STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint investigation survey was conducted on 11/6/19 through 11/7/19. Two (2) complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 160 at the time of the survey. The survey sample consisted of 16 resident reviews.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		12/11/19

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

Electronically Signed | 11/27/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical document review, and during the course of a complaint investigation, it was determined the facility staff failed to provide bathing according to a resident's interest for one (1) of sixteen (16) sampled residents (Resident #1). The findings include: Resident #1's clinical documentation failed to have documented evidence of a shower/bath occurring during two (2) separate weeks. Resident #1 was admitted to the facility on 4/9/15. Resident #1's diagnoses included, but were not limited to: Alzheimer's disease, diabetes, and high blood pressure. Resident #1's quarterly minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/27/19, had the resident's Brief Interview of Mental Status (BIMS) score documented as 15 out of 15; the resident was also documented as able to express ideas and wants and as "usually understands" others. Resident #1's clinical documentation was reviewed as part of a complaint investigation related to resident bathing. On 11/7/19 at 3:20 p.m., the facility's Administrator provided a copy of Resident #1's "Complex Alert Documentation Report" which indicated that the resident had no documentation to show he/she had received a shower/bath between the following dates: 9/22/19	F 561	The filing of this plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of correction is filed as evidence to comply with the requirements of participation and continue to provide high quality resident centered care. Resident #1 has received/offered 2 showers per week for the past 3 weeks. All residents have the potential to be affected. An Audit has been completed for documentation of residents having received/offered showers twice weekly or per resident preference. Education to the nursing department to ensure documentation is complete to reflect residents receiving/being offered showers twice weekly or per resident preference. Director of Nursing and/or designee will audit shower documentation for 15 residents per unit weekly for 4 weeks and then monthly for 2 months to ensure residents are receiving/being offered showers twice weekly or per resident preference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 through 10/2/19 and 10/6/19 through 10/15/19. The Administrator acknowledge the aforementioned two (2) weeks had no shower/bath documented; the Administrator also reported that no documentation addressed why a shower/bath had not been provided. The facility's Administrator was asked for the facility's policy and procedure related to bathing. On 11/7/19 at 3:50 p.m., the Administrator proved the survey team a copy of a facility document entitled "Bath, Shower/Tub". This document detailed the process for providing a bath but did not address how often a resident should receive a bath or shower. This document included the following information: "Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath ... 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." The Administrator was asked if the facility had a policy and procedure which discussed the frequency of which the residents received baths; the Administrator reported facility policy and procedure did not address the frequency of baths. The Administrator reported that residents were scheduled two (2) baths per week but stated facility staff would honor residents' bathing request. Resident #1's activity of daily living (ADL) care plan (revised on 7/8/19) included the following: "Assist to wp/shower or bed bath and shampoo 2 times weekly as tolerated". Resident #1 was interviewed about bathing on	F 561	Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 11/7/19 at 4:00 p.m. Resident #1 reported recently he/she had two weeks where only one (1) bath was provided during each week; Resident #1 indicated he/she would have preferred to have had more than one (1) bath per week. On 11/7/19 at 5:15 p.m., the failure of facility staff members to consistently provide Resident #1 baths according to his/her preferences/needs was discussed for a final time with the facility's Administrator and Director of Nursing during a survey team meeting. This is a complaint deficiency.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 577		12/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 4 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility document review, and during the course of a complaint investigation, it was determined the facility staff failed to ensure the most recent survey results were posted in a manner to make them readily available to residents, family, and visitors. The findings include: On 11/7/19 at 8:10 a.m., the surveyor reviewed the posted survey results with the facility's Director of Nursing (DON). The binder, which held the survey results for public viewing, was noted to contain survey results for 2018 and earlier surveys; the results for the 2019 survey which concluded in April of 2019 was not in the binder. The facility's Administrator was interviewed on 11/7/19 at 8:17 a.m., he/she reported that the 2019 survey results had been placed in the binder. The Administrator stated someone had removed the survey results in question without facility staff members being aware of their removal. On 11/7/19 at 5:15 p.m., the failure of facility's most recent annual survey results to be posted in a manner to make them readily available to residents, family members, and visitors was discussed for a final time with the facility's	F 577	The most recent survey for 2019 was replaced in the survey results binder on 11/7/19 during the complaint survey. Residents, families and visitors will be able to view the most recent annual survey results. Administrator and/or designee will provide education to the front desk staff to monitor survey results binder to ensure all required survey results are in place. Administrator and/or designee to monitor most recent survey results binder weekly for 6 weeks and then monthly for 2 months to ensure all the required survey results are in the binder. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/ trending and any necessary additional interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 5 Administrator and Director of Nursing during a survey team meeting. This is a complaint deficiency.	F 577		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility document reviews, staff interviews, and during the course of a complaint investigation, it was determined the facility staff failed to ensure medications were administered per provider orders on 09/02/19 for 7 of 26 residents assigned to staff member #19. (Resident #7, #8, #9, #10, #11, #12, and #13). The findings included: During the course of an unannounced complaint investigation, it was identified that staff member #19 (SM#19) was assigned to pass medications to a block of 26 residents on 09/02/19 for day-shift but left the facility before the end of the shift and never returned. During a review of the medication administration records (MAR) for the residents assigned to	F 684	Staff member #19 is no longer an employee of the facility to provide follow up documentation on the MARs for Resident #7, #8, #10, #11, #12, and #13. The attending Physicians have been notified of the omitted documentation. All residents have the potential to be affected. An audit has been completed for all residents to determine missed documentation for medications on the MARs for the past 2 weeks. Director of nurses and/or designee to provide education to licensed nurses on documentation of administration/refusal of medications, as well as to review the MARs prior to the end of each shift to ensure documentation and compliance.	12/11/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 SM#19 on 09/02/19, there were seven (7) residents with no documentation for various medications during day-shift. The clinical documentation on the MARs indicated for: Resident #7: failed to document the 08:00 a.m. scheduled dose of Acetaminophen Tablet (for pain). Resident #8: failed to document the 09:00 a.m. dose of Acetaminophen Tablet (for pain). Resident #9: failed to document the 09:00 a.m. dose of Lactulose Solution (for elevated ammonia). Resident #10: failed to document the 09:00 a.m. dose of Furosemide Tablet (for edema - swelling) and the 09:00 a.m. dose of Carbidopa/Levodopa Tablet (for tremors/Parkinsons). Resident #11: failed to document the 09:00 dose of Hydrocodone/APAP (acetaminophen) Tablet (for pain). Resident #12: failed to document the 08:00 a.m. dose of Lorazepam Tablet (for anxiety). Resident #13: failed to document the 08:00 a.m. dose of Artificial Tears Solution (for dry eyes). During an interview with the DON on 11/07/19 at approximately 12:45 p.m., the DON acknowledged there were blank areas on those residents' MARs and stated that if the residents had refused those medications, their refusal would be documented, not left blank. The facility's policy titled, "MEDICATION ADMINISTRATION GENERAL GUIDELINES FOR THE ADMINISTRATION OF MEDICATIONS" with an effective date of January 2015, was reviewed on 11/07/19 at 3:50 p.m. The policy read in part, "10. Nurse records the medication given on the Medication Administration Record. If the resident refuses the	F 684	Director of nurses and/or designee will audit 15 residents MARs per unit weekly for 4 weeks and then monthly for 2 months to ensure medication documentation on the MARs is complete. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495133	A. BUILDING _____ B. WING _____	C 11/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	940 EAST LEE HIGHWAY CHILHOWIE, VA 24319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 medication, s/he indicates the failure to administer on the MAR and in the Nurses' Notes." On 11/07/19 at 5:05 p.m., these findings were discussed with both the administrator and the DON and both denied having any further information related to the issues described above and denied needing further time to address the concerns. Note: This was a complaint deficiency.	F 684		