CENTERS FOR MEDICARE & MEDICARD SERVICES         OMB NO. 0938.03           AND PLAN OF CORRECTION         IN IPROVIDE/BURGELANDA NUMBER:         A BULONG         (R) DATE SUPPRY COMPLETED	DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					RM APPROVED	
AND PLAN OF CORRECTION     IDENTIFICATION NUMBER     A BUILDING     COMPLETED       34502     B. WNO     C     04/00/2017       TAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, 2P CODE     STREET ADDRESS, CITY, STATE, 2P CODE       VALLEY VIEW CARE & REHAB CENTER     STREET ADDRESS, CITY, STATE, 2P CODE     STREET ADDRESS, NO 28901       VALLEY VIEW CARE & REHAB CENTER     STREET ADDRESS, NO 28901     OVEL TO THE APPROVENTIAL DECONSTRUCTION SINUL DECONSTRUCTION SINUL DECONSTRUCTION SINUL DECONSTRUCTION SINUL DECONSTRUCTION SINUL DECONSTRUCTION DECONSTRUCTION CONSTRUCTION DECONSTRUCTION DECONSTRUCTIO	CENTER	S FOR MEDICARE &	MEDICAID SERVICES						
345426         B_WMO         04/06/2017           INVALE OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STREE, JP CODE           VALLEY VIEW CARE & REHAB CENTER         STREET ADDRESS, CITY, STREE, JP CODE           OWID         STREET ADDRESS, CITY, STREE, JP CODE           OWID         STREET ADDRESS, CITY, STREE, JP CODE           OWID SUMMY STREEM OF DEFICIENCES         STREET ADDRESS, CITY, STREE, JP CODE         OWID SUMMY STREEM OF DEFICIENCES           OWID SUMMY STREEM OF DEFICIENCES         STREEM STREEM OF DEFICIENCES         OPENDED TO THE APPROPRIATE         OWIP TO DEFICIENCY           STREEM SET TO MORE CONSTRUCTION         THE ORDERS PLAN OF CORRECTION         OWIP TO DEFICIENCY           STREEM STREEM SET ADDRESS, CITY, STREE, JP CODE         STREEM SET ADDRESS, CITY, STREE, JP CODE           TO STREEM SET ADDRESS, CITY, STREE, JP CODE           STREEM SET ADDRESS, CI				` '			COMPLETED		
VALLEY VIEW CARE & REHAB CENTER         SS KENT STREET ANDREWS, NC 28901           PHETRX Trac         SUMMARY STATEMENT OF DEPICIENCIES (exch DEPICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)         IPREFX TAG         CROSS-REFERENCED TO THE APPORTATE DEPICENCY         OCUMENTIAL (EACH OENDRECTIVE)         IPREFX (EACH OENDRECTIVE)         STATUS           F 155         483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES         F 155         5/3/17           483.10         (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.         F 155         5/3/17           (c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment and, at the residents concerning the right to accept or refuse medical or surgical treatment advance directives and applicable State law.         (i) These requirements advance directives and applicable State law.         (ii) Facilities are permitted to contract with other entities to furnish this incomposite to a refuse medical or surgical treatment advance directives and applicable State law.         (ii) Facilities are permitted to contract with other entities to furnish this incompacitated at the findom and provide for ensuring that the requirements of this secton are met.         (iv) If an adult individual is incappositeted at the findom and provide reference information or attrubate whether or on the or she has executed an advance directive, the facility my give advance directive information to the or she has executed an advance directive information to the			345426	B. WING			0	-	
VALUE VIEW CARE & REHAB CENTER         ANDREWS, NC 28901           (PA) IN PRETX TAG         ISJUMMARY SIXTEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE HEREDED BY FULL) REQUARCENT VALUE SETURATION OF LOS DEMINIFUNDATION REQUARCENT VALUE SETURATION OF LOS DEMINIFUNDATION REQUARCENT VALUE SETURATION OF LOS DEMINIFUNDATION REQUARCENT VALUE SETURATION OF LOS DEMINIFUNDATION REPORTS (INC.)         ID PRETX REPORTS (INC.)         PROVIDERS FUND OF CORRECTION (CROSS-REPERDEDING ALL OF CORRECTION REPORTS (INC.)         ID PRETX REPORTS (INC.)         ID PROVIDERS FUND OF CORRECTION (CROSS-REPERDEDING ALL OF CORRECTION REPORTS (INC.)         ID PRETX REPORTS (IN	NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
DATE         Description           PRETX TAG         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTIONY OR LSC DEPICIENCY MUST BE PRECEDED BY FULL REGULTIONY OF DEPICIENCY         PREFX TAG         CONVERTS CROSS REFERENCE TO THE MARPORENTE DEFICIENCY         S/3/17           F 155         483.10 (c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES         F 155         S/3/17           483.10 (c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES         F 155         S/3/17           (c)(8) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.         F 155         S/3/17           (j) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).         (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment advance directive.         (ii) Facilities are permitted to contract with other entities to furnish information to at a sull legally responsible for ensuring that the requirements of this section are met.         (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or aticulate whether or on t			NTED		5	551 KENT STREET			
PREFX Trog         (EACH DEFICIENCY MET & PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)         PREFX Tag         CEACH DEFICIENCE AND AND DEFICIENCE OF CROSS-REFERENCE OT OT ME APPROPRIATE DEFICIENCY)         COMULTINE DEFICIENCY           F 155         483.10 (c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.         F 155         5/3/17           (c)(8) Nothing in this paragraph should be construct as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.         (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart 1 (Advance Directives).         (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directives and applicable State law.         (ii) Facilities are permitted to contract with other entities to furnish this information to at a still legally responsible for ensurging that the requirements percented to contract with other entities to furnish this information to at as still legally responsible for ensurging that the requirements of this section are met.         (iv) If an adult individual is incapacitated at the tinor adult individual is incapacitated at the tinor advance directive, the facility my give advance directive,	VALLET					ANDREWS, NC 28901			
SS=D       REFUSE; FORMULATE ADVANCE DIRECTIVES         483.10       (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION	
<ul> <li>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</li> <li>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the</li> </ul>	F 155	483.10(c)(6)(8)(g)(12 REFUSE; FORMULA 483.10 (c)(6) The right to req discontinue treatment to participate in experi formulate an advance c)(8) Nothing in this p construed as the right the provision of media services deemed medi inappropriate. (g)(12) The facility murequirements specifie subpart I (Advance D (i) These requirement inform and provide wiresidents concerning medical or surgical tra- resident's option, form (ii) This includes a w facility's policies to im	), 483.24(a)(3) RIGHT TO TE ADVANCE DIRECTIVES uest, refuse, and/or t, to participate in or refuse rimental research, and to e directive. baragraph should be t of the resident to receive cal treatment or medical dically unnecessary or ust comply with the ed in 42 CFR part 489, irectives). ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directives.			DEFICIENCY)		5/3/17	
time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the		(iii) Facilities are pern entities to furnish this legally responsible fo	nitted to contract with other information but are still r ensuring that the						
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		time of admission and information or articula has executed an adva may give advance dir individual's resident r	d is unable to receive ate whether or not he or she ance directive, the facility rective information to the epresentative in accordance						

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.

05/02/2017

FICIENCIES RRECTION DER OR SUPPLIER CARE & REHAB CEI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILDIN B. WING _ ID PREFID TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION	(X3) DATH COM 04	D. 0938-0391 E SURVEY PLETED C /06/2017
CARE & REHAB CEI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	NTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 551 KENT STREET ANDREWS, NC 28901 C PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RRECTION SHOULD BE	/06/2017
CARE & REHAB CEI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	551 KENT STREET ANDREWS, NC 28901 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	RECTION SHOULD BE	(X5)
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	ANDREWS, NC 28901 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5)
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5)
(EACH DEFICIENCY REGULATORY OR L ntinued From page h State law.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5)
h State law.	1				COMPLETION DATE
X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 155       Continued From page 1 with State law.         (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.         483.24       (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.         This REQUIREMENT is not met as evidenced by:       Based on record review, resident and staff interview the facility failed to clarify resident choice for code status for 1 of 1 resident reviewed for advance directives (Resident #2).         The findings included:       Resident #2 was admitted to the facility on 03/24/17 with diagnoses including prostate			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         155         155         155         Advanced Directives Quality Review was completed on current residents by the Director of Clinical Services/or Nurse Supervisor on 4/13/2017 to identify any further issues. Issues identified were		DATE
mission Minimum D this investigation. cord review of the r lection tool, comple mission to the facilit was alert and orien ce with no memory lected also indicate	Data Set (MDS) at the time nursing admission data eted on 03/24/17 upon ty for Resident #2, indicated nted to person, time and problems. The data ed Resident #2 was		Nursing. The Regional Director of Clinic in-serviced Social Worker on of Advanced Directives upon adr Advance Directive policy and p on 4/6/2017. The Director of C Service and/or Nursing Super- re-educated Licensed Nurses	cal Services obtaining nission and procedure clinical visor	
ovisite provide solution of the solution of th	vide this information the is able to receir pow-up procedures information to the ropriate time. 24 3) Personnel provi- uding CPR, to a re- ergency care prior- lical personnel and sician orders and to ctives. REQUIREMENT sed on record revi- roiew the facility fa- ce for code status ewed for advance findings included: ident #2 was adm 24/17 with diagnos cer with metastasi ers. Resident #2 co ission Minimum E is investigation. ord review of the fa- cition tool, comple- nission to the facili vas alert and orier e with no memory ected also indicate	The facility is not relieved of its obligation to vide this information to the individual once he he is able to receive such information. bw-up procedures must be in place to provide information to the individual directly at the ropriate time. 24 3) Personnel provide basic life support, uding CPR, to a resident requiring such ergency care prior to the arrival of emergency lical personnel and subject to related sician orders and the resident's advance ctives. 9 REQUIREMENT is not met as evidenced sed on record review, resident and staff rview the facility failed to clarify resident ce for code status for 1 of 1 resident ewed for advance directives (Resident #2). findings included: ident #2 was admitted to the facility on 24/17 with diagnoses including prostate cer with metastasis to the bone, among rs. Resident #2 did not have a completed hission Minimum Data Set (MDS) at the time his investigation. ord review of the nursing admission data ection tool, completed on 03/24/17 upon hission to the facility for Resident #2, indicated was alert and oriented to person, time and e with no memory problems. The data ected also indicated Resident #2 was	The facility is not relieved of its obligation to vide this information to the individual once he he is able to receive such information. ow-up procedures must be in place to provide information to the individual directly at the ropriate time. 24 3) Personnel provide basic life support, using CPR, to a resident requiring such ergency care prior to the arrival of emergency tical personnel and subject to related sician orders and the resident's advance ctives. <b>a</b> REQUIREMENT is not met as evidenced sed on record review, resident and staff riview the facility failed to clarify resident ce for code status for 1 of 1 resident eved for advance directives (Resident #2). findings included: ident #2 was admitted to the facility on PA/17 with diagnoses including prostate cer with metastasis to the bone, among ers. Resident #2 did not have a completed tission Minimum Data Set (MDS) at the time tis investigation. ord review of the nursing admission data action tool, completed on 03/24/17 upon tission to the facility for Resident #2, indicated was alert and oriented to person, time and the with no memory problems. The data acted also indicated Resident #2 was	The facility is not relieved of its obligation to ide this information to the individual once he he is able to receive such information.       Image: Constraint on the individual directly at the ropriate time.         24       3) Personnel provide basic life support, ording CPR, to a resident requiring such regency care prior to the arrival of emergency tical personnel and subject to related sician orders and the resident's advance ctives.       Image: Constraint on the individual of emergency tical personnel and subject to related sician orders and the resident's advance ctives.         REQUIREMENT is not met as evidenced       Image: Constraint on the individual order of the arrival of emergency tical personnel and subject to related sician orders and the resident seved for advance directives (Resident #2).       Image: Constraint on the individual order of the arrival of the facility on the facility on the tastasis to the bone, among the resident #2 was admitted to the facility on the facility for Resident #2, indicated was alert and oriented to person, time and ewith no memory problems. The data to the facility for Constraint on the facility for Resident #2, was       Advance Directive policy and on 4/6/2017. The Director of Clinical Services of Constraint on the service and/or Nursing Supervise on 4/6/2017. The Director of Clinical Service and/or Nursing Supervise on the facility on the facility for Resident #2, was	The facility is not relieved of its obligation to idde this information to the individual once he he is able to receive such information.       Image: Complete the im

Facility ID: 923155

If continuation sheet Page 2 of 9

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/02/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X1) PROVIDER/SUPPLIER/CLIA	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345426	B. WING				C / <b>06/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	•	·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IEW CARE & REHAB CE			55	51 KENT STREET		
VALLEIV		ENTER		Α	NDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 155	Continued From page speech.	e 2	F	155	rights concerning the right to accept or refuse medical or surgical treatment a		
	<ul> <li>Record review of the policies and procedures for advance directives for admission/social service with an effective date of 11/30/2014 indicated the following:</li> <li>"3. Social Services and/or Admissions staff must complete the Advance Directives Discussion Document <ul> <li>a. indicate the resident's wishes to provide or withhold Cardiopulmonary Resuscitation (CPR)".</li> </ul> </li> <li>Record review of the Advance Directive Discussion Document dated 03/24/17 indicated Resident #2 signed the document which indicated his wishes were for the facility to "withhold" CPR. A facility representative, the Admissions Coordinator, also signed the document, but was no longer employed by the facility at the time of this investigation.</li> <li>Record review of physician's orders dated 03/24/17 indicated "resident to be full code."</li> <li>During a staff interview with the Social Services Director (SSD) at 9:10 AM on 04/06/17, the SSD stated the Admissions Coordinator talked with all parties about advance directives upon admission. The SSD also stated there should be a Medical Orders for Scope of Treatment (MOST) form for every resident in the facility. Upon review of the chart for Resident #2, the SSD verified there was no MOST form present.</li> </ul>				to formulate advanced directives. Qua Improvement Monitoring of MOST/advanced Directive/physicians order for matching qualities one time week for three months then every oth week thereafter for one year by Exect Director, Director of Clinical Services introduced the plan of correction to Q Assurance Performance Improvemen Committee on 5/1/2017. The results of Quality Improvement Monitoring to be reported to the Quality Assurance Performance Improvement Committee the Director of Clinical Services or designee upon DCS absence. The Quality advance committee members consist of but no limited to Executive Director, Director Clinical Services, Assistant Director of	ality a er utive uality t of the e by uality t t of	
					Clinical Services, Unit Manager, Socia Services, Medical Director, Maintenar Director, Housekeeping Services, Die Manager, and Minimum Data Set Nur and minimum of one direct care giver Quality Improvement monitoring sche monitoring modified based on findings	al nce tary se dule	

If continuation sheet Page 3 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/02/2017 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		PLETED	
		345426	B. WING			C 04/06/2017		
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY V	IEW CARE & REHAB CE	NTER			551 KENT STREET ANDREWS, NC 28901			
(X4) ID PREFIX TAG			ID PREFIZ TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 155 F 441 SS=E	so a resident's wishes RDCS further acknow been in the facility for have expected this to day in the facility. During a staff interview Nursing (DON) at 10: DON stated her expect about a resident's pre- or do not resuscitate of shortly thereafter. During a staff interview Director (MRD) at 11: MRD stated she dropp physician's orders from her way home from w verified there was not physician's order for a signed and waiting to medical records. During an interview w on 04/06/17, Residen CPR withheld in the e pulse and not breathin 483.80(a)(1)(2)(4)(e)( PREVENT SPREAD, (a) Infection prevention	ance directives to be made a could be honored. The dedged Resident #2 had 14 days and she would be clarified before his 14th w with the Director of 14 AM on 04/06/17, the ctations for clarification ference for either a full code either on admission or w with the Medical Records 17 AM on 04/06/17, the ped off and picked up m the physician's office on ork every Friday. The MRD a MOST form or a a full code that had been be filed for Resident #2 in ith Resident #2 at 1:06 PM t #2 validated he wanted event he was found without a ng. f) INFECTION CONTROL, LINENS on and control program. blish an infection prevention IPCP) that must include, at		155			5/3/17	
	a minimum, the follow (1) A system for preve	enting, identifying, reporting,						

Facility ID: 923155

If continuation sheet Page 4 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
		(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER.	A. BUILDI	NG _		C		
		345426	B. WING				06/2017	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY V	IEW CARE & REHAB CE	NTER			551 KENT STREET ANDREWS, NC 28901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 441	<ul> <li>volunteers, visitors, an providing services und arrangement based u conducted according accepted national statimplementation is Phate (2) Written standards, for the program, which limited to:</li> <li>(i) A system of surveil possible communicable before they can spread facility;</li> <li>(ii) When and to whore communicable disease reported;</li> <li>(iii) Standard and transito be followed to prevere (iv) When and how isseresident; including bur (A) The type and durated depending upon the in involved, and (B) A requirement that least restrictive possible circumstances.</li> <li>(v) The circumstances</li> </ul>	Attrolling infections and ses for all residents, staff, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards (facility assessment ase 2); , policies, and procedures h must include, but are not lance designed to identify ble diseases or infections ad to other persons in the in possible incidents of se or infections should be asmission-based precautions ent spread of infections; olation should be used for a t not limited to: atton of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the is under which the facility ees with a communicable	F	441				

Facility ID: 923155

If continuation sheet Page 5 of 9

		ID HUMAN SERVICES				FORM	APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345426		IDENTIFICATION NUMBER:	A. BUILDI	NG_		COMP	LETED	
		B. WING			C 04/06/2017			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	00/2017	
				5	51 KENT STREET			
VALLEY V	IEW CARE & REHAB CE	INTER		A	NDREWS, NC 28901			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 441	Continued From page	2.5	F.	441				
		s or their food, if direct						
	contact will transmit th							
	(vi) The hand hygiene by staff involved in di	e procedures to be followed rect resident contact.						
	(4) A system for reconunder the facility's IPC actions taken by the f							
	(e) Linens. Personne							
	process, and transpo spread of infection.	rt linens so as to prevent the						
	annual review of its IF program, as necessa	•						
	Based on record revi	iew and staff interviews, the their infection control policy			F441			
		of 1 residents reviewed with			Resident #6 was assessed for further			
	head lice (Resident #	6) resulting in infestation to			evidence of lice on 4/7/2017 by the			
	5 employees (House				Director of Clinical Services and/or			
		ist, Speech Therapist, and who had provided Resident			Nursing Supervisor. No further issues identified.			
	Findings included:				The Director of Clinical Services and/o Nursing Supervisor did assessments o current residents and staff on 4/7/2017	f		
		s "Lice Infestation" policy an effective date of 11/30/14,			identify any new or re-occurring lice.			
	•	was "to prevent the spread			The Director of Clinical Services and/o	r		
	of lice and to provide	treatment to resident's with			Nursing Supervisor re-educated currer	ıt		
	a diagnosis of lice."				nursing staff on infection control/Lice			
	included the following	steps:			Infestation/Isolation Precautions and			
	1) "1 Notify physici	an of resident's symptoms			proper handling of linen 4/7/2017-5/2/2017. The Director of			
		an of resident's symptoms. orders and place resident in			Clinical Services and or Nursing			

Facility ID: 923155

If continuation sheet Page 6 of 9

						IO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345426	B. WING		0	C 4/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
VALLEY V	IEW CARE & REHAB CI	ENTER		551 KENT STREET		
				ANDREWS, NC 28901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 441	Continued From page	e 6	F 44	11		
	contact isolation"			Supervisor to preform hair in	spections on	
		perform a head check of all		nursing staff and residents t		
	other residents in the			for eight weeks and once a	week for four	
	<ol> <li>"13. Facility will   the staff"</li> </ol>	perform a head check of all		weeks for reoccurrence of li based on findings.	ce. Follow up	
	Resident #6 was adn	nitted to the facility on		Director of Clinical Services	introduced	
	3/15/17.	initied to the idenity of		the plan of correction to the		
				Assurance Performance Im		
	Review of the nurses	' notes for Resident #6		Committee on 5/1/2017. The	e results of the	
		ted 3/21/17 which read in		Quality Improvement Monito		
		at looks like lice in hair.		reported to the Quality Assu		
		d new order received.		Performance Improvement the Director of Clinical Servi	ces or	
	Review of Resident # the following Physicia	≉6's medical record revealed an Orders:		designee in DCS absence. Assurance Performance Im Committee members consis	provement	
		nair with NIX lice treatment." with NIX shampoo 3/22/17 for		limited to Executive Director Clinical Services, Unit Mana		
	second treatment."			Services, Medical Director,		
		ectin (medication used to		Director, Housekeeping Ser		
	mouth times one dos	as head lice) 12 milligram by		Manager, and Minimum Dat and a minimum of one direct		
		try 3/31/17: contact isolation -			conc giver.	
	-	/ topical lice shampoo per				
		nes. Comb hair, check for				
	nits/lice every 2-3 da	ys for 2-3 weeks until gone."				
		sident #6 on 4/5/17 at 9:49				
		d been notified by staff,				
		go" that she had head lice. ot recall being told she was				
		ons, but they had told her she				
		oom. Resident #6 added				
		when coming				
	into her room to prov					

If continuation sheet Page 7 of 9

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI				FORM OMB NO	D: 05/02/2017 APPROVED D: 0938-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	· · ·				(X3) DATE SURV COMPLETED	
		345426	B. WING			_		06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VALLEY VIEW CARE & REHAB CENTER					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 PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	responsible for infecti the facility's Infection DON indicated the ph Resident #6's sympto head lice on 3/21/17 a orders. The DON wa precautions were initi confirmed a facility-wi residents and staff ha 3/21/17. The DON st lice was found when I rechecked on 3/31/17 medication per physic a facility-wide head cl and staff was conduc revealed 5 employees Occupational Therapist wh contact with Resident found to be infected v only one other residen been infected, but up of head lice was ident all the employees me had all received treatur returning to work. An interview with the Services (RDCS) on she had not been info lice until 3/31/17. The expectation that staff infection control polici facility-wide head che on 3/21/17 when the I discovered. She furth have expected for sta	ion control as of 4/3/17 when Control Nurse had quit. The hysician had been notified of oms and was treated for and 3/22/17 per physician is not positive isolation ated on 3/21/17 and ide head check of all other ad not been conducted on rated evidence of more head Resident #6 had been 7 and was retreated with oral cian orders. She confirmed heck of all other residents ted on 3/31/17 which s (Housekeeper, Nurse Aide, ist, Speech Therapist, and no all had been in direct t #6 since 3/21/17) were with head lice. She added nt was suspected to have on assessment no evidence tified. The DON confirmed antioned were sent home and ment for head lice prior to Regional Director of Clinical 4/6/17 at 9:34 AM revealed ormed Resident #6 had head e RDCS stated it was her would have followed the y and performed a eck of all residents and staff	F	441				

Facility ID: 923155

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/02/2017 / APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345426	B. WING					C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STA	TE, ZIP CODE		
VALLEY	VIEW CARE & REHAB CE	INTER			51 KENT STREET NDREWS, NC 28901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 441	A follow-up interview conducted on 4/6/17 stated "the ball was d head lice was discove infection control proto followed. An interview with the at 11:34 AM revealed notified when it was o head lice and would g He further indicated o implemented until the for at least 24 hours. An interview with the 4:54 PM revealed he residents and staff sh 3/21/17 when the hea since Resident #6 wa be affected at that tim infection control polic	with the DON was at 10:14 AM. The DON lropped the first time the ered" and confirmed bool had not been initially Medical Director on 4/6/17 he would expect to be letermined a resident had give an order for treatment. contact isolation should be e resident had been treated Administrator on 4/6/17 at was unaware that other would have been checked on ad lice was first discovered is the only known person to ne. He reviewed the facility's	F	441				

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