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 11/02/2023

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/30/23 through 11/02/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OCL811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/30/23 through 11/02/23. Event ID# OCL811. The following intakes were investigated: NC00200213 and NC00208235. 1 of the 2 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		11/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/22/2023

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 11/02/2023

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to maintain a resident's dignity by not providing assistance when requested by a resident (Resident #259) with a wet brief for 1 of 2 residents reviewed for dignity. Resident #259 stated this made her feel "not too good, aggravated and worried that staff had forgotten her." The findings included: Resident #259 was admitted to the facility on 10/20/23 for Repair of Displaced Spiral Fracture of Right Tibia (a broken lower leg bone in a twisted motion) and Spondylosis (breakdown and separation of the lower spinal vertebra and disks). The 5-Day Admission Minimum Data Set Assessment on 10/25/23 indicated Resident #259	F 550	F-550 Resident Rights/Exercise of Rights Resident #259 discharged home on 11/2/2023. On 11/21/23, Social Worker and Activity Director performed a quality review on current residents regarding call light response time and ensuring resident needs are being met. Any irregularities were corrected. On 11/20/2023 through 11/24/2023, the Director of Nursing and Assistant Director of Nursing educated current staff regarding acceptable call light response time and maintaining resident dignity by ensuring they are clean and dry. New staff will be educated during orientation.	

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 550	Continued From page 2 was cognitively intact. She was frequently continent of bladder and continent of bowel function. She had an impairment on her right lower extremity. She required partial/moderate assistance with toileting. Her vision was impaired and used glasses for reading small prints. During an interview on 10/30/23 at 2:52 PM, Resident # 259 said she had periods of urinary incontinence since half of her perineal area was numb. She said she pressed her call light button because she had wet herself on 10/25/23 at 6:20 PM. Resident # 259 said there was a staff member who came after a while to check and ask what she needed and left. She said Nurse #4 came in next after an hour and gave her medications. She said the nurse told her she would leave her call light on and would ask staff to attend to her. She said nobody came to assist her until 9:50 PM. She said she laid in bed wet the whole time. She told the Social Worker and another nurse about the incident 3 to 4 days ago. Resident # 259 said she thought it was the Director of Nursing (DON) and Assistant Director of Nursing (ADON) who went to talk to her that next day, and they had a staff meeting. During a follow-up interview on 11/1/23 at 10:45 AM, Resident # 259 clarified how she kept track of the time she had to wait for staff to assist her in changing her brief. She pointed to the clock in her room above the bathroom door and said that was how she knew how long she waited to be changed on 10/25/23. She said she used to be a nurse and worked in health care and knew she may have to wait a little bit. She stated it was a lady with long black hair that finally helped her at 9:50 PM. She stated she did not feel good about it mentally but physically, the urine started to burn	F 550	Starting on 11/20/2023 the Director of Nursing, Executive Director, and/or designee will conduct random Quality Reviews to ensure that call lights are being answered timely and resident needs are being met with emphasis on residents being clean and dry on 5 random residents 3 times per week for 8 weeks, then 2 times per week for 8 weeks, then 1 time per week for 6 months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Date of Compliance: 11/27/23	

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 550	Continued From page 3	F 550		

on her back side. Resident # 259 stated what aggravated her the most was that they left her call light on, and she could not press it again when she got worried that the staff had forgotten her. Resident # 259 said she called her family member on her cell phone that night on 10/25/23 and her family member got mad and offered to go to the facility, but she told him not to. She said she had her call light on for twenty minutes the morning of 11/1/23. She said the medication nurse came in to give her medications around 9:00 AM. The nurse told her the staff were passing out ice in the other hallway and left her call light on. Resident # 259 said she got worried and thought "here we go again". She said Nurse Aide (NA) #7 finally came after about 20 minutes and assisted her with changing her brief. She stated residents' needs should take precedence over passing out ice.

During another follow-up interview on 11/2/23 at 8:55 AM, Resident # 259 said it was Receptionist #1 who came to check on her first the night of 10/25/23. She said she told Receptionist #1 she needed to be dried. Resident # 259 said she could not remember the exact time and said it was between 7:00 to 8:00 PM. She said she was not changed after dinner that night because staff said they could not change anybody until trays were out. She said the staff usually served dinner at 5:30 PM. Resident # 259 said nobody ever turned her call light off when she turned it on, not even the nurse who gave her medication.

During an interview on 11/1/23 at 4:05 PM, NA #11 said she worked from 4:00 PM to 7:00 PM on 10/25/23 on D Hall where Resident #259 resided. She said NA #10 took over D Hall at 7:00 PM. She said she did remember Resident # 259's call

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F 550	Continued From page 4	F 550		

light was on at dinner time. NA #11 said she went in and asked what the resident needed. She said Resident #259 needed her brief changed. NA #11 said she told Resident # 259 that they were passing out dinner trays and were not allowed to change residents until all trays were passed out. She said she left the call light on and went to help pass out trays. NA #11 said she got re-assigned to work on the A, E and F halls and started doing her rounds. NA #11 stated she did not provide incontinence care to Resident #259 after dinner. Nobody made her aware that Resident # 259's call light was still on after she did her rounds. NA #11 stated she was told by nurses that the resident was pretty much continent but did not want to go to the bathroom. NA #11 said Resident # 259 could go to the bathroom by herself but said she had always changed Resident # 259's briefs when she was assigned to D hall and that the resident never asked for a bed pan.

During an interview on 10/31/23 6:05 PM, NA #10 said she worked from 7:00 PM to 7:00 AM on 10/25/23 on B, C and D hall where Resident #259 resided. NA #10 said she did not remember Resident #259's call light being on for a long time. She said that she might have been with another resident in another hall and was doing her rounds with another nurse aide. She said no one told her about Resident #259 needing to be changed and did not notice her call light being on for a long time. NA #10 said there were 2 nurses and 2 nurse aides working on the night of 10/25/23 and that was the normal staffing numbers. She said Resident #259's call light was on when she responded to her, and that the resident did not complain about her call light being on for a long time. NA #10 said the resident needed her brief changed. She said she could not remember

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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F 550	Continued From page 5	F 550		

exactly what time she responded to the resident's call light but said that was after her rounds at around 9:30 PM.

During a follow up telephone interview on 11/1/23 3:20 PM, NA #10 said Resident #259's brief was not fully soaked when she went to change her on 10/25/23. She said the resident's brief was a little wet but not soaking wet. NA #10 reported Resident #259 was able use the bedside commode some. NA #10 said when she went to answer the resident's call light, she just asked to be changed. She said Resident #259 did not say anything about being upset or having to wait for a long time.

During a telephone interview on 11/2/23 at 11:55 AM, Receptionist #1 said she answered Resident # 259's call light at around 7:45 pm on 10/25/23. She asked the resident what she needed, and Resident # 259 stated she needed her brief changed. Receptionist #1 said she told Resident # 259 that she would let the staff know. Receptionist #1 stated she saw NA #11 in another hall passing out ice/snack and told her at around 7:50 PM that Resident #259 needed to be changed. Receptionist #1 also found NA #10 near the nurse's station at around 8:03 PM and told her about Resident # 259's brief needing to be changed. Receptionist #1 said she did not see NA #11 go in Resident #259's room and did not see NA #10 go in the resident's room since she clocked out and left after telling NA #10. Receptionist #1 said Resident # 259's call light had been on since after dinner at around 5:30 PM and nobody cut it off, so she went to see what she needed.

During a telephone interview on 11/1/23 at 6:50

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 550	Continued From page 6	F 550		

PM, Nurse #4 said she remembered answering Resident #259's call light last week at around 8:20 PM and asked what the resident needed. She said she could not remember the exact days but Resident #259 told her she needed "changed." Nurse #4 said she told Resident #259 that she would tell NA #10 and told the resident she would leave her light on. Nurse #4 said NA #10 was passing out ice and snacks at that time. Nurse #4 said she told NA #10 that Resident #259 would like to be changed if she could. Nurse #4 said NA #10 went to Resident #259's room within 5 minutes. Nurse #4 said she went to pass out medications on the other hall and did not know if Resident #259's brief was changed at that time. Nurse #4 said the nurse aides do what they could. There were not enough of them at night. Nurse #4 said Resident #259's turned her call light on again the next night, and she might have had to wait longer that next night because NA #10 was checking other residents' vital signs and was changing other residents' briefs also. Resident #259 had to wait longer for maybe an hour. Nurse #4 said Resident #259 was concerned her call light was not working that night, but Nurse #4 said it was working because she turned it off while in resident's room and turned it back on when she left Resident #259's room.

During a telephone interview on 11/1/23 8:30 AM, the Assistant Director of Nursing (ADON) said the Staff Development Manager told her about Resident #259's complaint on 10/26/23. She said Resident #259 was upset about having to wait for a long time the night before to be changed. The ADON said she and the Social Worker (SW) went in to talk to Resident #259 on 10/26/23. ADON said Resident #259 reported that she turned her light on at around shift change and the nurse

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F 550	Continued From page 7	F 550		

came in to give her medication. She said Resident #259's medication nurse told the resident that she would get somebody to help her and that she would leave her call light on so she would not be forgotten. The ADON said Resident #259 told her from 8:00 PM to 8:30 PM, the receptionist went to check on Resident #259 and told resident she would go find someone. The ADON said Resident #259 told her that it was close to 10:00 PM when staff came in to change her. The ADON said Resident #259 did have a clock in her room and had her personal cell phone. The ADON stated it was her expectation for anybody nearby to answer call lights immediately and for the nurses to supervise their nurse aides. She said she was not done with her investigation because NA #10 was not back to work until the evening of 11/1/23.

During a telephone interview on 11/2/23 at 3:10 PM, the Director of Nursing (DON) said they have had a staffing problem since she took the DON job 3 months ago. She also stated there was an existing culture problem with regards to not answering call lights immediately in the building. She said it was the Administrator's and her goal to continue improving the building to ensure residents were taken care of. The DON said the nurses were also expected to help check on the call lights and not just the nurse aides. She said she was not aware of a written protocol for nurse aides not to assist in changing resident's briefs if the nurse aides were passing out ice, snacks, or meal trays. She said she recently asked the nurse aides to do their rounds 30 minutes before meals to ensure the residents were dry. She said she asked them to do hourly rounding and was still trying to educate them. The DON said if the rounding was performed correctly, it would help

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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 550	Continued From page 8 everything including maintaining residents' dignity.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to ensure a dependent resident could access a light switch located behind her bed for 1 of 1 resident reviewed for accommodation of needs (Resident #1). Resident #1 was admitted to the facility on 05/07/21. Review of Resident #1's medical records revealed she had moved to her current room on 04/17/23. The significant change in status Minimum Data Set (MDS) dated 08/15/23 assessed Resident #1 with moderate impairment in cognition. The MDS indicated walking between locations inside the room did not occur for Resident #1 during the assessment period. During an observation conducted on 10/30/23 at 10:15 AM, the switch for the light fixture behind Resident #1's bed on the wall approximately 5 feet from the floor and 5 feet from Resident #1's	F 558	F-558 Reasonable Accommodation of Needs: Pull Cord for over bed light fixture. Residents #1 had pull cord on overbed light fixture replaced on 11/1/2023. On 11/1/23 a quality review was completed by Maintenance Director on current residents pull cords for over bed light fixtures and corrected as needed. 11/13/2023-11/17/2023 the Executive Director and/or designee re-educated Maintenance Director regarding repairs of pull cords for overbed light fixtures. Director of Nursing and/or designee will re-educate current staff and all new hires regarding notifying the Maintenance Director immediately of any overbed light fixture without a pull cord. Starting on 11/13/2023 the Executive Director and/or designee will conduct	11/27/23

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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F 558	Continued From page 9 bed with a cord approximately 4 inches attached. Resident #1 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #1 on 10/30/23 at 10:17 AM. She stated that she was bed bound and non-ambulatory. She did not have any control of the light fixture behind her bed as she could not reach the broken switch cord on the wall from her bed. She had to rely on nursing staff to control the light fixture for her each time and it was very inconvenient to her. Resident #1 added the switch cord was broken since she moved into this room about 6 months ago. She had never brought up her concern to any staff so far. However, she wanted the maintenance staff to fix it as soon as possible. Subsequent observations conducted on 10/31/23 at 9:42 AM and 11/01/23 at 10:11 AM revealed that the switch cord for the light fixture behind Resident #1's bed remained in disrepair. During a joint observation conducted with Nurse Aide (NA) #1 and Nurse #2 on 11/01/23 at 1:11 PM, the switch cord for the light fixture behind Resident #1's bed remained inaccessible from her bed. Both nursing staff acknowledged that the switch cord needed to be fixed immediately. An interview was conducted with NA #1 on 11/01/23 at 1:15 PM. She stated that she worked in A hall frequently and had provided care for Resident #1 on a regular basis. She did not notice that the switch cord for the light fixture behind Resident #1's bed was broken and inaccessible from her bed. NA #1 explained Resident #1 never voiced accessibility concerns for the light fixture behind her bed when receiving	F 558	random Quality Reviews to ensure residents overbed light fixtures have pull cords on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks.Also, Administrative rounds will be completed monday through friday to monitor pull cords for light fixtures will be in place .Maintenance requisition forms will be filled and given to maintenance director for repairs for any identified isses. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Date of Compliance 11/27/23	

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F 558	Continued From page 10	F 558		

care so far. She added the light fixture behind Resident #1's bed should always be accessible.

During an interview conducted with Nurse #2 on 11/01/23 at 1:18 PM, she confirmed she had provided care for Resident #1 frequently, but she did not notice that the switch cord for the light fixture behind Resident #1's bed was broken and inaccessible from her bed. She added Resident #1 was bed bound and it was important for her to have accessibility to the light fixture behind the bed all the time.

An interview was conducted with the Maintenance Director on 11/01/23 at 1:22 PM. He stated that he did not notice the switch cord for Resident #1's light fixture behind her bed was broken and acknowledged that it needed to be fixed as soon as possible. He performed daily walk throughs for the facility to identify repair needs. Once a week, he would conduct a more detailed walk through that included the interior of residents' rooms and bathrooms. In most cases, he depended on the staff to report repair needs via work orders or verbal notifications. He checked the work orders at least twice daily to ensure all repair needs being addressed in a timely manner.

During a phone interview conducted on 11/02/23 at 2:10 PM, the Director of Nursing (DON) expected the staff to be more attentive to residents' living environment and report repair needs in a timely manner.

An interview was conducted on 11/02/23 at 2:57 PM with the Administrator. She expected nursing staff to be more attentive to residents' homes and reported repair needs to the Maintenance Manager in a timely manner. It was her

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 558	Continued From page 11 expectation for all the dependent residents to have accessibility and full control of the light fixture behind their bed all the time.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to	F 561	F-561 Self Determination: Resident choice- not	11/27/23

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 561	Continued From page 12 honor a resident request to have two showers per week for 1 of 1 resident (Resident #51) reviewed for choices. The findings included: Resident #51 was admitted to the facility on 8/22/23 with diagnoses that included cerebrovascular disease and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 9/5/23 indicated Resident #15 was cognitively intact, had no rejection of care behaviors, and it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. The MDS further indicated that Resident #15 required extensive physical assistance with bathing and had impairment to one side of her upper extremities. Resident #51's care plan revised on 9/19/23 indicated Resident #51 has an activities of daily living self-care performance deficit related to history of cerebrovascular accident, decreased range of motion, unsteady gait, and general weakness. Interventions included Resident #51 required partial assistance by one staff with bathing/showering at a minimum of twice weekly and as necessary. A review of the undated facility shower schedule indicated Resident #51 was scheduled to receive bathing and personal hygiene twice weekly on Tuesdays and Fridays during day shift (7:00 AM to 7:00 PM) under shower aide 2. A review of the Documentation Survey Report for October 2023 indicated Resident #51 was recorded as having received a shower on	F 561	receiving preferred number of showers per week. Resident #51 received a shower on 11/1/2023. Shower preferences for resident #51 reviewed and updated on 11/10/23. On 11/9/23 a quality review was completed by Social Worker and/or designee on current residents shower preferences with emphasis on number of showers weekly. 11/13/2023-11/17/2023 the Director of Nursing and/or designee re-educated current Licensed Nursing staff and Certified Nursing Assistants regarding providing showers per residents requested number of showers weekly, documentation of showers, and reporting refusals to Director of Nursing and/or designee. All newly hired nursing staff will receive this education during orientation. Starting on 11/20/2023 the Director of Nursing and/or designee will conduct random Quality Reviews to ensure residents are receiving showers per preference. Director of Nursing and/or designee will ensure that showers are documented, and refusals are reported to Director of Nursing and/or designee on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on	

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F 561	Continued From page 13 10/3/23, 10/6/23, 10/10/23, 10/13/23, 10/20/23 and 10/24/23, and a partial bed bath on 10/31/23. There was no documentation for 10/17/23 and 10/27/23 as indicated by blank spots on the report. An observation and interview with Resident #51 on 10/30/23 at 9:50 AM revealed she was supposed to receive two showers per week, but she only received one shower because the facility did not have enough staff. Resident #51 stated she last received a shower on 10/24/23. No body odors were observed during the interview. An interview with NA #7 on 10/31/23 at 5:13 PM revealed she worked an extra shift on 10/17/23 and came in at 9:00 AM to work until 5:00 PM. NA #7 was assigned to do the shower aide 2 list which included Resident #51. However, she was not able to give Resident #51 a shower that day because she didn't have enough time to do it. NA #7 stated whoever was assigned to do showers the next day should have given Resident #51 a make-up shower. An interview with NA #8 on 11/1/23 at 2:48 PM revealed she was assigned to care for Resident #51 on 10/17/23 from 7:00 AM to 7:00 PM but she did not have enough time to give her shower on that day. NA #8 stated it was hard to do the scheduled showers when they had to watch the floor, assist residents during meals and provide incontinence care at least every two hours. An interview with NA #1 on 10/31/23 at 3:55 PM revealed she started working as a shower aide on 10/30/23 but had been working as a nurse aide on the halls prior to that. NA #1 stated she was assigned to Resident #51 on 10/27/23 but she did	F 561	11/21/2023.The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Date of Compliance 11/27/23	

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 561	Continued From page 14 not have enough time to give her scheduled shower. An interview with NA#2 on 11/1/23 at 3:08 PM revealed she had been assigned to do showers from Mondays to Fridays from 8:00 AM to 4:00 PM but she sometimes got pulled to work as a nurse aide on a hall when they didn't have enough nurse aides working. NA #2 stated she had never given Resident #51 a shower because she was not on her list of residents to do. NA #2 stated she had shower aide 1 list and shower aide 2 list was assigned to NA #1. A follow-up interview with NA #1 on 11/2/23 at 11:17 AM revealed she was assigned to give Resident #51 a shower on 10/31/23 but she did not have enough time to give her one because she had a lot of other residents to give showers to, so they moved her shower to 11/1/23. A phone interview with the Director of Nursing (DON) on 11/2/23 at 2:02 PM revealed she was not aware that Resident #51 had not been receiving her two scheduled showers per week. The DON stated that the facility had a staffing problem, and she hoped that every staff member was doing all they could do to provide care to the residents. The DON stated that she wished the residents could get bathed more than twice a week and it was heartbreaking to find out that Resident #51 was only receiving one shower a week.	F 561		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in	F 582		11/27/23

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 582	Continued From page 15	F 582		

writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 582	Continued From page 16 facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide completed Skilled Nursing Facility Advanced Beneficiary Notices (SNF-ABN) prior to discharge from Medicare Part A skilled services to 3 of 3 residents (Resident #47, Resident #23 and Resident #29) and failed to issue a Notice of Medicare Non-Coverage (NOMNC) at least two days before the end of a Medicare part A stay for 1 of 3 residents (Resident #47) reviewed for beneficiary notification. The findings included: 1. Resident #47 was admitted to the facility on 5/17/23. A review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with Resident #47 on 7/24/23 which indicated Resident #47's Medicare Part A coverage for skilled services would end on 7/24/23. Resident #47 remained in the facility. A review of Resident #47's medical record revealed no evidence a SNF-ABN was also provided to Resident #47.	F 582	F 582E - Liability Notice Residents #47, #23 and #29 will be informed of their right to have been notified of cessation of Part A and Part B services 3 days prior to discharge. This will be done by the Business Office Manager (BOM) before 11/23/23. On 11/1/2023, Billing Office Manager conducted a quality review of current residents with changes in payor to ensure liability notice was provided. Irregularities corrected; residents notified of oversight as of 11/1/2023. Newly admitted residents will be notified by the BOM/Designee of their Medicare A and B benefits ending 3 days prior to the cessation of Medicare A and B benefits. Inservice of the BOM and the Director of Rehab (DOR) of this requirement was done on 11/14/23 by the Executive Director. Resident Council will be in-serviced by the ED and or designee by 11/23/23.	

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 582	Continued From page 17 An interview with the Business Office Manager on 11/1/23 at 11:22 AM revealed Resident #47 had used 69 days of his Medicare Part A days and had 31 days remaining, but she didn't issue a SNF-ABN because she thought it was only used for Part B residents. She explained that she had only been issuing a NOMNC to residents who were discharged from Medicare Part A but remained at the facility because this was how she was trained by the main office. The Business Office Manager stated that she normally tried to give the notice at least three days in advance but she just found out from therapy on the same day that Resident #47 was being discharged on 7/24/23. An interview with the Administrator on 11/2/23 at 2:55 PM revealed the residents who got discharged from Medicare Part A services but remained at the facility should be issued both notices and she just talked to the Business Office Manager about this. The Administrator also stated the notices should be issued at least 2 days in advance prior to the end of the Medicare Part A stay. 2. Resident #23 was admitted to the facility on 3/30/23. A review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with Resident #23 on 6/5/23 which indicated Resident #23's Medicare Part A coverage for skilled services would end on 6/15/23. Resident #23 remained in the facility. A review of Resident #23's medical record	F 582	Quality reviews for newly admitted Part A and B residents will be audited by Executive Director and/or designee to ensure that residents know and understand their liability notice x every newly admitted resident within 7 days of admission x every week x 3 months. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date Certain: 11/27/23	

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F 582	Continued From page 18	F 582		

revealed no evidence a SNF-ABN was also provided to Resident #23.

An interview with the Business Office Manager on 11/1/23 at 11:30 AM revealed Resident #23 had used 78 days of his Medicare Part A days and had 22 days remaining, but she didn't issue a SNF-ABN because she thought it was only used for Part B residents. She explained that she had only been issuing a NOMNC to residents who were discharged from Medicare Part A but remained at the facility because this was how she was trained by the main office.

An interview with the Administrator on 11/2/23 at 2:55 PM revealed the residents who got discharged from Medicare Part A services but remained at the facility should be issued both notices and she just talked to the Business Office Manager about this.

3. Resident #29 was admitted to the facility on 10/19/23.

A review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with Resident #29 on 9/26/23 which indicated Resident #29's Medicare Part A coverage for skilled services would end on 10/2/23. Resident #29 remained in the facility.

A review of Resident #29's medical record revealed no evidence a SNF-ABN was also provided to Resident #29.

An interview with the Business Office Manager on 11/1/23 at 11:33 AM revealed Resident #29 had used 37 days of her Medicare Part A days and

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 582	Continued From page 19 had 63 days remaining, but she didn't issue a SNF-ABN because she thought it was only used for Part B residents. She explained that she had only been issuing a NOMNC to residents who were discharged from Medicare Part A but remained at the facility because this was how she was trained by the main office. An interview with the Administrator on 11/2/23 at 2:55 PM revealed the residents who got discharged from Medicare Part A services but remained at the facility should be issued both notices and she just talked to the Business Office Manager about this.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		11/27/23

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 584	Continued From page 20 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 2 residents reviewed for a safe comfortable, homelike environment (Resident #37). The findings included: Resident #37 was admitted to the facility on 6/15/21. Review of the quarterly Minimum Data Set on 7/29/23 revealed Resident #37 had moderate cognitive impairment. She was independent with transfer and was able to walk in her room. Resident #37 used wheelchair primarily for mobility. During an observation and interview on 10/30/23	F 584	F-584 Safe, Clean, Comfortable, Homelike Environment: Arm rests on wheelchair were torn/broken. Resident #37 had wheelchair arm rests replaced on 11/1/2023. On 11/1/23 a quality review was completed by Maintenance Director on current residents arm rests and corrected as needed. 11/13/2023-11/17/2023 the Executive Director and/or designee re-educated Maintenance Director regarding repairs of wheelchair armrests. Director of Nursing and/or designee will re-educate current	

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 584	Continued From page 21 at 10:35 AM, Resident #37 was seen sitting on her wheelchair. She was wearing a short-sleeved blouse and both arms were propped on the arm rests of her wheelchair. She was holding a folded washcloth on her right hand. Both armrests on her wheelchair had lines of exposed yellow sponge with cracked, peeling black vinyl tears at the side. Resident #37 stated they were scratchy, so she used the washcloth to cover her arm to keep from getting scratched. She stated she had the wheelchair since she got to the facility, and she needed a new one. She could not remember how long the wheelchair had been torn and said her family member was supposed to get her a new one. During a follow up observation of resident on 10/30/23 at 1:15 PM, Resident # 37 was inside her bedroom, sitting on her wheelchair and was eating her lunch. Both elbows were propped on her arm rests while she fed herself. She had the same short-sleeved blouse she was wearing earlier that day, and the washcloth was on her lap. During a follow up observation on 10/31/23 at 10:13 AM, Resident #37 was lying in bed with eyes closed. She was wearing a long sleeve blouse. The same wheelchair with torn vinyl covering on both arm rests was parked beside her bed. During a follow up observation on 11/1/23 8:47 AM, Resident #37 was lying in bed with eyes closed. She was wearing a long sleeve tunic. The same wheelchair with torn vinyl covering on both arm rests was parked beside her bed. During an interview on 11/2/23 at 9:48 AM, Nurse	F 584	staff and all new hires regarding notifying the Maintenance Director immediately of any damaged, torn, or broken arm rests. Starting on 11/13/2023 the Executive Director and/or designee will conduct random Quality Reviews to ensure resident wheelchair arm rests are without damage on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. Also, Administrative rounds will be completed Monday through Friday to monitor Wheel chair arms are in good repair. A Maintenance requisition form will be filled and given to maintenance director for repairs for any identified isses.The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance 11/27/23	

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 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 584	Continued From page 22	F 584		

Aide (NA) #7 stated she started working in January and had not noticed the resident's wheelchair being torn. She stated she mostly got in Resident #37's room to check on the resident herself and did not observe her wheelchair.

During an interview on 11/2/23 at 9:52 AM, Nurse #5 stated she regularly worked D Hall where Resident #37 resided. She stated she did not notice Resident #37's wheelchair being torn. She stated the night shift staff did the cleaning of the wheelchair but was not aware of the cleaning schedule.

During an interview on 11/2/23 at 10:30 AM, the Maintenance Director stated the nursing staff on third shift were responsible for cleaning the residents' wheelchairs every day. He stated his maintenance staff were responsible for repairs and maintenance of equipment. The Maintenance Director stated his staff repaired broken wheelchairs if the nursing staff would let them know. He stated nobody notified him of Resident #37's wheelchair being in disrepair.

During a telephone interview on 11/2/23 at 2:25 PM, the Director of Nursing (DON) stated the third shift nursing aides were responsible for cleaning the wheelchairs daily and as needed. If there were cracked wheels, peeling or if they needed replacement, the staff needed to replace those wheelchairs. She stated the staff had access to the Therapist's storage room at night if they needed replacement wheelchairs. The DON stated if there were repairs needed, the nurse aides knew to fill out maintenance request forms. She stated they were taught how to do that and should have submitted repair requests.

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 11/02/2023

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 584	Continued From page 23 During an interview on 11/2/23 at 10:30 AM, the Administrator stated the nursing staff on third shift were responsible for cleaning the residents' wheelchairs every day. The Administrator stated the maintenance department was responsible for repairs and maintenance of equipment. The Administrator stated she was not sure if the night shift staff knew to submit repair requests when they find issues with the wheelchairs but would check on it.	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 and interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to transcribe a probiotic as ordered by the physician resulting in 6 months additional administration of probiotic for 1 of 5 sample residents reviewed for unnecessary medications (Residents #28). The findings included: Resident #28 was admitted to the facility on 11/17/20 with diagnoses including cystitis. The nurse's progress notes dated 04/24/23 charted by Nurse #1 revealed Resident #28 was assessed by the physician during rounds. New orders were received to start 1 tablet of Bactrim double strength (DS) 800/160 milligrams (mg) by	F 658	F-658 Services Provided meet professional Standards- Probiotic transcription Error. Medical Director notified of probiotic transcription error on 11/1/2023 for resident #28. Probiotic order was discontinued on 11/1/2023 for resident #28. Medication error report completed for resident #28 on 11/1/2023. Starting on 11/13/2023 the Director of Nursing and the Assistant Director of Nursing and/or designee reviewed current resident nursing notes for last 30 days with emphasis on transcription of new orders and stop dates with any abnormalities corrected. This will be	11/27/23

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 11/02/2023

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 658	Continued From page 24	F 658		

mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for 7 days for antibiotic use. Nurse #1 documented she had completed transcribing the orders in the Medication Administration Records (MARs) on the same day.

Review of physician's orders dated 04/24/23 revealed Nurse #1 had input Resident #28's orders in the MARs to receive 1 tablet of Bactrim DS 800/160 mg by mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for "ABT" use. The probiotic order did not have a stop date.

Review of the MARs for the past 6 months revealed Resident #28's Bactrim DS was started on 04/25/23 and discontinued as ordered on 05/01/23. However, the MARs indicated that she had received 1 capsule of probiotic once daily from 04/25/23 until 10/31/23.

The quarterly Minimum Data Set (MDS) dated 09/01/23 assessed Resident #28 with moderate impairment in cognition.

An attempt to interview Resident #28 on 11/01/23 at 1:05 PM was unsuccessful. She was terminally ill and unresponsive to the surveyor's greetings. Her sisters were accompanying her at the bedside.

During an interview conducted on 11/01/23 at 1:56 PM, Nurse #1 confirmed she was the nurse who received the phone orders from the physician on 04/24/23 to administer 1 tablet of Bactrim DS 800/160 mg twice daily for 5 days for cystitis and 1 capsule of probiotic once daily for 7 days for Resident #28. She input both orders in

completed by 11/20/23.

Starting on 11/13/2023 to 11/17/2023, the Director of Nursing and the Assistant Director of Nursing and/or designee began educating the current licensed nursing staff on transcribing orders into Point Click Care with emphasis on including stop dates. Newly hired licensed nurses will receive this education upon hire.

Starting on 11/20/23 the Director of Nursing and/or the Assistant Director of Nursing and/or designee will complete a random audit on 5 resident orders and nurses notes 3 times a week times 4 weeks, then 1 time a week times 8 weeks to review new orders and ensure licensed nursing staff are transcribing physician orders to include stop dates. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. 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 11/02/2023

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 658	Continued From page 25 the MARs on the same day and acknowledged that she had forgotten to set the 7-day stop date for the probiotic order during the transcription process. She confirmed Resident #28 had received probiotic daily from 04/25/23 until 10/31/23. She stated that probiotic should be discontinued after 7 days and acknowledged that her transcription error had caused Resident #28 to receive almost 6 additional months of unnecessary probiotic. During an interview conducted on 11/02/23 at 1:19 PM, the MD stated that the probiotic order was for antibiotic use and should be discontinued after 7 days. He denied it would cause any adverse effects to Resident #28's health for taking approximately 6 additional months of probiotic. However, he expected the nurse to transcribe the order correctly to stop the probiotic as ordered after 7 days. A phone interview was conducted with the Director of Nursing on 11/02/23 at 2:10 PM. She stated that the probiotic should be stopped after 7 days. It was her expectation for the nurse to transcribe all the physician's orders correctly. During an interview with the Administrator on 11/02/23 at 2:57 PM, she expected the nurse to transcribe the physician's order correctly to stop Resident #28's probiotic after 7 days.	F 658	Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance: 11/27/2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		11/27/23

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 11/02/2023

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 677	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide a complete bed bath and hair care to a dependent resident for 1 of 3 residents (Resident #13) reviewed for activities of daily living. The findings included: Resident #13 was admitted to the facility on 6/22/23 with diagnoses that included congestive heart failure and muscle weakness. Resident #13's care plan dated 10/3/23 indicated that she had an activities of daily living self-care performance deficit related to poor activity tolerance, generalized weakness and deconditioning. She was totally dependent on staff to provide bath on scheduled bath day and as necessary, and required maximum assistance by one to two staff with personal hygiene. The quarterly Minimum Data Set (MDS) assessment dated 10/6/23 indicated Resident #13 was cognitively intact, had no rejection of care behaviors, and had impairment to both sides of the lower extremities. The MDS further indicated that Resident #13 required substantial or maximal assistance with bathing and personal hygiene. A review of the undated facility shower schedule indicated Resident #13 was scheduled to receive bathing and personal hygiene twice weekly on Tuesdays and Fridays during day shift (7:00 AM to 7:00 PM) under shower aide 2. A review of the Documentation Survey Report for	F 677	F677 ADL Care Provided for Dependent Residents Bed bath provided with hair washed for resident #13 on 11/2/2023. On 11/20/2023, a quality review was completed by the Director of Nursing and/or Designee ensuring that current residents are receiving shower and/or bed bath with hair washed per preference. 11/13/2023 □ 11/22/2023 the Director of Nursing and/or designee re-educated current Nursing Staff regarding ADL care with emphasis on washing residents□ hair with bed baths per preference. Newly hired nursing staff will receive this education during orientation. Starting on 11/20/2023 the Director of Nursing and/or designee will conduct random Quality Reviews of residents to ensure residents are bathed with hair washed per preference with Activities of Daily Living (ADL) care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance	

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 11/02/2023

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 677	Continued From page 27 October 2023 indicated Resident #13 was recorded as having received a partial bed bath on 10/3/23 and 10/31/23, and a bed bath on 10/10/23 and 10/17/23. "Not applicable" was documented for Resident #13's baths on 10/6/23, 10/13/23, 10/24/23, and 10/27/23. There was no documentation for 10/20/23 as indicated by a blank spot on the report. A review of the nurses' progress notes from 10/1/23 through 10/31/23 in Resident #13's medical record indicated no notes regarding Resident #13 refusing baths or hair care. An observation and interview with Resident #13 on 10/30/23 at 10:40 AM revealed her hair was tousled, oily and greasy with a large amount of white flakes observed on the top of her head. Resident #13 stated that she received one bed bath per week, but it had been awhile since her hair had been washed. A follow-up observation of Resident #13 on 10/31/23 at 4:52 PM revealed Resident #13 sleeping on her bed with her head turned towards the left side. Her hair remained oily, and knots and tangles were observed at the back of her head. A phone interview with Nurse Aide (NA) #3 on 10/31/23 at 3:49 PM revealed she was assigned to take care of Resident #13 on 10/6/23, 10/13/23 and 10/27/23 from 7:00 AM to 7:00 PM. NA #3 stated she documented "not applicable" for Resident #13's baths because they did not occur. NA #3 stated she didn't know she was supposed to give Resident #13 a complete bed bath on the days that she was assigned to her. NA #3 further stated that when she was assigned to Resident	F 677	Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of compliance 11/27/2023	

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	345426	A. BUILDING _____ B. WING _____	C 11/02/2023

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 677	Continued From page 28	F 677		

#13's care, she usually wiped her off which meant washing her face, hands, underarms and providing perineal care as needed. NA #3 shared that there was usually a nurse aide assigned to do just the showers or complete bed baths. She added that she had never washed Resident #13's hair.

A phone interview with NA #4 on 11/1/23 at 1:13 PM revealed she was assigned to care for Resident #13 on 10/3/23 and 10/24/23 from 7:00 AM to 7:00 PM. On 10/3/23, NA #4 documented that she gave Resident #13 a partial bed bath because she washed her underarms, back, leg and perineal area but she didn't wash her hair. NA #4 stated she must have been assigned to Resident #13's hall on those days which was why she only provided her a partial bed bath on 10/3/23. On 10/24/23, NA #4 documented "not applicable" on Resident #13's bath record because the shower aide for that day must have already left when she did her charting, and she didn't know whether she gave Resident #13 a bed bath or not. NA #4 shared that she didn't notice anything different with Resident #13's hair and could not describe what it looked like to her.

An interview with NA #1 on 10/31/23 at 3:55 PM revealed she started working as a shower aide on 10/30/23 but had been working as a nurse aide on the halls prior to that. NA #1 stated that Resident #13 was supposed to receive a complete bed bath instead of a shower, but she was not sure whether it was because Resident #13 didn't want to get up out of the bed or because of her needing at least two staff due to her size. NA #1 stated that she had washed Resident #13's hair once which was about two to three months ago while she was helping 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 11/02/2023

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 677	Continued From page 29	F 677		

nurse aide assigned to Resident #13. NA #1 further stated that Resident #13 receiving a complete bed bath and her hair washed depended on the staffing level because she required two staff members to give her a complete bed bath. NA #1 remembered seeing Resident #13 on 10/30/23 and noticed that her hair looked greasy and unkempt. She also stated that she remembered when she washed Resident #13's hair a few months ago, she had a mat at the back of her bed. NA #1 shared that Resident #13 did not refuse care or be given a bed bath and hair care.

An interview with NA#2 on 11/1/23 at 3:08 PM revealed she had been assigned to do showers from Mondays to Fridays from 8:00 AM to 4:00 PM but she sometimes got pulled to work as a nurse aide on a hall when they didn't have enough nurse aides working. NA #2 stated she had never given Resident #13 a bed bath or hair care because she was not on her list of residents to do. NA #2 stated she had shower aide 1 list and shower aide 2 list was assigned to NA #1.

A follow-up interview with NA #1 on 11/2/23 at 11:17 AM revealed she did not have enough time to give Resident #13 a complete bed bath and wash her hair on 10/31/23 because she had a lot of residents she needed to give a shower to.

An interview with NA #5 on 10/31/23 at 4:41 PM revealed she was assigned to take care of Resident #13 on 10/31/23 from 7:00 AM to 7:00 PM but she didn't give her a bed bath or washed her hair. NA #5 stated she changed Resident #13 twice on her shift, changed her gown twice and repositioned her three times. NA #5 further stated that Resident #13 asked her to shave her

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 11/02/2023

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 677	Continued From page 30	F 677		

hair, but she didn't look at the back of Resident #13's hair if she had any mats.

A follow-up interview with Resident #13 on 10/31/23 at 6:38 PM revealed she did not receive a bed bath on 10/31/23 and they didn't usually wash her hair. Resident #13 stated that she had never refused to get her hair washed or combed and had never refused a bed bath. Resident #13 further stated that she had requested a nurse aide to shave her hair in the back because it would feel more comfortable for her. Resident #13 stated that her hair was matted at the back of her head, and she could feel it. Resident #13 shared that it had been a long time since they had washed her hair.

An interview with NA #6 on 11/1/23 at 3:23 PM revealed she had given Resident #13 a bed bath and washed her hair on 10/17/23. NA #6 stated she used a shower cap and let her hair soak as she did her bed bath. NA #6 stated she remembered Resident #13's hair was hard to manage, and she had to brush it twice to get the tangles out of her hair. NA #6 further stated that Resident #13's hair could get tangled easily because she laid on her bed all the time and she had noticed her hair being oily, greasy and flaky because she had dry skin.

An interview with Nurse #1 on 10/31/23 at 6:59 PM revealed she had noticed Resident #13's hair being oily and tangled but this was because she stayed in bed all the time and she liked to lie as flat as she could in her bed. Nurse #1 stated that the nurse aides were supposed to use a shower cap to wash Resident #13's hair whenever they gave her a bed bath, but she wasn't there all the time to make sure that they were doing what they

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 11/02/2023

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 677	Continued From page 31 were supposed to do. A phone interview with the Director of Nursing (DON) on 11/2/23 at 2:02 PM revealed she did not notice any changes with Resident #13's hair but they had a bath schedule that the nurse aides should be following. The DON stated that she was not aware that Resident #13 had not been receiving a complete bed bath as scheduled or her hair not being washed. The DON further stated that Resident #13 should receive bed baths no less than twice a week as scheduled.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Medical Director interviews, the facility failed to assess, obtain a physician's order and perform dressing changes for a weeping area on a resident's lower extremity for 1 of 1 resident reviewed for skin condition (Resident #25). The findings included: Resident #25 was admitted to the facility on 1/5/23 with diagnoses including hypertension, congestive heart failure, and basal cell carcinoma	F 684	F684 Quality of Care Dressing changed and order written on 11/1/2023 for skin impairment to left lower extremity for resident #25 by Wound Care Nurse. On 11/13/2023 through 11/17/2023, a quality review was completed by the Director of Nursing and/or Designee to	11/27/23

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 11/02/2023

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 684	Continued From page 32 of the left lower limb and hip. Review of discontinued physician orders included an order written on 7/10/23 for Muciprocin External Ointment 2%. Apply to left lower extremity topically every 24 hours as needed for chronic recurrent skin condition. Cleanse with normal saline, pat dry, apply Muciprocin Ointment, cover with Xeroform and apply dry dressing as needed (PRN). This order ended on 10/13/23. Review of the quarterly Minimum Data Set (MDS) dated 8/23/23 revealed Resident #25 had moderate cognitive impairment. He did not have an open lesion at the time of assessment. Review of the Physician Orders dated 10/13/23 included consult wound care PRN, weekly skin sweeps, and monitor left lower extremity (LLE) for open blister or drainage every shift. An observation of Resident #25 on 10/30/23 at 3:30 PM revealed he had a yellow gauze dressing with petrolatum taped on his lower leg above his ankle that was dated 10/25/23. A moderate amount of brownish stain was showing through the tape. Resident #25 said a nurse put the dressing on but was not sure why. An observation of Resident #25 on 10/31/23 at 10:10 AM revealed the same dressing dated 10/25/23 was still on his left lower leg. The same brownish stain was observed through the tape. An observation of Resident #25 on 11/1/23 at 9:13 AM revealed the same dressing dated 10/25/23 was still on resident's left lower leg.	F 684	ensure that current residents have had a full body skin assessment with active orders for any dressings in place and/or skin impairments and changed as ordered. 11/13/2023 □ 11/22/2023 the Director of Nursing and/or designee re-educated current Licensed Nursing Staff regarding ensuring active orders are in place for treatments and/or dressings applied and that orders are in place for any identified skin impairments requiring treatment and changed as ordered. Starting on 11/20/2023 the Director of Nursing and/or designee will conduct random Quality Reviews of residents to ensure dressings in place have active orders and/or identified skin impairments have active order and changed per order on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a	

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 11/02/2023

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 684	Continued From page 33 During an initial interview on 11/1/23 at 9:08 AM, Nurse #5 said she did not know Resident #25 had a dressing on that leg. She said the resident's leg swelled up from sitting too long and started draining. That dressing was to catch the drainage. Nurse #5 said the Wound Care Nurse (WCN) changed dressings Mondays to Wednesday and the nurses on the hall changed dressings on Thursdays and Fridays. She said there was a nurse coming in at 11:00 AM that day of the interview to take over the WCN's assigned hall so the WCN could change dressings. During a follow up interview on 11/1/23 at 9:39 AM, Nurse #5 said she usually worked D hall where Resident #25 resided. She said Resident # 25 came to her on 10/25/23 showing his left lower leg that was draining light yellow substance. Nurse #5 said she was busy and thought Resident #25 had an existing PRN dressing order. She said she just put a gauze dressing with petrolatum and covered it with a dry dressing on his left lower leg. She said the WCN could enter the order if it was for simple dressings like that. Nurse #5 said she did not look at the Treatment Administration Record (TAR) and just assumed Resident #25 still had his PRN dressing order. She said she would have entered the order herself if she looked at the TAR and found there was no order. Nurse #5 said Resident #25's lower legs were edematous on 10/25/23. She said there was an old dressing on Resident #25's left lower leg that was intact and did not look saturated. Nurse #5 said she did not know who put it on and when it was applied. She said she took off the old dressing and said the skin on the resident's left lower leg was pink and had a white macerated area. She added that the skin under the macerated area was draining a lot of light	F 684	minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of compliance 11/27/2023	

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 684	Continued From page 34	F 684		

yellowish drainage. Nurse #5 said the staff usually discouraged Resident #25 from staying in his wheelchair, but he did not remember instructions. Nurse #5 said she had not observed the resident out of his wheelchair very often and was always sitting on it during the day.

During an interview on 11/1/23 at 9:14 AM, the Wound Care Nurse (WCN) revealed Resident #25 had edema on his left lower leg that drained from time to time, and he had a PRN order for that dressing. The WCN checked the resident's electronic record during the interview and stated she could not find it. She said Resident #25 used to have a PRN order and for nurses to change the dressing three times a week.

On 11/1/23 at 9:30 AM, during an observation of wound care to Resident #25, the WCN peeled the resident's dressing off his left lower leg. The outer dressing had a moderate amount of yellowish-brownish liquid on it. The WCN took out two gauze pads directly over the skin and wiped the area with normal saline. The skin area had some whitish superficial skin layer that easily came off when wiped with normal saline. The whole area under the dressing, with a size approximately four inches in length and four inches in width, was reddish in color. The WCN patted the cleaned area with dry gauze and left it to air dry.

During a follow up interview on 11/1/23 at 9:35 AM, the WCN revealed that the nurse who applied the initial dressing should have entered the order so other nurses would know when to change the dressing when they looked at the Treatment Administration Record. The WCN stated Resident #25's dressing used to be

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 684	Continued From page 35	F 684		

changed three times a week. She stated she changed dressings for 16 hours a week only. Most of the time she was filling up holes in the schedule and worked in the hallway. She stated that they were short of nurses and so she had to help a lot of times. She stated that she did rounds with the wound care provider every Mondays and that took up majority of her time during the day.

Review of nursing progress note written on 11/1/23 at 10:10 AM revealed a late entry by Nurse #5 for 10/25/23 stating Resident #25 had a reddened open area to left lower extremity with light yellow drainage. The area was cleaned, dried and dressing applied. Order was written for wound care.

Review of the physician order written on 11/1/23 at 10:00 AM stated to apply dry dressing on Resident#25's left lower extremity as needed (PRN) and to change the dressing three times a week.

During an interview on 11/2/23 at 1:25 PM, the Medical Director (MD) revealed Resident #25 had a chronic wound on his left lower extremity. The MD said it was an old site where the wound specialist took out a basal cell carcinoma (skin cancer) and that kept draining occasionally. The MD said the nurses should enter orders for dressing changes if it did not involve any antibiotics. He said the nurses also informed him and the wound care specialist when he came in if there was a new wound care needed.

During an interview on 11/2/23 at 2:15 PM, the Director of Nursing said if there were changes in resident's condition such as break in skin integrity, she said she expected the nurses to

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 684	Continued From page 36 notify the doctor and obtain orders for treatment and complete their documentation	F 684		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide sufficient nursing staff to assist residents with incontinence care, showers, bed baths and hair care, wound	F 725	F-725 Sufficient Nursing Staff Resident #259 discharged home on 11/2/2023 and did not receive	11/27/23

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 725	Continued From page 37	F 725		

care, and to provide pneumococcal vaccines to eligible residents for 5 of 12 residents (Residents #259, #51, #13, #25, and #7) reviewed for sufficient staffing.

The findings included:

This tag was cross-referenced to:

F550 - Based on record review and resident and staff interviews, the facility failed to maintain a resident's dignity by not providing assistance when requested by a resident (Resident #259) with a wet brief for 1 of 2 residents reviewed for dignity. Resident #259 stated this made her feel "not too good, aggravated and worried that staff had forgotten her."

F561 - Based on record review, observation, and resident and staff interviews, the facility failed to honor a resident request to have two showers per week for 1 of 1 resident (Resident #51) reviewed for choices.

F677 - Based on record review, observations, resident and staff interviews, the facility failed to provide a complete bed bath and hair care to a dependent resident for 1 of 3 residents (Resident #13) reviewed for activities of daily living.

F684 - Based on observations, record review, resident, staff and Medical Director interviews, the facility failed to assess, obtain a physician's order and perform dressing changes for a weeping area on a resident's lower extremity for 1 of 1 resident reviewed for skin condition (Resident #25).

F883 - Based on record review, and staff

pneumococcal vaccine prior to discharge. Resident #7 received pneumococcal vaccine on 11/7/2023. Resident #51 received a shower on 11/1/2023. Shower preferences for resident #51 reviewed and updated on 11/10/23. Bed bath provided with hair washed for resident #13 on 11/2/2023. Dressing changed and order written on 11/1/2023 for skin impairment to left lower extremity for resident #25 by Wound Care Nurse.

On 11/13/2023, the Executive Director met with the Director of Nursing and Human Resources Coordinator to ensure recruiting efforts for open positions were in place along with approved incentives for new hires and referrals. Additionally, bonus structure reviewed by the Executive Director for staff who work additional shifts as needed. The Executive Director, Director of Nursing and the Human Resources Coordinator reviewed staffing levels on 11/13/2023 to ensure adequate staffing levels based on residents□ needs and acuity. No inadequacies noted. On 11/13/2023 the Executive Director and the Director of Nursing verified that the nursing staffing schedule was completed and if there was sufficient staff scheduled to care for the residents. Additionally, the staffing assignment sheets were reviewed to ensure adequate staffing to the residents as per the schedule on 11/13/23 with corrections made as needed.

Beginning on 11/20/2023 through 11/24/2023, the Director of Nursing, Assistant Director of Nursing, and/or

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 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 725	Continued From page 38 interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents (Resident #259 and Resident #7) reviewed for immunizations. An interview with Nurse Aide (NA) #7 on 10/31/23 at 5:13 PM revealed they used to have two shower aides at the facility but a few months ago, one of the shower aides got injured so she had to go back to working on a hall. The shower aide 2 list got assigned to the hall nurse aides which was too much for them because there were usually only two to three nurse aides to care for at least 50 residents on both the day and evening shifts. NA #7 stated that they didn't have enough time to get everything done. An interview with Nurse #1 on 10/31/23 at 3:41 PM revealed she was supposed to be the wound care nurse, but she did not get to do this full-time because she got pulled to work on the hall most of the days she was scheduled to work. An interview with the Scheduler on 11/2/23 at 8:47 AM revealed the staffing goal was to have at least 6-8 nurse aides, 2 hall nurses and a wound nurse for day shift but they had been down to 5-6 nurse aides depending on what day of the week it was. The Scheduler stated she still had been working around vacation requests since August. They normally had 2-3 hall nurse aides and 1-2 shower aides for day shift. For the evening shift from 7:00 PM to 7:00 AM, they had 2 nurses and 2 nurse aides but sometimes a nurse aide came in at 4:00 PM and helped until 11:00 PM. The Scheduler stated they needed at least 3 nurse aides for the evening shift. She shared that the current open positions at the facility were for 2 day shift nurses, 1 night shift nurse and 2 night	F 725	Executive Director educated current nursing staff and will educatre all new staff on regulation F-725 and to directly notify the Director of Nursing, Assistant Director of Nursing and/or Executive Director for any call outs, so that facility leadership is aware of and can intervene with any staffing needs that could lead to inadequate staffing to meet residents□ needs. The Executive Director, Director of Nursing, Assistant Director of Nursing, and/or Scheduler will attempt to replace the staff member who is calling out by calling on facility staff to stay over or come into work, using a current nursing staff roster/phone list. If staffing needs cannot be met using these means, the Executive Director and Director of Nursing may enforce mandating for staff member(s) currently working. Current Nursing Staff has been educated on waiting for their relief to arrive prior to leaving the facility at the end of their shifts. Current Nursing Staff educated on giving a shift-to-shift resident report, including bedside rounds, to the oncoming employee relieving them of their job duties to ensure needs have been met. Starting on 11/20/2023 the Director of Nursing, Executive Director, and/or designee will conduct random Quality Reviews to ensure sufficient direct care nursing staff to meet the needs of the residents including call bells being answered timely, timely assistance provided to assist with resident needs including incontinence care, residents are receiving showers per preference,	

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F 725	Continued From page 39 shift nurse aides. The Scheduler stated they had been trying to recruit staff online and had patient care aides who were getting ready to take their certification test. She also revealed that the facility did not currently use agency staff and it had been over a year since they had last used them due to a corporate decision. A phone interview with the Director of Nursing (DON) on 11/2/23 at 2:02 PM revealed the facility had a staffing problem and she herself had been pulled to work on a hall at least 4-5 times since August. She shared that in the past two weeks, they had hired more nurses and nurse aides to cover some of the current open positions the facility had. An interview with the Administrator on 11/2/23 at 2:55 PM revealed they did have some openings but the staffing number each day had been going up as far as how many people were employed by the facility. The Administrator stated some of the staffing challenges the facility faced was due to some staff being out due to health issues and a few of the nurse aides were terminated even before the Administrator started working at the facility. She shared that they had increased their wages, offered sign-on bonuses and referral bonuses, advertised on all the social media platforms, and ordered some signs to post around town that they were hiring. The Administrator acknowledged that staffing had been worse this week than it had been in a while.	F 725	dressings in place have active orders and/or identified skin impairments have active orders and changed per order, and review of current resident vaccine consent forms with vaccines given if appropriate on 5 random residents 3 times a week for 8 weeks then weekly for 4 months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance: 11/27/23	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	Continued From page 40 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, Consultant Pharmacist, and Medical	F 756	F756	

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F 756	Continued From page 41 Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 sample residents reviewed for unnecessary medications (Residents #28). The findings included: Resident #28 was admitted to the facility on 11/17/20 with diagnoses including cystitis. The nurse's progress notes dated 04/23/23 charted by Nurse #1 revealed Resident #28 had reported burning in vaginal area. Her urinalysis results were received and placed in physician's box. On 04/24/23, Nurse #1 documented Resident #28 was assessed by the physician during rounds. New orders were received to start 1 tablet of Bactrim double strength (DS) 800/160 milligrams (mg) by mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for 7 days for antibiotic use. Nurse #1 documented she had completed transcribing the orders in the Medication Administration Records (MARs) on the same day. Review of physician's orders dated 04/24/23 revealed Nurse #1 had input Resident #28's orders in the MARs to receive 1 tablet of Bactrim DS 800/160 mg by mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for "ABT" use. The probiotic order did not have a stop date. Review of the MARs for the past 6 months revealed Resident #28's Bactrim DS was started on 04/25/23 and discontinued as ordered on 05/01/23. However, the MARs indicated that she had received 1 capsule of probiotic once daily	F 756	Drug Regimen Review, Report and Act on Irregularities Medical Director notified of probiotic transcription error on 11/1/2023 for resident #28. Probiotic order was discontinued on 11/1/2023 for resident #28. Medication error report completed on 11/1/2023. Starting on 11/13/2023 the Director of Nursing and the Assistant Director of Nursing and/or designee reviewed current resident nursing notes for the past 30 days with emphasis on transcription of new orders and stop dates with any abnormalities corrected. This will be completed by 11/20/23. 11/13/2023 □ 11/17/2023 the Director of Nursing and the Assistant Director of Nursing and/or designee began educating the current licensed nursing staff on transcribing orders into Point Click Care with emphasis on including stop dates. Newly hired licensed nurses will receive this education upon hire. 11/20/2023-11/24/2023, the Executive Director and the Director of Nursing will educate the pharmacist on identifying and recommending changes to the physician with emphasis on stop dates and duration of medication. The pharmacist will document the recommendations in the electronic record. Starting on 11/20/2023, The Director of Nursing and/or designee will ensure that the pharmacist will review newly ordered	

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 11/02/2023

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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 756	Continued From page 42 from 04/25/23 until 10/31/23. Review of medical record revealed the Consultant Pharmacist had conducted monthly medication regimen reviews for Resident #28 on 05/17/23, 06/20/23, 07/18/23, 08/20/23, 09/17/23, and 10/16/23. However, he did not identify any drug irregularities related to probiotic and did not make any specified recommendations to the physician or nursing staff to correct the error. A phone interview was conducted with the Consultant Pharmacist on 11/01/23 at 2:32 PM. He confirmed he had reviewed Resident #28's medication regimens once monthly in the past 10 months. He recalled seeing the probiotic order without a stop date and thought the physician might want to use it for some other purposes. He noted the probiotic order was written for "ABT use" and stated that it was not a proper abbreviation for antibiotic. That was why it did not alert him to probe the order further. If the word "ABT" was written as "antibiotic", most likely he would investigate the order and determine the needs of continuous probiotic therapy. During an interview conducted on 11/02/23 at 1:19 PM, the MD stated that the probiotic order was for antibiotic use and should be discontinued after 7 days. He denied it would cause any adverse effects to Resident #28's health for taking approximately 6 additional months of probiotic. The MD added the Consultant Pharmacist had full access to Resident #28's medical records and had reviewed her medication regimen at least once monthly, he expected the Consultant Pharmacist to identify the drug irregularities and report it in a timely manner.	F 756	medication monthly. Starting on 11/20/2023, new orders and orders for new admits and/or readmits will be reviewed on 5 random residents 2 times a week times 8 weeks then monthly times 6 months. The report will be communicated to the Director of Nursing and then communicated to the physician. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of compliance 11/27/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 756	Continued From page 43 A phone interview was conducted with the Director of Nursing on 11/02/23 at 2:10 PM. She stated that the probiotic should be stopped after 7 days. It was her expectation for the Consultant Pharmacist to identify the drug irregularities and report the findings to the facility in a timely manner. During an interview with the Administrator on 11/02/23 at 2:57 PM, she stated the Consultant Pharmacist reviewed Resident #28's medications at least once monthly. It was her expectation for the Consultant Pharmacist to identify the drug irregularities and report the incident to the facility in a timely manner.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		11/27/23

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 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW CARE & REHAB CENTER	551 KENT STREET ANDREWS, NC 28901

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F 757	Continued From page 44 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to discontinue a probiotic as ordered by the physician resulting in 6 months additional administration of unnecessary probiotic for 1 of 5 sample residents reviewed for unnecessary medications (Residents #28). The findings included: Resident #28 was admitted to the facility on 11/17/20 with diagnoses including cystitis. The nurse's progress notes dated 04/23/23 charted by Nurse #1 revealed Resident #28 had reported burning in vaginal area. Her urinalysis results were received and placed in physician's box. On 04/24/23, Nurse #1 documented Resident #28 was assessed by the physician during rounds. New orders were received to start 1 tablet of Bactrim double strength (DS) 800/160 milligrams (mg) by mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for 7 days for antibiotic use. Nurse #1 documented she had completed transcribing the orders in the Medication Administration Records (MARs) on the same day. Review of physician's orders dated 04/24/23 revealed Nurse #1 had input Resident #28's orders in the MARs to receive 1 tablet of Bactrim DS 800/160 mg by mouth twice daily for 5 days for cystitis and 1 capsule of probiotic by mouth once daily for "ABT" use. The probiotic order did	F 757	F757 Drug Regimen is Free From unnecessary Drugs Medical Director notified of probiotic transcription error on 11/1/2023 for resident #28. Probiotic order was discontinued on 11/1/2023 for resident #28. Medication error report completed on 11/1/2023. Starting on 11/13/2023 the Director of Nursing and the Assistant Director of Nursing and/or designee reviewed current resident nursing notes for the past 30 days for use of unnecessary drugs with emphasis on transcription of new orders and stop dates with any abnormalities corrected. This will be completed by 11/22/23. 11/13/2023 □ 11/22/2023 the Director of Nursing and the Assistant Director of Nursing and/or designee began educating the current licensed nursing staff on transcribing orders into Point Click Care with emphasis on including stop dates to avoid use of unnecessary drugs. Newly hired licensed nurses will receive this education upon hire. Starting on 11/20/23 the Director of Nursing and/or the Assistant Director of Nursing and/or designee will complete a	

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F 757	Continued From page 45 not have a stop date. Review of the MARs for the past 6 months revealed Resident #28's Bactrim DS was started on 04/25/23 and discontinued as ordered on 05/01/23. However, the MARs indicated that she had received 1 capsule of probiotic once daily from 04/25/23 until 10/31/23. The quarterly Minimum Data Set (MDS) dated 09/01/23 assessed Resident #28 with moderate impairment in cognition. An attempt to interview Resident #28 on 11/01/23 at 1:05 PM was unsuccessful. She was terminally ill and unresponsive to the surveyor's greetings. Her sisters were accompanying her at the bedside. During an interview conducted on 11/01/23 at 1:56 PM, Nurse #1 confirmed she was the nurse who received the phone orders from the physician on 04/24/23 to administer 1 tablet of Bactrim DS 800/160 mg twice daily for 5 days for cystitis and 1 capsule of probiotic once daily for 7 days for Resident #28. She input both orders in the MARs on the same day and acknowledged that she had forgotten to set the 7-day stop date for the probiotic order during the transcription process. She confirmed Resident #28 had received probiotic daily from 04/25/23 until 10/31/23. She acknowledged that her transcription error had caused Resident #28 to receive almost 6 additional months of unnecessary probiotic. A phone interview was conducted with the Consultant Pharmacist on 11/01/23 at 2:32 PM. He confirmed he had reviewed Resident #28's	F 757	random audit on 5 resident orders and nurses notes 3 times a week times 4 weeks, then 1 time a week times 8 weeks to review new orders and ensure licensed nursing staff are transcribing physician orders to include stop dates to avoid use of unnecessary drugs. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAP. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of compliance 11/27/2023	

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F 757	Continued From page 46 medication regimens once monthly in the past 10 months. He recalled seeing the probiotic order without a stop date and thought the physician might want to use it for some other purposes. He noted the probiotic order was written for "ABT use" and stated that it was not a proper abbreviation for antibiotic. That was why it did not alert him to probe the order further. If the word "ABT" was written as "antibiotic", most likely he would investigate the order and determine the needs of continuous probiotic therapy. During an interview conducted on 11/02/23 at 1:19 PM, the MD stated that the probiotic order was for antibiotic use and should be discontinued after 7 days. He denied it would cause any adverse effects to Resident #28's health for taking approximately 6 additional months of probiotic. However, he expected the nurse to transcribe the order correctly to stop the probiotic as ordered after 7 days. A phone interview was conducted with the Director of Nursing on 11/02/23 at 2:10 PM. She stated that the probiotic should be stopped after 7 days. It was her expectation for the nurse to transcribe all the physician's orders correctly to avoid Resident #28 from receiving 6 months of unnecessary probiotic. During an interview with the Administrator on 11/02/23 at 2:57 PM, she expected the nurse to transcribe all the physician's order correctly to stop Resident #28's probiotic after 7 days and to avoid unnecessary probiotic for over 6 months.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		11/27/23

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F 812	Continued From page 47 The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean kitchen floor, discard expired food items available for resident use in 1 of 1 walk-in cooler, label and date food in 1 of 1 reach-in refrigerator, maintain a clean refrigerator in 1 of 1 nourishment room on E Hall and maintain air vents free from dust buildup in the kitchen. These practices had the potential to affect food and beverages served to the residents. The findings included: a. An initial observation of the kitchen on 10/30/23 at 9:10 AM was made with the Dietary Manager (DM). During the observation, the kitchen floor had drops of liquid spilled and when walked across, shoes stuck to the floor.	F 812	F-812 Food Procurement: Dirty Vent over clean dish storage. Vent over the clean dish storage was cleaned by the Maintenance Director on 11/1/2023. Expired pineapple and red gelatin were removed from the walk-in cooler on 10/30/2023 by the Dietary Manager. Unlabeled and undated bag of sliced cheese was removed from reach in cooler and discarded by Dietary Manager on 10/30/2023. The unlabeled frozen chocolate milkshake was removed from E hall nourishment room freezer and discarded by Dietary Manager on 10/30/2023. The nourishment room refrigerator on E hall was cleaned by the Dietary Manager on 10/30/2023. Kitchen	

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F 812	Continued From page 48 A follow up observation of the kitchen on 10/30/23 at 11:20 AM revealed a clean, dry floor but shoes still stuck to the floor when walking. A follow up observation on 10/31/23 at 10:30 AM, revealed a sticky dry floor with several drops of liquids under the tea dispenser. The DM stated that those were spilled tea and would be mopped after serving breakfast. b. An initial observation of the walk-in cooler on 10/30/23 at 9:12 AM revealed two brown bowls with 10/26 written on lids and a red gelatin in a small brown cup with 10/26 written on the lid. The two brown bowls contained light yellow fruit chunks. The Dietary Manager (DM) stated the two brown bowls were pineapple and should have been discarded when they were not served to the residents on 10/26/23. She stated the red gelatin should also have been discarded on 10/26/23. c. An initial observation of the reach in cooler on 10/30/23 at 9:20 AM revealed a pack of sliced cheese inside an unlabeled plastic bag. The DM said the kitchen staff used it to make sandwiches the night before. DM took it out and stated the kitchen staff should have put a date and time on it. d. An initial observation of the nourishment refrigerator on E hall on 10/30/23 at 9:30 AM revealed an unlabeled frozen chocolate milk shake with a straw inside the freezer compartment. The DM stated it belonged to a staff member and stated it should not have been in there. The DM took the milkshake out of the refrigerator and threw it in the trash can. There was also a plastic bag containing a disposable container which was on a glass shelf inside the	F 812	floor was mopped on 10/31/2023 after breakfast was served by the Dietary Manager and Executive Director verified floor was clean and not sticky. On 11/1/2023 a quality review was completed by Maintenance Director and Dietary Manager on all vents in the dietary department and cleaned if needed. On 11/1/2023 a quality review was completed by the Dietary Manager on all food in walk-in cooler, reach in cooler, and E Hall nourishment room refrigerator/freezer ensuring all food was dated, labeled, and stored per guidelines with food being discarded as necessary. E Hall refrigerator/freezer was cleaned again by Dietary Manager on 10/31/2023 and 11/1/2023. On 11/1/2023, kitchen was mopped after every meal by Dietary Manager and/or designee to ensure clean and not sticky. 11/13/2023-11/17/2023 the Executive Director and/or designee re-educated Maintenance Director and Dietary Manager regarding keeping vents in the dietary department clean. 11/13/2023-11/17/2023 the Executive Director and/or designee re-educated the Dietary Manager and current dietary staff and will educate all new employees on proper labeling and storage of food items, mopping of kitchen floors, and maintaining cleanliness of E Hall nourishment room refrigerator/freezer. Starting on 11/20/2023 the Executive	

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F 812	Continued From page 49 refrigerator. The plastic bag was labeled with a name and was dated 10/29/23. There was a large, dried puddle of a sticky yellowish substance underneath the plastic bag. The shelves on the refrigerator door were dusty and had food crumbs on them. The DM stated the plastic bag was for a resident. The DM wet a bunch of paper towels and wiped down the refrigerator's shelves. During an interview with the Dietary Manager (DM) on 10/30/23 at 9:35 AM, she stated the kitchen staff was supposed to clean the nourishment refrigerator every day. The DM was not aware when the refrigerator was last cleaned. The DM stated staff were not supposed to store their food in the nourishment refrigerator. She stated she checked the kitchen coolers and freezers three times a week for expired and unlabeled food items and her staff were supposed to check them every day. She stated she did not get to check this morning because a kitchen staff had to leave early, and she had to help with serving breakfast trays. DM stated there were only 2 of them serving breakfast this morning. The kitchen staff should have discarded the expired food items and should have labeled food items before storing them. e. A follow up observation of the kitchen on 10/30/23 at 11:20 AM revealed an aluminum drying rack containing washed lids and plastic cups was parked close to the kitchen sink. Beside it was an old door with a rectangular vent above the door. The rectangular vent had grates full of thick, black, fibrous, oily looking material. Another aluminum rack containing washed plates was parked across the dishwasher. Above this rack was a square vent on the ceiling. The grates were	F 812	Director and/or designee will conduct random Quality Reviews to ensure that vents in the dietary department are clean, food is labeled, dated, and stored appropriately, E hall nourishment room refrigerator/freezer clean, and kitchen floor clean and dry 3 times a week for 8 weeks then monthly for 6 months. Also, Administrative rounds will be completed Monday through Friday to monitor Nourishment room, labeling and dated food correctley snd vents are clean and in good repair.Maintenance requisition forms will be filled and given to maintenance director for repairs for any identified isses,. The Diatary manager and ED will be notified of any issues indetified. .The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance 11/27/23	

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F 812	Continued From page 50	F 812		

covered with gray, dusty material.

During a follow up observation of the kitchen on 10/31/23 at 10:30 AM, there was a short aluminum drying rack containing wet blue lids beside the door with a rectangular vent full of thick, black, fibrous, oily looking materials. Another taller aluminum rack containing red cups, blue lids and white dishes was under the square ceiling vent that still had gray dust on its vents.

During another follow up kitchen observation on 11/1/23 at 10:10 AM, the short aluminum drying rack containing white dishes and cups was beside the door with the dirty rectangular vent above it. Another tall aluminum drying rack with lids and dishes was under the dusty square ceiling vent.

During an interview with the Dietary Manager (DM) and the Administrator on 11/1/23 at 10:15 AM, the DM stated the maintenance staff were responsible for cleaning the vents. She stated the maintenance staff cleaned the vents sometime in September of this year. The Administrator pointed out another clean vent over the sink and stated that vent was cleaned but not those two vents. The Administrator stated the kitchen staff were responsible for cleaning the kitchen and food storage and preparation, and maintenance was responsible for cleaning the vents and the ice machine.

During an interview on 11/1/23 at 2:45 PM, the Maintenance Director stated they cleaned the vents today. He said his staff cleaned the vents in September and was not aware where the dirt on the vents came from. The Maintenance Director said there was not a definite schedule, but they

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F 812	Continued From page 51 tried to clean the vents at least twice a year. He said he did not realize those vents got that dirty. During a follow up interview on 11/2/13 at 2:58 PM, the Administrator stated the maintenance crew were responsible for cleaning those vents and cleaned them in September. She said maintenance cleaned the vents twice a year and said she would have to look at a definite cleaning schedule.	F 812		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control	F 882	F-882 Infection Preventionist Qualifications/Role The Staff Development Coordinator attending the Statewide Program for	11/13/23

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F 882	Continued From page 52 Program. This had the potential to affect 56 of the 56 residents at the facility. The findings included: During the Entrance Conference with the Administrator on 10/30/23 at 9:15 AM, she revealed that the facility's designated Infection Preventionist was the Staff Development Manager. She also stated that the Assistant Director of Nursing (ADON) also helped as needed with infection control activities. An interview with the Staff Development Manager (SDM) on 11/2/23 at 2:27 PM revealed in early September, the previous Administrator encouraged her to take the next Statewide Program for Infection Control and Epidemiology (SPICE) training and registered her for the class in November 2023. The SDM stated that she was told that most staff development coordinators were designated the IP role, but she had not gone through any type of infection control training. She shared that the current ADON helped her hold the recent influenza clinic, but the ADON had not received specialized training in infection control either. A phone interview with Nurse #3 on 11/2/23 at 4:49 PM revealed she used to be the ADON, but she stepped down in September to be a floor nurse. She stated that she now only worked as needed but she was required to work at least one shift every two weeks. Nurse #3 stated that she had received specialized training in infection control but had not been actively doing infection control activities except showing the SDM how to do the Tuberculosis test audits.	F 882	Infection Control and Epidemiology (SPICE) training November 8th, 2023, through November 10th, 2023. Course completed as of November 10th, 2023. Current residents have a potential to be affected. On 11/13/2023 the Regional Director of Clinical Services provided education to the Executive Director and the Director of Clinical Services on making sure a nurse is designated as the Infection Preventionist and be Statewide Program for Infection Control and Epidemiology (SPICE) trained. Starting on 11/20/23 the Director of Nursing and/or the Assistant Director of Nursing and/or designee will complete an audit once weekly for 6 months to ensure that the Infection Preventionist is certified with the Statewide Program for Infection Control and Epidemiology (SPICE). The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director,	

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F 882	Continued From page 53 An interview with the Administrator on 11/2/23 at 2:55 PM revealed the SDM was already designated as the IP when she started working at the facility. The Administrator stated the SDM was registered for the next SPICE training this month and she was going to register the current ADON as well for the class.	F 882	Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance 11/13/2023	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		11/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 54 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents (Resident #259 and Resident #7) reviewed for immunizations. The findings included: A review of the facility's policy entitled "Policies and Procedures" with a revision date of 9/18/17 indicated under Subject: Pneumonia Vaccines:	F 883	F883 Influenza and Pneumococcal Immunizations Resident #259 discharged home on 11/2/23 prior to receiving vaccine. Resident #7 received pneumococcal vaccine on 11/7/2023. On 11/13/2023 through 11/24/2023, a	

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(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 883	Continued From page 55 Residents admitted to the facility will be given the opportunity to receive the pneumococcal vaccine (PPSV23) and/or the Prevnar 13 (PCV13) vaccine per physician's order. 1. Resident #259 was admitted to the facility on 10/20/23 with diagnoses that included right lower leg fracture and chronic obstructive pulmonary disease. A review of a physician's order dated 10/20/23 indicated to administer pneumovax if needed. The Informed Consent for Pneumococcal Vaccine dated 10/20/23 indicated Resident #259 had received information about the PCV-20 vaccine and understood the risk and benefits of receiving this vaccine. Resident #259 indicated consent to receiving the vaccine by signing the consent form on 10/20/23. An interview with the Staff Development Manager (SDM) on 11/2/23 at 2:27 PM revealed she hadn't gotten around to giving Resident #259's pneumococcal vaccine because she had been busy working on the floor as a hall nurse. The SDM stated she had just compiled the consent forms and ordered the pneumococcal vaccines from the pharmacy on 10/31/23. She had planned on setting up a clinic with the Assistant Director of Nursing who would help her administer the pneumococcal vaccines to eligible residents, but it was hard to schedule this because they both had been busy working on the halls. A phone interview with the Director of Nursing (DON) on 11/2/23 at 2:22 PM revealed she knew that the SDM had ordered the pneumococcal	F 883	quality review was completed by the Director of Nursing and/or facility Infection Preventionist to ensure that current residents have received vaccines that have been consented for. Vaccines will be ordered and given to any resident that has consented and not received with documentation reflecting vaccine administration in medical record. 11/13/2023 □ 11/22/2023 the Regional Director of Nursing a re-educated Director of Nursing and Infection Preventionist regarding obtaining consents for vaccines upon admission and/or annually and providing vaccines within an acceptable time frame. Facility policies regarding influenza and pneumococcal vaccines reviewed with Director of Nursing and Infection Preventionist. Starting on 11/20/2023 the Director of Nursing and/or designee will conduct random Quality Reviews of current resident vaccine consent forms with vaccines given if appropriate on 5 random residents 2 times a week for 8 weeks, then weekly for 3 months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/21/2023. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Assistant Director of Nursing, Staff	

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 11/02/2023

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F 883	Continued From page 56 vaccines, but she was not aware of the process of offering these to eligible residents. 2.Resident #7 was admitted to the facility on 5/7/21 with diagnoses that included chronic obstructive pulmonary disease. A review of a physician's order dated 5/7/21 indicated to administer pneumovax if needed. The Informed Consent for Pneumococcal Vaccine dated 10/20/23 indicated Resident #7 had received information about the PCV-20 vaccine and understood the risk and benefits of receiving this vaccine. Resident #7 indicated consent to receiving the vaccine by signing the consent form on 10/26/23. An interview with the Staff Development Manager (SDM) on 11/2/23 at 2:27 PM revealed she hadn't gotten around to giving Resident #7's pneumococcal vaccine because she had been busy working on the floor as a hall nurse. The SDM stated she had just compiled the consent forms and ordered the pneumococcal vaccines from the pharmacy on 10/31/23. She had planned on setting up a clinic with the Assistant Director of Nursing who would help her administer the pneumococcal vaccines to eligible residents, but it was hard to schedule this because they both had been busy working on the halls. A phone interview with the Director of Nursing (DON) on 11/2/23 at 2:22 PM revealed she knew that the SDM had ordered the pneumococcal vaccines, but she was not aware of the process of offering these to eligible residents.	F 883	Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of compliance 11/27/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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