PRINTED: 06/30/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			06/09/2020	
	ROVIDER OR SUPPLIER  URSING CENTER			STREET ADDRESS, CITY, STATE, ZIF 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI			
F 880 SS=D	Initial Comments  An unannounced on-Survey was conducted additional information 06/08/20 and 06/09/2 the survey is 06/09/2 in compliance with 42 E-0024 (b)(6), Subpaterm Care Facilities. Infection Prevention & CFR(s): 483.80(a)(1)  §483.80 Infection Control facility must established to provide a comfortable environmed evelopment and transitional designed to provide a comfortable environmed evelopment and transitional states and control program. The facility must established and control program a minimum, the follow §483.80(a)(1) A system and communicable distaff, volunteers, visit providing services un arrangement based up conducted according accepted national states §483.80(a)(2) Written §483.80(a)(a)(a)(a) Written §483.80(a)(a)(a)(a)(a) Written §483.80(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(	esite COVID-19 Focused and on 06/04/2020 with a obtained on 06/05/20, and Therefore the exit date of 020. The facility was found a CFR §483.73 related to rt-B-Requirements for Long Event ID# NLMT11 and Control (2)(4)(e)(f) and control program a safe, sanitary and ment and to help prevent the assission of communicable ins.  Drevention and control blish an infection prevention (IPCP) that must include, at ving elements:  The for preventing, identifying, and controlling infections are assess for all residents, ors, and other individuals der a contractual upon the facility assessment to §483.70(e) and following and orgam, which must include,	F 8	DEFICIE		6/30/20	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	=	TITLE		(X6) DATE	

Electronically Signed 06/25/2020

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.

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	(i) A system of survey possible communications before the persons in the facility. When and to who communicable disereported; (iii) Standard and the to be followed to previously for the involved, and (B) A requirement the least restrictive poscircumstances. (v) The circumstance must prohibit emploidisease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in the corrective actions to \$483.80(e) Linens. Personnel must har transport linens so a infection.	eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the esses under which the facility eyees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents facility's IPCP and the aken by the facility.  Indie, store, process, and as to prevent the spread of				

NAME OF PROVIDER OR SUPPLIER    SIMPLEY NURSING CENTER    SIREET ADDRESS. CITY, STATE, 2/P CODE   SET NO. INCHMANY 16 SOUTH   TAYLORSVILE, NC. 28681   TAYLORSVILLE, NC. 28681	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
VALLEY NURSING CENTER  SITECTA DORSING. CITY. STATE, ZP CODE SST NC CHORMAY 16 SOUTH TAYLORSVILLE, NC 2881  SUMMAY 16 SOUTH TAYLORSVILLE, NC 2881  SUMMAY 16 SOUTH TAYLORSVILLE, NC 2881  F 880  Continued From page 2 Based on observations, review of the facilities staff education logs and infection control documents, record reviews, and staff, physician, Health Department Emergency Management/infection Control/Assistant Health Director, and Associate Director of North Carolina Statewide Prevention of Infection and Epidemiology interviews, the facility failed to ensure staff performed proper hand hygiene after contact with a resident and objects in the residents room for 2 of 2 residents (Resident #1, and #2), failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage that indicated Contact Precautions for 2 of 2 residents (Resident #1 and #2) and failed to clean and sanitize multi-use lift equipment after use in a room with signage that indicated Contact Precautions for 1 of 1 resident (Resident #2). This occurred for 2 of 2 sampled residents.  Findings included:  An undated facility document titled *Crisis Capacity Strategies for Gown per the CDC guidelines,* which read in part that facilities may consider suspending the use of gowns for endemic multifurge resistant organisms). It further reads isolation gowns may be used for extended periods by the same health care provider if interactions were made with residents with the same confirmed infectious disease, housed in the same location, and could only be considered when no additional co-infectious diagnosis were present. When gowns were limited in availability, prioritization of isolation and procedure and control proper			345247	B. WING		06/09/2020	
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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 _			06/	09/2020
	ROVIDER OR SUPPLIER		•	58	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	F 880 Continued From page 3 splashes or sprays are anticipated, high-contact procedures such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care.  A current review of the CDC guidelines dated 06/08/2020 revealed a three step approach to gown conservation strategies. The three steps included conventional capacity, contingency capacity, and crisis capacity. Contingency capacity included shifting gown usage to cloth gowns or coveralls. Crisis capacity included extended use of isolation gowns, re-use of cloth gowns, and finally prioritizing the use of gowns with a possible suspension of gowns for endemic multidrug resistant organisms (e.g. MRSA, VRE, ESBL-producing organisms).  According to a facility document titled "Pandemic-Gloves and Handwashing" dated 04/02/20 revealed staff were to remove gloves before leaving the resident 's room and wash their hands immediately with an antimicrobial agent or a waterless antiseptic agent.  A facility document titled "Pandemic-Prevention of Person to Person Transmission" dated 04/02/20 revealed staff were to wear a gown when entering a room if you anticipate you will have substantial contact with the resident, environmental surfaces, or items in the resident, environmental surfaces, or items in the resident, environmental surfaces, or items in the resident 's room. It further indicated when common use equipment or items is avoidable, then adequately clean and disinfect them before use for another resident.  1. Resident #1 was readmitted to the facility on 02/02/19. His diagnosis included chronic respiratory failure with hypoxia and hypercapnia		F	education included necessity of proper hand hygiene, PPE - particularly the required use of gowns and acceptabl standards for gown conservation according to availability and current guidance, cleaning multi-use lifting equipment between residents, and infection control practices to prevent contamination with objects taken in a removed from the residents rooms. E of these listed staff members exhibite understanding of posted precautions, proper and consistent hand hygiene, proper and consistent use of PPE, ar infection control measures and disinfection process to prevent cross contamination through objects and equipment.			
					Other residents having the potential to affected:  Any other resident on transmission-base precautions could have been affected, therefore on 6/5/20, the DON and the I unit managers performed care observations of residents who were on transmission-based precautions to ensure that infection control practices were brifollowed. They observed for hand washing or use of ABHR, availability of PPE, appropriate use of required PPE disinfection of multi-use equipment between residents, and potential cross contamination of objects and surfaces. No other instances of non-adherence to the infection control practices based on posted precautions were observed on	sed RN sure ing f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING		0	6/09/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/00/2020
				581 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING CENTER			TAYLORSVILLE, NC 28681		
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F 880	Continued From page	÷ 4	F 88	0		
	including tracheoston	ny, ventilator dependence, pneumonia, and sepsis.		6/5/20.		
	Resident #1 was at ricomplications related tracheostomy dependent additional care plant of Resident #2 was at ricovident and tracheostomy dependent and tracheostomy dependent #2 was at ricovident #2 was at ricovident #1 growth for three isolar Pseudomonas Aerug and Proteus Mirabillist A quarterly Minimum 04/16/20 indicted Resmoderate cognitive in extensive to total depactivities of daily living A continuous observation at 10:58 AM to 11:06	to ventilator and lence. Review of an ated 04/02/20 revealed sk for infection related to alture dated 01/28/20 to be positive with heavy ted organisms that included nosa, Providencia Stuartii, s.  Data Set (MDS) dated sident #1 had some npairment and required endence of staff for all g (ADL). care.		Measures initiated to prevent recof alleged deficient practice:  On 6/8/20, the DON initiated detafacility wide in-service educationatraining, to be completed by all fastaff. This education covers differed levels of transmission-based prevand the importance of adherence infection control standards. The educational training details when to perform proper hand hygiene, donning and doffing and consister required PPE for each level of transmission based precautions, multi-use equipment between resonad infection control practices to cross contamination with objects into or removed from the residen This detailed in-service education initiated on 6/8/20 and will run the 6/30/20. All staff must complete	ailed al acility rent cautions and how proper ent use of cleaning sidents, prevent taken ts room. n was rough the	
	the room of Resident the outside of the doc Precautions and inclu of a gown and gloves not wearing a gown capproached the bed a bed with her torso an to turn it off. Respirat and the nurse perform the room to notify the respiratory therapist tapproached the beds	and touched the side of the d the call light with her hand bry suctioning was needed, ned hand hygiene and left respiratory department. A hen entered the room and		required in-service by 06/30/20. Shave not completed the in-service required date of 06/30/20 will not allowed to work until the training completed.  The DON received clarification of transmission-based precautions for residents who are cohorted at colonized with CRE. The clarification guidance included the implement Enhanced Barrier Precautions whis no active CRE infection. These Enhanced Barrier Precautions	e by the be is not the required ation tation of then there	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			06/	09/2020
	ROVIDER OR SUPPLIER URSING CENTER		•	STREET ADDRES  581 NC HIGHWA  TAYLORSVILL		,	
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F 880	Continued From pag	ge 5	F8	30			
	he provided respirat tracheostomy. He w bedside of Resident curtain facing the exgloves but no isolati Therapist disposed receptacle and exite proper hand hygiene hands or using alcoloto sanitize his hands.  An interview with Nu AM revealed she was for day shift. Nurse is room to see what Rehis call light was lit. #1 had signage on to indicated Contact Progown and glove usa PPE including gown on the door of the residuents.	ory suctioning from the as observed leaving the #1 and came around the tit door wearing a mask and on gown. The Respiratory of the used gloves in the trash and the door without completing the which included washing his hol-based hand rub (ABHR) is after care.  The word of the used gloves in the trash and the door without completing the which included washing his hol-based hand rub (ABHR) is after care.  The word of the series of the esident #1 indicated she entered the esident #1 needed because She acknowledged Resident the outside of his door which recautions with illustrations of the ge when in the room and that is and gloves were available soom. She stated she never act precaution rooms until		precaution tasks are be other restricted and begar Infection E for the facincularing infection c monitoring	hything greater than standard his when specific resident can being performed but have notictions on the resident or the on inside the facility.  It ransmission-based precausor the residents of the cohord event unit with CRE on and no active infection, when 06/17/20 to reflect Enhance ecautions instead of Contact has as was previously posted qualified RN with duties in the ection Preventionist, was him him work on 6/22/20. The RN Preventionist will be responsibility infection control program but not limited to, ongoing control survellience, staffing, and the restructuring the control and prevention programs.	re o o eir tion t vas ced t l. the ed sible m	
	was conducted on 0 interview revealed F provided respiratory #1 indicated Reside Precautions which r during care and that and gloves were avenue did not wear an icare and had not pethis observation. He a gown and perform	espiratory Therapist #1 (RT) 6/04/2020 at 11:06 AM. The RT #1 acknowledged he had suction to Resident #1. RT int #1 was on Contact equired a gown and gloves PPE which included gowns ailable on the door. He stated solation gown while providing informed hand hygiene during stated he should have worn led proper hand hygiene after care to Resident #1 and didn't on this date.		The Direct comprehe performan audits on (adhering to the posted precaution conduct of where resistransmissi	conitoring to ensure compliant ed:  tor of Nursing initiated ensive Infection Control ace improvement observation 06/17/20 to ensure staff are no infection control practices of transmission-based as. The Nursing Managers we beservation audits of rooms idents are on ion-based precautions. The II observe to ensure staff additional compliants are on ion-based precautions.	n per vill RN	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING			06/	09/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				58	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)
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F 880	Continued From page	e 6	F	880			
	An interview with the		•	000	to infection control standards of practic	-00	
		20 at 11:30 PM revealed she			per the posted level of precautions.	C3	
		supervision and part of the			These observations include staff provide	lina	
		e nursing department. The			care or treatment to the resident as we	-	
		ed the facility initially had a			as staff entering the room for social or		
	_	plies in March 2020, but they			environmental interactions. The audit		
		ufficient supply level and			includes availability of required PPE,		
	were using items as	single use followed by its			proper donning and doffing of required		
	disposal. The Unit Manager indicated PPE which				PPE, hand hygiene at appropriate time	:S	
	-	gloves were supplied on the			using correct methods, cross		
		1's room due to Contact			contamination of objects brought in an		
		ted staff had been educated			out of rooms, and disinfection of multi-		
		s when on duty, don and doff			equipment between patients. Under the	Э	
	transmission-based p	hen providing patient care in			direction of the DON, the Nursing  Management team (comprised of the		
		e after removal of PPE.			DON, Infection Preventionist, and 2 RN	J	
	perioriii nand nygieni	e alter removal of 1.1 L.			Unit Supervisors) will conduct 25 of the		
	An interview with the	Respiratory Therapy director			Infection Control observation / monitor		
		6/04/20 at 12:00 PM via			audits weekly beginning 06/17/20, and	•	
	telephone. She state	d her staff had received			continue at various times on various sh	nifts	
		n all transmission-based			each week for through 07/31/20. The		
	·	giene, and donning and			audits will then decrease to 15 audits		
	_	providing resident care. She			weekly beginning 08/01/20 for two mor	nths	
		therapy staff should wear			through 09/30/20. Then the audits will		
		surgical mask when in the			decrease to 8 random audits weekly		
		on Contact Precautions. She			beginning 10/01/20 through 11/30/20 to	ט	
		mportance of performing efore and after patient care			ensure sustained compliance with the infection control practices for residents	on	
		ng provided by respiratory			transmission-based precautions.	OH	
	therapy staff.	ng provided by respiratory			transmission-based precautions.		
	, ,				The results of each audit will be forwar	ded	
	An interview with the	Director of Nursing (DON),			to the DON weekly. The DON and		
		or, and Administrator was			Infection Preventionist will review them	for	
		20 at 12:20 PM revealed			trends and patterns and will address st	aff	
	administrative staff ha				as needed to ensure proper		
		of PPE, hand hygiene, and			understanding and implementation of t	he	
	transmission-based p				transmission-based precautions.		
		wledged multiple residents					
	∣ that included Resider	nt #1 and 2 in the ventilator			The Infection Preventionist RN will		

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 _			06/	09/2020
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
VALLEY N	IURSING CENTER				81 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	F 880 Continued From page 7		F 8	380			
	unit had signage on the outside of the resident room that reflected Contact Precautions with illustration of need for gown and gloves when in the room. The DON and Assistant Administrator collaboratively indicated they had been advised through the Health Department, State Health Lab, and the Centers for Disease Control and Prevention that staff were not required to wear gowns when entering a room and providing care to residents with signage indicating Contact Precautions. The Assistant Administrator indicated she had received supplies through the local health department and through the Federal Emergency Management Agency (FEMA) since the start of the pandemic. The DON and Assistant Administrator agreed there were enough PPE supplied including gloves and gowns on the doors of the rooms that indicated Contact Precautions during the survey and that proper hand hygiene			present the results of the Infection of monitoring audits to the QAPI commevery month through the duration of audit.  The QAPI committee will review an monitor the results of this infection performance improvement action performance improvement action performance will make recommendate extend, or modify the plan as neces in order to ensure sustained complimity with F880 Infection Prevention and Control.  Date corrective actions are comples 06/30/20			
	PM revealed he had unaware of a shortag Center during his were requested PPE since pandemic. He further enough gowns and had of their extra supply ventity who had a desphad provided the facil Respiratory Protectio pandemic, delivered but had not given any	nent Planner and nator on 06/05/20 at 03:19 not been contacted and was e of gowns at Valley Nursing ekly visits to deliver the start of the COVID-19 stated he was told they had ad recently shared a portion with another local health care perate need. He revealed he lity with an Emergency n Plan at the start of the PPE supplies almost weekly, advice to Valley Nursing necessity to wear a gown in room because it was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` '	PLE CONSTRUCTION  G	1, ,	(X3) DATE SURVEY COMPLETED	
		345247	B. WING	·····		06/09/2020	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Control Nurse on 06 she and the Alexand Director had contact during the pandemic shortage of PPE incomplete She further stated shot acceptable practic when providing care Contact Precaution. important to perform use gown and glove indicated Contact Precaution one resident to an individual or surfain the room.  An interview with the Health Director on 0 she had contact with the pandemic and we gowns in the facility advised the facility to not wear gowns in Contact Precautions perform proper hand appropriate PPE incroom of residents the signage. She stated following a complain	e Alexander County Infection /05/20 at 03:45 PM indicated ler County Assistant Health with Valley Nursing Center but were unaware of any luding gowns at the facility. he had not advised the facility be being not to use a gown in a room that indicated She further stated it was proper hand hygiene and to s when in rooms that recautions in order to retransmission of infection another through contact with faces potentially contaminated  e Alexander County Assistant 6/05/20 at 05:27 PM revealed of Valley Nursing Center during as unaware of a shortage of She stated she had not mat it was acceptable practice of rooms that indicated and it was a necessity to I hygiene and use the luding gown and gloves in a fat Contact Precautions she had made a site visit t related to infection control bound 04/07/20 and had sent a	F 88	30			
	Assistant Health Dire	m the Alexander County ector on 06/05/20 at 05:35 d made a site visit following					

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	ROVIDER OR SUPPLIER			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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 880	ventilator unit at Va COVID-19 testing s time. An email attace emailed to the Assis 04/22/20 at 09:32 A toolkit included preprocessivation/optimit that had been provided by the attack of the attack.  An interview with the 10:29 AM revealed to include gown and patient care in room Contact Precaution unaware the facility gowns and would for the attack of the attack	complaint with a patient in the ley Nursing Center and supplies were supplied at that chment revealed a toolkit was stant Administrator on M. The Long-Term Care paration of gown station during the pandemic ded by the Deputy sief of Division of Public  The Physician on 06/08/20 at staff should wear proper PPE digloves when providing as with signage indicating so that a shortage of isolation bellow-up.  The Associate Director of the ewide Program for Infection and hygiene should be including gowns and gloves are in rooms with signage that precautions to decrease the	F 88		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345247	B. WING		06/09/2020
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	,
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 880	rooms that indicate the CDC website.  2. Resident #2 was 07/23/14 with curre chronic respiratory hypercapnia, COPI ventilator.  A review of the care Resident #2 reveal complications relate tracheostomy depe additional care plar Resident #2 is at risisolation related to  An Annual Minimum 05/12/20 revealed intact and required of staff for bed mob hygiene. It further infection present.  A review of a progrepractitioner dated 0 had been febrile will greater than 99.0 a protocol for testing, culture was available record during the real and the cord of the	readmitted to the facility on nt diagnoses that included failure with hypoxia or D, and dependence on a e plan dated 11/19/19 for ed she was at risk for ed to ventilator and ndence. Review of an as dated 04/01/20 revealed sk for infection and social COVID-19.  In Data Set (MDS) dated Resident #2 was cognitively extensive to total dependence illity, transfer dressing, and revealed no diagnoses of ess note written by the Nurse 05/19/20 revealed Resident #2 the a temperature reading nd was placed on COVID-19 but no lower respiratory le in the electronic medical	F 88	0	
	revealed an Assista plastic bags with pe hallway and enter t	ant Activity Director carrying ersonal belongings down the he room of Resident #2 by PPE that included a gown or			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			6/09/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	0/00/2020	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From page 11 gloves. Signage on the outside of the door of Resident #2's room indicated Contact Precautions and included illustrations of the use of gown and gloves when entering the room. After entering the room, she placed the plastic bags on		F 88	30			
	a chair at the bedside removing multiple ite showing them to the was in the bed. Items Resident #2 were pla and the remainder of put away in the room	e of Resident #2. She began ms from the bag and resident while the resident s that were not requested by aced back in the plastic bags the items she touched and s. She then performed hand d the plastic bags from					
	was conducted on 06 interview revealed shitems purchased from acknowledged the sign Resident #2's room i Contact Precautions aware she needed to not providing patient placed the plastic batouch surfaces in the unwanted items back	Assistant Activity Director 6/04/20 at 10: 50 AM. The ne had delivered personal noutside the facility. She gnage on the door of indicated the room was on she indicated she was not owear a gown since she was care. She confirmed she gs in Resident #2's chair, is resident room, and placed of in the bags and removed without wearing a gown.					
	two nursing aides (N room. The signage o #2 was on Contact P gown and gloves whentered the room brithad been retrieved frend of the hall. Both	As made on 06/04/20 M. The observation revealed As) entered Resident #2's In the door indicate Resident Irecautions and the need for en in the room. NA #1 Inging a mechanical lift that iom a storage closet at the NAs were wearing surgical ut were not wearing isolation					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		06/09/2020	
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  581 NC HIGHWAY 16 SOUTH  TAYLORSVILLE, NC 28681	1 00.00.2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 880	walked across the h. Resident #2's room gown. The NAs comdressing, and transfer mechanical lift before mechanical lift was to closet without being Contact Precaution of An interview with Nu 06/04/20 at 11:10 All had provided activiting for Resident #2. She on the door of the rowas on Contact Precuse of gown and glothe room and stated during the care of Robservation but show entered the room. Somechanical lift in the sanitizing it. She stated between each use. Sowere no wipes availated for use to sanitize mould have to ask at the Attempts to interview made on 06/04/20 with the conducted on 06/04/20 with the conduc	If the room of Resident #2 and all to a room then returned to without wearing an isolation ipleted incontinence care, erring Resident #2 using the exiting the room. The taken directly to the storage sanitized after use in a room.  It is Aide #1 was made on M. The interview revealed she es of daily living (ADL) care acknowledged the signage from indicated Resident #2 cautions which indicated the exes were necessary when in she did not wear a gown esident #2 during the full wear one each time she he stated she placed the extra stated she placed she extra sta	F 88			

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 _			6/09/2020	
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, Z 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 PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	disposal. She stated when on duty and do gloves when providin surfaces in the reside hygiene after remova indicated there were gloves available on the door due to Contact survey.  An interview with the Assistant Administratic conducted on 06/04/2 administrative staff heducation on the use transmission-based procome indicating contact included Resider unit had signage on the room. The DON a indicated they had be Health Department, Sometimes for Disease staff were not require entering a room and with signage indicating assistant administrative ceived supplies the start of the pander administrator agreed supplied including gloof the rooms that indicated including gloof the rooms that indicated including gloof the rooms that indicated supplied including gloof the rooms that indicated including gloof the rooms	staff always wore masks in and doff a gown and gipatient care, contact with entirooms, and perform hand all of PPE. She further PPE including gown and ne outside of Resident #2 's Precautions during the  Director of Nursing (DON), or, and Administrator was 20 at 12:20 PM revealed and provided ongoing of PPE, hand hygiene, and precautions. They wiledged multiple residents in #1 and 2 in the ventilator the outside of the resident act precautions with and Assistant Administrator the advised through the State Health Lab, and the Control and Prevention that and to wear gowns when providing care to residents in grontact precautions. The providing care to residents in grontact precautions in the providing care to residents in grontact precautions. The providing care to residents in grontact precautions in the doors cated Contact Precautions in the proper hand hygiene	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	\ , ,	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Emergency Manag Preparedness Coo PM revealed he ha unaware of a short. Center during his w requested PPE sim- pandemic. He furth enough gowns and of their extra supply entity who had a de revealed he had pr Emergency Respira start of the pandem advice to Valley Nu non-necessity to we Precaution room be scope of practice.  An interview with the Control Nurse on 0 she and the Alexan Director had contact during the pandem shortage of PPE in She further stated so of acceptable pract when providing car contact precaution important to perforn use gown and glov indicated Contact F decrease the risk fo from one resident to an individual or pot in the room.  An interview with the	ne Alexander County	F8	880			

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			06/09/2020	
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		•	1 00/00/2020	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 880	the pandemic and wa gowns in the facility. advised the facility the to not wear gowns in precautions and it was proper hand hygiene PPE including gown residents that Contact stated she had made complaint related to it received around 04/0 to the facility with strapandemic.  A follow-up email from Assistant Health Directon Control of the vertilator unit at Vallecton CoVID-19 testing sure An email attachment emailed to the Assistant Health Directon/Section Chief Health.  An interview with the 10:29 AM revealed she include gown and patient care in rooms Contact Precautions unaware the facility in gowns and would followed.	Valley Nursing Center during as unaware of a shortage of She stated she had not at it was acceptable practice rooms that indicated contact as a necessity to perform and use the appropriate and gloves in a room of a sterile recautions signage. She a site visit following a necessity to perform and use the appropriate and gloves in a room of a sterile recautions signage. She a site visit following a necessity to perform and use the appropriate and sterile recautions signage. She a site visit following a necessity to perform the had 17/20 and had sent a toolkit at a tegies for PPE during the set on 06/05/20 at 05:35 dimade a site visit following complaint with a patient in the easy Nursing Center and pplies had been provided. The Long-Term Care aration of gown ation during the pandemic and by the Deputy of of Division of Public Physician on 06/08/20 at taff should wear proper PPE gloves when providing a with signage that indicated He further indicated he was nad a shortage of isolation	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING		0	6/09/2020
NAME OF PROVIDER OR SUPPLIER  VALLEY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	·	
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F 880	North Carolina States Control and Epidemic revealed proper hand performed and PPE i should be worn wher indicated Contact Pre  A follow-up interview Assistant Administrat She revealed she felt of gowns to use in ro Precautions and had occasions when she isolation gowns. She records of any denial gowns. She further si guidance that gowns	wide Program for Infection blogy on 06/08/20 at 1:37 PM I hygiene should be ncluding gowns and gloves n in rooms with signage that	F 88			