	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345247	B. WING		C 08/17/2017			
NAME OF PR	OVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/17/2017			
			5	581 NC HIGHWAY 16 SOUTH				
VALLEYN	JRSING CENTER		т	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC			
F 000	INITIAL COMMENTS		F 000					
	the State Agency rem F-353 that was in the report. Event ID# M4I	vided to the facility because noved information from tag facility's original CMS 2567	F 253		9/5/17			
	necessary to maintain comfortable interior; This REQUIREMENT by: Based on observatio facility failed to repain residents on 1 of 4 ha Resident #13), removing in 1 of 60 resident rood (Resident room #210) doors in 2 of 60 resident (Resident room #114) repain worn varnish of resident rooms on 1 of #114 and #410), repain caulking around base and jagged sides on the frames of inside bather and missing door framing missing tiles, remove and repain dry wall for on 3 of 4 halls (Resid between rooms #205)), repair 2 holes in bathroom ent rooms on 1 of 4 halls and Resident room #115), n the sink cabinet in 2 of 60 of 4 halls (Resident room iir dirty/black and cracked e of toilets, repair chipped bathroom doors, paint door room doors, repair rusted mes inside bathrooms, repair stained tile around toilet r 7 of 31 shared bathrooms ent shared bathrooms and #203, #206 and #208, and #214, #414 and #416, #506 and #508.)		Valley Nursing Center acknowledges receipt of the statement of deficiencie and proposes this plan of correction to extent that the summary of findings is factually correct and in order to mainta compliance with applicable rules and provisions of qualify of care of resider The plan of correction is submitted as written allegation of compliance. Valley Nursing Center's response to th Statement of Deficiencies and Plan of Correction does not denote agreemen with the Statement of Deficiencies non does it constitute an admission that an deficiency is accurate. Further Valley Nursing Center reserves the right to re any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal app procedure and/or administrative or leg proceedings.	s o the ain ain a state of the a			
				deficiency and processes that lead to				

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.

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTIO			ATE SURVEY OMPLETED
		345247	B. WING _			C 08/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRES	S, CITY, STATE, ZIP CODE	•	
	URSING CENTER			581 NC HIGHWA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253	Continued From page	e 1	F2	53			
	1. a. Observations m	ade of Resident #33's in room #207-2 on 08/15/17		deficiency	cited:		
	at 8:50 AM and 08/1 bilateral arm rests we padding was expose	7/17 at 5:50 PM revealed the ere ripped and white foam d.		replaced th	 b. The Maintenance Direct b. wheelchair armrests fo 33 and for resident #13 or 	r	
	Director (ESD) during	Environmental Service g rounds on 08/17/17 at 5:50 lity had extra wheelchair al arm rests could be		repaired and was sande	room door for room #114 nd worn varnish on sink c ed and stained 8/17/17. om door for room #115 wa n 8/17/17.	abinet	
	wheelchair in room # AM and 08/17/17 at \$	e of Resident #13's personal 214-B on 08/15/17 at 11:30 5:20 PM revealed the ere cracked and worn with		c. Bathroo was cleane wood vene patched, a	om 203 & 205: Base of toi ed and re-caulked; chippe eer on door was smoothed and stained; rusted door fr and both door frames pain	d I, ame	
	An interview with the 17 at 5:20 PM reveal	ESD during rounds on 08/17 ed the facility had extra the bilateral arm rests could		8/23/17. d. Bathroo toilet base 8/21/17. e. Room 2	om 206 & 208: Caulking a was removed and replace 210: The yellow stain next ot come out with floor strip	around ed on	
	and 08/17/17 at 5:07 hole in the middle of	ade on 08/14/17 at 2:40 PM PM of room #114 revealed a the bathroom door (room sh on the front and sides of e sink had worn off.		therefore t were repla f. Bathroo toilet base 8/21/17.	he floor tiles in the stained iced on 8/25/17. im 210 & 212: Caulking ar was removed and replace	d area round ed on	
	Director during round revealed the bathroo	ed with the Maintenance Is on 08/17/17 at 5:07 PM m door in room #114 would 0 hall was remodeled and ded to be sanded and		toilet base 8/21/17. h. Bathroo toilet base 8/21/17. i. Room 4	om 215 & 217: Caulking a was removed and replace om 214 & 216: Caulking a was removed and replace 10: Worn varnish on sink as sanded and stained on	ed on round	
	08/17/17 at 12:27 PM	e on 08/14/17 at 2:49 PM, / and 08/17/17 at 5:08 PM of a hole in the middle of the		8/22/17. j. Bathroo	m 414 & 416: Missing pie of toilet was replaced on		

Facility ID: 953152

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345247 B. WING 08/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH VALLEY NURSING CENTER TAYLORSVILLE, NC 28681 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 253 Continued From page 2 F 253 bathroom door (room side). 8/22/17 k. Bathroom 415 & 417: The discolored An interview conducted with the Maintenance tile at the base of the toilet was replaced Director during rounds on 08/17/17 at 5:08 PM on 8/22/17. revealed the bathroom door of room #115 would I. Bathroom 506 & 508: The previous wall be replaced when 100 hall was remodeled. repairs were painted, both rusted door frames were repaired, stain was removed c. Observations of the shared bathroom for from tile at base of toilet, and caulk was rooms #205 and #203 made on 08/14/17 at 2:07 removed and replaced. All stated repairs PM, 08/15/17 at 8:35 AM and 08/17/17 at 5:30 were completed by 8/25/17. PM revealed black caulking around the base of the toilet, chipped and jagged wood on the #205 Facility staff failed to identify these areas room door sides (doorknob and hinge sides), listed that required additional rusted area on the bottom of the door frame on Housekeeping and/or Maintenance room #203 frame side and paint peeling off of services. both inside door frames in the bathroom. On 8/18/17, the Maintenance Director An interview with the Maintenance Director during and the Environmental Services Director rounds on 08/17/17 at 5:30 PM revealed he did (ESD) audited all wheelchairs, resident not even think the caulking needed to be around rooms, and resident bathrooms in the the base of the toilets and he planned to check on facility to identify any other arm rests in that. He also stated that he needed to "bondo" the need of replacement; doors, door frames, bottom of the door frame to remove the rust and and walls in need of repair; discolored caulk at toilets; stained or missing tiles; repaint it. and sink cabinets with worn varnish. d. Observations of the shared bathroom between Repairs or services for any other areas rooms #206 and #208 made on 08/15/17 at 8:39 identified during this audit were completed AM and 08/17/17 at 5:37 PM revealed black by 09/01/17. caulking around the base of the toilet. Procedure for implementing the An interview with the Maintenance Director during acceptable plan of correction for the rounds on 08/17/17 at 5:37 PM revealed he would specific deficiency cited: check to see if the caulking around the toilet base actually needed to be used. On 8/18/17, the Environmental Services staff received in-service education by the e. Observations made of the floor in room #210 ESD on need for increased room, on 08/15/17 at 9:04 AM and 08/17/17 at 5:25 PM bathroom and equipment observation revealed a large yellow stain in the middle of the during their daily cleaning and the room next to the wall opposite the beds. requirement to report areas observed to

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 953152

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PRINTED: 09/12/2017

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		3 NO. 0938-039 DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` ´	G	· · · ·	COMPLETED
						С
		345247	B. WING			08/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	URSING CENTER			581 NC HIGHWAY 16 SOUTH		
				TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 253	Continued From page	e 3	F 2	53		
				need additional housekee		
		Maintenance Director during		maintenance services. S		
		at 5:25 PM revealed the stain		reminded to note and repo		
	long time.	hair that sat in that spot for a		observed to the ESD daily available Maintenance Re		
	long time.			which are picked up by m		
	An interview with the	ESD during rounds on		twice daily, for all issues r		
		revealed they had tried to				
	remove the stain but	it would not come off.		The maintenance staff an		
				address all requests made		
		e of the shared bathroom 2 and #210 on 08/15/17 at		services daily, to ensure c interventions. The Mainter		
		7 at 5:25 PM revealed black		will ensure that repairs are		
	caulking around the t			and satisfactorily and the		
	0			areas requiring additional		
		Maintenance Director during		services handled timely a	nd satisfactorily.	
		at 5:25 PM revealed he would				
		the caulking actually needed		" The monitoring proce		
	to be used.			that the plan of correction that the specific deficiency		
	g. Observations mad	e of the shared bathroom		corrected and/or in compl		
	•	5 and #217 on 08/14/17 at		regulatory requirements:		
		7 at 5:20 PM revealed black				
	caulking around the b	base of the toilet.		New auditing tools were o		
	.			implemented for use to do		
		Maintenance Director during		resident rooms, bathroom		
		at 5:20 PM revealed he would e caulking actually needed to		wheelchairs in need of ad housekeeping or mainten		
	be used.			The Assistant Administrate		
				Maintenance Director and		
		ESD during rounds on		use of their auditing tool o		
		revealed the caulking was		Audits will be done twice		
	old and she would ha			time by the Maintenance I		
	Assistant to repair it.			time by the ESD. This will areas in need of additionation		
	h. Observations mad	e of shared bathroom		or maintenance services a		
		6 and #214 on 08/14/17 at		and addressed. Areas ob		
		7 at 5:10 PM revealed yellow		require additional services		
	caulking around the b			and will receive timely ser		

Facility ID: 953152

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY OMPLETED
			A. BUILDING	G			С
		345247	B. WING				08/17/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				58 ⁻	1 NC HIGHWAY 16 SOUTH		
VALLET	URSING CENTER			TA	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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	Continued From page	9 4	F 25	53			
					Maintenance Director and the ESD with	ill	
	An interview with the	ESD during rounds on			complete these audits and will forward	da	
	08/17/17 at 5:10 PM	revealed they would have to			copy of the monthly audits to the Assi		
	replace it because the come off.	e yellow caulking would not			Administrator for review.		
					The Assistant Administrator will comp		
		of cabinet under the sink in			and document random observations of		
		17 at 2:22 PM and 08/17/17 the varnish on the cabinet			resident wheelchairs, 10 resident roor		
	had worn off.	the variation on the cabinet			and 5 resident bathrooms weekly for 4 weeks, then monthly for 3 months. If		
					audit reveals any area to require		
	An interview with the	ESD during rounds on			additional services, the Assistant		
		revealed the cabinet would			Administrator will meet with the		
	be repaired when 400) hall was remodeled.			Maintenance Director and/or the ESD	to	
					discuss audit findings and provide sta	ff	
	-	of the shared bathroom			education as needed to ensure that a		
		and #416 on 08/15/17 at			sanitary, orderly, and comfortable inte	erior	
		17 at 5:43 PM revealed a			is maintained.		
	side next to the base	rom the floor on the right			The Assistant Administrator will report		
	Side hext to the base	or the tollet.			The Assistant Administrator will report finding of these random observations		
	An interview with the	Maintenance Director during			the QAPI committee monthly for 4 mo		
		t 5:43 PM revealed he would			for review and discussion. The QAPI		
		ulking actually needed to be			committee will evaluate and modify ad	ction	
	used.	. .			plan as needed to ensure continual		
					compliance.		
		e of the shared bathroom					
		and #415 on 08/15/17 at			" The title of the person responsible	e for	
		7 at 5:45 PM revealed a			implementing the acceptable plan of correction:		
		e on the tile which extended irrent oval shaped toilet.			The Assistant Administrator will be		
					responsible for implementing the		
	An interview with the	ESD during rounds on			acceptable plan of correction.		
		revealed they had tried to					
		the stain would not come off.			" Date when corrective action will b	be	
	The ESD stated it wa	s out of her control.			completed: September 5th, 2017		
	I Observations made	of the shared bathroom					
		of the shared bathroom and #508 on 08/15/17 at					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345247	B. WING				C / 17/2017
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	NURSING 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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	9:04 AM and 08/17/17 walls on both sides ha on it, rust on the botto the bottom, tile around black caulking around An interview with the on 08/17/17 at 6:30 P know not know that be condition and it was n Administrator further sist bathroom would have the resident that used become upset if she H bathroom so it would An interview was com PM the Maintenance each hall by making v month and made repais stated the staff filled of checked his box twice The Maintenance Dire the facility was in the at a time and they wo after they placed the of was to remodel 100 h During an interview of ESD stated she made hall every day and ch for needed repairs by Maintenance. The ES time she fixed needed repair requisitions to h departments worked of	7 at 6:30 PM revealed the ad patched unpainted areas on of both door frames at d the toilet was stained and d the base of the toilet. Administrator during rounds PM revealed she did not athroom was in that not acceptable. The stated the repairs to the e to be scheduled because d that commode would knew she could not use the have to be planned. ducted on 08/17/17 at 4:55 Director revealed he audited walking rounds once a airs accordingly. He also but work requisitions and he e a day for needed repairs. ector continued to state that process of remodeling a hall build be finished with 300 hall decorative items. Their plan hall next. n 08/17/17 at 4:55 PM the e walking rounds on each hecked the resident rooms both Housekeeping and SD stated that most of the d repairs and not wait for be made out because both	F	253	3		

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					OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345247	B. WING		08/17/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/17/2017
				581 NC HIGHWAY 16 SOUTH	
VALLEY N	URSING CENTER			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 253	Continued From page	e 6	F 25	3	
		ent's home and if something	1 25	~	
		xed and if a resident wanted			
	their room a certain v				
	accommodate them i	•			
		her expectation was for the			
	Maintenance Director				
		epairs and the remodeling 00 hall after they finished 300			
	hall.	o nail after they infished 300			
F 282	-	/ICES BY QUALIFIED	F 28	2	9/5/17
SS=D	PERSONS/PER CAF		. 20	_	
	(b)(3) Comprehensive	e Care Plans			
		d or arranged by the facility,			
	as outlined by the con must-	mprehensive care plan,			
	(ii) Be provided by qu				
		n resident's written plan of			
		「 is not met as evidenced			
	by: Based on record rev	iew and staff and resident		" Plan for correcting the specific	
	interviews, the facility			deficiency and processes that lead to	
		ve care plans for services to		deficiency cited:	
		al abilities for 2 of 4 sampled			
	residents (Residents	#48 and #162).		1. Resident #48 received restorative	
	-			services per the plan of care on 8/18/1	
	The findings included	I:		These restorative services continued p	
	1 Resident #48 was	admitted to the facility on		the care plan until resident was put ba in skilled Physical Therapy on 8/29/17	
		ses including cryptogenic		screening of the resident s current	
	pneumonia, anemia,			abilities by the Physical Therapist show	wed
	pulmonary disease a	nd depression.		that resident #48 had a functional improvement in his abilities indicating	that
	The admission Minim	um Data Set (MDS) dated		he would benefit from skilled PT service	
	04/18/17 coded Resid				
	cognition, having no l	behaviors, requiring		2. Resident #162 received restorative	

Facility ID: 953152

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		MEDICAID SERVICES	1			OMB NC	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY
			B. MINIO				С
		345247	B. WING			08/	17/2017
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY N	URSING CENTER				11 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 PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page	e 7	F 28	82			
		for bed mobility and total	1 20	52	services per the care plan on 8/15 and		
	assistance with transf				8/16. These services have continued a		
		vas coded as having lower			listed in this resident⊡s plan of care.		
		on both sides and receiving			Resident #162 was screened by Physi	cal	
	physical therapy.	-			Therapist on 8/25/17, but no skilled PT		
					services were indicated as the resident	t	
		rge summary from physical			remained at her normal baseline		
		17 revealed Resident #48			functional status.		
	was discharged from						
		luding restorative nursing to			The restorative services had not been		
	prevent functional dec	cline.			consistently documented as per the pla	an	
	A sere plan establish	ad an 00/00/17 and reviewed			of care for resident⊡s #48 and #162.		
		ed on 06/06/17 and reviewed restorative nursing needed			The Rehab Director audited 100 perce	nt	
		ilateral active range of			of residents who is plan of care include		
		ses and bed mobility to			restorative nursing services on 8/18/17		
		ties. The goals included:			All residents who are to receive	•	
		I complete upper and lower			restorative nursing services, have		
		eights or blue theraband for			received those services per their plan	of	
		ons or the omnicycle on			care since 8/21/17.		
	level 1 for at least 15	minutes up to 2 times a					
	week; and				" Procedure for implementing the		
		complete rolling side to			acceptable plan of correction for the		
		ing from lying to sitting with			specific deficiency cited:		
		for at least 15 minutes up to				11-	
	2 times a week.	re the same as the goals			On 8/21/17, the Rehab Director met wi		
	THE INCOVENCIONS WEI	re the same as the goals.			and educated the restorative nursing s This education included time	an.	
	Review of the restora	tive documentation service			management of restorative case load,		
		n 06/06/17 through 08/15/17,			documentation of restorative services		
	-	d restorative therapy 5 days			provided and resident refusals of service	ces.	
	as follows:	- 1: 5 5 -			and communication to ensure restorati		
	*On 06/16/17 15 minu	utes of arom;			services are provided as per the plan of	of	
		utes of arom and 15 minutes			care by other qualified staff members i		
	of bed mobility;				they are unavailable or unable to		
	*On 07/19/17 15 minu of bed mobility;	utes of arom and 15 minutes			complete those services.		
	-	utes of bed mobility; and utes of bed mobility.			The DON and ADON began in-service education on 8/29/17 for all CNA staff		

Facility ID: 953152

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. (0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		345247	B. WING		C 08/17	//2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		/2011
				581 NC HIGHWAY 16 SOUTH		
VALLEY	IURSING CENTER			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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From page	2 8	E 2	82		
F 282	282 Continued From page 8 Resident #48 stated on 08/16/17 at 12:26 PM that he has not received any assistance with restorative exercises or weights. Interview with the Director of Rehab on 08/16/2017 at 2:45 PM revealed she developed the restorative plans for services "up to" 2 times a week to give some leeway in meeting the goals and set up a schedule for the restorative aides to follow which scheduled each resident on restorative exercises two days a week and each resident needing splint application 5 days a week. Resident #48's plan was developed on 06/06/17 as stated in the plan of care. She further stated that administration was aware the restorative services were still not being provided and the facility was continuing to rebuild the restorative program via weekly restorative meetings held with the Administrator, Director of Nursing, MDS nurses and herself. She stated the facility lost some restorative aides and the restorative aides on staff had the responsibilities of the restorative exercises, splint application, monthly and weekly		F 2	 82 the importance of providir nursing services to all res the services per their indiv care. Hall staff will be res assist with providing resto services to ensure that all receive those services, as their care plan, by a qualit The Rehab Director review restorative care plans and necessary revisions to en plans reflected the resider restorative service needs. " The monitoring proce that the plan of correction that the specific deficiency corrected and/or in compling regulatory requirements: New monitoring tool creat Director for auditing resto This audit will ensure that who are to receive restoration 	idents requiring vidual plan of sponsible to orative nursing residents indicated in fied person. wed all the d made sure the care ints current edure to ensure is effective and y cited remains iance with red by the Rehab rative services. all residents	
	often the restorative a to work as medication stated Resident #48 v restorative plan to be Wednesday each we permitted flexibility ar a missed service late On 08/16/2017 3:21 I stated during intervie able to complete rest scheduled twice a we from restorative servi	PM Restorative Aide (RA) #1 w that she was not always orative services as eek as she was often pulled		receive those services rous specified in each resident unless there is a document reason or the resident exert to refuse services. The Rehab Director or the conduct Restorative Nurs beginning 8/21/17. These conducted weekly x4 weet monthly for 3 month. The address any areas of con- during the audit and provi- staff education as needed	atinely as s plan of care, nted medical ercises their right ADON will ing audits a audits will be ks, then twice ADON will cern discovered de additional	

Facility ID: 953152

If continuation sheet Page 9 of 36

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345247	B. WING				C 17/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	IURSING CENTER			58	81 NC HIGHWAY 16 SOUTH		
VALLET				T/	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page floor as a nurse aide		F	282	compliance is maintained.		
	10:20 AM that she har restorative aide about include obtaining wee providing restorative p working in the dining stated she has never services to Resident a sometimes she can d including splints and a she cannot. On 08/17/17 at 4:08 F (DON) was interviewe has recently hired two started about a month nurse aide duties to re She stated the facility restorative services a plan to improve the re not been finalized as aware that restorative provided as care plan 2. Resident #162 was 04/13/17. Her diagno fracture, difficulty wall Alzheimer's disease. The admission Minim coded her with severe having no behaviors, assistance for most a except eating, being r physical and occupati	t a month. Her duties ekly and monthly weights, olans and services, and room during meals. She provided restorative #48. RA #2 stated that o all restorative tasks exercises and sometimes PM, the Director of Nursing ed. DON stated the facility or restorative aides. One n ago and one moved from estorative duties last week. identified a problem with nd have been working on a estorative program but it has of yet. She stated she was e services were not being ined. s admitted to the facility on oses included left femur king, diabetes and um Data Set dated 04/20/17 ely impaired cognitive skills, requiring extensive ctivities of daily living skills nonambulatory and receiving			The ADON will report findings of the Restorative Audits to the QAPI commit monthly for 4 months for review and discussion. The QAPI committee will evaluate and modify action plan as needed to ensure continual compliance " The title of the person responsible implementing the acceptable plan of correction: The Assistant Director of Nursing will b responsible for implementing the acceptable plan of correction. " Date when corrective action will be completed: September 5th, 2017	e. for e	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING		_	08/ [.]	C 17/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		-
VALLEY N	URSING CENTER			81 NC HIGHWAY 16 SOU ⁻ AYLORSVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page restorative plan on 07	//24/17.	F 282				
	motion (arom) to bilat lower extremities and her current abilities. from chair to toilet and with moderate assista minutes up to 2 times included: 1. Bilateral upper ext unweighted dowel roo in all planes and bilate motion with 2 pound v for 2 sets of 10 repeti	blished 07/25/17 for complete active range of eral upper and bilateral transfer training to maintain The goals were for to go d back with 5 repetitions ance of 1 staff for at least 15 a week. The interventions remity range of motion with d for 2 sets of 10 repetitions eral lower extremity range of weights or blue theraband tions in all planes for 15					
	minutes; and 2. Resident to comple bed, chair and toilet for moderate assistance.	•					
	log revealed that from revealed Resident #4 restorative services: *On 08/04/17 15 minu arom; *On 08/15/17 15 minu arom; and	tive documentation service 0 07/25/17 through 08/16/17 8 received the following utes of transfer training and utes of transfer training and utes of transfer training and					
	identified a problem w restorative services. the restorative plans f week to give some lea	M revealed the facility had					

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	MENT OF HEALTH AN					FORM): 09/12/2017 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING		_) 180 (; 17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
VALLEY	URSING CENTER			581 NC HIGHWAY 16 SOU ⁻ TAYLORSVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	follow which scheduler restorative exercises of resident needing splin She further stated that the restorative service provided and the facil the restorative progra meetings held with the Nursing, MDS nurses facility lost some restor restorative aides on s of the restorative exer monthly and weekly w duties. In addition, of were pulled to the floo aides and nurse aides were scheduled for 2 permitted flexibility an a missed service later On 08/16/2017 3:21 F stated during interview able to complete restor scheduled twice a we from restorative service transportation, obtain floor as a nurse aide of RA #2 stated during in restorative aide about include obtaining wee providing restorative p working in the dining in stated that sometimes tasks including splints sometimes cannot.	ed each resident on two days a week and each at application 5 days a week. At administration was aware es were still not being ity was continuing to rebuild m via weekly restorative e Administrator, Director of and herself. She stated the portive aides and the taff had the responsibilities rcises, splint application, veights and transportation ften the restorative aides or to work as medication s. She stated all exercises days a week but staff were and if needed, could make up r in the week. PM Restorative Aide (RA) #1 w that she was not always porative services as ek as she was often pulled ces to complete weights, and or work the or medication aide. Meterview on 08/17/17 at s worked here as a t a month. Her duties ekly and monthly weights, polans and services, and room during meals. RA #2 is she can do all restorative	F 282				

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OLIVIEI		MEDICAID SERVICES			OMB NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					с	
		345247	B. WING		08/17/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IURSING CENTER			581 NC HIGHWAY 16 SOUTH		
VALLET	IORSING CENTER			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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 282	Continued From page	e 12	F 28	32		
		ed. DON stated the facility				
		o restorative aides. One				
		n ago and one moved from				
		estorative duties last week.				
	-	identified a problem with				
		nd have been working on a				
		estorative program but it has of yet. She stated she was				
		e services were not being				
	provided as care plan	•				
F 311	483.24(a)(1) TREATM		F 3 ⁻	11	9/5/17	
SS=D	IMPROVE/MAINTAIN	IADLS				
	(a)(1) A resident is giv	ven the appropriate				
		es to maintain or improve his				
		out the activities of daily				
		specified in paragraph (b)				
	of this section.					
		is not met as evidenced				
	by:	in the staff and variable st		" Plan for correcting the specific		
	interviews, the facility	iew, staff and resident		 Plan for correcting the specific deficiency and processes that lead 	to	
	· · ·	ervices to maintain the		deficiency cited:	10	
	· ·	g skills for 2 of 4 residents				
	-	ve services (Residents #48		1. Resident #48 received restorative	e	
	and #162).			services per the plan of care on 8/1		
				These restorative services continue		
	The findings included	:		the care plan until 8/29/17 when res		
	1 Resident #48 was	admitted to the facility on		was put back in skilled Physical The due to the resident exhibiting a fund		
		ses including cryptogenic		improvement in physical abilities for		
	pneumonia, anemia,			activities of daily living skills since h		
	pulmonary disease a	nd depression.		discharge from skilled PT services		
		d 01/12/17 included		5/22/17.		
	Physician orders date physical therapy to be			2. Resident #162 received the resto	prative	
	priysical therapy to be			services per the care plan on 8/15 a		
	The admission Minim			8/16 and again on 8/21/17. These		

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						O. 0938-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY
			A. BUILDING			С
		345247	B. WING		08	B/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				581 NC HIGHWAY 16 SOUTH		
VALLETN	IURSING CENTER			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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 311	Continued From page	- 12				
гэн			F 31			
	04/18/17 coded Resid			services have continued		
	cognition, having no b	for bed mobility and total		listed in this resident⊡s was screened by Physic		
	assistance with transf			8/25/17, but no skilled P		
		vas coded as having lower		indicated as the resident		
	-	on both sides and receiving		her baseline functional s		
	physical therapy.	Ŭ		maintained her level of a	ctivities of daily	
	Review of the dischar	rge summary from physical		living skills.		
		17 stated Resident #48 did		The restorative services	had not been	
		progress toward goals,		consistently documented		
		e to improve trunk motor		of care for resident s #4		
		ity and bed mobility since the		however, neither resider		
		nt #48 was discharged from		maintain their activities of	of daily living	
	physical therapy with	recommendations including		skills.		
	restorative nursing to	prevent functional decline.				
				The Rehab Director aud	•	
		rative Plan dated 05/30/17		of residents who s plan		
		d by the Physical Therapist		restorative nursing service		
		ve Range of Motion for lower		who s care plan include		
		und weights or theraband to nities with 10 repetitions		nursing services have co received those services	-	
		er extremity omnicycle level		No decline in activities of		
		dition the referral included		were identified during the		
		de to side and bridging		lieie laeillie a annig an		
		tting with assistance as		" Procedure for imple	menting the	
	tolerated.	-		acceptable plan of corre		
				specific deficiency cited:		
		ed on 06/06/17 and reviewed				
		restorative nursing needed		On 8/21/17, the Rehab E		
		ilateral active range of		and educated the restora		
		ses and bed mobility to		on the importance of pro necessary to maintain th	•	
		ties. The goals included: I complete upper and lower		activities of daily living sl		
		eights or blue theraband for		of care. This education		
		ons or the omnicycle on		management of restorati		
		minutes up to 2 times a		documentation of restora		
	week; and	······		provided and resident re		
		l complete rolling side to		and communication to er		

Facility ID: 953152

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	MPLETED
						С
		345247	B. WING			08/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		56/17/2017
				581 NC HIGHWAY 16 SOUTH	ODE .	
VALLEY	IURSING CENTER			TAYLORSVILLE, NC 28681		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETION
F 311	Continued From page	e 14	F 31	1		
		ing from lying to sitting with	_	services are provided as pe	er the plan of	
		for at least 15 minutes up to		care by other qualified staff		
	2 times a week.			they are unavailable or una		
	The interventions we	re the same as the goals.		complete those services.		
	Review of the restora	tive documentation service		The DON and ADON bega	n in-service	
	log revealed that from	n 06/06/17 through 08/15/17,		education on 8/29/17 for al		
	Resident #48 receive	d restorative therapy 5 days		the importance of providing	necessary	
	as follows:			services to maintain the res	sident⊡s	
	*On 06/16/17 15 minu			activities of daily living skill		
		utes of arom and 15 minutes		restorative nursing services		
	of bed mobility;			residents requiring these se		
		utes of arom and 15 minutes		their care plan. Hall staff w		
	of bed mobility;	utes of bed mobility; and		responsible to assist with p necessary services to main		
	*On 08/04/17 15 min	-		resident⊡s activities of dail		
		ates of bed mobility.		and providing restorative n		
	Resident #48 stated of	on 08/16/17 at 12:26 PM that		to ensure that all residents	-	
	he has not received a			services by a qualified pers		
	restorative exercises,	-		by their care plan.		
	Interview with the Dire			The Rehab Director review		
		M revealed upon admission,		restorative care plans and		
		d therapies. On 05/22/17		necessary revisions to ens		
		harged him and wrote a		plan reflected each residen		
		e services. The Director of		service needs to maintain t	heir activities	
		e facility had identified a		of daily living skills.		
		very of restorative services. loped the restorative plans		The skilled therapy staff wi	Il continue to do	
		times a week to give some		routine screens of resident		
	leeway in meeting the	-		in functional abilities and w		
		prative aides to follow which		skilled services as appropri		
		lent on restorative exercises		or improve functional activi		
		each resident needing splint		living skills.		
		week. Resident #48's plan				
	-	06/17 as stated in the plan		" The monitoring proceed		
		stated that administration		that the plan of correction is		
		ative services were still not		that the specific deficiency		
	peing provided and the peing provided and the peing provided and the peing period of the period	ne facility was continuing to	1	corrected and/or in complia	ance with	1

Facility ID: 953152

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	· · /	ATE SURVEY DMPLETED
		0.150.17				С
		345247	B. WING			08/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
VALLEYN	IURSING 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 311	Continued From page	o 15				
1 511	Continued From page		F 3			
	rebuild the restorative	e program via weekly held with the Administrator,		regulatory requirements:		
	-	ADS nurses and herself.		New monitoring tool created	for auditing	
		/ lost some restorative aides		restorative services to ensur	•	
	and the restorative ai			receive services, per their in	dividual plan	
	responsibilities of the	restorative exercises, splint		of care, to assist in maintaini	ng their	
		and weekly weights and		activities of daily living skills.		
		In addition, often the		will ensure that all residents		
		e pulled to the floor to work		receive restorative services,		
		and nurse aides. She stated heduled for the restorative		services as specified in each plan of care unless there is a		
		Nonday and Wednesday		medical reason or the reside		
	each week, however,			their right to refuse services.	III EXELCISES	
		ed, could make up a missed				
	service later in the we	-		The Rehab Director or the A	DON will	
				conduct the Restorative Nurs	sing audits	
		PM Restorative Aide (RA) #1		beginning 8/21/17. These a	udits will be	
		w that she was not always		conducted weekly x4 weeks		
	able to complete rest			monthly for 3 month. The Al		
		eek as she was often pulled		address any areas of concer		
	from restorative servi	•		during the audit and provide		
		e weights, and or work the or medication aide. She		staff education as needed to compliance is maintained.	ensure	
		ed,she tried to provide		compliance is maintained.		
		such as splint applications in		The ADON will report finding	s of the	
		stated this has been a		Restorative Audits to the QA		
		an 2 months but with new		monthly for 4 months for rev		
	staff hired it was impr	roving.		discussion. The QAPI comn	nittee will	
				evaluate and modify action p		
	-	nterview on 08/17/17 at		needed to ensure continual of	compliance.	
	10:20 AM that she ha					
		t a month. Her duties		" The title of the person re		
		ekly and monthly weights, plans and services, and		implementing the acceptable correction:	pian oi	
		room during meals. She				
	stated she has never			The Assistant Director of Nu	rsing will be	
		#48. She further stated that		responsible for implementing	-	
		pulled from restorative		acceptable plan of correction		
	-	floor as a nurse aide for				

Facility ID: 953152

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIPI	LE CONSTRUCTION	(X3) DATE	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
						С
		345247	B. WING		08	/17/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE	
	IURSING CENTER			581 NC HIGHWAY 16 SOUTH		
VALLET	IONSING CENTER			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 ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 311	Continued From page	2 16	F 31	1		
1 011		that sometimes she can do		Date when corrective act	ion will bo	
	all restorative tasks in			completed:		
		mes cannot. RA #2 stated		September 5th, 2017		
		3 restorative aides with 2				
	scheduled daily inclue	ding the weekends.				
		at when we formed Desident				
		st who referred Resident vices stated during interview				
		17 at 11:07 AM that upon				
		48 still had some trouble				
	-	ing to sitting position. He				
		B to restorative in order for				
		tain strength and range of				
		ated he saw Resident #48 le resident's request to have				
	more therapy and he	-				
	On 09/17/17 at 2:26 I	PM the staffing coordinator				
	was interviewed. She					
		sometimes, she had to pull				
		to work on the halls as				
	nurse aides or medic	ation aides. Due to call outs				
		o use the restorative aides				
		y and this date. She stated				
	have been pulled to v	h know when restorative staff vork on the floor.				
		PM, the Director of Nursing				
		ed. DON stated the facility o restorative aides. One				
		h ago and one moved from				
		estorative duties last week.				
	-	videntified a problem with				
		nd have been working on a				
		estorative program but it has				
		of yet. She stated she was e services were not being				
	provided as planned.	•				
	provided as plainted.		1	1		1

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FOR OMB NO	D: 09/12/2017 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION	Сом	E SURVEY PLETED C
		345247	B. WING				/17/2017
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 311	 Resident #162 war 04/13/17. Her diagnot fracture, difficulty wall Alzheimer's disease. The admission Minim coded her with severe having no behaviors, assistance for most a except eating, being r physical and occupati The Physical Therapis restorative plan on 07 bilateral upper extrem unweighted bar and a (arom) to all joints and referral included lowe bilateral lower extrem theraband to all plans A third intervention or resident to complete s tolerated. A care plan was estat restorative nursing to upper and bilateral low training to maintain he goals were for to go fi with 5 repetitions with staff for at least 15 mi The interventions incl 1. Bilateral upper ext unweighted dowel roo in all planes and bilater motion with 2 pound for 2 sets of 10 repetit minutes; and 	s admitted to the facility on bases included left femur king, diabetes and um Data Set dated 04/20/17 ely impaired cognitive skills, requiring extensive ctivities of daily living skills nonambulatory and receiving ional therapies. st wrote a referral for a 7/24/17 for services including hity range of motion with an active range of motion d plans as tolerated. The r strengthening exercises to ities with 2 pound weights or 6 for 2 sets of 10 repetitions. In this referral included for the sit to stand transfers as blished 07/25/17 for complete arom to bilateral wer extremities and transfer er current abilities. The rom chair to toilet and back in moderate assistance of 1 inutes up to 2 times a week.	F	311			

Facility ID: 953152

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CENTER	S FOR MEDICARE & I					FORM OMB NO	: 09/12/2017 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	LETED
		345247	B. WING				, 17/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
VALLEY	IURSING CENTER			81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 311	Continued From page bed, chair and toilet fo moderate assistance.		F 311				
	log revealed that from revealed Resident #4. restorative services: *On 08/04/17 15 minu arom; *On 08/15/17 15 minu arom; and	tive documentation service 0 07/25/17 through 08/16/17 8 received the following utes of transfer training and utes of transfer training and utes of transfer training and					
	identified a problem w restorative services. It the restorative plans f week to give some lea and set up a schedule follow which schedule restorative exercises resident needing splin She further stated that the restorative service provided and the facil the restorative progra meetings held with the Nursing, MDS nurses facility lost some restor restorative aides on s of the restorative exer monthly and weekly w duties. In addition, of were pulled to the floo aides and nurse aides were scheduled for 2	M revealed the facility had with the delivery of As a result, she developed for services "up to" 2 times a eway in meeting the goals a for the restorative aides to ad each resident on two days a week and each at application 5 days a week. at administration was aware as were still not being ity was continuing to rebuild m via weekly restorative a Administrator, Director of and herself. She stated the					

Facility ID: 953152

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING			08/	C 17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		
				581 NC HIGHWAY	16 SOUTH		
VALLEY N	URSING CENTER			TAYLORSVILLE,	NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	stated during interview able to complete restores scheduled twice a we from restorative service transportation, obtain floor as a nurse aide of stated that when puller restorative services so between duties. She so problem for longer that staff hired it was impre- RA #2 stated during in 10:20 AM that she hat restorative aide about include obtaining wee providing restorative providing restorative aide providing restorative providing restorative duties nurse aide for awhile. sometimes she can de including splints and e cannot. RA #2 stated restorative aides with the weekends.	r in the week. PM Restorative Aide (RA) #1 w that she was not always prative services as ek as she was often pulled ces to complete weights, and or work the primedication aide. She ed, she tried to provide uch as splint applications in stated this has been a an 2 months but with new oving. hterview on 08/17/17 at is worked here as a a month. Her duties kly and monthly weights, plans and services, and room during meals. She is morning she was pulled is to work on the floor as a RA #2 stated that o all restorative tasks exercises and sometimes there were currently 3 2 scheduled daily including PM the staffing coordinator e stated there were 3 sometimes, she had to pull	F 3	11	DEFICIENCY)		
	nurse aides or medica she stated she had to on the floor yesterday	to work on the halls as ation aides. Due to call outs use the restorative aides and this date. She stated know when restorative staff vork on the floor.					

Facility ID: 953152

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345247	B. WING				C 17/2017
NAME OF PI	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY N	IURSING CENTER				81 NC HIGHWAY 16 SOUTH 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	On 08/17/17 at 4:08 F	20 PM, the Director of Nursing ed. DON stated the facility	F	311			
F 353	has recently hired two started about a month nurse aide duties to re She stated the facility restorative services a plan to improve the re not been finalized as aware that restorative provided as planned. 483.35(a)(1)-(4) SUF	o restorative aides. One ago and one moved from estorative duties last week. identified a problem with nd have been working on a estorative program but it has of yet. She stated she was e services were not being FICIENT 24-HR NURSING	F	353			9/5/17
SS=D	the appropriate comp provide nursing and re- resident safety and at practicable physical, re- well-being of each res- resident assessments and considering the re- diagnoses of the facil accordance with the f at §483.70(e). [As linked to Facility A- be implemented begin (Phase 2)] (a) Sufficient Staff. (a)(1) The facility mus sufficient numbers of of personnel on a 24-	e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care umber, acuity and ity's resident population in acility assessment required Assessment, §483.70(e), will nning November 28, 2017					

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	-	D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345247	B. WING _				C 17/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
				58	1 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			TA	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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	21	F 3	53			
	(i) Except when waive this section, licensed	ed under paragraph (e) of nurses; and					
	(ii) Other nursing pers limited to nurse aides	sonnel, including but not					
	this section, the facilit	aived under paragraph (e) of y must designate a licensed narge nurse on each tour of					
	nurses have the spec sets necessary to car	at ensure that licensed ific competencies and skill e for residents' needs, as ident assessments, and of care.					
	assessing, evaluating resident care plans ar needs. This REQUIREMENT	includes but is not limited to , planning and implementing nd responding to resident's is not met as evidenced					
	interviews the facility restorative staff to pro	ews, and staff and resident failed to have sufficient wide restorative services to nts. Residents #48 and			" Plan for correcting the specific deficiency and processes that lead to deficiency cited:		
		restorative services which			1. Resident #48 received restorative services per the plan of care from 8/18 until 8/29/17 when resident was put ba		
	The findings included	:			in skilled Physical Therapy due to exhibiting a functional improvement in		
					physical abilities for activities of daily linskills since being discharged from skille PT services.	•	
		um Data Set (MDS) dated			2. Resident #162 has consistently received restorative services, per her p	lan	

Event ID: M4DK11

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		ATE SURVEY OMPLETED
		345247	B. WING			C 08/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		00/17/2017
				581 NC HIGHWAY 16 SOUTH		
VALLEY	IURSING CENTER			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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 353	Continued From page	a 22	F 35			
1 000	04/18/17 coded Resid		F J		he was sereened	
	cognition, having no b			of care, since 8/16/17. Sl by Physical Therapy on 8		
		for bed mobility and total		skilled PT services were i		
	assistance with transf			resident remained at her		
		vas coded as having lower		functional status. She ha		
	-	on both sides and receiving		level of activities of daily l		
				Restorative staff experien	iced recent	
	Review of the dischar	rge summary from physical		turnover and had failed to	consistently	
	therapy dated 05/22/2	17 stated Resident #48 did		document the restorative	services as per	
	not make significant p	progress toward goals,		the plan of care for reside	ent⊡s #48 and	
	however, he was able	e to improve trunk motor		#162.		
		ity and bed mobility since the				
		nt #48 was discharged from		The Rehab Director audit	•	
		recommendations including		of residents who s plan of		
	restorative nursing to	prevent functional decline.		restorative nursing service		
				who are to receive restora	•	
		rative Plan dated 05/30/17		services have consistently	•	
		d by the Physical Therapist		services per the plan of c	are since	
		ve Range of Motion for lower		8/21/17.		
	-	und weights or theraband to		" Dropoduro for implan	conting the	
		nities with 10 repetitions		" Procedure for implen	0	
		er extremity omnicycle level dition the referral included		acceptable plan of correc specific deficiency cited:		
		de to side and bridging				
		tting with assistance as		On 8/21/17, the Rehab D	irector met with	
	tolerated.			and educated the restora		
				on the importance of prov	•	
	A care plan establishe	ed on 06/06/17 and reviewed		services per the care plar		
		restorative nursing needed		maintain the resident s a		
		ilateral active range of		living skills. This education	-	
		ses and bed mobility to		management of restorativ		
	maintain current abilit	ties. The goals included:		documentation of restorat		
		complete upper and lower		provided and residents re	fusal of services,	
		eights or blue theraband for		and communication to en		
		ons or the omnicycle on		services are provided as		
		minutes up to 2 times a		care by other qualified sta		
	week; and			they are unavailable or ur	nable to	
	2 The resident would	complete rolling side to		complete those services.		

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	· · ·	MPLETED
						С
		345247	B. WING)8/17/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				581 NC HIGHWAY 16 SOUTH		
VALLEY	IURSING CENTER			TAYLORSVILLE, NC 28681		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLETIC
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	DATE
F 353	Continued From page	e 23	F 3	53		
	side in bed and bridg	ing from lying to sitting with				
		for at least 15 minutes up to		The Administrator advised	the Staffing	
	2 times a week.			Coordinator, on 8/21/17, th		
	The interventions we	re the same as the goals.		must be given to her by the		
				ADON prior to utilizing a re		
		ative documentation service		for medication aide or assig		
	•	n 06/06/17 through 08/15/17,		CNA. The staffing coordinate		
		ed restorative therapy 5 days		told to ensure that hall staf Rehab Director are advised		
	as follows: *On 06/16/17 15 minu	utos of arom:		aides are given hall assign		
		utes of arom and 15 minutes		to ensure that qualified sta		
	of bed mobility;			need to provide and docun		
		utes of arom and 15 minutes		necessary restorative servi		
	of bed mobility;			resident⊡s plan of care.		
		utes of bed mobility; and				
	*On 08/04/17 15 min	-		The DON and ADON bega	n in-service	
		,		education on 8/29/17 for al		
	Resident #48 stated	on 08/16/17 at 12:26 PM that		the importance of providing	g necessary	
	he has not received a	any assistance with		restorative services per the		
	restorative exercises,	, weights or such.		maintain the resident⊡s ac	•	
				living skills and it is the res		
	Interview with the Dir			CNA s to provide those se		
		M revealed upon admission,		Hall staff and therapy staff		
		d therapies. On 05/22/17		responsible to assist with p		
		harged him and wrote a		necessary services to main		
		e services. The Director of e facility had identified a		resident⊡s activities of dail and providing restorative s		
		very of restorative services.		ensure that all residents re		
		loped the restorative plans		services as indicated in the		
		times a week to give some		by a qualified staff person.		
	leeway in meeting the	-				
		prative aides to follow which		" The monitoring procee	lure to ensure	
	scheduled each resid	lent on restorative exercises		that the plan of correction i		
		each resident needing splint		that the specific deficiency		
		week. Resident #48's plan		corrected and/or in complia	ance with	
		6/06/17 as stated in the plan		regulatory requirements:		
		stated that administration				
		ative services were still not		New monitoring tool create	-	
	peing provided and the provided and t	ne facility was continuing to		restorative services to ensu	ure that	

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ATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) [DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	Ć	OMPLETED
						С
		345247	B. WING			08/17/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
	URSING CENTER			581 NC HIGHWAY 16 SOUTH		
VALLETIN	UKSING CENTER			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)	I SHOULD BE	(X5) COMPLETIC DATE
F 353	Continued From page	- <u>24</u>	F 3	53		
	rebuild the restorative			residents receive those servic	es hy a	
		held with the Administrator,		qualified staff person as per th	-	
		IDS nurses and herself.		care unless there is a docume		
	0,	/ lost some restorative aides		medical reason or the resider		
	and the restorative ai			their right to refuse services.		
	responsibilities of the	restorative exercises, splint		5		
	application, monthly a	and weekly weights and		The Rehab Director or the AD	ON will	
	transportation duties.	In addition, often the		conduct the Restorative Nurs	ing audits	
		e pulled to the floor to work		beginning 8/21/17. These au		
		and nurse aides. She stated		conducted weekly x4 weeks,		
		heduled for the restorative		monthly for 3 month. The AD		
		Ionday and Wednesday		address any areas of concern		
	each week, however,	ed, could make up a missed		during the audit and provide a staff education as needed to		
	service later in the we	-		compliance is maintained.	ensure	
		PM Restorative Aide (RA) #1		The ADON will report findings		
	•	w that she was not always		Restorative Audits to the QAF		
	able to complete rest			monthly for 4 months for revie		
		eek as she was often pulled		discussion. The QAPI comm		
	from restorative servi	-		evaluate and modify action pl		
		weights, and or work the		needed to ensure continual co	ompliance.	
		or medication aide. She		" The title of the person re-	noncible for	
		ed,she tried to provide		" The title of the person re- implementing the acceptable	•	
		such as splint applications in stated this has been a		correction:		
		an 2 months but with new				
	staff hired it was impr			The Assistant Director of Nurs	sina will be	
		5		responsible for implementing		
	RA #2 stated during i	nterview on 08/17/17 at		acceptable plan of correction.		
	10:20 AM that she ha					
	restorative aide abou	t a month. Her duties		Date when corrective action v	vill be	
		ekly and monthly weights,		completed:		
		plans and services, and		September 5th, 2017		
		room during meals. She				
	stated she has never	-				
		#48. She further stated that				
	uns morning she was	pulled from restorative				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 09/12/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING				08/	C 17/2017
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZI	IP CODE	•	
				5	81 NC HIGHWAY 16 SOUTH			
VALLEY N	URSING CENTER			Т	AYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD B		(X5) COMPLETION DATE
F 353	Continued From page awhile. RA #2 stated f all restorative tasks in exercises and sometin there were currently 3 scheduled daily includ The Physical Therapis #48 to restorative serv conducted on 08/17/1 discharge Resident #4 with moving from a lyi referred Resident #48 Resident #48 to main motion. He further sta two weeks ago per the more therapy and he On 08/17/17 at 2:26 F was interviewed. She restorative aides and each day so weekend stated she normally h medication aide for each had to pull restorative nurse aides or medica she stated she had to on the floor yesterday she let administration have been pulled to w further stated restorat to be pulled when the stated she was unawa were not being provid On 08/17/17 at 4:08 F (DON) was interviewed	25 hat sometimes she can do cluding splints and mes cannot. RA #2 stated restorative aides with 2 ling the weekends. at who referred Resident vices stated during interview 7 at 11:07 AM that upon 48 still had some trouble ng to sitting position. He to restorative in order for ain strength and range of ated he saw Resident #48 e resident's request to have had not lost function. PM the staffing coordinator stated there were 3 there were 2 scheduled s were also covered. She ad 3 nurse aides and a ach halls but sometimes she staff to work on the halls as ation aides. Due to call outs use the restorative aides and this date. She stated know when restorative staff ork on the floor. She ive staff were the last resort re were call outs. She are that restorative services		353				
	started about a month	ago and one moved from estorative duties last week.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345247	B. WING		_		C 17/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VALLEY	IURSING CENTER			81 NC HIGHWAY 16 SOUT AYLORSVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	She stated the facility restorative services a plan to improve the re- not been finalized as aware that restorative provided as planned. The Director of Rehat 08/17/17 at 5:22 PM. plan to develop the re- included monitoring to being provided. She not being provided as services could be pro- kept on restorative du for medication aides a further stated she did related to the schedul 2. Resident #162 war 04/13/17. Her diagno fracture, difficulty wall Alzheimer's disease. The admission Minim coded her with severe having no behaviors, assistance for most a except eating, being r physical and occupati The Physical Therapia restorative plan on 07 bilateral upper extrem unweighted bar and a (arom) to all joints and referral included lowe bilateral lower extrem	 identified a problem with nd have been working on a estorative program but it has of yet. She stated she was a services were not being b was interviewed again on She provided an action estorative program which o ensure the services were stated that services were stated that services were and nurse aides. She not have any responsibility ling of staff. s admitted to the facility on bases included left femur king, diabetes and um Data Set dated 04/20/17 ely impaired cognitive skills, requiring extensive ctivities of daily living skills nonambulatory and receiving ional therapies. st wrote a referral for a 7/24/17 for services including nity range of motion with an 	F 353				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345247	B. WING				C 17/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
VALLEY N	IURSING 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 353	A third intervention or resident to complete s tolerated. A care plan was estal restorative nursing to upper and bilateral loo training to maintain he goals were for to go f with 5 repetitions with staff for at least 15 m The interventions incl 1. Bilateral upper ext unweighted dowel roc in all planes and bilate motion with 2 pound for 2 sets of 10 repeti minutes; and 2. Resident to comple bed, chair and toilet for moderate assistance. Review of the restora log revealed that from revealed Resident #4 restorative services: *On 08/04/17 15 minu arom; *On 08/16/17 15 minu arom. Interview with the Dir 08/16/2017 at 2:45 Pl identified a problem w restorative plans f	a this referral included for the sit to stand transfers as oblished 07/25/17 for complete arom to bilateral wer extremities and transfer er current abilities. The rom chair to toilet and back in moderate assistance of 1 inutes up to 2 times a week. uded: remity range of motion with d for 2 sets of 10 repetitions eral lower extremity range of weights or blue theraband tions in all planes for 15 ete transfers from and to or 5 repetitions with tive documentation service n 07/25/17 through 08/16/17 8 received the following utes of transfer training and utes of transfer training and	F	35:	3		

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 09/12/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING					C 17/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
VALLEY	IURSING 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 PREF TAG	ΊX	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 353	and set up a schedule follow which schedule restorative exercises resident needing splir She further stated that the restorative service provided and the facil the restorative progra meetings held with the Nursing, MDS nurses facility lost some restor restorative aides on s of the restorative exer monthly and weekly w duties. In addition, of were pulled to the floo aides and nurse aides were scheduled for 2 permitted flexibility and a missed service later On 08/16/2017 3:21 F stated during interview able to complete restor scheduled twice a we from restorative service transportation, obtain floor as a nurse aide of stated that when pulle restorative services si between duties. She si problem for longer that staff hired it was impro- RA #2 stated during in restorative aide about include obtaining wee	e for the restorative aides to ad each resident on two days a week and each at application 5 days a week. It administration was aware as were still not being ity was continuing to rebuild m via weekly restorative e Administrator, Director of and herself. She stated the prative aides and the taff had the responsibilities rcises, splint application, veights and transportation ten the restorative aides or to work as medication s. She stated all exercises days a week but staff were d if needed, could make up r in the week. PM Restorative Aide (RA) #1 w that she was not always prative services as ek as she was often pulled ces to complete weights, and or work the or medication aide. She ed,she tried to provide uch as splint applications in stated this has been a an 2 months but with new oving.	F	353				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345247	B. WING		_) /80	C 17/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
VALLEY N	IURSING CENTER			581 NC HIGHWAY 16 SOU [.] FAYLORSVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	working in the dining in further stated that this from restorative duties nurse aide for awhile. sometimes she can de including splints and e cannot. RA #2 stated restorative aides with the weekends. On 08/17/17 at 2:26 F was interviewed. She restorative aides and each day so weekend stated she normally h medication aide for each had to pull restorative nurse aides or medica she stated she had to on the floor yesterday she let administration have been pulled to w further stated restorat to be pulled when the she was unaware that not being provided. On 08/17/17 at 4:08 F (DON) was interviewed has recently hired two started about a month nurse aide duties to re She stated the facility restorative services a plan to improve the re- not been finalized as	room during meals. She s morning she was pulled s to work on the floor as a RA #2 stated that o all restorative tasks exercises and sometimes I there were currently 3 2 scheduled daily including	F 353				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 09/12/2017 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345247	B. WING _				C 17/2017
NAME OF PF	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
	URSING CENTER			58	1 NC HIGHWAY 16 SOUTH		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				T/	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 353 F 431 SS=D	Continued From page The Director of Rehat 08/17/17 at 5:22 PM. plan to develop the re- included monitoring to being provided. She should not being provided as services could be pro- kept on restorative du for medication aides a further stated she did related to the schedul 483.45(b)(2)(3)(g)(h) LABEL/STORE DRUC The facility must provid drugs and biologicals them under an agreer §483.70(g) of this par unlicensed personnel law permits, but only of supervision of a licens (a) Procedures. A face pharmaceutical service that assure the accurate dispensing, and admiti biologicals) to meet the (b) Service Consultati employ or obtain the sis pharmacist who (2) Establishes a syste disposition of all contr	 a 30 b was interviewed again on She provided an action storative program which o ensure the services were stated that services were planned and stated the vided if restorative were ties and not pulled to cover and nurse aides. She not have any responsibility ing of staff. DRUG RECORDS, 35 & BIOLOGICALS ide routine and emergency to its residents, or obtain nent described in t. The facility may permit to administer drugs if State under the general sed nurse. clility must provide the acquiring, receiving, nistering of all drugs and he needs of each resident. on. The facility must 	F	431			9/5/17
	(3) Determines that di that an account of all	rug records are in order and controlled drugs is					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345247	B. WING				C 17/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY N	URSING CENTER				81 NC HIGHWAY 16 SOUTH 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	labeled in accordance professional principles appropriate accessory instructions, and the e applicable. (h) Storage of Drugs a (1) In accordance with the facility must store locked compartments controls, and permit of have access to the ke (2) The facility must p permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 and abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to removie were available for use rooms (Medication Ref.	dically reconciled. and Biologicals. used in the facility must be with currently accepted s, and include the y and cautionary expiration date when and Biologicals. In State and Federal laws, all drugs and biologicals in under proper temperature only authorized personnel to eys. rovide separately locked, ompartments for storage of d in Schedule II of the Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced ms and staff interviews the re expired medications that e from 1 of 3 medication for fall cart) checked for	F	431	 Plan for correcting the specific deficiency and processes that lead to deficiency cited: 1. & 2. The expired over-the counter medications were removed from the 6 hall Medication Room and the 600 Medication Cart by the Registered Nu who accompanied the surveyor at the time of observation on 8/16/17. 	600 Irse	

Event ID: M4DK11

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		MEDICAID SERVICES			OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345247	B WING		C	4-
	ROVIDER OR SUPPLIER	343247		STREET ADDRESS, CITY, STATE, 2	08/17/20/	17
				581 NC HIGHWAY 16 SOUTH		
VALLEY	IURSING CENTER			TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COMP	(X5) PLETIO DATE
F 431	Continued From page	e 32	F 43	21		
		2:41 PM the following	1 -0	Those medications wer	e delivered to the	
		600 hall Medication Room's		DON who then conduct		
	storage cabinet were			audit of the 600 hall Me		
				the 600 hall medication		
	* An unopened water with the expiration	1 250 milliliter bottle of sterile tion date of 01/2017.		no other expired medica		
	* •			All other medication sto		
		1 16 ounce bottle of iron		medication carts receive		
	supplement with the	expiration date of 08/2016.		audited on 8/18/17. No medications or supplies		
	* An unopened	1 16 ounce bottle of milk of			were observed.	
		piration date of 04/2017.		The over-the-counter m	edications in 600	
				hall Medication Room s		
	* 2 unopened b	bottles of 120 milligram		had not been effectively		
	magnesium oxide tat	plets with the expiration		expiration dates and ex	-	
	dates of 07/2017.			not been observed whe medication cart from the	5	
		2:54 PM the following				
		00 hall medication cart were		" Procedure for imple		
	made:			acceptable plan of corre		
	* An opened 16	ounce bottle of milk of		specific deficiency cited	ı.	
		piration date of 04/2017.		In-service education be	gan 8/22/17 for	
				licensed nursing staff a		
	* An opened bot	tle of aspirin 325 milligram		aides on the proper rota		
	tablets with the expira	ation date of 01/2017.		medications, observation	on of expiration	
				dates prior to stocking r		
				and prior to administerin		
		PM at interview with the		and the requirement for		
		DON) revealed the stock dered and delivered once a		removal and sequesteri medications located. T		
		dication room. The DON		Director of Nursing (AD		
		ursing supervisor was		the return to pharmacy		
		ig the medications up and		expired medications pe		
	restocking the 400/50	00 halls and 600 hall		guidelines.		
		inets with the delivered				
		N further stated it was her		The Lead Nurse Consu		
		first shift nursing supervisor		pharmacy provided add		
	check for expiration of	dates as she stocked the		education for licensed r	nurses and	

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	<u>SFOR MEDICARE &</u> DF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	COMPLETED
						С
		345247	B. WING			08/17/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
	IURSING CENTER			581 NC HIGHWAY 16 SOUTH		
VALLETT	UNOING GENTER			TAYLORSVILLE, 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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 431	Continued From pag		F 43	-		
expiration medication	expiration dates as the	dications and the nurses check the n dates as they resupplied their on carts as well as before they poured up ons for use.		medication aides on prop storage and auditing pro 9/5/17.		
				The ADON will be respond medication room and me audits are conducted we then every other week for continue monthly therea will ensure that no expire are available for use.	edication cart ekly x4 weeks, or 1 month, then fter. The audits	
				" The monitoring proc that the plan of correctio that the specific deficient corrected and/or in comp regulatory requirements:	n is effective and cy cited remains bliance with	
				New Medication Storage created and implemente ensure no expired medic present for use in the me or medication carts. Any medications observed w the auditor and given to	d for use to cations are edication rooms / expired ill be removed by	
				All medication rooms and carts will receive 100 per beginning 8/22/17. Thes conducted weekly x4 we other week for 1 month, monthly thereafter. The responsible for these au	rcent audits se audits will be eks, then every then continue ADON will be	
				The Pharmacy Staff, (co pharmacy technician, reg consultant, and pharmac conduct look behind aud storage rooms and medi	gistered nurse cist) will also lits of medication	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		345247	B. WING			C 08/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
	IURSING CENTER			581 N	IC HIGHWAY 16 SOUTH	
				TAYL	ORSVILLE, NC 28681	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 431	Continued From page	e 34	F4	431		
				1 rc P pr rc m P o o m s s re T th fc m a a a e e S T th fc m a c c c c c c T T T T T T	The Consultant Pharmacist conducted 00 percent audit of medication storage borns and medication carts on 8/29/1 Pharmacy staff will do additional 100 ercent audits of all medication storage borns and medication carts monthly finder months, Sept. □ Nov 2017. Pharmacy staff will then do rotating audit f medication rooms and medication of nonthly beginning in December. Any sues identified will be corrected and eported to the ADON. The ADON will be responsible to ensu- nat no expired medications are available or use in the medication rooms or the nedication carts. The ADON will add ny issues or concerns identified durin Il medication storage audits and providitional staff education as needed to nsure compliance is maintained. The ADON will report finding of the Medication Storage Audits to the QAPI ommittee monthly for 4 months for eview and discussion. The QAPI ommittee will evaluate and modify action lan as needed to ensure continual ompliance. The title of the person responsible nplementing the acceptable plan of orrection: The Assistant Director of Nursing will esponsible for implementing the	ge 7. Je or 3 Judits carts
	7(02-99) Previous Versions Obs	solete Event ID·M4			Cceptable plan of correction.	wation sheet Page 35 of 36

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Facility ID: 953152

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		ND HUMAN SERVICES				OMB NC	/ APPROVE). 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345247	B. WING	i			C 17/2017
NAME OF PF	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				58	31 NC HIGHWAY 16 SOUTH		
VALLETN	URSING CENTER			Т	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From page 35		F	431	" Date when corrective action will t completed: September 5th, 2017	be	
	7(02-99) Previous Versions Ob	osolete Event ID: M4			sility ID: 953152 If conti		

Facility ID: 953152

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