STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 06/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 06/12/24 to conduct a complaint survey and exited on 06/13/24. Additional information was obtained on 06/14/24. Therefore, the exit date was changed to 06/14/24. Event ID# 5E4011. The following intake was investigated NC00217362. Three (3) of the 3 complaint allegations did not result in deficiency.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the Medical Director, Registered Dietitian, and staff the facility failed to ensure the	F 693	Corrective action taken for residents affected by alleged deficient practice:	6/28/24

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

Electronically Signed | 06/27/2024

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F 693	Continued From page 1 volume rate settings on the feeding pumps were correct to administer water flushes as ordered by the physician for 2 of 3 residents reviewed for the care of a feeding tube (Resident #1 and Resident #2). Findings included: 1. Resident #1 was admitted to the facility on 3/5/14 with diagnoses including chronic respiratory failure, and placement of gastrostomy tube (a tube placed directly into the stomach for the administration of fluids). An active physician's order dated 7/8/20 instructed the nurse to clear the feeding pump at midnight and document intake one time a day for nutrition. Resident #1's current enteral feed (delivery of nutrients through a feeding tube) physician's order dated 12/12/23 included instructions to receive a nutritional supplement at a volume rate of 45 milliliters (ml) every hour and water flushes at a rate of 60 ml every 2 hours via feeding pump. The quarterly Minimum Data Set dated 4/1/24 indicated Resident #1 was rarely understood and his cognition was severely impaired. His ability to eat was not assessed and nutrition and hydration were received via tube feeding with no known weight loss or gain. Special treatments included oxygen, suctioning, tracheostomy care, and use of an invasive mechanical ventilator. The care plan last reviewed on 4/15/24 included a focus area that identified Resident #1 was unable to safely tolerate oral intake and required tube feedings and was at risk for dehydration. The	F 693	On 6/12/24 the Director of Nursing accurately programmed the feeding pump for resident # 1 to administer the correct amount and frequency of water flush according to the physician orders. The DON educated Nurse #1 on the proper steps to ensure accurate programming of the pump at that time. Resident #1 was physically assessed for hydration status by the DON on 6/12/24. There were no signs of dehydration present. DON then notified Nurse Practitioner of the missing flush programming and labs were ordered. The NP reviewed the lab results and confirmed there were no clinical indications of dehydration. On 6/12/24 the Director of Nursing programed the feeding pump for resident #2 to accurately deliver the correct amount and frequency of flush water. Resident #2 was physically assessed for hydration status by the DON on 6/12/24. There were no physical signs of dehydration observed. DON notified NP of the missing flush programming and labs were ordered. The NP reviewed the lab results and confirmed there were no clinical indications of dehydration. Corrective action for residents identified as having the potential to be affected by the same deficient practice: Any resident receiving hydration via an enteral feeding pump could be affected therefore a 100 percent audit of pump flushes was completed on the evening of 6/12/24 by the DON. All pumps were	

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F 693	Continued From page 2 care plan goals included flushes would be safely tolerated to prevent dehydration with an intervention to provide tube feedings and flushes as ordered. During an observation on 6/12/24 at 1:47 PM Resident #1 had no signs of dry, peeling, or wrinkled skin and no signs of dry, cracked lips to indicate he was dehydrated. Resident #1's feeding pump was set up with a bag that held 1000 ml of water with approximately 850 to 900 ml in the bag. A bottle of nutritional supplement was set up and labeled with the date and time 6/12/24 at 5:20 AM. The rate of the water flushes was not displayed on the screen of the feeding pump. The nutritional supplement rate was displayed on the screen and read 45 ml every hour. During an interview and observation on 6/12/24 at 2:59 PM Nurse #1 revealed she worked from 7:00 AM through 7:00 PM. She checked the feeding pump setting for water flushes that were blank and read _____ml at ____hours to indicate Resident #1 did not receive 60 ml of water every 2 hours as ordered. Nurse #1 stated she did not set up the water bag or nutritional supplement that was done by the night shift nurses. Nurse #1 stated she had not checked the water flush settings on feeding pump, and she was unsure how to program the feeding pump for Resident #1 to receive water flushes as ordered by the physician. Nurse #1 stated she did check the feeding pump to ensure it was on and the nutritional supplement was being administered. During an observation and interview on 6/12/24 at 3:01 PM the Director of Nursing (DON) entered Resident #1's room and rechecked the water	F 693	checked against physician's orders to ensure the flushes were entered correctly for each resident receiving hydration via enteral pump. On 6/13/24 all residents receiving hydration via an enteral feeding pump were physically assessed for signs of dehydration by DON or Staff Development / Infection Prevention Nurse. There were no physical signs of dehydration observed for any of the residents utilizing feeding pumps for hydration during these assessments. Measures put in place or systemic changes made to ensure deficient practice will not recur: A new process has been implemented for ensuring water flush volumes are infused per the physician□s order. Flush volumes infused will be verified and recorded twice daily by the nurse assigned to the resident. On 6/12/24 the SDC / IP Nurse initiated ongoing education for all facility nurses and agency nurses on the proper programming of the feeding pumps to ensure rate and frequency is entered accurately according to the physician's order. This education was completed on 6/20/24. This required training includes programming the pump to the correct rate and frequency of tube feeding formula and the correct volume and frequency of	

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F 693	Continued From page 3 flush settings on the feeding pump that were blank and read _____ml at ____hours. The DON reviewed the physician's order and instructed Nurse #1 to program the feeding pump for Resident #1 to receive 60 ml of water every 2 hours. The DON revealed the nurses documented on the resident's electronic Medication Administration Record (MAR) the amount of the nutritional supplement received using milliliters but did not include the amount of water flushes. She was unable to verify Resident #1 received water flushes as ordered by the physician. The DON assessed Resident #1 for signs of dehydration and stated the skin turgor was plump and there were no signs of dry skin or dry and cracked lips. The DON stated the nurses should check the feeding pump settings including when the volume amounts were cleared. She revealed Resident #1 was dependent on the feeding pump water flushes for hydration and did not receive oral intake. The DON stated she expected the rate settings were checked by the nurses for accuracy and correctly programmed to administer the water flushes as ordered by the physician to prevent dehydration. A phone interview was conducted on 6/14/24 at 2:28 PM with Nurse #2. Nurse #2 confirmed she worked the night shift from 7:00 PM through 7:00 AM and it was her initials on Resident #1's MAR for 6/11/24 to indicate she had documented the volume amounts of nutritional supplement received at 12:00 AM. She confirmed it was her name written on the nutritional supplement bottle dated 6/12/24 at 5:20 AM. Nurse #2 revealed her process for the care of tube feeding was to pause the pump, make a note of the amount of nutritional supplement received then clear those values. She then set up a new bottle of nutritional	F 693	the additional flush water specified on the physician□s order. This training also includes the nurses requirement for reviewing and recording the volume of formula received as well as the volume of additional flush water received at specified times each day and night for every resident utilizing a feeding pump for nutrition and hydration. All newly hired and agency nurses must receive training on the proper use and programming of the feeding pumps before working on a hall assignment. Newly hired nurses will receive training on the proper use, programming, and reviewing and recording of volumes administered on the feeding pumps during orientation. All newly hired and agency nurses must receive training on the proper use and programming of the feeding pumps before working on a hall assignment. Newly hired nurses will receive training on the proper use and programming of the feeding pumps during orientation. On 6/19/24 the manufacturer representative of the feeding pump came to the facility to provide additional education to nurses and medication aides and to answer any questions regarding the pump. Indicate how facility plans to monitor its performance to make sure solutions are sustained: The DON or designee will complete	

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F 693	Continued From page 4 supplement and restarted the feeding pump and if needed she replaced the water bag. Nurse #2 revealed she did not recall if she checked the water flush settings or volume amounts Resident #1 received since the MAR documentation did not include water flushes. Nurse #2 stated she did check the settings on the feeding pump either when changing the nutrition bottle or during her shift to ensure it was correct. She did not know why or what happened to Resident #1's water flush setting and thought either her or another nurse could have cleared it. During a phone interview on 6/13/24 at 4:47 PM the Registered Dietitian (RD) stated the residents that were unable to receive oral intake were dependent on the feeding pump water flushes for hydration. She stated the water flush rate settings should be correct as ordered by the physician to prevent dehydration. A phone interview was conducted on 6/14/24 at 10:24 AM with the Medical Director. The Medical Director revealed he relied on the RD to make recommendations for residents receiving nutrition and hydration from a feeding tube. The Medical Director stated he expected the nurses to follow physician orders and set the rates on the feeding pump correctly for the resident to receive their water flushes. 2. Resident #2 was admitted to the facility on 3/19/21 with diagnoses including chronic respiratory failure. Resident #2's current diet order dated 3/15/21 instructed no oral intake. Resident #2's current physician's order dated	F 693	random observations each week of feeding pumps and to compare the programming entered and recorded volumes in the pump to the physician's order for flush rate volumes and frequency and the recorded volumes shown as received through the pump. Any discrepancy observed will be corrected and the nurse on duty will be re-educated at the time of the audit. The pump audit began 6/12/24 will occur for 20 pumps weekly for 4 weeks then 20 pumps monthly for 2 months. The DON will view the results of these audits and monitor for any trends or patterns and need for further education. The Director of Nursing will present the results of these audits to the Quality Assurance Performance Improvement committee for review and discussion monthly. The QAPI committee will assess and modify the action plan as needed to ensure continued compliance with F693. Date of completion: 6/28/24	

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F 693	Continued From page 5	F 693		

3/24/21 instructed the nurse to record the tube feeding amount and clear the feeding pump one time a day. The enteral feed order dated 7/21/23 instructed to provide the nutritional supplement at a volume rate of 40 ml every hour and water flushes at a rate of 90 ml every hour via feeding pump.

The annual MDS assessment dated 3/28/24 revealed Resident #2's cognition was severely impaired. His ability to eat was not assessed and nutrition and hydration were received via tube feeding with no known weight loss or gain.

The care plan last reviewed on 4/9/24 included a focus area that identified Resident #2 was unable to safely tolerate oral intake and required tube feedings and was at risk for dehydration. The care plan goals included flushes would be safely tolerated to prevent dehydration with an intervention to provide tube feedings and flushes as ordered.

During an observation and interview on 6/12/24 at 3:52 PM with the DON revealed Resident #2 had no signs of dry or peeling skin and no signs of dry and cracked lips to indicate he was dehydrated. Resident #2's feeding pump was set up with a bottle of nutritional supplement and bag of water for flushes with approximately 300 ml remaining. The supplement bottle was labeled with the date and time 6/12/24 at 12:45 AM with Nurse #3's initials to indicate she set up the feeding pump. The DON checked the feeding pump setting for water flushes that showed the rate was set to receive 90 ml of water every 2 hours and the volume amount received was 630 ml. The DON checked the physician's order and stated the water flush settings on the feeding pump were

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F 693	Continued From page 6	F 693		

incorrect and should be set to flush every hour. The DON reprogrammed the water flush setting for Resident #2 to receive a 90 ml water flush every hour as instructed on the physician's order.

During a phone interview on 6/13/24 at 4:21 PM Nurse #3 confirmed she worked from 7:00 PM to 7:00 AM and her initials were on the bottle of nutritional supplement dated 6/12/24 at 12:45 AM. Nurse #3 revealed what she did to manage Resident #2's feeding pump was to clear the volume amount of the nutritional supplement received and document the result on Resident #2's MAR. She started a new bottle, reloaded the tubing in the pump, and restarted the pump. Nurse #3 stated the rate settings for Resident #2's feeding pump were already setup, and she did not change or adjust it. She confirmed she did not review the physician's order to ensure the rate setting was correct.

During a phone interview on 6/13/24 at 4:47 PM the RD stated the residents that were unable to receive oral intake were dependent on the feeding pump water flushes for hydration. She stated the water flush rate settings should be correct as ordered by the physician to prevent dehydration.

A phone interview was conducted on 6/14/24 at 10:24 AM with the Medical Director. The Medical Director revealed he relied on the RD to make recommendations for residents receiving nutrition and hydration from a feeding tube. The Medical Director stated he expected the nurses to follow physician orders and set the rates on the feeding pump correctly for the resident to receive their water flushes.