician interviews the facility failed to begin wound care treatment upon facility admission for 1 of 3 residents (Resident #1) reviewed for providing care to maintain well-being. The findings included: Resident #1 was admitted to the facility on 01/09/17 with diagnoses including chronic lung disease, heart failure, kidney disease, diabetes, peripheral vascular disease (narrowing of the blood vessels supplying the legs and feet) and pain in his lower legs. The 5 day admission Minimum Data Set (MDS) dated 01/16/17 indicated Resident #1 required limited assistance with bed mobility, transfers, toileting and hygiene, and needed extensive assistance with bathing. The MDS also indicated Resident #1 received scheduled pain medications and as needed pain medications. The MDS also indicated Resident #1 had no pressure ulcers on admission but did have 2 venous or arterial ulcers present. Record review indicated Nurse #1 admitted Resident #1 and completed his admitting nursing assessment on 01/09/17. The assessment indicated Resident #1 told Nurse #1 he knew where his wounds were and acknowledged they	F 309	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR THE HIGHEST WELL BEING A. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #1 discharged from this facility on 1/25/17. B. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice: Skin Assessments were initiated on 3/15/17 and completed by 3/17/17 for all current residents by the Director of Nursing and/or the Nursing Supervisor. These skin assessments were completed to ensure that all current residents with identified skin issues requiring medical treatment had a current treatment ordered. No other residents identified to be affected by alleged deficient practice. C. Measures taken and systems changed to prevent repeat of alleged deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 309	Continued From page 9 were on his foot. The nursing assessment did not state whether Nurse #1 had examined his wounds at that time. Record review indicated a body map assessment (unclothed head to toe assessment of skin) was completed by Nurse #1 on 01/09/17. The assessment indicated Resident #1 had non-pressure wounds on his right foot. These included a diabetic foot ulcer on his right heel and an arterial ulcer on the 2nd toe of his right foot. Record review of the Treatment Administration Record (TAR) for January 2017 indicated the first treatment written and started on Resident #1's wounds to his feet was on 01/14/17. During an interview with the Wound Care Nurse (WCN) on 03/14/17 at 12:18 PM, the WCN stated Resident #1 had wounds on his right foot upon admission according to the nursing admission assessment. The WCN was unable to locate any documentation on the Treatment Administration Record (TAR), Medication Administration Record (MAR) or in nurse's notes that a treatment had been started for the wounds of Resident #1 on his admission date of 01/09/17. The WCN did state the first notation of a treatment for Resident #1's wounds was on 01/14/17, six days after his admission. The WCN stated she was out of work the week of 01/09/17 through 01/13/17 and did not know about his wound until her return to work on 01/16/17. The WCN stated Resident #1 had been to the Wound Care Clinic (WCC) on 01/16/17 and she discontinued the original physician's order written for 01/14/17 and wrote physician's orders indicated by the WCC on 01/16/17 to 1) clean the wound on his 2nd toe right foot with a wound cleanser, apply a	F 309	1. Registered Nurse #1 received one-on-one directed in-service on 3/14/17 from the Director of Nursing. The focus of the retraining is to ensure that full head to toe skin assessments are completed on every new admission and readmission to the facility, ensuring all identified skin issues requiring a treatment are addressed during the admission process, and ensuring appropriate treatment intervention is initiated per the standing order protocol or notification to medical provider if necessary for other prescribed treatment, and the impending consequences of failure to comply. 2. In-service training presented by the Director of Nursing for all licensed nursing staff, initiated on 3/14/17 and completed 3/21/17. The focus of the in-service was to ensure that head to toe skin assessments are completed on every new admission and readmission to the facility, ensure that skin issues identified during this assessment are addressed during the admission process by initiating treatment per the facility standing orders protocol or by notification to medical provider if needed for other prescribed treatment, and the consequences of failure to comply. 3. The DON initiated a Performance Improvement Project for the timely initiation of treatments to identified skin issues for all newly admitted and readmitted residents. The DON will review all head to toe skin assessments of new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 309	Continued From page 10 medicated ointment and bandage for his toe and wrap it and to 2) clean the open area on the right heel with a wound cleanser, apply a medicated ointment and wrap it. During an interview with the Physician (MD) for Resident #1 on 03/14/17 at 12:28 PM, the MD stated Resident #1 had come into the facility with significant vascular ulcers. The MD also stated the practice he was with also managed the previous facility Resident #1 came from and he was aware that Resident #1 had a history of having non-pressure ulcers on his feet. The MD further stated he saw Resident #1 on 01/10/17 but did not look at his feet because he knew he was going to the Wound Care Clinic. The MD also stated Resident #1 was asked about pain during this visit and denied any pain with his feet. During an interview with Nurse #1 by telephone on 03/14/17 at 12:39 PM, Nurse #1 acknowledged she had admitted Resident #1 but could not remember much about him. After reading part of her nursing admission note for Resident #1 dated 01/19/17 to her, Nurse #1 acknowledged if she asked Resident #1 if he knew where his wounds were and he told her, she would have looked at his wounds. Nurse #1 also stated if someone came into the facility with a wound and no orders she would start a treatment for wound care based on standing physician's orders or she would leave a message for the Wound Care Nurse (WCN), notifying her of the wound. Nurse #1 stated she was unsure whether she started a treatment or left a message for the wound care nurse. During an interview with Nurse #2 on 03/14/17 at 1:09 PM, Nurse #2 indicated one of the Nurse	F 309	admission and readmission residents to ensure skin issues identified during the admission process have timely initiation of the appropriate treatment during the completion of the admission process. The DON began the audits on the week of 3/26/17 and will conduct them weekly through the month of April, then every other week for one month, then monthly for two additional months through the end of July for a minimum of 4 months. D. Facility plans to monitor its performance to make sure that solutions are sustained: The DON began audits the head to toe skin assessments of newly admitted and re-admitted residents for the timely initiation of treatments to identified skin areas requiring medical treatments on 3/26/17 and the audits will run for a minimum of 4 months. The DON will present the results of this quality assurance performance improvement (QAPI) project for review and discussion in the monthly Quality Assurance Performance Improvement Committee meetings. The QAPI committee will assess and modify this performance improvement project as needed to ensure the timely initiation of treatments to identified skin areas and to maintain continual compliance with F309.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 309	Continued From page 11	F 309		

Aides (NAs) came to her on 01/14/17 and told her Resident #1 was having pain in his foot. Nurse #2 went to assess Resident #1 and stated he told her he was worried because they had not put a dressing on his foot since he arrived at the facility and he wanted it covered because when there was a dressing on his foot it did not hurt as much. Nurse #2 stated she checked his right foot and there was not a dressing on his heel or on his 2nd right toe. Nurse #2 stated she went by standing orders and started a treatment plan for Resident #1 and left notification for the WCN of what she had started for him.

During an interview with NA #2 on 03/15/17 at 10:07 AM, NA #2 stated Resident #1 did not need a lot of care and preferred to do as much for himself as possible. NA #2 did not recall seeing Resident #1 ' s wounds on his foot but remembered that he asked her twice for pain medication and she left the room on both occasions and went to the medication nurse to inform her.

During an interview with the Physician (MD #2) from the WCC on 03/15/17 at 11:04 PM, MD #2 stated Resident #1 had an arterial blood supply problem which was leading to his wounds. MD #2 acknowledged Resident #1 had been a patient of the WCC for several months. MD #2 also stated Resident #1 had ongoing vascular deterioration and his health decline was not affected by not having treatment or bandaging to the wounds on his feet for 6 days.

During an interview with NA #4 on 03/15/17 at 11:37AM, NA #4 stated Resident #1 usually refused morning care and preferred to do everything on his own. NA #4 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 03/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 309	Continued From page 12	F 309		

remembered he had something wrong with his foot but does not remember seeing his wounds. NA #4 also stated Resident #1 would only let you assist him on his terms and would often refuse care.

During an interview with the Director of Nursing (DON) on 03/15/17 at 12:45PM, the DON stated her expectations were for the admitting nurse to assess a wound and start treatment if there were no orders for a treatment. The DON also stated she expected the admitting nurse to let the MD know that day and get specific orders or to use standing orders to start wound treatment.