STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide a safe, clean environment as evidenced by loose floor tiles in 1 of 2 shower rooms, a loose commode seat in 1 of 3 bathrooms on the D hall affecting 3 sampled residents (Residents #6, #49, #55), stains on 1 of 1 feeding pumps as well as stained floor tiles under the feeding pump and a missing chair rail in 1 of 9 resident rooms on the A hall. The findings included: 1. On 09/21/17 at 12:30 PM observations were made of the shower room on D hall. A shower chair was observed in the shower stall. The flooring in the shower stall was tile and each tile measured approximately 2" X 2". Eighteen tiles were observed unattached to the floor and two tiles were loosely attached to the floor. These tiles were all in the vicinity of the area where the legs of the shower chair would come in contact when rolled into and out of the shower stall. Nurse Aide (NA) #1 was working on the D hall at the time of the observation and stated the loose tiles had been reported to maintenance approximately 8 weeks prior. NA #1 stated the loose tiles were concerning because the shower chair would get caught in the uneven flooring (when the tiles popped out) and the shower chair had to be steadied to keep from falling forward. On 09/21/17 at 4:15 PM the interim Director of	F 253	1.) Root cause analysis conducted and found a communication breakdown between different departments in reporting issues for repair and/or cleanliness.Maintenance Department or Housekeeping supervisor to repair the D hall shower room tiles after the plumber repairs the leak causing them to loosen by 10/18/17. The loose toilet seat in the bathroom shared by Res # 6, 49, 55 was repaired on 9/21/17 by the Housekeeping Supervisor. The floor tile in room 104 was replaced on 9/21/17 by the Maintenance Supervisor. The feeding pump/pole was cleaned on 9/21/17 by a licensed nurse. Painting to room 104 was completed on 10/2/17 by the Maintenance Supervisor. 2.) Observations of resident bathroom toilet seats, walls in residents room needing painting, floor tiles in residents rooms to identify any stains, and feeding pumps needing cleaning were completed by the Interdisciplinary Team including but not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping 10/9/17-10/13/17 areas noted were addressed. 3.) The Director of Clinical Services re-educated staff on reporting issues with resident walls, floor tiles, shower rooms, toilet seats, and soiled feeding pumps/poles 10/2/17-10/17/17. The Maintenance Director and/or Housekeeping supervisor and Executive Director to perform Quality Improvement Monitoring of resident walls and room tiles, toilet seats in need of repair 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of feeding pumps/poles needing to be cleaned 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year. 4.) The Executive Director introduced the plan of correction to the QAPI committee on 10/12/2017.	10/18/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne V. Mauldin — TITLE: Executive Director — (X6) DATE: 10.16.17

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
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 Nursing stated she was not aware of the loose tiles in the D hall shower stall and noted it was the primary shower used. On 09/21/17 at 6:05 PM the Administrator stated she was not aware of any problems with loose tiles in the shower stall. On 09/21/17 at 6:50 PM in a phone interview the Maintenance Director stated a couple months prior there had been an issue with 2-3 loose floor tiles in the D hall shower room and he reattached the tiles with waterproof caulking. The Maintenance Director stated the week prior he noticed a couple more tiles had come loose and needed to be repaired and slid the loose tiles back in place and was doing research on a permanent fix. The Maintenance Director stated he was not aware there were approximately 20 loose tiles in need of repair in the D hall shower. 2. On 09/18/17 at 2:34 PM an observation was made of the bathroom shared by Residents #6, #49 and #55. The toilet seat was observed ajar, and when touched, it readily wobbled side to side, with an approximate 5"-6" lateral movement. On 09/19/17 at 10:54 AM and 09/20/17 at 8:15 AM the toilet seat was observed again and wobbled, with an approximate 5"-6" lateral movement. Resident #55 was assessed on the current Minimum Data Set (MDS) dated 08/25/17 with no cognitive impairment. Resident #55 was interviewed on 09/20/17 at 3:30 PM and reported she independently used the bathroom that was shared with Residents #6 and #49. Resident #55 stated she had noticed the toilet seat in the shared bathroom wobbled quite a bit and it made her apprehensive. Resident #55 stated she placed her wheelchair in front of the commode and locked the brakes in the event there were issues with the toilet seat. Resident #55 stated	F 253	Continued... The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 2	F 253		

she had not said anything to staff about the condition of the toilet seat.

Resident #49 was assessed on the current MDS dated 08/21/17 with no cognitive impairment. Resident #49 was interviewed on 09/21/17 at 2:40 PM and reported she independently used the bathroom that was shared with Residents #6 and #55. Resident #49 stated she had noticed the toilet seat was wobbly and held on to the grab bars when seated on the commode to keep herself steady.

Resident #6 was not available to be interviewed as she was hospitalized on 09/19/17.

On 09/21/17 at 9:15 AM Nurse Aide (NA) #2 was asked about the toilet seat in the shared bathroom of Residents #6, #49 and #55. NA #2 stated she had never noticed the loose toilet seat and said she would have reported it to the Maintenance Director had she been aware of the concern. NA #2 stated Resident #6 did use the bathroom independently.

On 09/21/17 at 9:20 AM the Housekeeping Manager was asked about the toilet seat in the shared bathroom of Residents #6, #49 and #55. The Housekeeping Manager stated the toilet seat would be lifted every day when the commode was cleaned and the loose toilet seat should have been reported to the Maintenance Director for repair. The Housekeeping Manager stated he was not aware of the loose toilet seat in the shared bathroom of Residents #6, #49 and #55 and agreed it was in need of repair.

On 09/21/17 at 4:15 PM the interim Director of Nursing stated she was not aware of the loose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3 toilet seat in the shared bathroom of Residents #6, #49 and #55 and would have expected staff to report the concern to the Maintenance Director for repair. On 09/21/17 at 6:05 PM the Administrator stated she was not aware of the loose toilet seat in the shared bathroom of Residents #6, #49 and #55 and would expect the concern to be reported to the Maintenance Director for repair. On 09/21/17 at 6:50 PM in a phone interview the Maintenance Director stated he was not aware of the loose toilet seat in the shared bathroom of Residents #6, #49 and #55. 3. a. On 09/18/17 at 10:13 AM a large brownish/red colored stain was observed on the floor tiles by the A bed in room 104. The stain was approximately 2 floor tiles wide and 4 to 5 tiles in length and was visible from the hallway. At this time quarter sized debris on top of a feeding pump located by the A bed in 104 was also observed. This debris was the same color as the nutritional supplement that was presently being administered via tube feeding. Additional observations on 09/19/17 at 4:07 PM and on 09/20/17 at 8:43 AM revealed the stained tiles and the debris on the feeding pump were unchanged. b. On 09/18/17 at 2:25 PM a strip of removed paint was observed across the wall behind the B bed in room 104. The strip was approximately 3 inches wide and extended across the entire wall on the half of the room that belonged to the B	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 bed. On 09/21/17 at 9:31 AM, observations of room 104 and an interview were conducted with the Housekeeping Supervisor (HS). The HS stated for several weeks he had tried multiple cleaners and equipment in an attempt to remove the stain from the tiles on the floor by the A bed. He added nothing worked. He had reported this to the Maintenance Director. The HS stated housekeeping did not keep the feeding pump clean. That was a nursing responsibility. The HS explained the strip of unpainted wall on the B side of 104 occurred when a new electric bed was placed in the room. He stated as the bed was raised it caught a chair rail and ripped the rail off the wall. This, also, had been reported to the Maintenance Director for repair. On 09/21/17 at 9:32 AM the Administrator joined the observation of room 104. She stated she was not aware of the missing chair rail on the B side of 104. She added the wall should not look like that. The Administrator observed the debris on the feeding pump by the 104 A bed. She stated the nurses should be keeping the pump clean and obviously, this was not happening. The Administrator stated she would have this corrected. The Administrator observed the stained floor tiles by the A bed and stated the tiles should be replaced. On 09/21/17 at 10:01 AM an interview was conducted with Nurse #1. She explained the stain by the A bed in room 104 was from a floor mat that was beside the bed. Water was constantly spilled on the matt causing the tiles under it to be dyed. She stated the floor stain had been there for about 2 weeks and she had	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 observed housekeeping personnel working on it. Nurse #1 added she usually cleaned the feeding tube pump when she worked. She was unaware of the soiled pump and was surprised to hear this soiled area had been present for 4 days. An interview was conducted with the Maintenance Director via phone on 9/21/17 at 6:50 PM. The Maintenance Director stated he was aware of the stained floor tiles in room 104. He added the HS had tried to strip the tiles and buff them but the stain would not come out. The Maintenance Director stated he knew the tiles needed to be replaced but the resident never got out of bed. He added he did not want to bother the resident with the odor of glue and the noise since it would take 4 to 6 hours to replace the tiles. The Maintenance Director stated he knew about the area of stripped paint on the wall behind the B bed in room 104. He stated the resident knocked off the chair rail when he raised his electric bed. He added the screws were knocked out, too. The Maintenance Director explained he was now on the process of going room to room and redoing them. He added it will take a while but if there were problems that were hazardous he addressed those versus making rooms aesthetically pretty.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) to reflect medications received for 1of 5 residents reviewed for unnecessary medications (Resident #66). Findings included: 1. Resident #66 was admitted to the facility on 08/07/17 with the diagnoses of diabetes and hypertension.	F 278	1.) 1.) Root cause analysis conducted and found that MDS overlooked a documented diuretic that was given during the assessment period. Resident #66 Minimum Data Set was modified on 9/21/17 by the Regional MDS Coordinator. 2.) A review of residents on diuretics was completed on 10/7/17 for correct coding by the Minimum Data Set Nurse. Any issues identified were corrected. 3.) The Regional MDS Coordinator in serviced the Minimum Data Set Nurse on accurate coding of diuretics when reviewing the clinical record on 10/3/17.The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of accurate coding of diuretics on the MDS 3 times a week for 4 weeks, 2 times a week for 4 weeks and one time a week for 4 weeks then monthly thereafter for one year. 4.) The Executive Director introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 The most recent admission Minimum Data Set (MDS) dated 08/14/17 indicated Resident #66 was cognitively intact and had received insulin, antianxiety, and antidepressant medications from 08/08/17 through 08/14/17. A review of the physician orders dated 08/07/17 revealed 1 milligram (mg) of bumetanide (a diuretic medication used to reduce extra fluid in the body) was to be administered twice a day. A new order was written by the physician on 08/14/17 and revealed bumetanide was increased to 2mg twice a day. A review of the August 2017 Medication Administration Records (MAR) for Resident #66 revealed from 08/07/17 through 08/14/17 bumetanide was documented as given by the nurses. During an interview at 10:25 AM on 09/21/17, the MDS Coordinator confirmed the dates from 08/08/17 through 08/14/17 were used to document medications received during a 7 day period in section N of the MDS and diuretic medications were to be included in the section. She also revealed the Regional MDS Consultant (RMDSC) had documented the information in section N of the MDS. During a phone interview at 10:30 AM on 09/21/17, the RMDSC confirmed from 08/08/17 through 08/14/17 Resident #66 had been administered bumetanide according to the MAR. The RMDSC revealed it was an oversight that was missed and should have been coded as a diuretic given for 7 days. The RMDSC confirmed a coding correction of the MDS in section N would be done and she would request a	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 modification of the documentation to show a diuretic was administered for 7 days. During an interview at 6:32 PM on 09/21/17, the Administrator revealed it was her expectation for the MDS to be coded correctly by the MDS Consultant and MDS Coordinator.	F 278		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to follow physician orders to obtain a urine specimen, stool sample and laboratory tests for 4 of 7 residents reviewed for medications (Resident #7, #16, #66 and #108). Findings included: 1. Resident #66 was admitted to the facility on 08/07/17 with the diagnoses of diabetes and metabolic encephalopathy (conditions that adversely affect brain function). The most recent admission Minimum Data Set (MDS) dated 08/14/17 indicated Resident #66 was cognitively intact and needed extensive assistance with toileting and had an urinary catheter in place. A review of the care plan dated 08/07/17 focused	F 281	1) Root cause analysis conducted and found that the process for obtaining labs and following orders was not being followed by licensed nursing staff. On 9/21/17 the physician for resident #66 was notified of missing urine culture, no new orders. On 9/21/17 the physician for resident #108 was notified of missing CBC and BMP, no new orders. On 9/21/17 the physician for resident #7 was notified of the missing BMP, new orders received. On 9/21/17 the physician for resident #16 was notified of the missing stool sample, no new orders. 2) The Director of Clinical Services and/or Nursing Supervisor completed Quality Monitoring of labs order(s) for being completed as ordered through 10/2/2017-10/17/17. Issues identified were addressed. The Director of Clinical Services to in service licensed nurses on process for obtaining lab orders and follow through from order to obtaining labs and reporting results 10/2/17-10/17/17. 3) The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement Monitoring of lab orders and results 5 times a week for 4 weeks, 3 times a week for 4 weeks then 2 times a week for 4 weeks then weekly there after for one year. 4) The Director of Clinical Services introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director,	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 9 on the use of a urinary catheter and included nursing interventions to observe for pain and discomfort. The goal was for Resident #66 not to develop a urinary tract infection (UTI). The care plan also focused on the metabolic system with nursing interventions to monitor labs as ordered. The goal was for the labs to not worsen and remain within normal limits. A review of the physician order written at 12:00 PM on 09/01/17, revealed the Medical Doctor (MD) had requested a urine culture and sensitivity in the AM. A review of the nursing note dated 09/01/17 revealed Resident #66 had complained of back pain and had cloudy urine with a foul odor. A physician order was received for a urine culture and sensitivity lab that required nursing staff to collect a urine specimen. A review of a nurse note written at 8:00 AM on 09/02/17, revealed Nurse #4 had documented Resident #66 was resting quietly in the bed with her eyes closed and was easily aroused. Review of a nursing note written at 9:00 AM on 09/03/17, revealed Nurse #4 had documented the resident was resting quietly in the bed. There was no documentation by Nurse #4 to indicate a urine specimen had been collected as ordered by the physician. Review of a nurse note written at 1:50 AM on 09/04/17, revealed the urinary catheter was patent and draining yellow urine and a specimen had been collected for a urinalysis. During an interview conducted at 9:23 AM on 09/21/17, the Unit Manager confirmed Resident #66 had a urinary catheter at the time the physician order was written and the urine	F 281	continued... Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10	F 281		

specimen should have been collected by the nurse as ordered by the physician.

During an interview conducted at 9:37AM on 09/21/17, Nurse #4 confirmed working the morning shift on 09/02/17 and 09/03/17 and remembered there was an order to collect a urine specimen from Resident #66, but thought it had been collected by the nurse on the previous shift. Nurse #4 explained urine specimens were usually collected and picked up by the lab courier earlier than her shift. She also explained if the urine had been collected by the previous nurse that information would have been provided in a shift report. Nurse #4 could not remember what the previous nurse had reported, but did confirm she had not followed up to ensure the urine specimen had been collected.

During an interview conducted at 11:48 AM on 09/21/17, the MD revealed his expectation was for the urine sample to be collected when ordered. The MD also indicated waiting for labs could increase the chance of a worsening UTI.

During an interview conducted at 4:21 PM on 09/21/17, the Interim Director of Nursing (IDON) stated it was her expectation the nurse would collect the urine specimen as ordered by the physician when a resident has a urinary catheter in place. The IDON also revealed it took too long to collect the urine specimen.

During an interview conducted at 6:32 PM on 09/21/17, the Administrator revealed her expectation was for the urine specimen to be collected as written by the physician and for the nurses to follow up on the lab orders to ensure they were done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 2. Resident # 108 was admitted to the facility on 08/28/17 and readmitted from the hospital on 09/14/17 with the diagnoses of anemia and anxiety. A review of the interim care plan dated 08/29/17 focused on anticoagulant use with nursing interventions to monitor labs. A review of the physician orders revealed at 5:00 PM on 08/29/17, an MD order was received by Nurse #5 to check labs for a Complete Blood Count (CBC) and a Basic Metabolic Panel (BMP) on the next lab day. A review of the lab results for Resident #108 revealed there was no CBC or BMP done as ordered by the physician. During an interview conducted at 9:49 AM on 09/20/17, the Unit Manager (UM) revealed she had called the lab group used by the facility and confirmed no labs were done from 08/29/17 thru 09/10/17. The Unit Manager also confirmed "the next lab day" based on when the physician order was written was 09/03/17, and was the day the labs should have been drawn. The UM revealed the physician was notified of the missing labs and responded that the order still stood and the labs were drawn on 09/20/17. During an interview conducted at 1:18 PM on 09/20/17, the Unit Clerk (UC) and UM explained the nurses were responsible for writing the labs ordered by the physician in a book. On Monday and Wednesday the UC would review the book and fax the paperwork to the lab company and when the lab results were received the nurse	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12	F 281		

would either notify the MD of a critical value or would place them in the MD book for him to review on his next visit. They also explained if the lab was needed immediately the nurse was responsible for collecting the resident's blood and ensure it gets to the lab.

During an interview conducted at 10:08 AM on 09/21/17, Nurse #5 confirmed she had received an order for a CBC and BMP on 08/29/17 and explained she would have filled out and placed the lab paperwork in a book used by the phlebotomist (trained to draw blood) to draw on the next lab day and add the lab dates to the medication administration record. Nurse #5 revealed she was unaware of the process used by the facility to track and follow-up labs and was unsure why the labs were not drawn.

During an interview conducted at 11:54 AM on 09/21/17, the MD revealed his expectations of the nurses were for physician orders to be routinely followed and done as written by the physician.

During an interview conducted at 4:15 PM on 09/21/17, IDON revealed it was her expectation for the nurses to follow the MD orders as written, and that they follow-up to ensure labs were drawn and completed.

3. Resident #7 was admitted to the facility 10/05/04 with diagnoses which included vascular dementia, stage III kidney disease and atrial fibrillation. Medication taken by Resident #7 included Aldactone, a diuretic.

The care plan for Resident #7 included the following problem areas:
-"Nutrition/hydration with potential for imbalanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13	F 281		

nutrition. With weight loss greater than 10% in six months". Approaches to this problem area included, "Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated"
-"The resident has impaired skin integrity and has the potential for impaired skin integrity due to immobility, fragile skin, incontinence, hospice, refused to turn and position, refusing to keep feet elevated/floating, refusing to maintain optimal positioning, not eating and pressure ulcer." Approaches to this problem area included, "Obtain and monitor lab/diagnostic work as ordered. Report abnormal results to physician and follow up as indicated."
-"The resident has altered bladder elimination related to confusion, physical limitations, dementia, impaired mobility and self care deficit." Approaches to this problem area included, "Obtain and monitor lab/diagnostic work as ordered."

Review of physician orders in the medical record of Resident #7 included an order for a BMP (basic metabolic package) on 09/05/17.

On 09/20/17 at 12:26 PM the facility nurse consultant stated she called the lab and the lab stated they did not receive the order for the BMP dated 09/05/17.

On 09/20/17 at 12:48 PM the Unit Manager stated a new process for lab work had started several months ago which included when an order was written it was transcribed into the lab notebook, which was at the nurses station. The Unit Manager obtained the lab notebook and turned to the 09/05/17 date and noted there were no entries. The Unit Manager stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14	F 281		

resident's name, room number, test due, order date and date due were all supposed to be recorded in the lab notebook. In addition, the Unit Manager stated the nurse that writes the order was supposed to fill out the lab requisition slip and Fax it to the lab. The Unit Manager identified Nurse #4 as the nurse that wrote the order for the BMP for Resident #7 on 09/05/17. The Unit Manager stated third shift nursing staff was supposed to do a 24 hour chart check on all residents during their shift and write "chart check" on new orders to confirm they had been checked. The Unit Manager reviewed the original 09/05/17 order for the BMP for Resident #7 and stated "chart check" was not written on the order and the order was not transcribed into the lab book so it was never done. The Unit Manager stated there was no other system in place to ensure labs were done as ordered.

On 09/20/17 at 2:45 PM in a phone interview Nurse #4 reviewed the process for obtaining lab work. Nurse #4 stated the order should be transcribed into the facility lab book on the day the lab was due. Nurse #4 stated third shift nursing was supposed to check all charts during their shift to ensure all orders had been processed and, once completed, write "chart check" on the original order. Nurse #4 stated the ward clerk filled out the lab requisition sheet for any labs due. Nurse #4 stated she could not recall anything specific about the BMP ordered for Resident #7 on 09/05/17 or explain why it was not done.

On 09/20/17 at 3:18 PM Nurse #5 stated she routinely worked night shift from 7:00 PM-7:00 AM. Nurse #5 stated it was all she could do to get her charting done on her shift and thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15 Nurse #6 (that also worked night shift) did the chart checks. Attempts to contact Nurse #6 for interview were not successful. On 09/21/17 at 12:00 PM the physician for Resident #7 stated he expected all lab work to be done as ordered, including the BMP for Resident #7 from 09/05/17. On 09/21/17 at 3:30 PM the interim Director of Nursing stated she expected lab work to be done as ordered by the physician. The interim Director of Nursing stated there had been problems with chart checks not being done by night shift nursing staff and she had a recent meeting to remind staff of the need to check orders every night. The interim Director of Nursing looked at the 09/05/17 BMP order for Resident #7 and stated the chart check was never done so there was no second check to ensure the order was transcribed into the lab book and a lab requisition was completed. On 09/21/17 at 6:00 PM the Administrator stated she expected labs to be done as ordered and expected night shift to check all charts to ensure orders were processed. The Administrator stated she was in the process of putting a system in place to ensure labs were done as ordered. 4. Resident #16 was admitted to the facility 07/27/17 with diagnoses which included fracture of left tibia, chronic obstructive pulmonary disease, hypothyroidism, pancreatitis, obesity, hemiplegia, dementia without behavioral disturbance, depression and arthritis. The care plan for Resident #16 included a problem area dated 08/04/17 which read, "At risk for metabolic complications related to diabetes."	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16 An approach to this problem area was, "monitor labs as ordered." Review of physician orders for Resident #16 noted orders on both 09/05/17 and 09/07/17 to "check stool for c difficile due to loose stools." Review of the Medication Administration Record (MAR) for Resident #16 noted the order was transcribed on to the MAR 09/07/17 and 09/07/17-09/10/17 was blocked out. There were no signatures or notes written on the blocked out MAR beside the order. The back of the MAR for Resident #16 had the following documented: 09/07/17-"Refused Colace (a stool softener)-diarrhea X 2." 09/08/17-"Colace held complained of diarrhea." 09/09/17-"Colace held complained of diarrhea." On 09/20/17 at 3:45 PM the Unit Manager stated when ordered, the need for a stool sample would be transcribed on the MAR, not in the lab book. The Unit Manager stated the nursing assistants should be told by the nurse of the need for a stool sample during their shift. The Unit Manager stated once a sample was obtained it would be put in the lab refrigerator and picked up for testing. The Unit Manager identified Nurse #6 as the nurse that wrote the physician's order on 09/05/17 and, after review of the September MAR, noted the order had not been transcribed on the MAR. The Unit Manager identified Nurse #1 as the nurse that wrote the physician's order on 09/07/17 and transcribed it on the MAR Attempts to contact Nurse #6 for interview were unsuccessful. On 09/21/17 at 10:50 AM Nurse #1 stated she remembered the order and transcribing it on the MAR. Nurse #6 stated Resident #16 did not have a bowel movement	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

during her shift and she passed that on to the oncoming shift.

On 09/21/17 at 12:00 PM the physician of Resident #16 stated he expected the c difficile test to be done as ordered. The physician noted when he determined the test had not been done on 09/05/17 it was re-ordered on 09/07/17 with expectations the test would be done.

On 09/21/17 at 3:18 PM the interim Director of Nursing stated the need for the stool sample should have been put on the MAR as well as the lab book. The interim Director of Nursing stated the nursing assistants should be notified of the need of a stool sample and would alert the nurse when the resident had a bowel movement so a sample could be collected. The interim Director of Nursing stated the orders to test the resident's stool for c difficile were never done and could not explain what happened. The interim Director of Nursing stated night shift nurses should do a daily chart check to ensure orders were processed. The interim Director of Nursing checked the original orders for the stool sample for Resident #16 and noted the 09/05/17 order did not indicate the order was checked however, the 09/07/17 did indicate the order was checked.

On 09/21/17 at 5:35 PM Nurse #7 stated she worked on 09/07/17 from 7:00 PM-7:00 AM. Nurse #7 stated she wrote on the back of the MAR at 9:00 PM "refused Colace-diarrhea X2." Nurse #7 stated she remembered being told about the need for a stool sample for Resident #17 on 09/07/17 and recalled being told Resident #17 had 12 bouts of diarrhea that day, just not during her shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18 On 09/21/17 at 6:00 PM the Administrator stated she expected labs to be done as ordered. The Administrator stated she was in the process of putting a system in place to ensure labs were done as ordered.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and physician interviews the facility failed to assess a resident on a weekly basis consistent with the care plan for 1 of 6 sampled residents with wounds. (Resident #6) The findings included: Resident #6 was admitted to the facility 08/24/13 with diagnoses which included diabetes, peripheral vascular disease and obesity. The current Minimum Data Set (MDS) dated 08/03/17 for Resident #6 noted she was at risk for developing a pressure ulcer. The latest annual MDS for Resident #6 was dated 10/6/16 and included a Care Area Assessment (CAA) for pressure sores. The CAA for pressure sores read, "She does not have any current pressure ulcers. She is at risk for pressure ulcers because	F 282	1) Root cause analysis conducted and found that licensed nursing staff were not properly informed on the process of weekly skins assessments. Skin assessment was completed on resident #6 on 10/5/17 by a licensed nurse. 2) The Director of Clinical Services and/or Nursing Supervisor completed skin assessments on residents on 10/12/17. 3) The Director of Clinical Services and/or Nursing Supervisor in serviced licensed nurses on completing weekly skin assessments on residents 10/2/17-10/17/17. Certified Nurse Assistants were in serviced on notifying the nurse on any skin issues by the Director of Clinical Services and/or Nursing Supervisor 10/2/17-10/17/17. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement monitoring of skin assessments 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then weekly there after for one year. 4) The Director of Clinical Services introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 19	F 282		

she spends a large amount of her time sitting in her wheelchair. She does take rest periods during the day and lays down on her bed. She is able to shift her weight from side to side and is independent in bed mobility. Contributing diagnoses include: diabetes, hypertension, bipolar disorder, depression and chronic obstructive pulmonary disease. Pressure ulcer will be addressed on the care plan with the overall objective being to minimize the risk and to maintain the current level of no skin breakdown. Staff to continue to offer assistance on round and observe for signs/symptoms of breakdown during routine care, showers and weekly nurses skin assessments. Any signs/symptoms of skin impairment should be addressed to the nurse."

The care plan for Resident #6 dated 08/16/17 included the problem area, "At risk for skin breakdown related to need for occasional limited assist with activities of daily living and occasional episodes of bladder incontinence." Approaches to this problem area included, "assess skin weekly by licensed nurse."

A physician's order on the medical record of Resident #6 read, "Nails trimmed and cleaned once weekly with skin assessments."

Review of the skin assessment book noted Resident #6 was scheduled to have a weekly skin assessment done on Tuesday by the 7:00 AM-7:00 PM nurse on cart #3. Review of this book noted the last skin assessment for Resident #6 was dated 06/06/17 and noted "skin intact".

Review of the Treatment Records for Resident #6 noted the following:
June 2017-An order was written on the treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 20	F 282		

record for "nails cleaned once weekly with skin assessments." The days the skin assessments were due were blocked off on the treatment record and the only time signed as done for the month of June was 06/06/17.
July 2017-An order was written on the treatment record for "nails cleaned once weekly with skin assessments." The days the skin assessments were due were blocked off on the treatment record and none were signed as done.
August 2017-An order was written on the treatment record for "nails cleaned once weekly with skin assessments." The days the skin assessments were due were blocked off on the treatment record and none were signed as done.

An Interdisciplinary team (IDT) note dated 09/15/17 in the medical record of Resident #6 read, "IDT team met to discuss wound. (Name of business) podiatry in to facility to see residents. Resident was found to have unstageable diabetic neuro. wound to right outer ankle. Area measures 2.8 X 2.3 X .5. Wound has moderate amount of yellow thick drainage present. Odor is present at this time. Area also appears to have slough as well as eschar present. Will start current treatment of normal saline, Dakins solution and border gauze and follow up next week. Continue to monitor. No complaints of pain at this time."

On 09/19/17 at 4:30 PM the facility treatment nurse stated she had just recently started in her position. The treatment nurse stated she did not do weekly skin assessments except for residents with pressure sores or non pressure wounds. The treatment nurse stated the nurse working with a resident was expected to do weekly skin assessments and the current weekly skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 21	F 282		

assessments were located in the skin assessment book. The treatment nurse stated she could not explain why there were no weekly skin assessments for Resident #6 since 06/06/17. The treatment nurse stated Resident #6 had gone out of the facility to a doctor's appointment earlier in the day (09/19/17) and was admitted to the hospital to address medical issues. Resident #6 did not return to the facility for observation of the wound prior to the end of the annual review on 09/21/17.

On 09/19/17 at 5:13 PM the facility nurse consultant stated there had been a lot of management nursing staff changes in recent months and, as a result, skin assessments were not being monitored to ensure they were done on a weekly basis. The facility nurse consultant stated she was aware there were residents that missed skin assessments in July and August and she was in the process of putting measures into place to address the issue. In a follow-up interview on 09/21/17 at 10:00 AM the facility nurse consultant stated she expected skin assessments for Resident #6 to be done weekly consistent with physician orders and the care plan.

On 09/21/17 at 12:00 PM the physician of Resident #6 stated he expected skin assessments to be done consistent with physician orders and the individual resident care plan.

On 09/21/17 at 3:35 PM the interim Director of Nursing (DON) stated she expected weekly skin assessments to be done consistent with physician orders and the care plan. The interim DON stated there had been a lot of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 22 management changes in recent months and, when she became interim DON (around the end of August), she became aware that weekly skin assessments were not being done on residents. The interim DON stated she did a skin assessment on all residents around the end of August and expected staff to continue with weekly skin assessments after that audit. The interim DON produced a wound audit sheet from 08/29/17 which indicated the only area of concern for Resident #6 at that time was "red under abdominal folds." The interim DON stated she was not aware the weekly skin assessments for Resident #6 had not continued after the 08/29/17 wound audit. On 09/21/17 at 6:00 PM the administrator stated she expected skin assessments for Resident #6 to be done every week consistent with physician orders and the care plan.	F 282		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	1) Root cause analysis conducted and found a communication breakdown between different departments in reporting issues for repair and/or cleanliness. The broken seal above the window air conditioner was re sealed on 10/10/17 by Housekeeping Supervisor. Two expired milk cartons were disposed of by the Dietary Manager on 9/18/17. The Central Air will be repaired by an air conditioning company once quotes and parts are received in. The ice scoops and chest were cleaned on 9/18/17 by the Dietary Staff. A plumber will repair the 2 sinks with leaks by 10/18/17. 2) The Executive Director performed Quality Improvement monitoring of the kitchen for items out of date, needing to be cleaned and leaking sinks 10/10/17. Issues identified were addressed. The District Dietary Manager in serviced the Dietary Manager, Dietary Cooks, Dietary aides on proper cleaning of ice chests and scoops as well as storage, discarding out of date items and notifying the facility	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) identify and replace a seal above a window air conditioning unit in the kitchen, 2) remove two expired half pint containers of milk from the milk refrigerator, 3) repair the central air conditioning in the kitchen, 4) clean a scoop prior to placement in clean storage, 5) store two ice scoops in a sanitary manner and 6) repair leaks in two separate kitchen sinks. The findings included: 1. During the initial tour of the facility kitchen and main dining room (adjacent to the facility kitchen) on 09/18/17 from 10:45 AM-11:25 AM the following concerns were identified: a. An approximate 1/4" X 2' gap was observed above a window air conditioner in the facility kitchen. The window was in the vicinity of the food preparation area and above the food preparation sink. At the time of the observation, flies were observed in the facility kitchen. The Food Service Director stated she was not aware of the gap above the window air conditioner. The cook was present at the time of the observation and stated he had noticed the gap above the	F 371	Continued... of any equipment not working 10/10/17-10/17/17. 3) The Executive director re-educated Dietary staff regarding Regulation F 371 related to storage of food and sanitation. The Executive Director to perform Quality Improvement Monitoring of out dated items, clean ice chest and scoops, proper storage of scoops, seal on air conditioner, ambient temperature in kitchen, and any leaks in sinks 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks then monthly thereafter for a year. 4) The Executive Director introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 24	F 371		

window air conditioner before and wasn't sure if it had ever been reported to the Maintenance Director for repair.

b. Two, half pint cartons of buttermilk with an expiration date of 09/17/17 were stored, ready for use, in the milk refrigerator. The Food Service Director stated staff were expected to remove any outdated food items every morning and could not explain why the two expired cartons of buttermilk had not been removed from the milk refrigerator.

c. A 17 quart ice chest was observed stored on shelving in the main dining room. The ice chest was stored with the lid closed. When opened, moisture was observed on the inside of the ice chest and black discoloration was noted on the white interior walls. The black discoloration was easily removed to touch. The District Manager of food services was present at the time of the observation and could not explain what the 17 quart ice chest was used for or why it was stored in the condition observed.

d. A gray utility cart was observed in the main dining room, adjacent to the facility ice machine. Positioned on the upper shelving of the utility cart was a large blue ice chest. The inside of the ice chest was full of ice. The shelving unit the ice chest was stored on was lipped and bits of styrofoam and paper (from straws) was observed in water on this shelving. Two clear ice scoops were observed on this shelving; one, with the base of the scoop directly on the shelving and another, inside a clear ice scoop holder. The clear ice scoop holder had holes in the bottom of the holder (where the base of the ice scoop was positioned) and the holder was immersed in the area of shelving where water was pooled. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 clear ice scoop holder had what appeared to be brown dried spills on it and the interior of the holder (where the ice scoop was stored) was felt and had a slimy feel. The Food Service Director and District Manager were present at the time of the observation and stated they were not sure who was responsible for cleaning the utility cart, ice scoop and ice scoop holder. The Food Service Director stated the ice scoop (stored not in a holder and directly on the utility cart) was supposed to be stored in the ice scoop holder on the ice machine. The Food Service Director stated she did not know why that ice scoop was stored on shelving on the utility cart. 2. During a follow-up observation of the kitchen on 09/20/17 from 11:15 AM-11:42 AM the following concerns were identified: a. At the time of the observation staff were actively working on final preparations of the lunch meal. The temperature of the kitchen was extremely warm and thermostat in the kitchen registered at 88 degrees. Some of the staff working in the kitchen were observed with beads of sweat on their forehead. The Food Service Director stated the central air conditioning in the kitchen had not been operational for a couple months and one window air conditioner was all that was in place to cool the kitchen. The Food Service Director stated the Maintenance Director was aware the central air conditioning was not operational in the kitchen. b. In a follow-up interview the Food Service Director stated the 17 quart ice chest (observed during the initial tour on 09/18/17) had belonged to a former resident and didn't know why it was stored on shelving in the dining room. The Food	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 26	F 371		

Service Director indicated the 17 quart ice chest was discarded. The Food Service Director stated nursing staff was supposed to bring the utility cart (that was observed during the initial tour on 09/19/17) to the kitchen for the ice chest, ice scoop and ice scoop holder to be cleaned and sanitized.

c. Water was observed constantly dripping down the white plastic drain pipe from the 3 compartment sink. The exterior of the drain pipe under the sink had a brown/black matter which encompassed a majority of the surface area. A clear plastic container was observed under the 2 compartment food preparation sink with water dripping into the container from the elbow of the white plastic drain pipe. The Food Service Director stated the Maintenance Director was aware of the leak at the 2 compartment food preparation sink and 3 compartment sink.

d. A stainless steel scoop was observed in a drawer with scoops stored ready for use. Both the inside and outside of the scoop had dried white matter adhered to the scoop portion of the utensil. The Food Service Director stated the soiled scoop should not have been stored in the clean utensil drawer.

3. Follow-up interviews related to areas of concern included:

a. On 09/21/17 at 3:45 PM the interim Director of Nursing stated there was not a system in place to ensure the utility cart with the ice chest, ice holder and ice scoop were delivered to the kitchen on a regular basis for cleaning and sanitizing.

b. On 09/21/17 at 6:50 PM in a phone interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 27 the Maintenance Director stated he received a quote for repair of the central air conditioning at the beginning of the year and anticipated repairs would not be made until the first of 2018. The Maintenance Director stated he had been working on the two sinks in the kitchen and was aware of the leaks.	F 371		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441	1) Root cause analysis conducted and found that licensed nursing staff were not properly informed on the process of cleaning glucometers. Glucometers were disinfected on 9/19/2017 by a licensed nurse. 2) On 9/21/17 diabetics with physician orders for finger sticks were given their own individual glucometer by a licensed nurse. 3) The Workforce Manager began re in servicing licensed nurses on proper disinfecting of glucometers on 9/19/2017. The Director of Clinical Services and/or Nursing Supervisor to perform Quality Improvement monitoring of glucometers 3 times a week for 8 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. 4) The Director of Clinical Services introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to disinfect 2 of 2 glucometers (blood glucose meters) following use	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 29	F 441		

or preparing for use for 4 of 4 residents requiring finger stick blood sugar evaluations (Residents #30, #3, #66, and #133).

The findings included:

Contained in the facility's Infection Control Policy was a Policy and Procedure for Blood Glucose Monitoring & Disinfecting dated 11/30/14 included "Cleanse meter utilizing a disinfectant wipe according to manufacturer's guidelines for wet time".
Review of Centers for Disease Control (CDC) recommendations specified if glucometers were shared, the device must be cleaned and disinfected between each patient use. A risk of blood glucose testing is the opportunity for exposure to blood borne viruses Hepatitis B Virus and Human Immunodeficiency Virus (HIV) through contaminated equipment and supplies. Protection from bloodborne viruses is a basic requirement and expectation anywhere healthcare is provided.

1. On 09/19/17 at 5:02 PM Nurse #3 was observed obtaining a finger stick blood sugar evaluation on Resident #30. Following this procedure Nurse #3 returned to the E hall medication cart. She was observed wiping the glucometer with an alcohol swab. Nurse #3 was observed taking the glucometer wiped with the alcohol swab and additional supplies needed to obtain another finger stick blood sugar evaluation and proceeded to approach Resident #3's room. When asked if the glucometer had been disinfected, Nurse #3 stated she used an alcohol swab and got down into the area that held the test strip. When asked if this was the facility's protocol used to disinfect glucometers after use,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 30 she replied she could use an alcohol swab or a bleach wipe. Nurse #3 added she did not have bleach wipes on her medication cart so she used the alcohol swab. 2. On 09/19/17 at 5:29 PM Nurse #4 was observed obtaining a finger stick blood sugar evaluation on Resident #133. Following the procedure Nurse #4 brought the glucometer back to the F hall medication cart. She was observed placing the glucometer on the medication cart while she documented the blood sugar reading she just obtained. Nurse #4 then gathered supplies and picked up the glucometer and proceeded down the hall. She stated she was going to get a blood sugar reading from Resident #66. When asked if she usually used the glucometer on another resident without disinfecting the meter first, she replied she forgot. Nurse #4 returned to the medication cart. She was unable to find any bleach wipes on the cart. Nurse #4 delayed obtaining the finger blood sugar evaluation from Resident #66 until she found the bleach wipes. An interview was conducted with the Corporate Nurse Consultant (CNC) on 09/19/17 at 6:00 PM. The CNC stated she expected all glucometers to be disinfected after each use following the instructions on the bleach wipe container.	F 441		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520	1.) Root cause analysis conducted and found the root analysis was not completed on passed citations. Facility has QAPI committee in place and implements plans for improvement and monitors and revises as needed through the QAPI process. 2.) The RDCS re-educated the interdisciplinary team members on regulation F520 and the facility's policy and procedures for Quality Assurance Performance Improvement on 10/10/17. Observations of resident	10/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 31 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain	F 520	Continued... bathroom toilet seats, walls in residents room needing painting, floor tiles in residents rooms to identify any stains, and feeding pumps needing cleaning were completed by the Interdisciplinary Team including but not limited to Executive Director, Activities, Social Services, Minimum Data Set Nurse, Director of Clinical Services and Nursing Supervisor, Maintenance and Housekeeping 10/9/17-10/13/17 areas noted were addressed. A review of residents on diuretics was completed on 10/7/17 for correct coding by the Minimum Data Set Nurse. Any issues identified were corrected. The Regional Director of Clinical Services in serviced the Minimum Data Set Nurse on accurate coding of diuretics when reviewing the clinical record on 10/10/17. On 9/21/17 diabetics with finger sticks ordered were given their own individual glucometer by a licensed nurse. 3.) The Director of Clinical Services re-educated staff on reporting issues with resident walls, floor tiles, shower rooms, toilet seats, and soiled feeding pumps/poles 10/2/17-10/17/17. The Maintenance Director and/or Housekeeping supervisor and Executive Director to perform Quality Improvement Monitoring of resident walls and room tiles, toilet seats in need of repair 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then monthly thereafter for one year. The Director of Nursing and/or Nursing Supervisor to perform Quality Improvement Monitoring of feeding pumps/poles needing to be cleaned 5 times a week for 4 weeks, 3 times a week for 4 weeks, 2 times a week for 4weeks then monthly thereafter for one year. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement Monitoring of accurate coding of diuretics on the MDS 3 times a week for 4 weeks, 2 times a week for 4 weeks and one time a week for 4 weeks then monthly thereafter for one year. The Workforce Manager began re in servicing licensed nurses on proper disinfecting of glucometers on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 32 implemented procedures and monitor interventions that the committee had previously put into place. This failure related to four recited deficiencies which were originally cited during the facility's 09/30/16 recertification survey and were recited during the facility's current recertification survey. The recited deficiencies were in the areas of housekeeping and maintenance, accuracy of Minimum Data Set (MDS) assessment, services provided by qualified persons, food procurement and storage and one recited deficiency which was originally cited during the facility's 04/06/17 complaint investigation and was recited during the facility's current recertification survey. The recited deficiency was in the area of infection control. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee during two consecutive federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: 1.a. F 253 Maintenance and Housekeeping: Based on observations and staff interviews the facility failed to provide a safe, clean environment as evidenced by loose floor tiles in 1 of 2 shower rooms, a loose commode seat in 1 of 3 bathrooms on the D hall affecting 3 sampled residents (Residents #6, #49, #55), stains on 1 of 1 feeding pumps as well as stained floor tiles under the feeding pump and a missing chair rail in 1 of 9 resident rooms on the A hall. During the recertification survey of 09/21/17 the facility was cited for failure to provide a safe,	F 520	Continued... 9/19/2017. The Director of Clinical Services and/or Nursing Supervisor will perform Quality Improvement monitoring of glucometers 3 times a week for 8 weeks, 2 times a week for 4 weeks then monthly thereafter for one year. 4.) The Executive Director introduced the plan of correction to the QAPI committee on 10/12/2017. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Executive Director or designee. Quality Improvement Monitoring schedule to be modified based on the findings. QAPI committee meeting consists of but not limited to; Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. Quality Improvement Monitoring scheduled modified based on findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 33	F 520		

clean environment as evidenced by loose floor tiles in 1 of 2 shower rooms, a loose commode seat in 1 of 3 bathrooms on the D hall affecting 3 sampled residents (Residents #6, #49, #55), stains on 1 of 1 feeding pumps as well as stained floor tiles under the feeding pump and a missing chair rail in 1 of 9 resident rooms on the A hall. During the recertification survey of 09/30/16 the facility was cited for failure to maintain an air conditioning unit in 1 resident room (Room #127), failed to repair loose baseboard in resident bathroom (Room #130), failed to repair broken drawer handle in 1 resident room (Room #135), and failed to repair a broken faucet handle in 1 resident bathroom (Room #136) on 2 of 6 resident hallways.

b. F 278 Accuracy of Minimum Data Set (MDS) assessment: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set to reflect medications received for 1 of 5 residents reviewed for unnecessary medications (Resident #66).

During the recertification survey of 09/21/17 the facility was cited for failure to accurately code the Minimum Data Set (MDS) to reflect the medications received for 1 of 5 residents reviewed for unnecessary medications (Resident #66). During the recertification survey of 09/30/16 the facility was cited for failure to accurately assess the dental status on the Minimum Data Set assessment for 4 of 25 residents reviewed for MDS accuracy (Resident #4, #18, #24, and #64).

c. F 282 Services Provided by Qualified Persons: Based on medical record review, staff, and physician interview the facility failed to assess skin on a weekly basis consistent with the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 34	F 520		

plan for 1 of 6 sampled residents with wounds (Resident #6).

During the recertification survey of 09/21/17 the facility was cited for failure to assess skin on a weekly basis consistent with the care plan for 1 of 6 sampled residents with wounds (Resident #6). During the recertification survey of 09/30/16 the facility was cited for failure implement the dental care plan for 1 of 3 residents reviewed for oral care (Resident # 65).

d.. F 371 Food Procurement and Storage: Based on observations and staff interviews the facility failed to 1) identify and replace a seal above a window air conditioning unit in the kitchen, 2) remove two expired half pint containers of milk from the milk refrigerator, 3) repair the central air conditioning in the kitchen, 4) clean a scoop prior to placement in clean storage, 5) store two ice scoops in a sanitary manner and 6) repair leaks in two separate kitchen sinks.

During the recertification survey of 09/21/17 the facility was cited for failure to 1) identify and replace a seal above a window air conditioning unit in the kitchen, 2) remove two expired half pint containers of milk from the milk refrigerator, 3) repair the central air conditioning in the kitchen, 4) clean a scoop prior to placement in clean storage, 5) store two ice scoops in a sanitary manner and 6) repair leaks in two separate kitchen sinks. During the recertification survey of 09/30/16 the facility was cited for failure to label and date partially used food for 1 of 1 walk-in refrigerator and failed to maintain the nourishment room refrigerator temperature at or below 41 degrees Fahrenheit (F) for 1 of 1 nourishment refrigerators.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 35 e. F 441 Infection Control: Based on observations, record review, and staff interviews the facility failed to disinfect 2 of 2 glucometers (blood glucose meters) following use or preparing for use for 4 of 4 residents requiring finger stick blood sugar evaluations (Resident's #30, #3, #133, and #66). During the recertification survey of 09/21/17 the facility was cited for failure to disinfect 2 of 2 glucometers (blood glucose meters) following use or preparing for use for 4 of 4 residents requiring finger stick blood sugar evaluations (Resident's #30, #3, #133, and #66). During a complaint investigation on 04/06/17 the facility was cited for failure to follow their infection control policy and procedure for 1 of 1 residents reviewed with head lice (Resident #6) resulting in infestation to 5 employees (Housekeeper, Nurse Aide, Occupational Therapist, Speech Therapist, and Physical Therapist) who had provided Resident #6 with direct care. On 09/21/17 at 6:44 PM an interview was conducted with the Administrator and the Regional Director of Clinical Services (RDCS). The RDCS stated that after the prior survey monitoring tools had been put into place and were implemented for correcting deficiencies. The RDCS stated the monitoring tools were not continued because of a change in leadership at the facility. The RDCS stated as a result of changes in leadership the monitoring tool and correction plan process broke down and was not continued.	F 520		