PRINTED: 08/25/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345247	B. WING		07/24/2015
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 0172-42010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	3	F 000		
	the Administrator was 6:50 PM. Immediate 7/24/2015 at 5:11 PM an acceptable credib The facility will remai scope and severity le potential for more that immediate jeopardy (systems put in place training. 483.75 (F 490) at J Immediate Jeopardy the Administrator was 6:50 PM. Immediate 07/24/2015 at 5:11 P	began on 05/22/2015 and so notified on 07/22/2015 at Jeopardy was removed on May when the facility provided the allegation of compliance. In out of compliance at a evel of no actual harm with an minimal harm that is not D), to ensure monitoring of and 100% of employee began on 05/22/2015 and as notified on 07/22/2015 at Jeopardy was removed on May when the facility provided the allegation of compliance.			
F 202 SS=D	The facility will remai scope and severity le potential for more that immediate jeopardy (systems put in place training. 483.12(a)(3) DOCUM TRANSFER/DISCHA When the facility tran resident under any of in paragraph (a)(2)(i) the resident's clinical documented. The do by the resident's physical scope and several seve	n out of compliance at a evel of no actual harm with an minimal harm that is not D), to ensure monitoring of and 100% of employee MENTATION FOR ARGE OF RES sfers or discharges a fithe circumstances specified through (v) of this section,	F 202		8/12/15
ABORATORY	I DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE	(X6) DATE

Electronically Signed 08/14/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345247	B. WING _			C 07/24/2015
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		
VALLEY N	URSING CENTER			581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 202	Continued From page	e 1	F 2	02		
) of this section; and a fer or discharge is necessary 2)(iv) of this section.				
	by: Based on observation and family interviews documentation to just the needs of 1 of 4 redischarge (Resident: Findings included: Findings included: Resident #191 was a 4/28/2015 with diagn disease, Alzheimer's lack of coordination, Traumatic Stress Dis The admission comp Set [MDS] dated 5/5/was severely cognitive exhibited wandering period, The MDS also walking balance was	dmitted to the facility oses including Parkinson's disease, muscle weakness, anxiety, depression and Post order. Tehensive Minimum Data 2015 indicated the resident rely impaired but had not during the assessment or indicated the required of two staff members for		Valley Nursing Center acknown receipt of the statement of de and proposes this plan of context that the summary of find factually correct and in order compliance with applicable in provisions of qualify of care of The plan of correction is subwritten allegation of compliant Valley Nursing Center's respondatement of Deficiencies and Correction does not denote a with the Statement of Deficiencies and deficiency is accurate. Furth Nursing Center reserves the any of the stated deficiencies Statement of Deficiencies the informal dispute resolution, for procedure and/or administrations.	eficiencies rrection to the indings is to maintain ules and of residents. mitted as a nce. conse to the nd Plan of agreement encies nor on that any ner Valley right to refute s on this rough ormal appeal	
	indicated the residen memory problems du received medications and was at risk for fa A physician's order d	ated 5/12/2015 revealed the ve Physical Therapy three		F202 Documentation for Tra Discharge It is the policy of this facility t documentation to justify why residents could not be met ir and an unplanned transfer/d necessary for the resident's that the resident's needs car	to show the needs of n the facility ischarge is welfare and	

F 202 Continued From page 2 Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the patio dining room. The nursing documentation note included, "resident stoad up and opened patio door and tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair], resident stoad he was leaving and very determined to get out any door in facility, will monitor closely, call light within reach." A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that, with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident's bed and wheelchair to alert staff if the resident attempted to rise off of the pad. Resident #191's Plan of Care was updated on 5/14/2015 to indicate a wander guard bracelet was in place to prevent elopement. The facility was unable to provide any evidence of assessments or attempted interventions put in		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE SSI NC HIGHWAY 16 SOUTH			345247	B. WING			-
TAYLORSVILLE, NC 28681 CALID FORCED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETTION (EACH ORGEROTIVE DEFICIENCY) COMMETTION (EACH ORGEROTIVE DEFICIENCY) COMMETTION (EACH ORGEROTIVE DEFICIENCY) COMMETTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCE. THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCE. THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENC	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	'	
CALL DEPTICE PROPERTY CALL DEPTICE PROPERTY PROPERTY					581 NC HIGHWAY 16 SOUTH		
F 202 Continued From page 2 Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the pation indicated a pad alarm was to be placed in the resident attempted to rise off of the pad. A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that, with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident attempted to rise off of the pad. The facility was unable to provide any evidence of assessments or attempted interventions put in	VALLEY N	URSING CENTER			TAYLORSVILLE, NC 28681		
Review of the clinical record revealed that on 5/12/2015 resident #191 was observed in his wheelchair, propelling himself into the patio dining room. The nursing documentation note included, "resident stood up and opened patio door and tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair], resident stated he was leaving and very determined to get out any door in facility, will monitor closely, call light within reach." A physician order dated 5/13/2015, revealed Resident #191 was given a bracelet that, with the facility magnetic door lock system, would alarm if he attempted to leave through an alarmed door. The order also indicated a pad alarm was to be placed in the resident's bed and wheelchair to alert staff if the resident attempted to rise off of the pad. Resident #191's Plan of Care was updated on 5/14/2015 to indicate a wander guard bracelet was in place to prevent elopement. The facility was unable to provide any evidence of assessments or attempted interventions put in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
place regarding wandering behavior between 5/14/2015 and 5/25/2015 when the resident was discharged from the facility. Record review revealed a note by the Social Worker (SW) dated 5/21/2015 at 6:58 PM which included, "Resident went out patio door in dayroom, locked his wheelchair breaks, climbed over the short brick wall on the patio, ambulated around the facility and was walking down the 600 The facility's Transfer or Discharge Notice Policy and Procedure was reviewed and revised to include the following: If an unplanned transfer or discharge becomes necessary for the resident's welfare, and it is determined that the resident's needs cannot be met in the facility, the following steps will be taken: a. The Administrator or designee will	F 202	Review of the clinical 5/12/2015 resident # wheelchair, propelling room. The nursing do "resident stood up an tryed (sic) to go out u assisted resident bac resident stated he wadetermined to get out monitor closely, call limits and the state of the pad. A physician order dat Resident #191 was go facility magnetic door he attempted to leave The order also indicate placed in the resident alert staff if the resident alert staff if the resident the pad. Resident #191's Plant 5/14/2015 to indicate was in place to prevent was in place to prevent assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate regarding wand 5/14/2015 and 5/25/2 discharged from the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable assessments or attemptate was unable to the facility was unable to the fa	record revealed that on 191 was observed in his g himself into the patio dining ocumentation note included, and opened patio door and massisted, another nurse of kinto w/c [wheelchair], as leaving and very any door in facility, will ight within reach." ed 5/13/2015, revealed iven a bracelet that, with the clock system, would alarm if through an alarmed door. It do a pad alarm was to be the bed and wheelchair to ent attempted to rise off of the fact of the pad alarm and the control of the pad alarm was to be the through any evidence of any evidence of any evidence of the pad interventions put in the pation between the period of the pad and the resident was facility. The social of the social of the pation o	F 20	the facility. 1. Corrective actions taken for found to have been affected by deficient practice: Resident #191 was discharged on 5/25/15, therefore no other action could be taken. 2. Corrective actions taken for residents having the potential affected by alleged deficient p The Administrative Team met and reviewed the clinical docut of all current residents identifier risk" for elopement to determine were any needs for unplanned transfers/discharges because facility not being able to meet No other unplanned transfers discharges were identified. 3. Measures taken and system implemented to prevent allege practice: The facility's Transfer or Discher Policy and Procedure was revervevised to include the following of an unplanned transfer or discharge, and it is determined that the reside cannot be met in the facility, the steps will be taken:	d to home corrective other to be ractice: on 7/29/15 imentation ed as "high ne if there do for the their needs. or nic changes ed deficient or arge Notice iewed and guicharge sident's ent's needs ne following	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
				_			
		345247	B. WING _			1	24/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
V411 FV N	UDONIO OENTED			58	31 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			T/	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 202	facility. RP [Respons Assistant Administrate made that resident munit or discharged he due to this facility be needs/safety concert family had been made did not want the resid facility. The noted enstated she cannot call expressed understant believes resident needs he wishes he could everyone has been studied everyone has been s	ent redirected back into the ible Party] made aware. For made aware. Decision must be placed at a locked ome by Monday, 5/25/2015, ing unable to meet his ins." The note indicated the de aware of the decision but dent moved to another ded with, "(Family member) are for resident at home and adding of why the facility eds a locked unit, however stay at (this facility) because so good to resident. (A per) stated she would like to Administrator about the ident elsewhere and SW ber) that SW would pass on the door which read, "KEEP D AT ALL TIMES" these above the doorknob was door was locked. The door ked by turning the deadbolt arm sounded. Strator was interviewed on the Assistant wander guard alarm system exit doors were alarmed are was no electricity to this not be alarmed with the p a sign that said to keep	F 2	202	there is sufficient documentation to just why the needs of the resident cannot be met at the facility. This documentation should include, but not limited to, completed assessments, interventions implemented to address the resident response to the interventions and physician notes. b. The physician will be notified of the necessity for the unplanned transfer/discharge, and, if in agreementan order will be obtained for the discharge. c. The family and resident will be notified of the discharge decision and a Transfer/Discharge Notice will be implemented indicating the date of the pending discharge. A new form titled "Chart Review for Possible Initiation of Transfer/Discharge Notice" has been implemented that will utilized when reviewing the clinical documentation to determine if a transfer/discharge is needed to maintait the resident's safety and wellbeing. All licensed nursing staff were in-servicent on 8/11/15 and Administrative and Soc Work staff were in-serviced on 8/12/15 the Nurse Consultant regarding the importance of thorough and complete documentation including assessments completed, attempted interventions, resident outcomes and physician documentation related to the policy	e t, ed e be n	
	system so they put u	p a sign that said to keep sistant Administrator said					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345247	B. WING_				C 24/2015
NAME OF P	ROVIDER OR SUPPLIER	0.02.1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	24/2015
	10115211 011 001 1 21211				81 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER				AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 202		115, the facility attached a	F 2	202	4. How the corrective actions will be	:	
	someone had remove from the patio door so	or said she had noticed ed the personal body alarm on she placed one on the			monitored to ensure the deficient pract will not reoccur, i.e. quality assurance measures implemented:		
	know how long it had	o the interview. She did not been gone from the door. 1 AM, the Administrator and			The clinical documentation of residents who exhibit wandering or other adverse behaviors will be reviewed by the Administrator or designee to ensure		
	Assistant Administrate about the attempted 6 Both of them stated the	or were both interviewed elopement on 5/12/2015. ney had been made aware			proper documentation is present that includes assessments, interventions implemented and resident outcomes, a		
		t-seeking behavior but they a dattempted to leave by a			to ensure the facility procedure related Transfers/Discharges, as stated in #3 v followed. This will be done weekly for fo (4) weeks; and then monthly for four months. Nurse Consultant will also au	vas our	
	interviewed concernir	PM, the Social Worker was ng about her communication family about the discharge.			this area during routine monthly visits. The Administrator or designee will pres	ent	
		ner the Assistant ade aware and the decision are not a safe facility for him			results of these reviews in the monthly Quality Assurance Performance improvement Committee meetings. Th	ıe	
	at this point." She tol #191 would need to b discharge home sayir	d the family that Resident ee placed in a locked unit or ng, "so that by Monday e other would occur. I would			QAPI Committee will assess and modified the action plan as needed to ensure continual compliance.		
	be working with them explained that if it did administration but sor	to set up placement. It was n't happen they could talk to mething had to be in place					
	to accept him and the	ilities but neither were able					
	[the family] told me th home. Their main foc	ey were going to take him us was that he should stay the resident had reached					
	his maximum level of						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		OATE SURVEY OMPLETED	
		345247	B. WING			C 07/24/2045	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		07/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 202	been discharge from from the facility. Resident #191's famon 7/24/15 at 11:06 A about the expectation. The family member in on 5/21/2015 and staroom and said he has aid, 'You mean to the Veteran out on Memorize to made the definition when the definition of the stated that on Minimum placement had been member) went to pick Social Worker "did as packed up, if we wan see about maybe extended."	ly member was interviewed and about what she was told in of discharge on 5/25/2015. Indicated she was informed atted the SW, "came in the indicated the SW, "came in the indicated she was informed atted the SW, "came in the indicated she was informed atted the SW, "came in the indicated she was informed atted the SW, "came in the indicated she was informed in the sounday. I lime you are going to put a porial Day?' and she said the cision that he (Resident by Monday, either to a see or he had to go home." onday, because no found, she (the family in the resident up and the sk, once we had his things the totalk to the Director to the ending the stay. I said, 'No, ent #191) home. I'm not	F 2	02			
F 253 SS=E	interviewed about Re The Administrator inc staff had indicated to had to be out by 5/25 be notified immediate unexpected discharg resident to be kept so time to make a decis 483.15(h)(2) HOUSE MAINTENANCE SER	KEEPING &	F 2:	53		8/11/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2015
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH FAYLORSVILLE, NC 28681	1 01/2-12010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 253	Continued From page sanitary, orderly, and		F 253		
	by: Based on observation facility failed to repair prevention doors on a halls), repair resident splintered laminate a resident rooms (Resi #109, #111, #115, #1 #303, #306, #307, #3 #408, #409, #413, #4 and failed to repair a splintered laminate a bath doors (#400 hall). The findings included 1. a. Observations of 200 hall located on the entering the unit durit facility on 07/20/15 at had a metal edge probottom of the door wifacing outward. Observations on 07/2 the smoke barrier do the left side of the had a metal edge protection of the door wifacing outward. Observations on 07/2 the smoke barrier do the left side of the had a metal edge protection of the door wifacing outward. Observations on 07/2 the smoke barrier do the left side of the had a metal edge protection of the door wifacing outward.	dent room #102,#106, #108, 16, #204, #210, #211, #213, 811, #315, #316, #406, #407, 814, #501, #503, #504, #505) door with broken and nd wood on 1 of 2 central		F253 Housekeeping / Maintenance Services It is the policy of this facility to provide housekeeping and maintenance service necessary to maintain a sanitary, order and comfortable interior. 1. Corrective actions taken for resident found to have been affected by allege deficient practice: The metal edging was removed and straightened to repair the #200 and #3 smoke prevention doors on 7/27/15 by Maintenance Director. The doors to resident rooms #102, #1 #108, #109, #111, #115, #116, #204, #210, #211, #213, #303, #307, #311, #315, #316, #406, #407, #408, #409, #413, #414, #501, #503, #504, #505, #400 Central Bath; as identified by the surveyor as having broken and / or splintered laminate veneer; were all sanded, wood putty applied, and stain Repairs were completed to these door the Maintenance Director on 7/30/15. 2. Corrective actions taken for reside having the potential to be affected by same alleged deficient practice: The Maintenance Director conducted audit of all interior doors to inspect for bent edging, broken or splintered laminatered laminatere	ces erly, ats d and e ed. es by ents the

	TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345247	B. WING _				C 24/2015
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	2-112010
				58	1 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER				AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	the smoke barrier doc the left side of the ha	e 7 4/15 at 11:30 AM revealed or on the 200 hall located on Il when entering the unit had or that was bent at the	F 2	253	veneer, or other damage requiring repart on 7/30/15. Repairs were made to all doors identified to be in need of repair, a result of the audit. Those repairs wer	as	
	bottom of the door wi facing outward.	th a sharp pointed edge			completed on 8/11/15 by the Maintena Director.	nce	
	300 hall on 07/20/15 doors had a metal ed the bottom of the doo	at 9:30 AM revealed both ge protector that was bent at r with a sharp pointed edge			 Measures taken and systemic change implemented to prevent alleged deficies practice: The Assistant Administrator met with the 	nt	
	barrier doors on the 3 had a metal edge pro	2/15 at 4:29 PM of 2 smoke 300 hall revealed both doors tector that was bent at the			Maintenance Director on 7/27/15 to discuss the findings of the survey. A n "Door Maintenance Audit" tool was		
	facing outward. Observations on 07/2	th a sharp pointed edge 3/15 at 11:20 AM of 2 on the 300 hall revealed both			initiated. This audit is to ensure doors within the facility in need of repair are identified and repaired timely. The Maintenance Director will conduct a		
	the bottom of the doo facing outward.	ge protector that was bent at r with a sharp pointed edge			monthly inspection of all doors within the facility. All doors requiring repair will be listed on the Door Maintenance Audit to which will include the location of the do	e ool	
	smoke barrier doors of doors had a metal ed the bottom of the doo	on the 300 hall revealed both ge protector that was bent at r with a sharp pointed edge			and the type of repair needed. The maintenance staff will make necessary repairs to each door and indicate the d		
	facing outward.				the repair was completed and who completed the repair. A copy of the monthly audit will be given to the Assis Administrator when repairs are		
	tour of the facility on of AM revealed the door broken and splintered bottom half of the door	of the resident's room had I laminate on the front of the			completed. The Assistant Administrator and the Maintenance Director will then visually inspect all doors listed on that months audit to ensure all necessary repairs have been made.		
	the door of resident re	oom 102 had broken and the front of the bottom half			The Environmental Services Housekeeping staff was provided in-service training on 8/6/15. This		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY PLETED
	345247	B. WING		0.7	C // 24/2015
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	724/2013
			581 NC HIGHWAY 16 SOUTH		
RSING CENTER			TAYLORSVILLE, NC 28681		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
Continued From page	e 8	F 25	53		
Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations of Reput of the door. Observations of Reput of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations on 07/2 ne door of resident replintered laminate of the door. Observations of Reput of the facility on the door of the facility on the door on the right corresponding or on the right corresponding or 07/2 Observations on 07/2	23/15 at 11:20 AM revealed com 102 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 102 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 106 during the initial 27/20/15 at 9:30 or of the resident's room had diaminate on the front of the cor. 22/15 at 4:29 PM revealed com 106 had broken and in the front of the bottom half 23/15 at 11:20 AM revealed com 106 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 106 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 106 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 106 had broken and in the front of the bottom half 24/15 at 9:30 or of the resident's room had diaminate on the front of the cor of the bottom half of the 22/15 at 4:29 PM revealed	F 25	in-service emphasized the nee promptly fill out Maintenance R forms if they notice any splinter veneer, or other damage to the any other wood work while cleated. 4. How the corrective actions we monitored to ensure the deficient will not reoccur, i.e. quality assurance implemented: This plan was implemented and corrective action will be evaluate effectiveness. This plan of confinitegrated into the monthly Quality Assurance Performance Improvement (QAPI) program as follows: The Environmental Subcommitted Quality Assurance Performance Improvement (QAPI) Committed up of Maintenance Director, Environmental Supervisor and the Assistant Administrator, shather results of the monthly Door Maintenance Audits. They will audits monthly for 3 consecutive and then quarterly thereafter to that the doors are maintained in compliance with F253. The results of the monthly Door Maintenance Audits will be presented to the monthly Door Maintenance Audits will be presented as a compliance with F253. The results of the monthly Door Maintenance Audits will be presented as a compliance with F253. The results of the monthly Door Maintenance Audits will be presented as a compliance with F253. The results of the monthly Door Maintenance Audits will be presented as a compliance with F253.	tequest ring, broken e doors or aning. vill be ent practice measures d the ted for rection is ality vement e, made chaired by all review e months o ensure n or sented by he monthly e results nmittee ecutive	
	Continued From page Observations on 07/2 he door of resident resplintered laminate of the door. Observations on 07/2 he door of resident resplintered laminate of the door. Observations on 07/2 he door of resident resplintered laminate of the door. Observations on 07/2 he door of resident resplintered laminate of the door. Observations on 07/2 he door of resident resplintered laminate of the door. Observations on 07/2 he door of resident resplintered laminate of the door. Observations of Resident resplintered laminate of the door. Observations of Resident resplintered laminate of the door of resident resplin	WIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 Deservations on 07/23/15 at 11:20 AM revealed he door of resident room 102 had broken and uplintered laminate on the front of the bottom half of the door. Deservations of Room 106 during the initial pour of the facility on 07/20/15 at 9:30 AM revealed the door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/23/15 at 4:29 PM revealed he door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/23/15 at 11:30 AM revealed he door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/24/15 at 11:30 AM revealed he door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/24/15 at 11:30 AM revealed he door of resident room 106 had broken and uplintered laminate on the front of the bottom half of the door. Deservations on 07/24/15 at 9:30 AM revealed the door of the resident's room had uplintered laminate on the front of the bottom half of the door.	MIDENTIFICATION NUMBER: 345247 B. WING WIDER OR SUPPLIER RISING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 Deservations on 07/23/15 at 11:20 AM revealed he door of resident room 102 had broken and uplinatered laminate on the front of the bottom half of the door. Deservations on 07/24/15 at 11:30 AM revealed he door of resident room 102 had broken and uplinatered laminate on the front of the bottom half of the door. Deservations of Room 106 during the initial bour of the facility on 07/20/15 at 9:30 AM revealed the door of the resident's room had broken and splintered laminate on the front of the bottom half of the door. Deservations on 07/22/15 at 4:29 PM revealed he door of resident room 106 had broken and uplinatered laminate on the front of the bottom half of the door. Deservations on 07/22/15 at 11:30 AM revealed he door of resident room 106 had broken and uplinatered laminate on the front of the bottom half of the door. Deservations on 07/22/15 at 11:30 AM revealed he door of resident room 106 had broken and uplinatered laminate on the front of the bottom half of the door. Deservations on 07/22/15 at 11:30 AM revealed he door of resident room 106 had broken and uplinatered laminate on the front of the bottom half of the door. Conservations of Room 108 during the initial bour of the facility on 07/20/15 at 9:30 May revealed the door of the resident's room had broken and splintered laminate on the front of the loor on the right corner of the bottom half of the loor on the right corner of the bottom half of the loor on the right corner of the bottom half of the loor on the right corner of the bottom half of the loor of resident room 108 had broken and uplinatered laminate on the on the front of the loor.	A BUILDING 345247 WIDER OR SUPPLIER RSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 Observations on 07/23/15 at 11:20 AM revealed he door of resident room 102 had broken and plintered laminate on the front of the bottom half of the door. Observations of Room 106 during the initial our of the door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of resident room 102 had broken and plintered laminate on the front of the bottom half of the door. Observations of Room 106 during the initial our of the facility on 07/20/15 at 9:30 Mr evealed the door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/23/15 at 11:20 AM revealed he door of the resident's room had with the door of resident room 106 had broken and plintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 1:29 PM revealed he door of resident room 108 during the initial our of the facility on 07/20/15 at 9:30 Mr evealed the door of the resident's room had oroken and splintered laminate on the front of the bottom half of the door. Observations on 07/22/15 at 4:29 PM revealed he door of or resident norm 108 had broken and pintere	A BUILDING 345247 B WING STREET ADDRESS, CITY, STATE, 2IP CODE 851 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 2861 SUMMARY STATEMENT OF DESPICISACIES ((EACH DEFICIENCY WIST BE PRECEDED BY PULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 102 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/24/15 at 11:30 AM revealed he door of 7/24/15 at 11:30 AM revealed he door of resident room 102 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/24/15 at 19:30 MI revealed the door of 7/24/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 11:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 12:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 12:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservations on 07/23/15 at 12:20 AM revealed he door of resident room 106 had broken and plintered laminate on the front of the bottom half if the door. Disservati

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2015	
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	07/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 253	the door of resident resplintered laminate or right corner of the bood observations on 07/2 the door of resident resplintered laminate or right corner of the bood of the facility on AM revealed the door broken and splintered bottom half of the door of the door bottom half of the door splintered bottom half of the door right corner of the facility on AM revealed the door broken and splintered bottom half of the door splintered bottom half of the door splintered the door splintered bottom half of the door splintered the splintered that the sp	23/15 at 11:20 AM revealed room 108 had broken and in the front of the door on the attom half of the door. 24/15 at 11:30 AM revealed room 108 had broken and in the front of the door on the attom half of the door. 25/20/15 at 9:30 ar of the resident's room had d laminate on the front of the or.	F 253	The QAPI committee will assess and modify the action plan as needed to ensure continual compliance.		
	the door of resident resplintered laminate of the door. Observations on 07/2 the door of resident resplintered laminate of the door. Observations on 07/2 the door of resident	22/15 at 4:29 PM revealed from 109 had broken and fin the front of the bottom half 23/15 at 11:20 AM revealed from 109 had broken and fin the front of the bottom half 24/15 at 11:30 AM revealed from 109 had broken and fin the front of the bottom half				
	tour of the facility on AM revealed the doo broken and splintere bottom half of the do Observations on 07/2 the door of resident r splintered laminate of of the door.	or of the resident's room had d laminate on the front of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		COMPLETED		
		345247	B. WING			C 07/24/2015	
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		07/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 253	splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door. f. Observations of Fof the facility on 07/AM revealed the do 2 large areas of brocircular and approxithe center of the fro Observation on 07/2 door of resident roobroken laminate the approximately 2 incof the front side of the side of the servation of the side of the servations of the servation of the se	room 111 had broken and on the front of the bottom half /24/15 at 11:30 AM revealed room 111 had broken and on the front of the bottom half down the front of the bottom half stoom 115 during the initial tour 20/15 at 9:30 or of the resident's room had ken laminate that were smately 2 inches in diameter in the side of the door. 22/15 at 4:29 PM revealed the multiple 115 had 2 large areas of the were circular and thes in diameter in the center.	F 2:	53			
	of broken laminate approximately 2 incomplete of the front side of the Observations on 07 the door of resident of broken laminated approximately 2 incomplete of the front side of the front sid	/24/15 at 11:30 AM revealed room 115 had 2 large areas that were circular and hes in diameter in the center he door. Room 116 during the initial o7/20/15 at 9:30 or of the resident's room had ed laminate on the front of the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2015	
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	07/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 253	of the door. Observations on 0.5 the door of resident splintered laminate of the door. Observations on 0.5 the door of resident splintered laminate of the door. h. Observations of tour of the facility of AM revealed the door of the door. Observations on 0.5 the door of resident splintered laminate of the door. Observations on 0.5 the door of resident splintered laminate of the door. Observations on 0.5 the door of resident splintered laminate of the door. Observations on 0.5 the door of resident splintered laminate of the door.	roon the front of the bottom half 7/23/15 at 11:20 AM revealed t room 116 had broken and on the front of the bottom half 7/24/15 at 11:30 AM revealed t room 116 had broken and on the front of the bottom half Room 204 during the initial on 07/20/15 at 9:30 or of the resident's room had red laminate on the front of the door. 7/22/15 at 4:29 PM revealed t room 204 had broken and on the front of the bottom half 7/23/15 at 11:20 AM revealed t room 204 had broken and on the front of the bottom half on the front of the bottom half 7/24/15 at 11:30 AM revealed t room 204 had broken and on the front of the bottom half Room 210 during the initial tour //20/15 at 9:30	F 25	3		
	of the facility on 07 AM revealed the do broken and splinted bottom half of the co Observations on 07 the door of residen	/20/15 at 9:30 oor of the resident's room had red laminate on the front of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015	
	ROVIDER OR SUPPLIER	<u> </u>		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	<u> 077</u>	24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	the door of resident resplintered laminate or of the door. Observations on 07/2 the door of resident resplintered laminate or of the door. j. Observations of Roof the facility on 07/20 AM revealed the door broken and splintered bottom half of the door Observations on 07/20 the door of resident resplintered laminate or of the door. Observations on 07/20 the door of resident resplintered laminate or of the door. Observations on 07/20 the door of resident resplintered laminate or of the door. Observations on 07/20 the door of resident resplintered laminate or of the door.	23/15 at 11:20 AM revealed from 210 had broken and in the front of the bottom half at 11:30 AM revealed from 210 had broken and in the front of the bottom half at 12:30 are of the resident's room had at laminate on the front of the bottom half at 12:415 at 4:29 PM revealed from 211 had broken and in the front of the bottom half at 11:20 AM revealed from 211 had broken and in the front of the bottom half at 11:30 AM revealed from 211 had broken and in the front of the bottom half at 11:30 AM revealed from 211 had broken and in the front of the bottom half at 11:30 AM revealed from 211 had broken and in the front of the bottom half at 11:30 AM revealed from 211 had broken and in the front of the bottom half at 11:30 AM revealed from 213 during the initial 207/20/15 at 9:30	F	253	DEFICIENCY		
	a large area of broker the front of the botton Observations on 07/2 the door of resident ro	2/15 at 4:29 PM revealed com 213 had a large area of I laminate on the front of the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	` ′	TE SURVEY MPLETED
		345247	B. WING			C 7/24/2015
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		7/2-4/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	the door of resident broken and splintered bottom half of the do Observations on 07/the door of resident broken and splintered bottom half of the dowood broke off where. I. Observations of Resident of the facility on 07/2 AM revealed the door broken and splintered bottom half of the door of resident splintered laminate of the door. Observations on 07/the door of resident splintered laminate of the door. Observations on 07/the door of resident splintered laminate of the door. Observations on 07/the door of resident splintered laminate of the door.	23/15 at 11:20 AM revealed room 213 had a large area of d laminate on the front of the for. 24/15 at 11:30 AM revealed room 213 had a large area of d laminate on the front of the for and a large splinter of a touched. 20/15 at 9:30 20/15 at 9:30 20/15 at 9:30 20/15 at 4:29 PM revealed room 303 had broken and for the front of the bottom half 23/15 at 11:20 AM revealed room 303 had broken and for the front of the bottom half 24/15 at 11:30 AM revealed room 303 had broken and for the front of the bottom half 24/15 at 11:30 AM revealed room 303 had broken and for the front of the bottom half	F 25	53		
	tour of the facility on AM revealed the doc broken and splintere bottom half of the do Observations on 07/ the door of resident	or of the resident's room had diaminate on the front of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING				24/2015	
	ROVIDER OR SUPPLIER	1 11111		58	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	<u> </u>	24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 253	the door of resident resplintered laminate of of the door. Observations on 07/2 the door of resident resplintered laminate of of the door. n. Observations of Ro	23/15 at 11:20 AM revealed com 306 had broken and in the front of the bottom half 24/15 at 11:30 AM revealed com 306 had broken and in the front of the bottom half com 307 during the initial	F	253				
	broken and splintered bottom half of the door Observations on 07/2 the door of resident resplintered laminate of of the door. Observations on 07/2 the door of resident resplintered laminate of of the door. Observations on 07/2 the door of resident resplintered laminate of of the door.	r of the resident's room had I laminate on the front of the						
	tour of the facility on AM revealed the door broken and splintered bottom half of the doo Observations on 07/2 the door of resident resplintered laminate of of the door.	r of the resident's room had I laminate on the front of the						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 253	splintered laminate of the door. Observations on 07 the door of residen splintered laminate of the door. p. Observations of tour of the facility of AM revealed the dobroken and splinter bottom half of the cookservations on 07 the door of resident splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door. Observations on 07 the door. Observations on 07 the door of resident splintered laminate of the door.	t room 311 had broken and on the front of the bottom half 7/24/15 at 11:30 AM revealed t room 311 had broken and on the front of the bottom half Room 315 during the initial n 07/20/15 at 9:30 per of the resident's room had red laminate on the front of the	F 25	3		
	tour of the facility of AM revealed the do broken and splinter bottom half of the composition of the door of resident splintered laminate of the door. Observations on 07.	oor of the resident's room had red laminate on the front of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING		SURVEY LETED					
		345247	B. WING			l	24/2015
	ROVIDER OR SUPPLIER		1	5	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	of the door. Observations on 07/2 the door of resident r	e 16 n the front of the bottom half 24/15 at 11:30 AM revealed soom 316 had broken and n the front of the bottom half	F	253			
	of the facility on 07/2 AM revealed the doo broken and splintered bottom half of the doo Observations on 07/2 the door of resident r splintered laminate o of the door. Observations on 07/2 the door of resident r splintered laminate o of the door. Observations on 07/2 the door. Observations on 07/2 the door of resident r	r of the resident's room had d laminate on the front of the					
	tour of the facility on AM revealed the doo broken and splintered bottom half of the doo Observations on 07/2 the door of resident resplintered laminate of the door. Observations on 07/2 the door of resident r	r of the resident's room had d laminate on the front of the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345247	B. WING_			C 07/24/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	·	07/24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 253	the door of resident is splintered laminate of the door. t. Observations of Ro	24/15 at 11:30 AM revealed room 407 had broken and on the front of the bottom half bottom 408 during the initial tour	F 2	53		
	broken and splintere bottom half of the do Observations on 07/2 the door of resident of the door. Observations on 07/2 the door of resident of the door of resident of the door. Observations on 07/2 the door. Observations on 07/2 the door of resident of the door.	or of the resident's room had d laminate on the front of the				
	tour of the facility on AM revealed the door broken and splintere bottom half of the do Observations on 07/2 the door of resident splintered laminate of the door. Observations on 07/2 the door of resident in the door of r	or of the resident's room had d laminate on the front of the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		OMPLETED
		345247	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	the door of resident	ge 18 24/15 at 11:30 AM revealed room 409 had broken and on the front of the bottom half	F2	253		
	tour of the facility on AM revealed the document of the document of the document of the document of the door of resident splintered laminate of the door of resident splintered laminate of the door of resident splintered laminate of the door. Observations on 07/2 the door. Observations on 07/2 the door of resident of the door.	or of the resident's room had ad laminate on the front of the				
	tour of the facility on AM revealed the doo broken and splintered bottom half of the do Observations on 07, the door of resident splintered laminate of the door. Observations on 07, the door of resident splintered laminate of the door.	or of the resident's room had ad laminate on the front of the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED		
		345247	B. WING		C 07/24/2015		
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 253		ge 19 t room 414 had broken and on the front of the bottom half	F 25	3			
	tour of the facility of AM revealed the doubroken and splinter bottom half of the composition of the door of resident splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door. Observations on 07 the door. Observations on 07 the door of resident splintered laminate of the door.	oor of the resident's room had red laminate on the front of the					
	tour of the facility of AM revealed the doubroken and splinter bottom half of the composition of the door of resident splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door of resident splintered laminate of the door. Observations on 07 observati	oor of the resident's room had red laminate on the front of the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY MPLETED
		345247	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	Continued From pa splintered laminate of the door.	ge 20 on the front of the bottom half	F 2	253		
	tour of the facility of AM revealed the dobroken and splinter bottom half of the dObservations on 07 the door of resident splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door. Observations on 07 the door. Observations on 07 the door of resident splintered laminate of the door.	or of the resident's room had ed laminate on the front of the				
	tour of the facility of AM revealed the do broken and splinter bottom half of the d Observations on 07 the door of resident splintered laminate of the door. Observations on 07 the door of resident splintered laminate of the door. Observations on 07 the door. Observations on 07 the door of resident splintered laminate of the door.	or of the resident's room had ed laminate on the front of the				

			DATE SURVEY COMPLETED			
		345247	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	 	0112-412013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	Continued From page of the door.	ge 21	F 2	253		
	hall during the initial 07/20/15 at 9:30 AM areas of broken and wood on the front of Observations on 07/the central bath doo of broken and splint the front of the botto Observations on 07/the central bath doo of broken and splint the front of the botto Observations on 07/the central bath doo of broken and splint the front of the botto Observations on 07/the central bath doo	23/15 at 11:20 AM revealed or on 400 hall had large areas hered laminate and wood on or half of the door. 124/15 at 11:30 AM revealed or on 400 hall had large areas hered laminate and wood on				
	AM the Maintenance laminate on the resicentral bath door on sanded, patched an not have a defined prouple of times a yeand stain on the doche had time to do it. painting door frames not noticed the dam the door of Room 11 the door with a lift at He stated he had we 213 earlier that more	terview on 07/24/15 at 11:57 e Director confirmed the dent room doors and the the 400 hall needed to be d painted. He stated he did plan to repair doors but a ar he tried to put wood putty ors but that happened when He explained he had been a early in the week but he had aged laminate on the front of 5 and thought staff had hit had that broke the laminate. Orked on the hinge of Room hing but did not notice the on the door. He explained				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	ATE SURVEY DMPLETED	
		345247	B. WING _			C 07/24/2015	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	maintenance request each clean linen clos made rounds and charequests several time received any request on doors. He stated bent outward on the 200 hall and 300 hall equipment was bump needed to straighten outward and cause in During an interview of Assistant Administrate expectation for the M regular rounds and rebroken laminate or wexpected the Mainter metal edges on the should be monitoring edges did not stick of During an interview of Administrator explain in the maintenance of have repaired the brothe doors. She state repaired then they were	naged doors by filling out a form that was located in et. He further explained he ecked for maintenance es a day but he had not is to repair broken laminate the metal edges that were smoke barrier doors on the was caused when be dinto the door and he them so they did not stick injury. In 07/24/15 at 3:15 PM the for stated it was her aintenance Director to do epair any door that had food. She further stated she hance Director to repair the moke barrier doors and he doors to ensure the metal autward. In 07/24/15 at 5:10 PM the ed she had 2 full time staff epartment and they should oken laminate and wood on dif the doors could not be bould have to be replaced.	F 2	253			
F 272	fill out maintenance r things that needed re expected for the main regular rounds on a co	vere encouraged routinely to equests when they saw epair. She further stated she ntenance staff to make daily basis and look at doors in they were damaged.	F2	772		8/23/15	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345247	B. WING			l	24/2045
NAME OF PE	ROVIDER OR SUPPLIER	0.02	<u> </u>	_	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	24/2015
					581 NC HIGHWAY 16 SOUTH		
VALLEYN	URSING CENTER				TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page ASSESSMENTS The facility must conc a comprehensive, acc reproducible assessment functional capacity. A facility must make a assessment of a resident assessment by the State. The assesst the following: Identification and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior prescribed functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sur the additional assessi areas triggered by the Data Set (MDS); and	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information; atterns; ng; and structural problems; d health conditions; status;	TAG		DEFICIENCY)	ATE .	DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			07/3	24/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	/, STATE, ZIP CODE	0172	14/2010
				581 NC HIGHWAY 16 S			
VALLEY N	URSING CENTER			TAYLORSVILLE, NC			
(X4) ID PREFIX TAG			ID PREFIX TAG				(X5) COMPLETION DATE
F 272	Continued From page	e 24	F 2	72			
	by:	is not met as evidenced		F272 Compreh	noncii (a Aggaggamenta		
		ns, record reviews and staff failed to complete Care Area			nensive Assessments f this facility to conduct		
	_	dressed the underlying			odically a comprehensi		
		factors and risk factors for 1			ardized reproducible	v O,	
	of 27 sampled resider				each resident's function	al	
	The findings included	l:			ctions taken for resident een affected by alleged		
		dmitted to the facility on oses including Alzheimer's		deficient practic			
	disease.			Data Set (MDS)	comprehensive Minimu) dated 2/17/15 for was modified and	m	
		ed an evaluation by Speech			3/4/15 by the MDS Nurs		
		5, and that the resident's diet			(B) was correctly coded		
		anged from mechanical soft			resident is edentulous	(no	
	to a pureed diet.				tooth fragments). A ea Assessment (CAA) w	126	
					ompleted and a Care Pl		
	The Admission comp	rehensive Minimum Data			propriate interventions		
	Set (MDS) dated 02/1 resident was severely	17/2015 indicated the cognitively impaired. The		8/4/15 by the M	DS Nurse.		
		ent section of the MDS was			ctions taken for other		
		above present, which had		,	g the potential to be		
		en or ill-fitting dentures, no		affected by alleg	ged deficient practice:		
		fragments, abnormal mouth ken natural teeth, inflamed		All residents in t	the facility were		
		buth or face pain, discomfort		All residents in t	8/11/15 by the MDS		
	0 0	Because the Oral/Dental			status to determine if		
		concerns, the Dental Care			dentures were present.		
		AA) did not trigger for further		Section L of the			
	assessment.				Minimum Data Sets		
				(MDS) for all cu	rrent residents in the		
				facility was then	reviewed and compare	ed	

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		345247	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343247	1 2:	ет	REET ADDRESS, CITY, STATE, ZIP CODE	07/	24/2015
NAIVIE OF F	ROVIDER OR SUFFLIER						
VALLEY N	IURSING CENTER				1 NC HIGHWAY 16 SOUTH		
				TA	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag	e 25	F 2	272			
	Assessment for the I the resident, "was no mechanical soft mea speech therapy. Diet thin liquids. No difficit mouth pain with presindication if the resid at the time of the Sputhe problem with the to swallowing or check On 7/21/2015, Resid The resident did not	ts. She was evaluated by was changed to puree with ulty chewing/swallowing or sent diet." There was no ent had well-fitting dentures eech Therapy evaluation or if mechanical diet was related			to the oral status assessment to determine if this section was coded accurately. This task was completed by the MDS Nurses on 8/12/2015. All MDS coding errors related to the resident having dentures or natural tee were corrected on the most current comprehensive MDS, Dental Care Are Assessments or Nutrition Care Assessments (CAA's) were completed triggered or as appropriate to address underlying causes, contributing and ris factors related to oral status using RAI process guidelines by the MDS Nurses and this will be completed by the Completion Date listed of 8/23/15.	ith a if k	
	1	35 PM, Resident #149 was ig room for lunch. She was tures.			 Measures taken and systemic change implemented to prevent alleged deficie practice: 		
	At 8:25 AM on 7/23/ Resident #149 did no did not have denture			MDS Nurses were in-serviced on the proper coding procedure for Section L (Oral/Dental Status) of the MDS and the Care Area Assessment procedure per guidelines on 8/11/15 by the Nurse Consultant.			
	stated she had comp Nutrition Care Area A time of the assessme dentures. MDS Coor copied the dietary no summary. The MDS the resident had diffi swallowing or both, b	M. MDS Coordinator #1 bleted Resident #149's Assessment [CAA] and at the			L0200 (B) is now being coded on all residents who are edentulous. Care Area Assessments (Nutrition and Dental Care) are now being completed when triggered to address underlying causes, contributing and risk factors related to oral status using RAI process guidelines. The MDS Nurse will implement a care plan when appropria	s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			l	C 24/2015
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	011	24/2013
				58	31 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			T/	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	or why the resident so soft to pureed diet du During an interview o	tional status about dentures, witched from mechanical ring the assessment period. n 7/24/15 1:40 PM, the ated the CAA summary er a total picture of the	F	2272	monitored to ensure the deficient practivill not reoccur, i.e. quality assurance measure implemented: The DON and or designee will monitor admission comprehensive and annual MDS assessments to determine if Sect L (Dental Status) is coded accurately. This will be done weekly for one month then every other week for one month. This area will also be monitored during routine Nurse Consultant visits for the next 2 months. Results will be reviewe and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QAPI committee will assess and modify the action plan as needed to	ion	
F 278 SS=D	ACCURACY/COORD The assessment must resident's status. A registered nurse must each assessment with participation of health. A registered nurse must assessment is complete.	olination/CERTIFIED at accurately reflect the ust conduct or coordinate the appropriate professionals. ust sign and certify that the eted. completes a portion of the n and certify the accuracy of	F:	2278	ensure continual compliance.		8/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _		,	C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		772-72010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 278	willfully and knowing false statement in a subject to a civil more \$1,000 for each asses willfully and knowing to certify a material a resident assessment penalty of not more transpension and false statements. Clinical disagreement material and false statements. This REQUIREMENT by: Based on observation interviews, the facility Data Set accurately	Medicaid, an individual who by certifies a material and resident assessment is bey penalty of not more than ressment; or an individual who by causes another individual and false statement in a ris subject to a civil money than \$5,000 for each at does not constitute a reterment. This not met as evidenced ons, record review, and staff of failed to code the Minimum to reflect the dental status for idents (Resident #149).	F2	F278 Accuracy of MDS It is the policy of this facility to co initially and periodically a compre accurate, standardized reproduci assessment of each resident; s fi capacity.	ehensive, ble		
	Resident #149 was a 2/10/2015 with diagratisease. The Admiss Data Set (MDS) date resident was severel Oral/Dental assessm coded as none of the questions about broknatural teeth or tooth tissue, cavities or broor bleeding gums, mor difficulty chewing. section indicated no	admitted to the facility on closes including Alzheimer's close including Alzheimer's close incomprehensive Minimum and 02/17/2015 indicated the comprehensive Minimum and 02/17/2015 indicated the comprehensive Minimum and 02/17/2015 indicated the comprehensive Minimum and the		1. Corrective actions taken for refound to have been affected by a deficient practice: The Admission comprehensive M Data set (MDS) dated 2/17/15 for Resident #149 was modified and transmitted on 8/4/15 by the MDS Section L0200 (B) was correctly indicate that the resident is edent (No natural teeth or tooth fragme Dental Care Area Assessment (C triggered and completed for furth assessment on 8/4/15 by the MD	lleged finimum r S Nurse. coded to tulous nts). A CAA) was er		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 0//24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE COMPLETION
F 278	Continued From pag	e 28	F 27	8	
	assessment.			Corrective actions taken for oth residents having the potential to b affected by alleged deficient practi	e
	The resident did not natural teeth and wa On 7/22/2015 at 12:	lent #149 was in her room. have any upper or lower s not wearing dentures. 35 PM, Resident #149 was no room for lunch. She was tures.		The dental status of all current res was assessed by the MDS Nurse 8/11/15 and then compared to Sec of the most recent comprehensive Minimum Data Sets (MDS) to ider any coding errors were present re a resident having no natural teeth fragments (edentulous).	sidents on ction L tify if lated to
	During an interview on 7/23/2015 at 8:05 AM, Nursing Assistant [NA] #3 indicated she was not aware that Resident #149 ever had any dentures, but did know the resident had no natural teeth.			All coding errors were corrected a MDS modified and transmitted as appropriate. Dental Care Area Assessments or Nutrition Care Assessments (CAA's) were complete.	eted as
		15, Medication Aide #1 stated of have any natural teeth and s.		appropriate to address underlying contributing and risk factors. Thes will be completed by the MDS Nur or before the Completion Date of 8	e tasks ses on
	MDS Coordinator #1 was interviewed on 7/23/2015 at 1:57 PM, about why her coding on the MDS indicated Resident #149 had natural teeth. MDS Coordinator #1 said, "She does have upper and lower dentures so if they have dentures I don't code them as having no teeth." After review of the MDS question again, the MDS Coordinator indicated she had misread the question, and said she did not accurately code the MDS for Resident #149 because the resident had.no natural teeth.			3. Measures taken and systemic of implemented to prevent alleged depractice: All MDS Nurses were in-serviced Nurse Consultant on the accuracy coding Section L (Oral/Dental Stausing the coding guidelines and delisted in the RAI Manual. All L0200 (B) is now being coded residents who are edentulous Care Area Assessments (Nutrition Dental Care) are now being compand addressed when triggered and	by the of of otus) efinitions on all and/or leted d a care
		on 7/24/2015 at 1:28 PM, the DON) indicated it was her		plan implemented when appropriate the MDS nurses.	те ру

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 7/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 279 SS=D	resident information a correctly before it was sometimes and the source of the source	DS to accurately reflect and should be coded as transmitted. 1) DEVELOP CARE PLANS are results of the assessment d revise the resident's		4. How the corrective actions will monitored to ensure the deficient will not reoccur, i.e. quality assurance me implemented: The Director of Nursing or design monitor 3 MDS assessments per one (1) month, then every other wone (1) month and taper to month two or more consecutive months the ensure accurate coding of resider dental status on the MDS assess Section L coding accuracy will als monitored by the Nurse Consultar routine visits. Results will be revied discussed in the monthly Quality Assurance Performance Improver Committee meetings. The QA corwill assess and modify the action needed to ensure continual comp	ee will week for eek for ly for o t's nents. o be nt during wed and nent nmittee plan as	8/12/15	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OMPLETED
		345247	B. WING _			C 07/24/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	<u> </u>	0172-42010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX (EACH CORRECTIVE ACTION		ULD BE	(X5) COMPLETION DATE
F 279	§483.25; and any se be required under §4 due to the resident's §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on staff interviolation facility failed to development for 1 of 3 elopement (Resident The findings included Resident #21 was ac 05/18/15 with demer 06/03/15. Review of notes revealed that of "pacing and wander how to get out. Anot 05/20/15 read in part to exit the facility. A read in part that a was security device) was resident due to the result of the part of	hysical, mental, and ing as required under rvices that would otherwise .83.25 but are not provided exercise of rights under e right to refuse treatment T is not met as evidenced views and record review the rop a care plan to address a ing behaviors and at risk for sampled residents at risk for sampled residents at risk for exercise It is mitted to the facility on resident #21's nurse's on 05/19/15 the resident was nog" the facility and asking her nurse's note dated that Resident #21 was trying nurse's note dated 05/21/15 ander guard bracelet (a unable to be applied to the resident being	F 2	F-279 Comprehensive Care Plan It is the policy of this facility to dev comprehensive care plan for each resident that includes measurable objectives and timetables to meet resident's medical, nursing, menta psychosocial needs that are ident the comprehensive assessment. 1.How the corrective action will be accomplished for those residents have been affected by the deficier practice: Resident #21 was discharged from facility on 6/3/15 therefore no other corrective actions could be taken. 2. Corrective actions taken for other residents having the potential to be	velop a a al and iffied in found to nt m the er	
	05/25/15 specified th impaired cognition, w and physical behavious wandered the facility	num Data Set (MDS) dated e resident had severely vas delusional, had verbal ors, rejected care and . The MDS also specified ring placed the resident at ting to a potentially		A 100% chart audit of all residents identified with wandering behavior conducted by the MDS Nurse on to ensure a care plan was in place assess the appropriateness of car	s rs was 7/24/15 e and to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	elopement or wander On 07/23/15 at 12:44 was interviewed and developing care plan each care plan to ref concerns. The MDS Resident #21's care resident had wander for elopement. She s should have had a ca	#21's care plan dated ress Resident #21's risk for ring behaviors. PM MDS Coordinator #2	F	279	goals and interventions. All other wandering care plans were in place an appropriate. 3. Measures taken and systemic change implemented to prevent alleged deficie practice: The MDS Nurses will review the 24-hor report on a daily basis to identify any residents exhibiting new wandering behaviors and a care plan will be implemented with appropriate interventions. The MDS/Care Plan Nurses were in-serviced on 8/11/15 by the Nurse Consultant regarding care plan development and update, specifically the specific conditions, risks, needs, etc., and current standards of practice (2) the need to include measurable objectives, approximate timetables, specific interventions and/of services needed to address those need and conditions, and (3) the process for reviewing and revising the care plan periodically and as necessary to reflect changes in resident conditions. 4. How the corrective actions will be monitored to ensure the deficient practivally not reoccur, i.e. quality assurance measure implemented. The DON or designee will review the	ges nt ur hat: h	
					nursing documentation of any resident exhibiting increased wandering/exit		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _			07/24/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
VALLEYN	URSING CENTER			581 NC HIGHWAY 16 SOUTH		
***************************************				TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
F 279			F 2	seeking behaviors to ensur plan has been implemented appropriate interventions. I done weekly for one month other week for one month. also be monitored during reconsultant visits for the nexure Results of the audit will be discussed in the monthly Quantity Assurance and Performance Improvement Committee many The QA Committee will assure the action plan as needed to continued compliance.	seeking behaviors to ensure that a care plan has been implemented with appropriate interventions. This will be done weekly for one month, then every other week for one month. This area will also be monitored during routine Consultant visits for the next two months. Results of the audit will be reviewed and discussed in the monthly Quality Assurance and Performance Improvement Committee meeting. The QA Committee will assess and modify the action plan as needed to ensure	
SS=J	This REQUIREMENT by: Based on observatio interviews, the facility in place to prevent 1 residents with wande unsupervised from th Resident #191 was sefacility through a non-	sion/devices are that the resident as free of accident hazards ach resident receives and assistance devices to is not met as evidenced an, record review, and staff failed to have interventions of 3 cognitively impaired ring behavior from exiting, e facility. On 5/12/2015 een attempting to leave the		F323 Free of Accident Hazards/Supervision/Devic It is the policy of this facility the resident environment re of accident hazards as is p each resident receives ade supervision and assistance prevent accidents.	to ensure temains as frossible; and equate	ee

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345247	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEYN	URSING CENTER			5	81 NC HIGHWAY 16 SOUTH		
VALLETIN	OKSING CENTER			T.	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page		F	323			
	Immediate Jeopardy Administrator was no PM. Immediate Jeopardy 7/24/2015 at 5:11 PM an acceptable credib The facility will remai scope and severity le potential for more thai immediate jeopardy (systems put in place training. Findings included: The facility Policy State [revised February 20 1. Staff shall promptries to leave the prerious missing to the Nursing. Resident #191 was a 4/28/2015 with diagn disease, Alzheimer's	began on 5/21/2015 and the tified on 7/22/2015 at 6:50 ardy was removed on 1 when the facility provided le allegation of compliance. In out of compliance at a evel of no actual harm with an minimal harm that is not D), to ensure monitoring of and 100% of employee attement, titled Elopements 14], included: otly report any resident who mises or is suspected of Charge Nurse or Director of dmitted to the facility oses including Parkinson's disease, muscle weakness, anxiety, depression and Post			1. Corrective actions taken for resident found to have been affected by alleged deficient practice: Resident #191 no longer resides in factor Resident #191 exited the facility through the locked patio door, went off the brick in patio, and was observed ambulating outside crossing the courtyard between the 200 and 600 hall. He was met by so on the grass beside the end of the 600 hall wing. He was seated in the wheelchair and brought back inside in presence of his wife and examined for injuries by the DON and his hall Nurse. There were no apparent injuries observand the resident was in no distress oth than he repeatedly stated he wanted to home. The VA, and the medical provide were notified of the incident. The resident's wife was present in the facility when the incident occurred and therefore was aware of the occurrence. On 5/21/15 it was determined Resident #191 could return to home with his farmand VA Home Care services as was the planned goal upon admission to the SN	ility. h ked staff the go er ty ore t illy e	
	Set [MDS] dated 5/5/ was severely cognitive exhibited wandering of period, The MDS also walking balance was	rehensive Minimum Data 2015 indicated the resident vely impaired but had not during the assessment o indicated the resident's not steady and he required of two staff members for			or if the family and VA choose, we initial referral and would seek placement in facility with a locked unit. He was discharged with his wife on 5/25/15. 2. Corrective actions taken for other residents having the potential to be affected by alleged deficient practice:		
		i dio dilit.			A keyed nadlock was placed on the do	or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
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VALLEY N	IURSING CENTER			581 NC HIGHWAY 16 SOUTH			
				TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 323 Continued From page		e 34	F 32	23			
F 323	The Plan of Care [ori indicated the residen memory problems dureceived medications and was at risk for fa Review of the facility 5/12/2015 revealed a name which read, "or shift" but did not indicated for the clinical 5/12/2015 resident # wheelchair, propelling room. The nursing do "resident stood up artryed (sic) to go out us assisted resident backersident stated he was determined to get our monitor closely, call I did not indicate the time the attempted elopent A physician order da Resident #191 was gacility magnetic door he attempted to leave	ginally dated 5/11/2015] It had short and long term the to Alzheimer's disease, Is for anxiety and depression Ills. 24 Hour Report Sheet dated In note by Resident #191's In pened patio door on second Cate a time for the incident. It record revealed that on 191 was observed in his If phimself into the patio dining Incumentation note included, Indicated patio door and Inassisted, another nurse It is into w/c [wheelchair], It is leaving and very It any door in facility, will I ight within reach." The note I me of the incident. I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for I the following and very I the note of the incident report for the i	F 32	to the bricked in patio, by the director, on 7/22/15 at 7:40pr will be kept locked at all times is present to unlock it with a k supervise residents. (Please door is NOT an emergency e approved by Life Safety). The used temporarily until a more solution can be implemented environmental services staff the day room daily 7 days ea be responsible to visually che and sign off daily on the "veri door is locked log that is post unalarmed patio door in the control of the documented by maintenance "Wander Guard monitors three times weekly for function documented by maintenance "Wander Guard and Fire Exit Monitoring" log. Wander Guard nor residents are verified for pand checked for functionality and documented each shift of All resident are assessed for Section E0900 "Wandering-Frequency" and Section E100 "Wandering and Impact" on the	m. The door is unless staff key and Note: This xit. This was is lock will be is permanent The that cleans ich week will ick, ensure, fy that patio ied on the day room. and doors are checked inality and staff on the Door Alarm and devices islacement by nursing in the eMAR. wandering in Presence and oo ine MDS		
	placed in the residen alert staff if the reside the pad. Resident #191's Plar	ated a pad alarm was to be t's bed and wheelchair to ent attempted to rise off of a of Care was updated on a wander guard bracelet ent elopement.		assessment upon admission quarterly. More frequent ass are completed if change in behaviors/condition are deter Interventions to maintain the safe environment are initiated Care Area Assessment (CAA of care process by the Interdi Care Plan Team. This inform	essments mined. resident in a d through the ¿s) and plan sciplinary		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
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VALLETIN	OKSING CENTER			TA	YLORSVILLE, NC 28681			
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F 323	Continued From pag	e 35	F3	323				
	5:28 PM read, "Reside facility this afternoon staff unsuccessful SV resident why he was indicated he was going indicated the Nurse Fand the resident was Ativan 1 milligram, in Further review of the resident succeeded in staff knowledge on 5 dated 5/21/2015 at 6 went out patio door in wheelchair breaks, characteristics."	record dated 5/20/2015 at dent attempting to leave . Redirection attempts by W [Social Worker] asked trying to leave, residenting home." The record also Practitioner was informed given a one-time dose of tramuscularly for agitation. clinical record revealed the n exiting the facility without 1/21/2015. A note by the SW 1:58 PM included, "Residenting dayroom, locked his limbed over the short brick bulated around the facility on the 600 hall driveway, ed to resident being outside.			available to all nursing staff and Care I team via the electronic charting softwa The list of residents identified as havin wandering behaviors is sent out to all inside facility email recipients to be prin by department managers and posted within their department and available to staff. The MDS Nurses are responsible update the list as changes are made and disseminate information via email and EMR. All staff will be oriented to this process upon hire and annually thereat All facility staff educated to policies. Wandering-Presence and Frequency put to beginning their next work shift. On the night of 7/22/15 a 100% audit or residents identified with wandering behaviors was conducted by the MDS Care Plan nurses. Care Plans were reviewed and revised as needed, to	nted o all e to nd ofter. of all		
	description of the inc of Nursing [DON] on included, "On 5/21/20 PM, resident was obresident's window ou Resident was walking independently. Staff and resident was coolead him back inside The patio dining roor 7/21/2015 at 11:50 AThere was a sign on THIS DOOR LOCKE Approximately 24 inca a deadbolt lock. The	n door was observed on M and again at 2:22 PM. the door which read, "KEEP D AT ALL TIMES" thes above the doorknob was door was locked. The door			ensure appropriateness of care plan grand interventions to maintain resident safety. On 7/24/15 all residents were assesse by Nurses using the new Wandering Rassessment tool implemented. Care Plans were reviewed and revised as needed, to ensure appropriateness of care plan goals and interventions to maintain resident safety. 3. Measures taken and systemic chang implemented to prevent alleged deficie practice: A keyed padlock was placed on the do	d disk ges ent		
		ked by turning the deadbolt			to the bricked in patio, by the maintena			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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	Continued From pag to the left and no alad door was a 15 foot so brick wall that was an A second brick wall is separated by a space. The space between the dirt which formed a gwere growing. Beyong grassy area with tree grassy area was a diffacility and then a chedownward sloping and The driveway behind the side of the buildir lot and then further at Nurse #1 was intervied PM. She stated she (attempted elopemer also on 5/21/2015 with found outside the 60 about the incident on the resident was obswheelchair, unlock the to step outside when nurse who brought hourse #1 indicated the time of his discharesident would go to out. She said after he were decreased and is when it started. He patio door and try to	e 36 rm sounded. Outside the quare patio surrounded by a proximately 26 inches high. surrounded the first wall, e of approximately 8 inches. the brick walls was filled with larden where tomato plants and the patio was a large as and bushes. Beyond the riveway which ran behind the	TAG	3323	CROSS-REFERENCED TO THE APPROPRIA	or taff io or, te: eck, / the tio" as t		
	not alarmed and was the wander guard loo sign, 'This door must already posted at tha	told the door could not have the country of the cou			within the facility was provided in-servi training beginning on 7/22/15, 7/23/15, 7/24/15 by nurse management and administration on emergency "Code E" missing resident procedures and the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _			07	7/24/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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F 323	Continued From pag	ge 37	F3	323				
		oatio, I guess." Nurse #1 said attempted elopement was			"Wandering, Unsafe Resident" Policy. Nurses were also instructed to			
		d on in report and was on the			immediately inform the nurse manage	r on		
	24 hour Report Shee				duty in facility, or to call the nurse			
	•				manager on call, if a resident			
	During the same inte	erview Nurse #1 described			demonstrates exit seeking behaviors a	and		
	the events on 5/21/2	015 when the resident was			interventions currently in place are not			
	_	the building unsupervised.			effective in maintaining the resident in			
Nurse #1 said she had spoken to the resident 10-15 minutes earlier and the resident's family				safe environment. The nurse manage	will			
		_			be responsible for re-assessing the			
		for him too when Resident			situation, implement additional			
		through the 100 hall window,			interventions and measures to ensure			
		backyard. Nurse #1 sent			resident¿s safety is maintained. Thes	е		
		she went around to the 600 hall with a wheelchair to			interventions may include but are not limited to: redirection, diversional activ	vities		
		esident's family member,			(recreation, music, IN2L, talking with	ilics		
		e." "My question was this an			family members) intensified visual			
	_	incident because he wasn't			monitoring, one-on-one with staff, initi	ation		
		DON said she would take			of wander guard, visual barriers (stop			
		itation and notifying the			signs, ribbons) etc. Effectiveness of the	ne		
	appropriate people a	and I could just go back to			interventions will be monitored and			
	what I was doing." N	Nurse #1 clarified that Nursing			documented by the nurse. The nursing			
		d told her the resident was			staff will report to the Nurse Manager			
		e was also aware a NA on			the new interventions implemented are			
		ident through another			not effective who will then notify the D	ON		
	resident's window or	n 600 hall.			and Administrative on call person			
	Th - A : - 4 4 A - ! : -	interest and a second and			(Administrator or Assistant Administration	-		
	7/22/2015 at 4:24 PM	histrator was interviewed on			As of 7/28/15 100% of the all current s			
		wander guard alarm system			to include Administration, Nurses, CN. Respiratory Therapy, Life Enrichment			
		exit doors were alarmed			Therapy, Environmental Services, Off			
	-	re was no electricity to this			Personnel, Medical Records, Dietary,			
		d not be alarmed with the			Maintenance; had received this training			
	l ·	ip a sign that said to keep			, , , , , , , , , , , , , , , , , , , ,	-		
	'	sistant Administrator said			A new assessment Wandering Data			
	after the investigatio	n on 5/25/2015 of the			Collection Tool was implemented on			
		2015, the facility attached a			7/24/15 by DON to help staff identify			
		to the patio door. The			residents at risk of wandering, presen	ce		
	Assistant Administra	tor said she had noticed			of wandering and the impact of wander	rina		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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VALLEY N	URSING CENTER			581 NC HIGHWAY 16 SOUTH		
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F 323	Continued From page	e 38	F 323	3		
	someone had remove	ed the personal body alarm		on resident safety/disruption a new.	The	
		she placed one on the		assessment will be completed upon		
	-	o the interview. She did not		admission and quarterly thereafter.	More	
		been gone from the door.		frequent assessments may be compl		
		3		if change in behaviors/condition is		
		n 600 hall on 5/21/2015 and /22/2015 4:46 PM. NA #1		determined.		
		a resident in room 621 and		4. How the corrective actions will be		
		and happened to look up		monitored to ensure the deficient pra	ctice	
		nt #191]. I went running out		will not		
	_	n." NA#1 went on to say, "I		reoccur, i.e. quality assurance measurance	ıres	
		or the door nearest (room)		implemented:		
		all and went out the door by				
		d ran down the side of the		The DON or designee will audit medi	cal	
		NA #1 clarified that Room		records to ensure that clinical		
	621 overlooked the fa	cility's side parking lot and		documentation of any resident who h	as	
	one could not see the	backyard from that room.		been reported as exhibiting exit-seek	ing	
				behaviors describes that appropriate		
				interventions have been initiated to e		
		1 AM, the Administrator and		resident safety. These audits will be		
		or were both interviewed		daily for one month, weekly for four v	veeks	
	-	elopement on 5/12/2015.		and monthly for six months. Nurse		
		ney had been made aware		Consultant will also audit these areas	6	
		t-seeking behavior but they		during routine visits.		
		nd attempted to leave by a		The Administrator or decision as will as		
	non-alarmed door.			The Administrator or designee will re		
				the 24-hour shift reports to ensure the	-	
	On 7/22/2015 at 10:4	9 AM the Director of		are aware of any unusual occurrence related to wandering residents. The	:S	
	On 7/23/2015 at 10:44 Nursing [DON] was in	,		Administrator or designee will also		
		on 5/12/2015. She stated		monitor the lock placed on the patio	door	
	she was present at th			to ensure it is in place. These audits		
	•	s discussed. The DON		be done daily for two weeks, weekly		
	indicated it was she w			four weeks and monthly for four mon		
		14/2015 for the wander		lead to the same than the real files		
		acelet and the pad alarm		Results of the audit will be reviewed	and	
	_	chair. When asked about the		discussed in the month Quality Assur		
		or where he had attempted		and Performance Improvement		
	-	ndicated the resident had		Committee meeting. The QA Commit	tee	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2045	
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	07/24/2015	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 323	also made attempts to doors. On 7/23/2015 at 11:2	o exit the facility by alarmed 5 AM, the Director of	F 323	will assess and modify the action plan needed to ensure continued complian		
	patio door on 5/21/20 the brick wall (approx taken a direct path to hall wing, the distance feet from the patio do a lower portion of the 12-14 inches high, wh	aken when he exited by the 15. If he had climbed over imately 26 inches high) and the other side of the 600 e was approximately 249 or. If the resident went over brick wall that was only nich is where he had parked stance covered would have				
	about where Resident found on 5/1/2015 aft stated that after the rebuilding she went to I said, "I walked around found the patio door windicated the wheelch the patio door and new wall that was just 12-"the wheels were lock off. It was a pad alarm remember as soon as loud." NA#2 approximatelopement. She states	nair was parked right beside xt to the area of the brick 14 inches high. She said, sed and the alarm was going				
	The Administrator wa Jeopardy on 7/22/20	s notified of the Immediate 5 at 6:50 PM.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OATE SURVEY OMPLETED
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F 323	Continued From pag	e 40	F 32	23		
		d a credible allegation of 2015 at 5:01 PM which				
	Center's credible Alla submission of the foll correction and allegal constitute an admiss provider as to the tru conclusions presente from NCDHSR relating practice with determing practice with determined with determined practice with	cept this corrective action as n of Compliance with F323: as taken for resident found to by alleged deficient practice: ager resides in facility. If the facility through the ent off the bricked in patio, anbulating outside crossing on the 200 and 600 hall. He he grass beside the end of a was seated in the ly member] and examined by and his hall Nurse. There carries observed and the stress other than he wanted to go home. The VA attion], and the medical dof the incident. The mber] was present in the lent occurred and therefore				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345247	B. WING			C)7/24/2015		
	ROVIDER OR SUPPLIER URSING CENTER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	0//24/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 323	could return to home Care services as wa admission to the SNF choose, we initiate replacement in facility of discharged with his was 2. Corrective action having the potential the deficient practice: A keyed padlock was bricked in patio, by the 7/22/15 at 7:40pm. The at all times unless states a key and supervises a key and supervises. This door is NOT and approved by Life Safetemporarily until a mode implemented. The staff that cleans the consumer, and sign offer door is locked" log the unalarmed patio door. All other facility door WanderGuard monitor weekly for functionality maintenance staff on Exit Door Alarm Monitor devices on residents and checked for function documented each she Medication Administration. All resident are assessed section E0900 "Wander Section E0900"	with his family and VA Home as the planned goal upon as the planned would seek with a locked unit. He was wife on 5/25/15. The taken for other residents to be affected by alleged as the placed on the door to the me maintenance director, on the door will be kept locked aff is present to unlock it with residents. (Please Note: emergency exit. This was eaty). The lock will be used one permanent solution can be environmental services alay room daily 7 days each as the proof of the to visually check, as along the "verify that pation at is posted on the "in the day room. The door will be used on the "verify that pation at is posted on the "in the day room. The door will be used on the "verify that pation at is posted on the "verify that pation at is posted on the "wanderGuard and Fire toring" log. WanderGuard and Fire toring" log. WanderGuard are verified for placement tionality by nursing and iff on the eMAR [electronic ation Record.	F3	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 50125			(c
		345247	B. WING			07/	24/2015
	ROVIDER OR SUPPLIER		•	58	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Impact" on the MDS admission and at leas assessments are conbehaviors/condition a Interventions to main environment are initia Assessment (CAAs) the Interdisciplinary Conformation is available Care Plan team via the software. The list of having wandering be inside facility email redepartment manager department manager department and avail Nurses are responsible changes are made and via email and EMR. A process upon hire and facility staff will be edwandering-Presence. On the night of 7/22/residents identified we conducted by the MD Plans were reviewed ensure appropriatenes interventions to main. Beginning on the modessessed by Nurses assessment tool " imwere reviewed and reappropriateness of calinterventions to main. 3. Measures taken.	assessment upon st quarterly. More frequent inpleted if change in are determined. Itain the resident in a safe ated through the Care Area and plan of care process by Care Plan Team. This alle to all nursing staff and the electronic charting aresidents identified as that it is sent out to all accipients to be printed by and posted within their able to all staff. The MDS alle to update the list as and disseminate information and listaff will be oriented to this disannually thereafter. All allecated to policies and Frequency by 07/28/15. It is a 100% audit of all and it is and revised as needed, to easy of care plan goals and tain resident safety. It is a safety.	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345247	B. WING		C 07/24/2015		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	0112412010		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 323	bricked in patio, by 7/22/15 at 7:40pm. at all times unless a key and supervise patio will be available Administration, Mai Charge Nurse. (Plean emergency exit. staff that cleans the week will be resporensure, and sign of door is locked "log unalarmed patio do a policy/procedure developed on 7/23/describes the steps policy was distribut Maintenance Direct DON, ADON, Life EN Urse Managers/Sen Administration. A control the patio door and who have a key to patio. Key will be a hours a day. Nursing Staff includes the pation of 7/22/15, 7/23/15 management and a "Code E" - missing "Wandering, Unsafe	the maintenance director, on The door will be kept locked staff is present to unlock it with the residents. The key to the ole from the Activity Director, intenance, DON, ADON, and the ase Note: This door is NOT (ase Note: Thi	F 323				
	the patio door and a who have a key to patio. Key will be a hours a day. Nursing Staff includes taff, as well as oth facility was provided on 7/22/15, 7/23/15 management and a "Code E" - missing "Wandering, Unsafiwere also instructed nurse manager on	also a list of all staff members unlock the door to use the available to unlock the door 24 ling all direct care staff, CNA er departments within the ed in-service training beginning 5, 7/24/15 by nurse administration on emergency resident procedures and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	7772-772010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	resident in a safe en manager will be resp situation, implement measures to ensure maintained. These i are not limited to: reactivities (recreation, family members) into one-on-one with staf visual barriers (stop Effectiveness of the monitored and docur nursing staff will report the new interventions effective who will the Administrative on ca Assistant Administrative on ca Assistant Administrative on the required to receive their next work shift. The regular full-time staff A new assessment to 7/24/15 by DON to how the fixed of wandering, primpact of wandering a new tool entitled "Wandering Review". Completed upon admithereafter. More free completed if change determined. Completion Date: 7/2 Immediate Jeopardy	tive in maintaining the vironment. The nurse onsible for re-assessing the additional interventions and the resident's safety is interventions may include but edirection, diversional music, IN2L, talking with ensified visual monitoring, f., initiation of wander guard, signs, ribbons) etc. Interventions will be mented by the nurse. The part to the Nurse Manager if is implemented are not in notify the DON and I person (Administrator or iteror). As of 7/24/15, 155 total of 240 (includes PRN re-training described above. Who has not been trained will be training prior to beginning. At this time 94% of all has received training. Tool was implemented on elep staff identify residents at esence of wandering and the on resident safety/disruption Risk of Elopement / The assessment will be hission and quarterly quent assessments may be in behaviors/condition is	F 32	23			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION	(X3) DATE	SURVEY
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		345247	B. WING _		07/	24/2015
	ROVIDER OR SUPPLIER URSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	direct care staff and linad received in-service residents with exit-se able to define the me ensure Administrative appropriate measures ensure safe environmed describe a new assest Elopement / Wanderi 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	e padlock. Interviews with icensed staff confirmed they cing on responding to eking behavior. Staff were thod of communication to e staff was made aware so is could be put in place to nent. Staff were also able to esment tool entitled "Risk of ing Review" OCURE, ERVE - SANITARY I sources approved or rry by Federal, State or local estribute and serve food	F3			7/27/15
	by: Based on observation record review the factor from dust and debrish blowing air over food. The findings included. On 07/20/15 at 9:30 / facility's kitchen was Manager (DM). The and noted to have an	: AM an initial tour of the made with the Dietary dish room was observed		F371 Food Procure, Store/Prepare/Serve - Sanitary It is the policy of this facility to store, prepare, distribute, and serve food ur sanitary conditions. 1. Corrective actions taken for reside found to have been affected by allege deficient practice: There were no specific residents ider to have been affected by the alleged	nts ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			l	24/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		1 NC HIGHWAY 16 SOUTH		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	the fan revealed a the debris covering the beautiful debris covering the beautiful debris covering the beautiful debris covering the initial tour was observed in use positioned on top of and it was in use blowstove and oven area dietary staff member. Observations of the faccumulation of dust back surface of the faccumulation of dust back surface of the faccumulation area. Of revealed a thick accurovering the back surface of the kitcher specified the fans were cleaned interviewed at 9:40 Are fans were cleaned on 07/08 fans and reported the be cleaned. The DM beautiful debris covering the back surface at 19:40 Are fans were cleaned and 19:40 Are fans and reported the be cleaned. The DM	the machine. Observations of fick accumulation of dust and tack surface of the fan. The fan was noted to be a food preparation counter wing air in the direction of the During the observation, a was preparing food. Fan revealed a thick and debris covering the an. Was also observed on the on 07/20/15 at 9:30 AM that ir in the direction of a food observations of the fan imulation of dust and debris rface of the fan. It's cleaning schedule are cleaned every two weeks. For the observations and the observed the at they were dirty and should added that during the on the fans were in use they	F3	371	deficient practice. All three fans in the kitchen were cleaned on 7/20/15. 2. Corrective actions taken for resident having the potential to be affected by the same alleged deficient practice: An assessment was completed by the Dietary Manager on 7/20/15 to determi if other fans were in use in the food preparation/storage/dining areas. Ther were no other fans in use in the kitcher dining areas. Only those listed and identified as having issues by the surveyor. 3. Measures taken and systemic changimplemented to prevent alleged deficie practice: The Dietary Manager revised the dietar equipment Cleaning Schedule on 7/20/to indicate all fans in use in the kitchen shall now be cleaned weekly, instead of every two weeks as previously listed. A Dietary staff was provided in-service training by the Assistant Dietary Managon the update to cleaning schedule and making sure all fans are cleaned weekly The in-service training was completed 7/27/15. All fans in the kitchen will be cleaned weekly to prevent dust and delibuild up. The staff member assigned to clean the fans will sign the Cleaning Schedule on the day the fans are clear The Assistant Dietary Manager will be responsible to review the cleanliness of the fans weekly to ensure that the fans	ne n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			07/	24/2015
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	077	24/2015
					1 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			TÆ	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page	÷ 47	F	371	have been satisfactorily cleaned and the is no dust or debris build up present. After observation of the fans, the Assist Dietary Manager will then sign the cleaning schedule to confirm timely and adequate cleaning of the fans. 4. How the corrective actions will be monitored to ensure the deficient practic will not reoccur, i.e. quality assurance measure implemented: This plan was implemented and the corrective action will be evaluated for effectiveness. This plan of correction is integrated into the monthly Quality Assurance Performance Improvement (QAPI) program as follows: The Assistant Administrator will be required to audit the kitchen fans for cleanliness weekly and will report the results of those weekly audits to the QAC Committee monthly for 3 months. If the QAPI Committee determines that the weekly fan inspections are satisfactory during the initial 3 month period, the inspections by the Assistant Administra may be reduced to monthly for 3 month. The QAPI Committee will monitor to ensure compliance is sustained with F371. The QAPI committee will assess and modify the action plan as needed to ensure continual compliance.	tant ce es	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/R	ESIDENT WELL-BEING	F4	490			7/28/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _	B. WING		C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH COF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 490	enables it to use its refficiently to attain or	ministered in a manner that resources effectively and maintain the highest mental, and psychosocial	F4	90			
	by: Based on observation interviews, the facility in place to prevent 1 residents with wands unsupervised from the staff were not inform seen attempting to le non-alarmed door or guard ankle bracelet 5/13/2015 did not preexiting the building un	on, record review, and staff y failed to have interventions of 3 cognitively impaired ering behavior from exiting, he facility. Administrative ed that Resident #191 was eave the facility through a h 5/12/2015. The wander intervention put in place on event the resident from nattended on 5/21/2015 on-alarmed exit door.		Well-Being 1. Corrective action found to have be deficient practice. Resident #191 New policies desimplemented to notification will if a resident is a	e Administration/Resident ctions taken for resident been affected by alleged ce: no longer resides in fact eveloped and intervention of ensure immediate be made to administration attempting to elope. Why andering and/or attempting and/or attempt	ility. ons on	
	the Administrator wa 6:50 PM. Immediate 7/24/2015 at 5:11 PM an acceptable credib The facility will rema scope and severity le potential for more that immediate jeopardy	began on 05/21/2015 and is notified on 7/22/2015 at Jeopardy was removed on the Manager of the M		elopement are in thorough invest immediately initiand or designed. Due to resident the facility to "Godetermined on safety and best to home with faservices as stat upon admission locked facility a possible. The North interest in thorough interest and the safety and the safet	reported, a complete an tigation and inquiry will I tiated by the Administra	nd be tor kit irn e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _			0.	7/24/2015	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				58	81 NC HIGHWAY 16 SOUTH			
VALLEY N	IURSING CENTER			T	AYLORSVILLE, NC 28681			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 490	Continued From pa	F4	490					
	The facility Policy S	Statement, titled Elopements			the locked dayroom door onto the pati	0		
	[revised February 2	2014], included:			and onto facility courtyard located			
	1. Staff shall pror	mptly report any resident who			between the 200 hall and the 600 hall			
tries to leave the prer		remises or is suspected of			The resident¿s wife was present in the)		
	being missing to th	e Charge Nurse or Director of			facility when he was observed by staff			
	Nursing.				outside and brought back into the buil	ding.		
		s admitted to the facility			2. Corrective actions taken for other			
		gnoses including Parkinson's			residents having the potential to be			
		's disease, muscle weakness,			affected by alleged deficient practice:			
		n, anxiety, depression and Post						
	Traumatic Stress D	Disorder.			To ensure other residents were not at			
					similar risk, on the night of 7/22/15 the			
		nprehensive Minimum Data			Administrator instructed the MDS/Care			
		/5/2015 indicated the resident			Plan Nurses to complete a 100% audi	t of		
		itively impaired but had not			all residents identified with wandering			
		g during the assessment			behaviors and to review/revise resider	ıt		
	1 *	llso indicated the resident's			Care Plans as needed, to ensure			
	_	as not steady and he required			appropriateness of care plan goals an			
		ce of two staff members for			interventions to maintain resident safe	-		
	locomotion on and	off the unit.			and to ensure that none of these identifications and to ensure that none of these identifications. The			
	The Plan of Care [originally dated 5/11/2015]			results of the audit showed that there			
		ent had short and long term			were no other noted elopement attem	ots		
	memory problems	due to Alzheimer's disease,			made by any other resident. The			
	received medicatio	ns for anxiety and depression			Administrator and Assistant Administra	ator		
	and was at risk for	falls.			reviewed the audit results on 7/23/15.			
	Review of the facili	ty 24 Hour Report Sheet dated			On 7/24/15 all residents were assesse	ed		
	5/12/2015 revealed	d a note next to Resident			by nursing using the newly implement			
	#191's name which	n read, "opened patio door on			Wandering Risk Assessment Tool. Ca	re		
	second shift" but di	id not indicate a time for the			Plans were reviewed and revised as			
	incident.				needed, to ensure appropriateness of			
					care plan goals and interventions to			
	Review of the clinic	cal record revealed that on			maintain resident safety. Residents			
	5/12/2015 resident	#191 was observed in his			identified with wandering behaviors ar			
	wheelchair, propell	ing himself into the patio dining			available to all nursing staff and Care	Plan		
	room. The nursing	documentation note included,			team via the electronic charting softwa	ıre.		
	"resident stood up	and opened patio door and			The list of residents identified as havir	ıg		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
				_		(
		345247	B. WING			07/24/2015	
NAME OF PR	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
			581 NC HIGHWAY 16 SOUTH		81 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			T.	AYLORSVILLE, NC 28681		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 490	Continued From page	e 50	F	490			
	tryed (sic) to go out unassisted, another nurse assisted resident back into w/c [wheelchair],				wandering behaviors is sent out to all		
					inside facility email recipients to be prir	ited	
	resident stated he wa	is leaving and very			by department managers and posted		
	determined to get out any door in facility, will monitor closely, call light within reach." The note				within their department and available to	all	
					staff. The MDS Nurses are responsible		
	did not indicate the tir	me of the incident.			update the list as changes are made ar	nd	
					disseminate information via email and		
	A physician order dated 5/13/2015, revealed				EMR. All staff will be oriented to this		
	_	iven a bracelet that with the			process upon hire and annually thereat	fter.	
		lock system, would alarm if					
	he attempted to leave through an alarmed door.				3. Measures taken and systems chang	ed	
		ted a pad alarm was to be			to prevent repeat of alleged deficient		
	•	t's bed and wheelchair to			practice:		
		ent attempted to rise off of			A keyed pedleck was placed on the de-		
	the pad.				A keyed padlock was placed on the do		
	Docidont #101's Plan	of Care was updated on	to the bricked in patio, by the mainter director, on 7/22/15 at 7:40pm. This				
		a wander guard bracelet			will be kept locked at all times unless s		
	was in place to preve				is present to unlock it with a key and	tan	
	was in place to preve	nt ciopement.			supervise residents. (Please Note: Thi	s	
	A note in the clinical r	ecord dated 5/20/2015 at			door is NOT an emergency exit.) The		
		lent attempting to leave			lock will be used temporarily until a mo	re	
		Redirection attempts by			permanent solution can be implemente		
		V [Social Worker] asked			The environmental services staff that		
		trying to leave, resident			cleans the day room daily 7 days each		
	indicated he was goir	ng home." The record also			week will be responsible to visually che	eck,	
	indicated the Nurse F	Practitioner was informed			ensure, and sign off daily on the "verify	,	
	and the resident was	given a one-time dose of			that patio door is locked" log that is		
	Ativan 1 milligram, int	tramuscularly for agitation.			posted on the unalarmed patio door in	the	
					day room. Administrator and/or Assista	ant	
		clinical record revealed the			Administrator reviewed the logs on 7/2	*	
		n exiting the facility without			7/23 and 7/24 and will continue to revie	w	
	_	/21/2015. A note by the SW			the logs regularly to assure continued		
		58 PM included, "Resident			compliance.		
	went out patio door in	-			, ,, , , , , , , , , , , , , , , , ,		
		imbed over the short brick			A policy/procedure titled "Bricked in Pa	tio"	
		oulated around the facility			was developed on 7/23/15 by		
		n the 600 hall driveway,			Administration that describes the steps		
	when stair were alerte	ed to resident being outside.			outlined above. A copy of the policy wa	สร	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _			07	7/24/2015	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
				58	1 NC HIGHWAY 16 SOUTH			
VALLEY N	IURSING CENTER			TA	AYLORSVILLE, NC 28681			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE			
F 490	Continued From pa	ge 51	F 4	190				
	Resident redirected	back into the facility."			distributed to and reviewed with the			
		,			Maintenance Director, Environmental			
	Review of the facility investigation included a description of the incident, written by the Director of Nursing [DON] on 5/25/2015. The description included, "On 5/21/2015, at approximately 4:30				services, Life Enrichment coordinator,			
					DON, ADON and Nurse			
					Managers/Supervisors on 7/23/15 by			
					Administration. Keys were distributed t			
		bserved by staff through a			Admin, Nurse Admin, Charge Nurse or			
		outside on the grounds.			Duty, Life Enrichment coordinator, EVS	3,		
	Resident was walking alongside the building				and Maintenance.			
		f immediately went to resident			All 11 6 33 1 1 1			
	and resident was cooperative and allowed staff to lead him back inside the building."				All other facility door alarms and doors with Wander Guard monitors are check			
					three times weekly for functionality and			
	The natio dining roo	om door was observed on			documented by maintenance staff on t			
		AM and again at 2:22 PM.			"Wander Guard and Fire Exit Door Ala			
		n the door which read, "KEEP			Monitoring" log. Wander Guard device			
	THIS DOOR LOCK				on residents are verified for placement			
	Approximately 24 in	nches above the doorknob was			and checked for functionality by nursin			
		e door was locked. The door			and documented each shift in the eMA	R.		
	was able to be unlo	cked by turning the deadbolt			Administrator and/or Assistant			
		arm sounded. Outside the			Administrator reviewed this process ar	ıd		
		square patio surrounded by a			verified compliance on 7/23/15.			
		approximately 26 inches high.						
		surrounded the first wall,			On the night of 7/22/15 a 100% audit of	f all		
		ce of approximately 8 inches.			residents identified with wandering	,		
		the brick walls was filled with			behaviors was conducted by the MDS Care Plan nurses. Care Plans were	1		
		garden where tomato plants and the patio was a large			reviewed and revised as needed, to			
		es and bushes. Beyond the			ensure appropriateness of care plan g	nals		
		driveway which ran behind the			and interventions to maintain resident	Jul 3		
	,	hain-link fence and a			safety. The audit results were reviewe	:d		
	_	area that was heavily wooded.			by the Administrator and Assistant			
		d the facility went around to			Administrator on 7/23/15 to assure			
	1	ling where there was a parking			completion.			
	lot and then further	around to the front parking lot.						
					Nursing Staff including direct care staff	:		
		viewed on 7/22/2015 at 3:16			was provided in-service training on			
		e was working on 5/12/2015			7/22/15, 7/23/15 and 7/24/15. Emphas			
	Lattempted elonema	ant through natio door) and	1		was placed on the immediate urgency	to.	1	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			71. 501251	_		С		
		345247	B. WING			07/24/2015		
NAME OF PE	ROVIDER OR SUPPLIER	0.02		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	24/2015	
TO THE OT THE	TO VIDER ON OUT FEILER				81 NC HIGHWAY 16 SOUTH			
VALLEY N	URSING CENTER				AYLORSVILLE, NC 28681			
					·			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From page	e 52	F	490				
	· -	en Resident #191 was			notify Administration if a resident attem	nts		
) hall wing. When asked			to Elope so that appropriate safeguard			
		5/12/2015, Nurse #1 said			can be initiated.			
		erved to stand up from his			The in-services were presented by nurs	se		
		e patio door and was going			management and Administration to			
		he was stopped by another			include emergency "Code E" - missing			
	nurse who brought hi	m back into the building.			resident and procedures from policy for			
	Nurse #1 indicated that between 5/12/2015 and the time of his discharge on 5/25/2015, the resident would go to all the doors and try to get out. She said after he was admitted, "His meds				Wandering, Unsafe Resident. Nurses			
					were also instructed to immediately info			
					the nurse manager on duty in facility, o	r to		
					call the nurse manager on call, if a			
		when he started to wake up			resident demonstrates exit seeking			
		would go to the 600 door or			behaviors and interventions currently in			
		go out." The nurse added			place are not effective in maintaining th			
	-	ned why the patio door was			resident in a safe environment. The nu	rse		
		told the door could not have k on it. The nurse said, "The			manager will be responsible for re-assessing the situation, implement			
	-	be locked at all times' was			additional interventions and measures	to		
	_	t door but he saw activity			ensure the resident¿s safety is	ıo		
		and go out with residents to			maintained. These interventions may			
		atio, I guess." Nurse #1 said			include but are not limited to: redirecti	on		
		tempted elopement was			diversional activities (recreation, music			
		on in report and was on the			talking, IN2L, time with family members			
	24 hour Report Sheet				intensified visual monitoring, one-on-or			
	·				with staff, initiation of wander guard, vis	sual		
	During the same inter	view Nurse #1 described			barriers (stop signs, ribbons) etc.			
	the events on 5/21/20	015 when the resident was						
	successful in leaving	the building unsupervised.			Effectiveness of the interventions will b	е		
		d spoken to the resident			monitored and documented by the nurs			
		and the resident 's family			The nursing staff will report to the Nurs	е		
		for him too when Resident			Manager if the new interventions			
		nrough the 100 hall window,			implemented are not effective who will			
		ackyard. Nurse #1 sent			then immediately notify the DON and			
		she went around to the			Administrator on call person	\		
		00 hall with a wheelchair to			(Administrator or Assistant Administrator	or).		
		tion was this an elopement			Each staff member employed by the	or		
		cause he wasn't off the			facility is required to receive training pr	UI		
	_	aid she would take care of notifying the appropriate			to beginning their next work shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015		
NAME OF P	ROVIDER OR SUPPLIER	1 - 1		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 011	24/2013	
					NC HIGHWAY 16 SOUTH			
VALLEY N	URSING CENTER				YLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From pag	e 53	F4	190				
F 490	people and I could judoing." Nurse #1 cla [NA] #2 had told her the nurse was also at the resident through 600 hall. The Assistant Admin 7/22/2015 at 4:24 PN Administrator said a was in place and all except this one. The patio door so it could system so they put ut door locked. The Assafter the investigation elopement on 5/21/2 personal body alarm Assistant Administration someone had remove from the patio door so door again just prior know how long it had NA #1 was working to was interviewed on 7 said, "I was assisting went to shut the blind and saw him [Reside the door to go get him didn't have the code 621 so I ran up the houlding to get him." 621 overlooked the formal same sales in the follooked the foll	st go back to what I was arified that Nursing Assistant the resident was outside and ware a NA on 600 hall saw another resident's window on istrator was interviewed on	F 4		A new assessment called Wandering Decilion Tool was implemented on 7/24/15 by DON to help staff identify residents at risk of wandering, presence of wandering and the impact of wander on resident safety/disruption. The assessment will be completed upon admission, with an increase in exit-seeking behavior, and then quarte thereafter. Administrator and Assistant Administrate reviewed the "Wandering, Unsafe Resident Policy" on 7/22/15 and revision to the policy written on 7/23/15 as follo #1. Language added to include the usaften new Wander Data Collection Tool, book Language added to notify the Administrator, DON immediately if a resident is suspected as "missing" and book Language added to contact the Administrator when the resident is returned to the facility and report finding and conditions of the resident. The content of this policy was used with the in-service training beginning 7/22/15. A of 7/28/15 100% of the all current staff include Administration, Nurses, CNA, Respiratory Therapy, Life Enrichment, Therapy, Environmental Services, Office Personnel, Medical Records, Dietary, a Maintenance; had received this training This training added to new hire oriental and added to the required annual in-services for all staff. On 7/22/15 (following the announcement of the policy was under the required annual in-services for all staff.	e ring rly tor ons ws: e of #4 #5 gs ess; to ce and g. tion		
	On 7/23/2015 at 10:3	31 AM, the Administrator and			of the IJ situation) the Administrator an Assistant Administrator met with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015		
NAME OF P	ROVIDER OR SUPPLIER	0.02.1	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07	124/2015	
	(0.11)				1 NC HIGHWAY 16 SOUTH			
VALLEY N	URSING CENTER				YLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 490	F 490 Continued From page 54		F4	190				
	about the attempted Both of them stated t of Resident#191's ex	or were both interviewed elopement on 5/12/2015. hey had been made aware it-seeking behavior but they ad attempted to leave by a			facility Management staff and all charg nurses on staff informing them of the need to contact the Administrator and Assistant Administrator when residents are suspected as ¿elopement risks¿ a exhibiting exit seeking behaviors.	;		
	Nursing [DON] was in attempted elopements she and the Assistant at the Clinical Meeting discussed but the emexit-seeking behavious been using. The DOI had obtained the phythe wander guard alapad alarm that was in	t on 5/12/2015. She stated t Administrator were present g on 5/13/2015 when it was aphasis was on the r, not on which doors he had N indicated it was she who esician order on 5/14/2015 for arm ankle bracelet and the n his wheelchair.			7/22/15 Administrator and Assistant Administrator checked each nurses; station to assure their contact informat (phone numbers) was readily accessib Compliance was noted. 7/22/15 (2nd shift) Administrator and Assistant Administrator immediately began rounding throughout the facility interviewing staff to assure they were aware of the Code E elopement policy/procedure and inquiring about a untoward incidents/resident behavior. Rounds continued on 3rd shift until 2 a	ny .m.		
	Maintenance measuresident could have to patio door on 5/21/20 the brick wall (approximate) taken a direct path to hall wing, the distance feet from the patio do a lower portion of the 12-14 inches high, whis wheelchair, the dibeen approximately 30 On 7/24/2015 at 3:42 interviewed about the	25 AM, the Director of the two routes the aken when he exited by the part of the had climbed over kimately 26 inches high) and to the other side of the 600 was approximately 249 for. If the resident went over the brick wall that was only hich is where he had parked istance covered would have a stance covered			Rounds resumed on 7/23/15 on first shat 7am. 7/23/15 8:30 Management staff were reminded again of the need to immediately communicate potential elopement risk concerns to Administrat Administrator and Assistant Administrator continued to round throughout the day until approximately 9:30 pm. 7/24/15 Assistant Administrator conducted rounds at 7am and received report from the DON who had also completed rounds prior to 7am. There were no issues reported.	tor. tor		
		oted to leave through a			Process was developed to enhance the	е		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345247	B. WING		C 07/24/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/2 11/2010
VALLEVA	URSING CENTER			581 NC HIGHWAY 16 SOUTH	
VALLETIN	UKSING CENTER			TAYLORSVILLE, NC 28681	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 490	Continued From pag	ge 55	F 490		
	been used. She said resident who is tryin that staff call me and to be done in that pa responsibility to kee The Administrator w	different measures could have d, "For any attempt by a g to elope, my expectation is d we can assess what needs articular area. It is my p these residents safe."		communication between the Nursing and Administrator of daily activities occur in the facility during "off" hour weekends. "Off" hours are defined hours outside of the normal work scheduled times (8:00 a.m. ¿ 5:00 p. The process "Facility Pulse Checks initiated 7/23/15. Administration will the "Facility Pulse Check" form whe call or come to the facility during "O	that s and as o.m.) " was log on in they
	Jeopardy on 7/22/2015 at 6:50 PM. The facility presented a credible allegation of compliance on 7/24/2015 at 5:01 PM which included:			hours. 4. How the corrective actions will be monitored to ensure the deficient pr will not reoccur, i.e. quality assurance measimplemented:	e actice
	Center's credible A submission of the for correction and allegations to the true conclusions present from NCDHSR relations practice with determine paractice with determine practice Allegation. Corrective actions	This plan of correction represents Valley Nursing Center's credible Allegation of Compliance. The submission of the following combined plan of correction and allegation of compliance does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to F490 alleged deficient practice with determination of immediate depardy. Please accept this corrective action as pur credible Allegation of Compliance with F490: Corrective actions taken for resident found to have been affected by alleged deficient practice:		The DON or designee will audit the medical record to ensure that clinical documentation of any resident who been reported as exhibiting exit-see behaviors describes that appropriate interventions have been initiated to resident safety. These audits will be daily for one month, weekly for four and monthly for six months. Nurse Consultant will also audit these area during routine visits.	al has eking e ensure e done weeks
	Resident #191 no longer resides in facility. New policies developed and interventions implemented to ensure immediate notification will			the 24-hour shift reports to ensure to are aware of any unusual occurrence related to wandering residents. The Administrator or designee will also monitor the lock placed on the pation	hey ces e
	attempting to elope.	tration if a resident is When incidences of tempted elopement are		to ensure it is in place. This will be of daily for two weeks, weekly for four weeks, and monthly for four months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 07/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	772-472010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	inquiry will be immed Administrator. Resident #191 exited locked patio door, we and was observed at the courtyard between was met by staff on the 600 hall wing. He wheelchair and broup presence of his [fam for injuries by the DO were no apparent injuresident in no distress tating the he "wan. Due to residents confacility to "Go Home" 5/21/15 that for his on he could returned to [Veteran's Administrated as his planned relocated to a locked possible. The VA, the notified of the unwith dayroom door onto the state of the state of the state of the state of the unwith dayroom door onto the state of the state of the state of the unwith dayroom door onto the state of the state o	d the facility through the ent off the bricked in patio, mbulating outside crossing en the 200 and 600 hall. He he grass beside the end of e was seated in the ght back inside in the ght back inside in the ght back inside in the lily member] and examined DN and his hall Nurse. There uries observed and the is except him repeatedly to go home ". Itinued efforts to exit the interests, home with family and VA ation] Home Care services as digoal upon admission, or be a facility as soon as feasibly the medical provider were essed exit from the locked the patio and onto facility	F 49		Quality ting. The and modify		
	600 hall. The reside facility when he was and brought back int 2. Corrective action having the potential deficient practice: To ensure other resident the hight of 7/22/2 instructed the MDS/0	ns taken for other residents to be affected by alleged dents were not at similar risk, 15 the Administrator					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		C 07/24/2015
	NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 01/24/2010
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 490	resident Care Plans appropriateness of interventions to mai ensure that none of attempted to elope. showed that there wattempts made by a Administrator and A reviewed the audit of the control of the co	aviors and to review/revised as needed, to ensure care plan goals and ntain resident safety and to these identified residents had The results of the audit vere no other noted elopement ny other resident. The ssistant Administrator	F 49	,	
	Systematic changes Administration inclu A keyed padloc the bricked in patio, on 7/22/15 at 7:40p locked at all times u unlock it with a key				

ORRECTION (X5) N SHOULD BE APPROPRIATE COMPLETION DATE
ORRECTION (X5) N SHOULD BE COMPLETION
N SHOULD BE COMPLETION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
345247 B. WING				C		
	ROVIDER OR SUPPLIER	343247	B. Will	STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	<u> </u>	07/24/2015
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Plans were reviewed ensure appropriated interventions to mair audit results were re and Assistant Admin completion. Nursing Staff in provided in-service t and 7/24/15. Empha immediate urgency tresident attempts to safeguards can be in The in-services were management and Ademergency "Code E procedures from poli Resident. Nurses w immediately inform the facility, or to call the resident demonstrate interventions current maintaining the resident re-assessing the situinterventions and maresident's safety is interventions may incredirection, diversion music, talking, IN2L, intensified visual mostaff, initiation of war (stop signs, ribbons) interventions will be by the nurse. The nurse Manager if the	OS / Care Plan nurses. Care I and revised as needed, to ess of care plan goals and stain resident safety. The viewed by the Administrator istrator on 7/23/15 to assure Cluding direct care staff was raining on 7/22/15, 7/23/15 sis was placed on the onotify Administration if a Elope so that appropriate initiated. The presented by nurse Iministration to include inc	F 4	90		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345247	B. WING				24/2015
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER				5	STREET ADDRESS, CITY, STATE, ZIP CODE 181 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 490	call person (Administ Administrator). As of of a total of 240 (inclureceived re-training dimember employed by been trained will be reprior to beginning the A new assessment too wandering to wandering, preimpact of wandering, preimpact of wandering (See assessment too Wandering Review"). completed upon admithereafter. More frequently completed if a changed determined. Administrator and revisions 7/22/15 and revisions 7/22/15 and revisions 7/23/15 as follows: #include the use of the Collection Tool, #4 bethe Administrator, DC is suspected as "mis added to contact the resident is returned to findings and condition content of this policy training beginning 7/2 7/28/15. As of today, staff have been trained part-time, and PRN strained. Every staff me prior to beginning the	e DON and Administrator on rator or Assistant 7/24/15, 155 employees out udes PRN staff) have escribed above. Each staff y the facility who has not equired to receive training ir next work shift. ent tool was implemented on elp staff identify residents at esence of wandering and the on resident safety/disruption of titled "Risk of Elopement / The assessment will be ission and quarterly usent assessments may be in behaviors/condition are d Assistant Administrator ering, Unsafe Policy" on set to the policy written on 1 Language added to	F	490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
	345247					C 07/24/2015	
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	0772-42013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 490	in-services for all star 7/22/15 (followi situation) the Admin Administrator met w staff and all charge them of the need to Assistant Administrator suspected as "elope 7/22/15 Adminis Administrator check assure their contact was readily accessil 7/22/15 (2nd sh Assistant Administrator check assure they were policy/procedure an untoward incidents/ic continued on 3rd sh resumed on 7/23/15 7/23/15 8:30 - N reminded again of the communicate potento Administrator continued ay until approximation 7/24/15 - Assistrounds at 7am and it who had also complements were no issued Process was defined to Process was defined as the process	ed to the required annual aff. Ing the announcement of the IJ istrator and Assistant ith the facility Management nurses on staff informing contact Administrator and attor when residents are ement risks". Istrator and Assistant ed each nurses station to information (phone numbers) ble. Compliance was noted. Inft) Administrator and attor immediately began at the facility interviewing staff aware of the Code Ed inquiring about any resident behavior. Rounds iff until 2 a.m. Rounds on first shift at 7am. Management staff were ne need to immediately tial elopement risk concerns diministrator and Assistant ued to round throughout the tely 9:30 pm. Itant Administrator conducted received report from the DON eted rounds prior to 7am.	F4				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C	
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 490	Administrator of daily facility during "off" h hours are defined as work scheduled times process "Facility Puls 7/23/15. Completion Date: 7/2 Immediate Jeopardy 5:11 PM. Observatio was equipped with the direct care staff and lihad received in-services able to define the meensure Administrative appropriate measures ensure safe environments.	activities that occur in the ours and weekends. "Off" hours outside of the normal is (8:00 a.m5:00 p.m.) The se Checks" was initiated 4/15 was removed on 7/24/015 at ms revealed the patio door e padlock. Interviews with idensed staff confirmed they be compared to exist was made aware so as could be put in place to ment. Staff were also able to esment tool entitled "Risk of	F 4	90			