Our Lady of The Valley

FOIA Data Base - The Law Office of Jeffrey Downey Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com

Our Lady of The Valley
650 North Jefferson Street
Roanoke, VA 24016

Characteristics:

- Non-Profit Corporation with 70 certified beds
- Legal Business Name – Our Lady of the Valley, Inc.
- Website: www.ourladyofthevalley.com
  Operator Managerial Control – Francis Dilorenzo

As of February 11, 2021 – Our Lady of The Valley is listed as a three-star facility by the Centers of Medicare and Medicaid Services, according to Medicare.gov

A note by attorney Jeffrey J. Downey about researching nursing homes:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing home facilities including Our Lady of The Valley in Roanoke, Virginia. Periodically they do inspections as complaint surveys which should be public record. State law requires that all nursing facilities obtain a license to operate in Virginia. In Virginia, nursing facilities and inspected every two years under the state licensure and on an average of 12 months under Medicare/Medicaid certification. When the Virginia Office of Licensure and Certification (OLC) conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the OLC or its employees from making reports under §63.2- 1603 et. seq. of the Code of Virginia. (Ref. §32.1- 127.1:03 of the Code of Virginia) You can register a complaint by mailing to Virginia Department of Health, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Henrico, VA 23233-1463 or via email at OLC-Complaints@vdh.virginia.gov or Fax to (804) 527-4503.

For Assisted Living Facilities in the Virginia, you may call directly or send in a complain online at https://www.dss.virginia.gov/about/email_licensing_complaint.cgi. There is a 24-hour number at (888) 832-3858 to report abuse of an elderly person.

Having already researched Our Lady of The Valley and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PRO VIDER/SUPPLIER/CUA IDENTIFICATION**NUMBER:**	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	496357	A. BUILDING _____ B. WING _____	**06/18/2020**

NIWE OF PROVIDER OR SUPPLIER	STREET ADORES$, CITY. STATE, ZIP CODE
OUR LADY OF THE VAUEY	**850 NORTH JEFFERSON STREET ROANOKE, VA 24016**

(X4)10 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 OATE
E 000	Initial Comments An unannounced Emergency Preparedness (EP) COVID-19 Focused Survey was conducted onsite on 06/18/2020. Emergency Preparedness information was reviewed off site on 06/18/2020 and 06/22/2020. The facility was in substantial compliance with 42 CFR Part 483.73 Requirement for Long-Term Care Facilities.	EOOO		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted onsite on 06/18/2020 and information updated off site on 06/18/2020 and 06/22/2020. Infection Control information was reviewed offsite on 06/18/2020 and 06/22/2020. Corrections are not required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). On 6/18/2020, the census in the 70 certified bed facility was 55. Of the 55 current residents, no residents had tested positive for the COVID-19 virus. Five (5} residents' test results were negative with the rest of the residents' test results pending.	FOOO		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X610ATE

Electronically Signed | 07/06/2020

Any deficiency statement ending with **an asterisk** (') **denotes a** deficiency which the institution may be excused from **correcting** pro viding 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 folowing the date *ol* 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 lo the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	495357	A. BUILDING _____ B. WNG_____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/07/19 through 04/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	EOOO		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey and State licensure survey were conducted 04/07/19 through 04/08/19. Corrections are required for compliance with 42 CFR Part 483 Federal long Term Care requirements and Virginia Rules and Regulations for the licensure of Nursing Facilities. The life Safety Code survey/report will follow. The census in this 70 certified bed facility was 65 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	FOOD		
F 6841 SS=D	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 observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for 1 of 19 Residents in the	F684	F684 Resident #14 has had her TED hose applied and removed as per her MD	5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X8) DATE

Electronically Signed | 05/02/2019

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDERISUPPUERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A BUILDING _____ B V\IING _____	04/08/2019

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OUR LADY OF THE VALLEY	**650 NORTH JEFFERSON STREET ROANOKE, VA 24016**

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F 684	Continued From page 1 survey sample, Resident# 14. The findings included: The facility staff failed to ensure that Resident # 14 was wearing physician ordered TED hose. Resident# 14 was an 86-year-old- female who was originally admitted to the facility on 9/20/18, with a readmission date of 3/26/19. Diagnoses Included but were not limited to, congestive heart failure, type 2 diabetes mellitus, major depressive disorder, and hyperlipidemia. The clinical record *for* Resident# 14 was reviewed on 417/19 at 2:55 pm. The most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/2/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident# 14 had a BIMS (brief interview for mental status) score of 1O out of 15, which indicated that Resident# 15's cognitive status was moderately impaired. The current plan of care for Resident # 14 was reviewed and revised on 4/5/19. The facility staff documented a focus area as, "Self care deficit related to muscle weakness from long standing chronic medical conditions. Requires total assistance with: None Requires extensive assistance with: bed mobility, transfers, dressing, toileting, and personal hygiene and locomotion. Requires limited assistance with: eating at times. Requires set up assistance with: eating is independent with eating requires hands on assistance with: bathing Required 2 (#) staff members to assist with transfers and bed mobility." Interventions included but were not	f 684	orders since 417/19 . The nurse who charted that the TEDS **were** applied on 4n/19 was counseled regarding charting accurately and application of special garments. Any residents with TED orders are at risk for having them not applied. A 100% audit of the residents MD orders will be conducted by the DON or designee in order to identify those residents who should have TED hose applied every AM. Staff **will be** inserviced on the importance of applying TED hose. The DON, or designee will check those residents having TED orders daily for 4 **weeks** and then spot check monthly for 3 months to make sure the TEDS were applied. If it is discovered that the ordered TEDS were not applied, the certified nursing assistant **assigned** to provide care for that resident **will receive** counseling. The findings of the TED audit will be discussed at the weekly risk meeting for 4 weeks. Any findings of the deficient practice will be addressed and revisions made with an action plan. The audit will also be reviewed by the quarterly QA Committee.	

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F 684	Continued From page 2	F684		

limited to, "TED hose on in am off in pm." Resident # 14 had current orders that included but were not limited to, "TED hose on in AM, off in PM," which was initiated by the physician on 3/26/19.

On 417/19 at 11:06 am, the surveyor was in Resident# 14's room conducting a Resident interview. The surveyor observed that Resident# 14 was fully dressed and wearing nonskid socks. The surveyor did not observe and TED hose in place on Resident# 14.

On 417/19 at 2:51 pm, the surveyor observed Resident #14 sitting in her room in wheelchair her wheelchair. The surveyor observed that Resident # 14 was wearing nonskid socks and no TED hose were in place.

On 417/19 at 3:05 pm, the surveyor spoke with LPN #1 (licensed practical nurse) regarding the TED hose for Resident #14. The surveyor and LPN reviewed the physician's orders for Resident # 14 and LPN# 1 agreed that Resident# 14 had an active order for TED hose to be placed on in the AM off in PM. The surveyor informed LPN #1 that Resident# 14 was not wearing TED hose on 417119 during observations. LPN # 1 along with the surveyor went into Resident# 14's room and observed that Resident # 14 was not wearing TED hose. LPN # 1 asked Resident# 14 where her TED hose were. Resident# 14 stated, "They are in the drawer." LPN# 1 asked Resident# 14 if she would like to put on her TED hose. Resident # 14 stated, "I don't see any point in putting them on, they haven't been on all day and I would be putting them on and have to take them right back off." The surveyor and LPN # 1 reviewed the treatment administration history for

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	495367	A. BUILDING _____ B/VING _____	04/0812019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	660 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CXSJ COMPLETION DATE
F 684	Continued From page 3 Resident # 14 and observed documentation that TED hose had been applied at 3:18 am in 4ll/19. On 4/8/19 at 3:24 pm, the administrator and director of nursing were made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 4/8/18.	F684		
F 690 SS:aD	j sowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F690		5/17/19

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F 690	Continued From page 4 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to provide services to prevent urinary tract infections for 1 of 19 Residents in the survey sample, Resident # 52. The findings included: The facility staff failed to ensure that Resident # 52 Foley catheter was secure with a leg strap. Resident# 52 was an 84-year-old-female who was originally admitted to the facility on 417/16, with a readmission date of 5/25117. Diagnoses included but **were** not limited to, obstructive and reflux uropathy, type 2 diabetes mellitus, dementia with behavioral disturbance, and hypertension. The most recent MOS (minimum data set) assessment for Resident # 52 was an annual assessment with an ARD (assessment reference date) of 3/16/19. Section C of the MOS assesses cognitive patterns. In Section C0SO0, the facility staff documented that Resident # 52 had a **BIMS** (brief interview for mental status) score of 5 out of 15, which indicated that Resident # 52's cognitive status was severely impaired. Section Hof the	F690	F690 A foley leg strap was procured for resident #52. The foley leg strap is changed twice weekly or as needed. Placement of the leg strap is verified every shift. The nurse responsible for applying a leg strap was counseled regarding following physician orders. Residents who have foley catheter orders are at risk for not having leg strap applied to secure foley tubing. A 100% audit of physician orders will be conducted by the DON or designee to identify those residents with orders for a foley catheter. Staff will be inserviced on the policy for care of a foley catheter including the use of a leg strap to prevent the increased risk of infection. The DON or designee will check daily for 4 weeks, then weekly for 2 months to make sure that a leg strap was applied for each resident having a foley catheter. The audit results will be reviewed at the weekly risk meeting. Deficient findings will	

STATEMENT OF DEFICIENCIES N«l PI.AN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____	( )DATE SURVEY COMPLETED
	495357	8WNG _____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
OUR LADY OF THE VALLEY	860 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 690	Continued From page 5 MDS assesses bowel and bladder. In Section H0100, the facility staff documented that Resident # 52 had an indwelling catheter. The current plan of care for Resident # 52 was reviewed and revised on 4/1/19. The facility staff documented a focus area for Resident # 52 as, "Resident # 52 is at risk for urinary tract infections due to chronic Foley cath use and disease process." Interventions included bit were not limited to, "Follow principles of infection control and universal precautions." Resident # 52 had current orders that included but was not limited to, "Check catheter strap placement q (every) shift." On 4/8/19 at 9:31 am, the surveyor was in Resident # 52's room conducting a Resident interview. During the interview, Resident showed the surveyor her Foley catheter. The surveyor observed that Resident # 52's catheter was not secured with a leg strap. On 4/8/19 at 10:06 am, the surveyor along with RN # 1 (registered nurse). The surveyor along with RN # 1 **observed** that Resident # 52's Foley catheter was not secured with a catheter strap. The surveyor asked RN # 1 if Resident # 52's Foley catheter should be secured with a strap. RN # 1 stated, "Yes she is supposed to have one on." On 4/8/19 at 3:26 pm, the administrator and director of nursing were made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit	F690	be **addressed** and an action plan initiated. The audit results wm be discussed at the quarterly QA meeting.	

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	495357	A BU LO NG _____ .B WNG_____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	**650 NORTH JEFFERSON STREET ROANOKE, VA 24016**

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F 690	Continued From page 6 conference on 4/8/19.	F690		
F 761 SS=O	Drugs and Biologicals } ; FR(s): 483.45(g)(h)(1)(2) §483.45(9) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have **access** to the **keys.** §483.45(h)(2) The facility must provide separately locked, permanently **affixed** compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to securely store medication in 1 of 2 medication rooms. On 4/07/19, when the surveyors arrived to the facility at 7:45 AM, the door to the medication room behind the nurse's station on Sullivan hall	F 761	F761 There have been no reports or sightings of the medication room door being left open, any of the medication or treatment carts left unlocked and unattended, or of the medication room refrigerator being left unlocked.	5/17/19

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	495357	A. BUILDING _____ B. WNO_____	04/08/2019

NAME OF PROVIDER OR SUPf't.IER	STREET ADDRESS. CffY, STATEZIP CODE
OUR LADY OF THE VALLEY	860 NORTH JEFFERSON STREET ROANOKE, VA 24D16

(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) COMPU:TION DATE
F 761	Continued From page 7 was open. The treatment cart was unlocked. No nursing staff were present in the room or at the nurse's station nearby. Two nurses were working medication carts in the hall and the nursing supervisor was in the dining room. The medication refrigerator was unlocked. There were no controlled substances in the refrigerator. None of the stored medications were expired. The door to the medication room was closed by 8:15 ***AM.*** The medication rooms were not observed open and unattended again during the SUNey. The director of nursing was notified of the concern during a discussion on 4/8/19 at approximately 3 PM. The director of nursing stated she would address the issue with nursing staff.	F 761	Any medication or treatment cart, medication room, and medication refrigerator are at risk for being left unsecured and unattended. Licensed nurses will be inserviced on the section #25 in the Medication Administration policy regarding keeping the refrigerator locked to prevent a medication security policy breach when controlled substances require refrigeration. The DON or designee will conduct a review of the Medication Administration Policy, item #19 which addresses keeping the medication and treatment carts locked when unattended. Staff will receive an inservice reminder to keep the medication room door locked when no licensed nurse is physically present in that room. The facility administrator and other administrative personnel will daily inspect the medication and treatment carts, the medication room door and the med room refrigerator to make sure they are all locked when unattended. The findings of the administrative rounds will be discussed in the weekly risk meeting. Any deficient practice will be addressed at the time of discovery with the employee responsible for the security breach and the progressive disciplinary process will be applied. The audit results **will be** discussed at the quarterly QA meeting.	

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NAME OF PRO'\IIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP COOE
OUR LADY OF THE VALLEY	**850 NORTH JEFFERSON STREET ROANOKE, VA 24016**

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F 812	Continued From page 8	F 812		
F 812 SS=F	Food Procuremen.tStore/Prepare/Serve-Sanitary CFR(s): **483.60(i)(1)(2)**	F 812		5117/19

§483.60{i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not predude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility policy review it was determined the kitchen staff failed prepare food in a clean and sanitary manner for facility residents.

Findings:

The facility kitchen staff failed to prepare foods in a clean and sanitary manner. The initial tour of the kitchen environment began 4n/19 at 8:00 AM. The surveyor entered the second floor dining room. A kitchenette at the rear of the dining section contained a steam table and refrigerator. A kitchen employee was stirring the breakfast foods on the steam table. None of the foods were

Food temps are being tested and logged at each meal by the dietary staff.
Frozen foods are being thawed according to the policy. the finding was corrected when the inspector noted the chicken being thawed. Raw chicken was thrown away and all three sinks were washed out.
Cooks have been educated and inserviced on policy and procedure.
Unsanitary environments can affect residents and employees if not appropriately maintained.

Any residents receiving meals being prepared at the facility are at risk with

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	860 NORTH JEFFERSON STREET ROANOKE, VA 24018

(JU)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 SE CROSSREFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION CATE
F 812	Continued From page 9 covered with lids or wrap of any sort. The surveyor asked to see the temperature log on the foods contained in the steam table. The employee did not understand what the surveyor was asking about When asked if she had obtained the temperatures on the food, the kitchen employee held up her hands and shook her head. She did not understand when the surveyor asked if she had a thermometer to take the food temperaUH'8S. At this point, another staff member called down to the kitchen to find someone to take the food temperatures of the steam table. Cook I appeared with alcohol swabs and a thermometer to take the temperatures of the foods ready to be served to the residents in the dining hall. The temperatures on the steam table were obtained. The hot cereal/grits were 130 degrees; scrambled eggs were 130 degrees; baked apples were 140 degrees. Cook I said the food had to be kept at 145 degrees on the steam table and removed alt the food and took it back downstairs to **the** kitchen to reheat. The surveyor accompanied Cook I and the food cart downstairs to the regular kitchen. Cook I said the server had removed the plastic covers from the foods after placing them on the steam table and that is why they had cooled down so much. Inside the kitchen the surveyor observed a three bay sink with two bays full of raw chicken in the bottom of the basins. Water was running from the faucets across the chicken and back washing onto the surface of the sink before returning to the sink or splashing onto the floor. The surface	F 812	health being compromised with a breach in policy. Staff personal drinks are not being stored in the food prep area. Staff has been educated and lnserviced on this issue. Food Service Director, or designee will monitor daily. Wet baking pans are not being nested and are placed in the appropriate area to dry. Food Service Director or designee will continue to monitor daily with kitchen rounds. The gas stove, kitchen floor, kitchen walls, and fire sprinkler above the stove have been cleaned Food Service Director or designee will monitor daily to keep burners clean and maintenance will conduct monthly checks on sprinklers. The sugar in the bin with trash on top and a liquid leaking into the bin was discarded. The bin was cleaned and refilled and was also relocated to another area in the kitchen to prevent debris near the sugar bin. Dietary staff will be inserviced on the Dietary Policy for sanitation, food storage, food delivery, and the kitchen area and equipment cleaning schedule. The Food Service Director, or designee will audit the food temp and the cleaning schedule logs daily. The Food Service Director, or designee will perform an inspection of the kitchen	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A BUILDING _____ B WING _____	04/08/2019

NAME OF PROVIDER OR SUPPI..IER	STREET ADDRESS, CITY, STATE. ZIP CODE
OUR LADY OF THE VALLEY	6110 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PfU:FIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE.TIOH OA1E
F 812	Continued From page 10 of the sink was observed to have food debris and used, unwashed dishes on the surface surrounding the basins. The back washing water was running through/around the dishes and back into the basin. The surveyor asked Cook I about the facility policy for thawing out frozen chicken. Cook I said she was supposed to put the chicken into buckets and place it into the sink to thaw with water running over it. Cook I pointed out the two buckets that were to be used in this process. They were stored on **a wire** rack in the kitchen. Cook I said she was going to throw the chicken in the trash, since she had not followed the appropriate procedure to place in containers to thaw it under running water In the sink. The facility administrator was entering the kitchen and informed of the findings prior to the surveyor leaving the area. She said she would oversee the chicken being thrown in the trash. Other areas of concern in the kitchen induded: 1. The staff use of styrofoam and refillable drink cups left in various areas of the food preparation area. Three white styrofoam cups with lids and one refillable mug-type cup were seen on the table tops in the food preparation area. They had staff names/initials on them. They were all moved back to one table in the rear of the kitchen. 2. 36 baking pans were observed nested on wire racks for storage. All the pans were observed to have moisture between them and had been nested prior to drying, trapping the moisture in side. 3. Baking pans stored under food preparation	F 812	area dally to ascertain that trash is stored in the proper receptacles, pans are not wet nested, and the food prep area is free of staffs personal items. Any deficient practice noted in these areas will be immediately corrected and the responsible employees wlll be counseled and disciplined. The dietary audit results will be discussed at the weekly risk meeting. Action plans wm be initiated or revised as needed. The results of the dietary audits will be discussed at the quarterly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496357	A BUILDING _____ B VIING _____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY STATE. ZIP CODE
OUR LADY OF THE VALLEY	HO NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 812	Continued From page 11 tables were observed to have built-up food debris on them. Cook I said they had already been washed, and she removed them to run them back through the dishwasher. 4. The six burner gas stove top was crusted with built-up/blackened food debris. The eyes of the burners contained trash and food debris. Cook I said she didn't know what the schedule was to clean it. 5. The fire sprinkler system had four faucets over the cook stove top. The ends of the faucets were caked with dust and smut-taggles. A large open pan was placed on the stove top directly underneath the sprinkler system with food boiling in the pot. 6. The sugar bin on the floor was observed to have trash and debris on the lid which fell onto the surface of the sugar when the lid was opened. The inside of the sugar bin had what appeared to be splash marks on it. (Drops of something yellow had run down the inside.) 7. The kitchen floor was slippery with grease. This was pervasive throughout the kitchen and accumulated beside stoves. sinks and under countertops. Built-up food debris was observed throughout the kitchen at the base of the walls. On 417/19 at 12:44 PM the OM (dietary manager) was interviewed. She was informed about the surveyor's findings. The OM said thawing the chicken in the sink was appropriate and they had measures in place to ensure the sink was sanitized prior to the procedure. The surveyor asked to the see the policy and procedure for the sanitation process and requested proof of inservices that the staff had been trained in the process. (The kitchen staff members spoke *very* little-to-no English and it could not be established what they actually understood by interviewing	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. W NG _____	04/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	**6110 NORTH JEFFERSON STREET ROANOKE, VA 24016**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCYMUST 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) COMPIETION DATE
F 812	Continued From page 12 them about the process.) The DM also told the surveyor the staff were not supposed to have their personal drinking cups in the food preparation area. They were provided with a table outside the food prep area for personal drinks and had to have their names and dates on them. The facility administrator provided a few pages of the facility dietary policy-which was computerized and over 200 pages long. On page 47 the policy referenced frozen foods being thawed under refrigeration or under cold running water. The policy did not reference the vessel the food should be contained in or the procedure for sanitizing the sink basins prior to water thawing food. There was no evidence presented that referred to any training the kitchen staff had to sanitize the basins and surround sink surface prior to placing food into it for thawing. No additional evidence was provided prior to the survey team exit.	F 812		

STATEMENT OF DEFICIENCIES N/0 PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IOENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A BUILDING _____ B . WNG_____	C 02/15/2018

NAME OF PROVDER OR SUPPLIER	STREET ADDRESS. CIIY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	HO NORTH JEFFERSON STREET ROANOKE, VA 24016

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/13/18 through 02/15118. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	EOO0		
F 000	**INITIAL COMMENTS** An unannounced Medicare/Medicaid standard survey was conducted on 2/13118 through 2/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 70 certified bed facility was 65 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.	F000		
F 580 SS=O	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.1O(gX14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there ls- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention: (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F580		3/30/18

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

Electronically Signed | 03/14/2018

Arly dellcieocy 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 dlsdouble 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 oorrection are disdosable 14 days following the **date** these documents **are** made available to the facility. If deficiencies are cited, an approved plan of corredion Is requisije to oontinued program participation.

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PRO\IIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3J DATE SURVEY COMPLETED
	495357	A . BUILDING _____ B WING _ _ __ _ _ _ _ _ _	C 02/15/2018

NAME Of PROVIOER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S Pl.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSs-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(I COMPLETION DATE
F 580	Continued From page 1 a need to discontinue an existing form of treatment due to **adverse** consequences, or to commence **a new** form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified In §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- **(A)** A change in room or roommate assignment as specified in §483.10(e)(6); or **(B)** A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(9)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to notify the physician and the Resident's responsible party (RP) of changes for 1 of 19 Resident's, Resident	F580	The filing of this plan of correction does not constitute an admission that deficiencies alleged did in fact exist. This plan of correction is filed as evidence	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. 'MNG_____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	**150 NORTH JEFFERSON STREET ROANOKE, VA 24016**

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 #266. The findings included: Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to anemia, syncope and collapse, thrombocytopenia, gastroesophageal reflux disease, history of urinary tract infection, and pain. There is no current MOS (minimum data set) due to Resident being a new admit. Resident is alert and oriented x 3. Resident #266's clinical record was reviewed on 02/13/18. It contained a physician's order summary for the month of February which read in part, "Xifaxan tablet; 550mg; amt: 1 tab; oral [DX (diagnosis): personal history of urinary (tract) infections] Twice a day: 08:00 AM, 04:00 PM". Resident #266's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part, "Xifaxan (rifaximin) tablet; 550 mg; Amount to administer: 1 tab; oral twice a day". The entry for 02/09/18 at 4pm was initialed, with parentheses around initials. A note in the comments section for 02/09/18 read in part "02/09/18 05:06 PM Not administered: Drug/Item unavailable". Surveyor spoke with DON on 02/15/18 at approximately 1500 regarding Resident #266 missing a dose of medication. Surveyor asked DON what should be done if a medication is not available and DON stated the nurse should make sure to reorder medication, notify the physician and Resident's RP, and make a progress note of	F580	of Our Lady of the Valley's desire to comply with the requirements of participation and to continue to provide high-quality resident care. 1. The attending MD & RP for resident #266 have been notified of missed dose of medication. 2. Those residents who have experienced a change in condition or a change in prescribed medication or treatment plan are at risk for facility failure to notify the attending MD and/or RP of that change. 3. Staff have been and will continue to be educated on need to notify both the resident r s attending MD and their RP of any changes in the resident J s condition, change in prescribed plan or care or treatment 4. The DON or designee **will review** the 24-hour report and EMAR daily to ensure licensed nurses have documented that the MD and RP were made aware of changes in the resident o s condition, prescribed plan of care of treatment. The QA Committee will review the findings of the DON or designee regarding compliance of the notification requirements. An amended plan will be initiated if the facility is found to be	

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	495357	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, $TATE, ZIP CODE
OUR LADY OF THE VALLEY	860 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	jX5) COM ION DATE
F 580	Continued From page 3 the same. The surveyor could not locate a note in the clinical record that indicated the physician or the Resident's RP had been notified of the missed dose of medication. The concern of not notifying the physician and Resident's RP of a missed dose of medication was discussed with the administration team during a meeting on 02/15/18 at approximately 1700. No further information was provided prior to exit.	F580	non-compliant with current plan.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	f 583		3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CUA 10£NTIFICATIONNUMBER;	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
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OUR LADY OF THE VALLEY	850 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 583	Continued From page 4 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain resident privacy concerning the care of 1 of 19 residents in the survey sample (Resident #49). The findings included: Resident #49 was readmitted to the facility on 5/9/16 with the following diagnoses of, but not limited to dementia, Parkinson's disease and depression. On the quarterly MOS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #49 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. On 2/14/18 at approximately 10:30 am, this surveyor went on to Unit 1 nursing station and saw the following note taped to the nurses' station for all staff to see which stated: "___ (name of Resident #49) must (with 2 lines underlying must) be assisted to bed every day after lunch & then helped up before dinner. Reposition her to make certain she is comfortable. No (with 2 lines	F583	1. The note regarding resident #49 which was posted at the nurses□ station was removed. 2. All residents residing in the facility are at risk of experiencing an invasion of their privacy. 3. Notes containing residentinformation or communication will not be posted in a public area unless requested by the resident or RP. Staff **will be** educated on maintaining privacy regarding requests and communications involving the care of a resident Nursing staff will conduct daily rounds to ensure resident info is not posted in public areas. Findings will be reported to the Administrator and/or DON who will initiate necessary counseling or disciplinary actions to ensure compliance. 4. The findings of the daily rounds will be reported to the QA Committee who will Initiate further counseling or disciplinary action if deemed necessary to ensure compliance.	

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F 583	I Continued From page 5 underlying no) exceptions. Thanks." RN #1 was asked by the surveyor who and why this put up here at the nurses' station was. RN #1 stated, "It was here when I came into work this morning. And I don't know why this is up unless her family came in and requested this to be done." The surveyor observed RN #1 removing this note from where it was hanging up in the nurses' station. The surveyor interviewed Resident#49 at 11 am. The surveyor asked the resident if she was sitting up more during the day. The resident stated, "I'm trying to because I believe that what the doctor wants me to do. I just don't know if I can." On 2/14/18 at 5:03 pm, the surveyor notified the administrative team of the above documented findings. The surveyor asked the administrative team what was the expectation of where the staff could put these requests or communications when it involved care of a resident. The administrator stated, "It could be found in the care plan of the resident." The surveyor asked the administrator if it was acceptable for staff to post these kinds of information or communication up in the nurses' station. The administrator stated, "No, it is not acceptable. It should be communicated in the resident's care plan." No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F583		
F 5841 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOERISUPPLIER/CLIA IOENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE **VALLEY**	**650 NORTH JEFFERSON STREET ROANOKE, VA 24016**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER"$ PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 584	Continued From page 6 The facility must provide- §483.10(i)(1) **A safe,** clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, family interview and staff interview, the facility failed to maintain a clean, comfortable, and homelike environment on one of	F584	1. The dining room window and carpet in room #408 were cleaned.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 7 two floors (floor 1). The findings included: The carpet in room 408 was observed to be stained by a red substance and a window in the dining room had a dried red substance on the bottom pane. During initial tour of the facility on 02/13/18, the surveyor **observed** a red stain on the carpet in room 408 this stain was observed to be present throughout the survey process. On 02/13/18 at approximately 1:40 p.m., a family member directed the surveyor to the dining room and stated there was a dried red substance on the lower window and it had been there for some time. Immediately after this conversation, the surveyor went to the first floor dining room and was able to observe several small areas of a dried red substance. The surveyor rechecked this window on 02/14/18 at 7:54 a.m. and again at 2:00 p.m. the dried substance was observed at both times. On 02/14/18 at approximately 2:13 p.m., the director of environmental **services** accompanied the surveyor to the dining area and room 408. After observing the areas, the director of environmental services stated maybe these areas were red jello. The administrative staff of the facility were made aware of the stain on the carpet and the dried red substance on the windowpane in the dining area on 02/14/18 at approximately 4:25 p.m.	F584	2. Residents residing in the facility are at risk of being exposed to an environment which falls short of providing a clean, comfortable and homelike environment. 3. Nursing or housekeeping staff will initiate immediate cleanup of spills. Spills which cannot be contained and cleaned properly by nursing staff **will be** reported to housekeeping staff who will perform proper sanitation of the area. Housekeeping department will conduct daily rounds on the nursing units to ensure clean and safe areas. 4. Daily round□s observations will be reported to the QA Committee who will review the information. Areas needing improvement in this plan will be amended to promote compliance.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
OUR LADY OF THE **VALLEY**	**650 NORTH JEFFERSON STREET ROANOKE, VA 24016**

(X4)IO PREFIX TAG	**SUMMARY** STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'SPLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CR05S-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	( ) COMPLETION DATE
F 584	Continued From page 8 No further information regarding this issue was provided to the survey team prior to the exit conference.	F584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b){2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure a current professional license was in good standing for 2 of 25 employees (Employee #7 and #16). The findings included: 1. The facility staff failed to ensure a current professional license was in good standing for Employee #7. This surveyor conducted an employee record review on 2/15/18 at 8:15 am. During this review, it was noted by the surveyor that Employee #7's CNA (Certified Nursrng Assistant) license had expired on 1/31118. There were no other records found in the employee file of a current professional CNA license for this employee.	F607	1. Both CNA licenses were verified as being active. 2. All professional facility staff, who by law are allowed to practice only with proof of certification or licensure, are at risk of allowing their certificate or licensure to expire. 3. Business Office Manager or Designee, will perform an initial 100% audit of all licenses and certifications. Once initial compliance has been established, all new employeeos certificates/licenses will be verified at tme of hire. A monthly report will be reviewed to identify any license/certificate which must be updated in the employee file to ensure regulatory	3/30/18

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATIONNUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET.ADDRESS CITY. STATEZIP CODE
OUR LADY OF THE VALLEY	150 NORIli JEFFERSON STREET ROANOKE, VA 24016

(X<4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY}	(X$) COMPLETION DATE
F 607	Continued From page 9 At 8:45 am. the surveyor notified the administrator of the above documented findings. The administrator stated, "I will go and talk to Human Resources and get back to you concerning this." The administrator returned to the surveyor at approximately 9 am. The administrator stated, "Here is a copy of the license that had expired on this employee." The administrator provided a copy of the current lookup for Employee #7's CNA license. **The** surveyor noted the following on the top of the page of the employee's license: "License Lookup Current as of 2/15/18 at 09:10 ..." The surveyor requested a copy of the facility's policy concerning current professional license of **aCNA.** The administrator provided the surveyor a copy of the facility's policy titled "Right to Dignity from Abuse Neglect and Exploitation" at 11 am. The surveyor noted under the section of "Resident Abuse and Neglect Prevention Program ...Screening ..." which stated, " ...1b. Licensed nurses' and certified nurses' aides must be listed on their respective Board of Nursing registry as having a current license in good standing ..." The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm. No further information was provided to the surveyor prior to the exit conference on 2/15/18. 2. The facility staff failed to ensure a current professional license was In current and in good standing for Employee #16.	F607	compliance. **4**. Compliance with these audits and their findings **will be** reported to QA Committee for their **review.**	

STATEMENT OF DEFICIENCIES AND **PLAN** OF CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A BUILDING _____ B.WNG_____	C **02/15/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
OUR LADY OF THE VALLEY	**650 NORTN JEFFERSON STREET ROANOKE, VA 24016**

(X4)1O 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)	(X51 COMPLETION DATE
F 607	1 Continued From page 10	F607		

This surveyor conducted an employee record review on 2/15/18 at 8:15 am. During this review, it was noted by the surveyor that Employee #16's CNA (Certified Nursing Assistant) license had expired on 1/31/18. There were no other records found in the employee file of a current professional CNA license for this employee.

At 8:45 am, the surveyor notified the administrator of the above documented findings. The administrator stated, "I will go and talk to Human Resources and get back to you concerning this."

The administrator returned to the surveyor at approximately 9 am. The administrator stated, "Here is a copy of the license that had expired on this employee." The administrator provided a copy of the current lookup for Employee #16's CNA license. The surveyor noted the following on the top of the page of the employee's license: "License Lookup Current as of 2/15/18 at 09:10 ..." The surveyor requested a copy of the facility's policy concerning current professional license of **aCNA.**

The administrator provided the surveyor a copy of the facility's policy titled "Right to Dignity from Abuse Neglect and Exploitation" at 11 am. The surveyor noted under the section of "Resident Abuse and Neglect Prevention Program ...Screening ..." which stated," ...1b. Licensed nurses' and certified nurses' aides must be listed on their respective Board of Nursing registry as having a current license in good standing ..."

The surveyor notified the administrative team of the above documented findings on 2/15/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 11 5:03pm. No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for one of 19 Residents, Resident #68. The findings included. For Resident #68, the MDS coordinator coded the Resident as being discharged to an acute hospital when in fact he had been discharged home. The record review revealed that Resident #68 had been admitted to the facility 12/05/17. Diagnoses included, but were not limited to, psychotic disorder and malnutrition. Section C (cognitive patterns) of the Residents admission MDS assessment with an ARD (assessment reference date) of 12/12/17 was coded to indicate the Resident had memory problems. The Resident had been discharged home on 12/23/17.	F641	1. The MDS for resident #68 was amended to provide accurate place of discharge. 2. All residents requiring MDS assessment are at risk for inaccurate coding. 3. The MDS assessment for residents who are discharged from the facility for the last six months were reviewed for accurate place of discharge. Any corrections needed to be made were corrected at that time. The MDS nurse will review MDS assessments of all residents being discharged for proper coding. Any errors found will be corrected at that time. 4. The MDS nurse will report audit findings to the QA committee.	3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
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()(4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY}	(X&) COMPU:TIO.. DATE
F641	Continued From page 12 The Residents discharge MOS assessment with an ARO of 12123/17 had been coded to indicate the Resident had been discharged to an acute hospital. The clinical record included a physician telephone order dated 12122/17 to "Discharge home with Daughter on 12123/17 at 1:00 pm." On 02/15/18 at 10:43 a.m., the surveyor reviewed the discharge MDS with the MOS coordinator. After reviewing the MDS, the MDS coordinator stated she had marked acute hospital in error and she would find out how to fix it. The administrative staff were notified of the inaccurate MDS assessment during a meeting with the survey team on 02/15/18 at approximately 5:00 p.m. Prior to the exit conference on 02115/18 the MOS coordinator provided the surveyor with a copy of a corrected **MDS** indicating the Resident had been discharged to the "col'Mlunity." No further information regarding this issue was provided to the survey team prior to the exit conference.	**F641**		
F655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(aX1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident	F655		**3/30/18**

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F 655	Continued From page 13 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a residenfs admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- **(A)** Initial goals based on admission orders. **(B)** Physician orders. **(C)** Dietary orders. **(D)** Therapy services. **(E)** Social services. **(F) PASARR** recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the residenfs admission. (ii) **Meets** the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident interview and clinical record review the facility staff failed to	F655	1. The baseline care plan for resident #266 was updated to reflect falls and the	

STATEMENT OF DEFICIENCIES ANO PI.AN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3J DATE SURVEY COMPLETED
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F 655	Continued From page 14 initiate a baseline care plan for 1 of 19 Residents, #266. The findings included: For Resident #266, the facility staff failed to initiate a baseline care plan for falls and risk of incontinence. Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to **anemia,** syncope and collapse, thrombocytopenia, **gastroesophageal** reflux disease, history of urinary tract infection, and pain. There is no current MOS (minimum data set) due to Resident being a new admit Resident is alert and oriented x 3. Surveyor spoke with Resident on 02/13/18 at approximately 1400. Resident stated that she had fallen at previous facility. Resident also stated that **she was** recently on contact precautions for urinary tract infection and was still taking an antibiotic. Resident #266's baseline care plan was reviewed on 02/15/18. Surveyor could not locate a care plan for falls or risk of incontinence. Surveyor spoke to the MOS coordinator on 02/15/18 at approximately 1335 regarding Resident #266's baseline care plan. MDS coordinatorstated that if Resident has had a recent fall, then a baseline care plan should have been initiated. MOS coordinator also stated that a baseline care plan for risk for incontinence should have been initiated due to urinary tract infection.	F655	risk of incontinence. 2. All residents who are admitted to the facility are at risk for not having their needs addressed on the baseline care plan. 3. Staff have been and will continue to be educated on timely completion of baseline care plan. The DON or designee will audit all new admission baseline care plans weekly to ensure baseline care plans are complete. 4. Baseline care plan audit findings will be reviewed in the quarterly QA committee.	

STATEMENT OF' DEFICIENCIES NIO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
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F 655 I	Continued From page 15 Resident #266's clinical record was reviewed and contained a progress note dated 02/12/18 1:49 PM which read in part "CNA was transferring Resident to toilet. When Resident legs gave away. Resident was lowered to floor. Denies any pain and discomfort at this time. Denies hitting head. Able to move all extremities x 4 well. MD and RP (responsible party) made aware". The concern of not having a complete baseline care plan was discussed with the aclrninistrative team during a meeting on 02/15/17 at approximately 1700. No further information was provided prior to exit.	F655		
F 657 1 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) **A** registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F657		3/30/18

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OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F6671	Continued From **page** 16	F657		

(F) Other appropriate staff or professionals in disciplinesas determined by the residenfs needs or as requested by the resident.
(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced **by:**
Based on staff interview and clinical record review, the facility staff failed to review and revise the person centered comprehensive care plan for 6 of 19 residents in the survey sample (Resident #46, #7, **#49**, **#6, #5,** #219).

The findings included:

1. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #46.

Resident #46 was admitted to the facility on 11/2/16 with the following diagnoses of, but not limited to anemia, heart failure and high blood pressure. On the quarterly MOS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/14/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing.

The surveyor conducted a review of Resident #46's clinical record on 2/14 and 2/15/18. During this review, it was noted by the surveyor that Resident #46 had a fall on 11f7/17. When the surveyor reviewed the care plan, the care plan did not reflect the fall that the resident had on

1. The care plans for residents #46, 7, 49, 6, 5 and 219 **were** revised to instruct staff on the new wound care ordef'S. falls, eye treatment orders, inappropriate behaviors and frequency of safety checks.

2. All residents who have new orders for falls, other unusual incidents, behaviors or any other changes In condition are at risk for not having their care plans updated.

3. The 11-7 charge nurse will review new orders for falls and other occurrences as listed on the 24 hour report to check for appropriate entries being entered on the individual care plan. Charge nurses will be educated on the timely documentation of care plan updates.

4. The results of the 11-7 audits will be reviewed and any necessary actions will be taken to ensure compliance. Findings will be reviewed in quarterly QA.

STATEMENT OF DEFICIENCES ANO Pl.AN Of CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION **NUMBER:**	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 6571	Continued From page 17 1117/17. On 2/15/18 at 5:03 pm, the su,veyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 2115/18. 2. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #7. Resident #7 was readmitted to the facility on 10/16/17 with the following diagnoses of, but not limited to heart failure, dementia, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data **Set)** with an ARD (Assessment Reference Date) of 11/13/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member for dressing and being totafly dependent on 1 staff member for bathing. The surveyor conducted a review of Resident #7's clinical record on 2/14 and 2115118. During this review, the surveyor noted that on 2/8/18 the physician had ordered the resident to receive an antibiotic twice a day for an Infection to the resident's left lower extremity. The surveyor also noted that on 2/8118, the physicianhas also ordered the wound to be cleansed daily with hibaclens cleanser. The surveyor also reviewed Resident #7's care plan. The surveyor noted that the residenfs care plan had not be updated to reflect the physician orders on 2/8/18.	F657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 18	F657		

The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm in the conference room.

No further information was provided to the surveyor prior to the exit conference on 2/15/18.

3. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #49.

Resident #49 was readmitted to the facility on 5/9/16 with the following diagnoses of, but not limited to dementia, Parkinson's disease and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #49 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing.

The surveyor conducted review of Resident #49's clinical record on 2/15/18. During this review, the surveyor noted that the physician ordered antibiotics to be placed in the resident's eyes three times a day for 14 days and the eyelids to be washed with baby shampoo at bedtime each night. The physician ordered these on 2/9/18. The surveyor reviewed the care plan for Resident #49. It was noted by the surveyor that the resident's care plan had not be updated to reflect the physician orders on 2/8/18.

The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm.

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OUR LADY OF THE VALLEY	860 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 657	Continued From page 19 No further information was provided to the surveyor prior to the exit conference on 2/15/18. 4. For Resident fl6 the facility staff failed to review and revise the care plan for falls to include recent falls. Resident fl6 was admitted to the facility on 05/15/13. Diagnoses included but not limited to depression, osteoporosis, rheumatoid arthritis, dementia, macular degeneration, gastroesophageal reflux disease, anemia, glaucoma and hypertension. The most recent MDS (minimi.m data set) with an ARD (assessment reference date) of 12/ 17 coded the Resident as 3 of 15 in section C, cognitive status. Resident's clinical record was reviewed and contained nurse's progress notes which read In part "02/09/18 02:56 AM Rsd (Resident) had a fall *02108* no injuries observed...", "02/04/18 10:28 **AM** Resident did have a fall today in her bathroom on the 7 to 3 shift, Resident was un-harmed....", "12125//17 03:50 **AM** Resident was sleeping in her bed, the CNA (certified nurses aid) heard thumping coming from her room and the bed alarm going off. V\Jhen the aide went to check on Resident, she found the Resident laying on the floor banging her hand on the floor to get help Resident stated that she rolled out of bed ...", and "12101/17 06:15 **PM** Resident found on floor by CNA, laying on back beside her bed....". Resident fl6's care plan was reviewed and contained a plan for falls, with multiple falls listed. The last fall listed on the care plan was on 12/01/17. The aforementioned falls were not	F657		

STATEMENT OF DEFICIENCIES N/0 PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVIEY COMPLETED
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F 657	Continued From page 20 included in the care plan. Surveyor spoke with the MDS coordinator on 02/15/18 at approximately 0910 regarding care plan for Resident *116.* MOS coordinator stated that care plans are reviewed and revised quarterly. Also stated that the nurses on the floor and the unit coordinators helped out with updating care plans. Surveyor asked if a Resident had a fall, how soon should it be put on the care plan, and MOS stated that she tries to put it on as soon as possible. Surveyor asked if a Resident had a fall in December, if it should be on care plan by now and she stated that it should. The concern of not reviewing and updated the care plan was discussed with the administrative team during a meeting on 02/15/18 at approximately 1700. No further information was provided prior to exit. 5.The facility staff falled to review and revise the comprehensive care plan for Resident #5 to reflect the resident removes her clothing in public. Resident #5, was admitted to the facility on 07/12/12, and readmitted on 12/2/13, with the following diagnoses: dementia with behaviors, high blood pressure, depression,angina pectoris, arthritis, and hypothyroidism Resident #S's most recent MOS (minimum data set) assessment completed on this resident was an annual assessment with an ARD (assessment reference date) of 11/09/17. Section C (cognitive patterns} of this assessment scored the resident to have both short and long-tern, memory problems. Section B coded Resident #5 to sometimes understand and to sometimes be	F657		

STATEMENT OF DEFICIENCIES ANO PLAN Of CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WNG _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 657	I Continued From page 21	F657		

understood. She was also coded requiring assistance of two persons for bed mobility, dressing, toileting, bathing, and hygiene.

02/13/18 11:45 AM Resident #5 was observed without her top in the dining room at lunch. The staff replaced it, CNA #1, told the surveyor "she removes her top when she gets hot."

The surveyor reviewed the comprehensive care plan on 2/13/18. The care plan revealed the resident incontinent and requires assistance with all activities of daily living. It also indicated she had behaviors of wandering. The care plan did not contain a information of the residents removing her own clothing in public.

The admmistrator and director of nursing were informed of the findings during a meeting with the survey team on 2/14/16 at 4:30 p.m.

Prior to exit updated care plan information was provided to the surveyor related to the resident removing her clothes.
6. For Resident #219, the facility staff failed to review and revise the Residents care plan to indicate the Resident was on 15-minute checks.

The record review revealed that Resident #219 had been admitted to the facility 02/09/18. Diagnoses included, but were not limited to, left partial infarct, acute renal failure, chronic pain syndrome, essential hypertension, and Alzheimer's disease.

There was no completed MDS (minimumdata **set}** assessment on this Resident. The Resident was alert and orientated to self. Numerous observations were made of the Resident during

STATEMENT OF DEFICIENCIES N/0 PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUM8ER:	(X2) MULTIPLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
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F 657	Continued From page 22 the survey process. The Resident would present as confused at times. Per the dinical record review, the Resident was placed on 15-minute checks on 02/11/18 after attempting to leave the facility. **A** review of the Residents baseline care plan revealed that the care plan had not been revised to include the 15-minute checks. On 02/15/18 at 1:50 p.m., during an **interview** with the DON (director of nursing), the DON vert>alized to the surveyor that she would expect to see the 15-minute checks on the care plan. The administrative staff were notified that the facility staff had failed to review and revise the Residents care plan in regards to 15-minute checks during a meeting with the survey team on 02/15/18 at approximately 5:00 p.m. Prior to the exit conference, the DON provided the surveyor with a copy of an updated care plan that included the 15-minute checks. No further information regarding this issue was provided to the survey team prior to the exit conference.	F657		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive	F740		3/30/18

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F 740	Continued From page 23 assessment and plan of care. Behavioral health encompasses a residenfs whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record **review,** the facility staff failed to provide the necessary behavioral health care and services to attain the highest practical of well-being for 1 of 19 residents in the survey sample (Resident #7). The findings included: Resident #7 was readmitted to the facility on 10/16/17 with the following diagnoses of, but not limited to heart failure, dementia, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (MinimumData Set) with an ARD (Assessment Reference Date) of 11/13/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 5 out of a possible score of 15. Resident #7 was also coded as requiring extensive assistance of 1 staff member for dressing and being totally dependent on 1 staff member for bathing. The surveyor reviewed the clinical record of Resident #7 on 2/15/18. During this **review,** the surveyor noted that on 9/27/17 documentation on the "Nursing Communication Form" notified the physician of Resident #7 exhibiting increased behaviors and anxiety at night. The physician ordered the resident to have medication changes to help in decreasing these behaViors and anxiety at night. The surveyor also noted on the physician order sheet during September 2017. the resident had an order for a "...psychiatric	F740	1. Resident #7 will be evaluated and assessed by behavioral health professionals on an as needed basis. 2. Those residents exhibiting behavior signs and symptoms are at risk of not being provided with timely behavioral health care services. 3. An audit will be preformed by the DON or Designee of each resident Js electronic physicianos orders to ensure that those residents who have orders to be evaluated by behavioral health professional have been seen. New telephone orders indicating the need for behavioral consults will be reviewed by 11 -7 charge nurse, who will assure that there is documented evidence that a behavioral health professional has been contacted to evaluate residents. 4. The results of the 11-7 shift telephone audits for new behavioral health referrals will be reviewedby the QA committee.	

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F 740	Continued From page 24 consult prn (as needed)". The surveyor noted a psychiatric consult that was dated for 11/14/17. On 2/15/18 at approximately 10:30 am, the surveyor notified the administrator of the above documented findings. The surveyor **asked** the administrator how soon a resident should be seen for a psychiatric consult once increased behaviors and anxiety has been seen in a resident with a diagnosis of psychotic disorder, anxiety disorder and dementia. The administrator stated, "The resident should be seen within a month." The surveyor pointed out to the administrator that Resident #7 had increased behaviors and anxiety noted by the staff in September, 2017 and the resident was not seen for a psychiatric consult until November, 2017. The administrator stated, "That resident should have been seen in October." The surveyor notified the administrative team of the above documented findings by the surveyor at 5:03 pm on 2/15/18. No further information was provided to the surveyor prior to the exit conference on 2/15/18.	F740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(bX1}-(3} §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70{9). The facility may pennit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/30/18

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F 755	\ Continued From page 25 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the acrurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45{b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure medications were available for administration for 1 of 16 Residents, Resident #266. The findings included: For Resident #266 the facility staff failed to ensure the medication Xifaxan was avaWable for administration. According to the Physician's Desk Reference, Xlfaxan is an antibiotic used to treat traveler's diarrhea due to non-invasive **strains** of E . coli, irritable bowel disease with diarrhea and to	F755	1. The Xifaxan for resident #266 has been administered since the date of the survey exit with no further documented entries of medication unavailable. 2. Residents receiving any type of medication or medicated treatment are at risk of missing a dose of prescribed medication or treatment. 3. 3. If a 4-day supply of pills or capsules are counted as remaining, the licensed nurses will re-order it from the pharmacy. If a medication is not available for administration, the charge nurse will	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTON	(X1) PRO\IIDER/SUPPI.IER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 26 reduce the risk of hepatic encephalopathy. Resident #266 was admitted to the facility staff on 02/06/18. Diagnoses included but not limited to anemia, syncope and collapse, thrombocytopenia, gastroesophageal reflux disease. history of urinary tract infection, and pain. There is no current MDS (minimum data set) due to Resident being a new admit. The Resident is alert and oriented x 3. Resident #266's clinical record was reviewed on 02/13/18. It contained a physician's order summary for the month of February which read in part, "Xifaxan tablet; 550mg; amt: 1 tab; oral [DX (diagnosis): personal hist()()' of urinary (tract) infections] Twice a day; 08:00 AM, 04:00 **PM".** Resident #266's **eMAR** (electronic medication administrationrecord) was reviewed and contained an entry which read in part, "Xifaxan (rifaximin) tablet; 550 mg; Amount to administer: 1 tab; oral twice a day". The entry for 02/09/18 at 4pm was initialed, with parentheses around initials. A note in the comments section for 02/09/18 read in part "02/09/18 05:06 PM Not administered: Drug/Item unavailable". Surveyor spoke with DON on 02/15/18 at approximately 1500 regarding Resident#266 missing a medication. Surveyor asked DON what should be done if a medication is not available and DON stated the nurse should make sure to reorder medication, notify the physician and Resident's RP, and make a progress note of the same.	F755	get the medication from the stat box or by stat delivery from the pharmacy. Licensed nurses will be in serviced on the medication reordering policy and procedure. The DON or Designee will audit 10% of the resident...s medications weekly to ensure that all medications are available for administration per MD orders. 4. The findings of medication availability audit will be reported to the QA committee and the pharmacy for any necessary interventions.	

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F755	Continued From page 27 Surveyor requested and was provided with a policy entitled "Administration of Medications" which read in part, "12. Medication fills and refills shall be timely to avoid missed dosages. Medications should be reordered according to the pharmacy procedures or electronic record vendor procedures. If a medication that is ordered does not arrive as scheduled, the Director of Nursing or designee shall be notified so that the pharmacy can be contacted via telephone for a stat deliver or follow electronic record for policy for checking status". The concern of the medication not being available was discussed with the administrative team during a meeting on 02/15/16 at approximately 1700. No further information was provided prior to exit.	f 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and pennit only authorized personnel to have access to the keys.	F761		3/30/18

STATEMENT OF DEFICIENCIES ANO PI.ANOF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COM?LETED
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F 761	Continued From page 28 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff Interview, and facility document review, the facility staff failed to ensure medications were stored securely on 1 of 2 units. The findings included: The surveyor observed one box of culturelle on top of the medication cart. Culturelle is a probiotic/dietary supplement. On 02/13/18 at 3:57 p.m., the surveyor entered the unit. Upon entering, the unit the surveyor observe LPN (licensed practical nurse) #4 at the medication cart. The surveyor informed LPN #4 that she would be observing her give medications. After the administration of medication to the second resident, the surveyor and LPN #4 both approached the medication cart. Upon reaching this cart, the surveyor was able to observe one box of culturelle. The surveyor asked LPN #4 if she had intended to leave this medication on top of the cart to which LPN #4 stated that she did not intend to leave the medication on top of her cart. The surveyor observed a Resident in the vicinity of the medication cart.	F 761	**1.** The LPN who left the Culturelle on top of the medication cart has been in **se,viced.** 2. Any medications received from the pharmacy could be improperly stored. 3. Administrativestaff will note any items stored on top of medication carts during their daily rounds. Licensed staff who are noted to be Improperly storing mediations on the medication carts will be in-serviced at the time of discovery. The medication will be immediately stored in its proper place. 4. Medication storage compliance will be **reviewed** with the members of the QA committee.	

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F 761	Continued From page 29 The administrative staff was notified of the unsecured medications during a meeting with the survey team on 02/14/18 at approximately 11:05 a.m.	F 761		
F 8681 SS=D	QM Committee CFR(s): 483.75(9)(1)(i)-{iii)(2)(i) §483.75(9) Quality assessment and assurance. §483.75(9)(1) A facility must maintain a quality assessment and assurance committee consisting at aminimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) **Meet** at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the medical director or their designee was present at the QA (quality assurance) meeting In January 2017. The findings included. The facility failed to ensure the medical director or their designee attended the QA meeting held 01/09/17 {1st quarter). This was the QA meeting held after the FOSS (federal overaight survey)	F868	1. The Medical Director has attended all QA meetings in the last six months. 2. The Quarterly QA Meetings cannot effectively identify and address issues when not represented by a physician. 3. The Medical Director was educated on the necessity of her presence at each QA Meeting. If she is unable to attend, she will appoint an appropriate representative.	3/8/18

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F 868	Continued From page 30 completed December 2016. On 02/15/18 at approximately 2:50 p.m., the surveyor requested of the administrator documentation that would indicate the medical director and/or designee was present at the quarterly QA meetings that had been held since the last survey (December 2016). The administrator provided the surveyor with documentation to indicate the medical director or their designee was present at all the QA meetings except the one held on 01/09/17. When asked about the missing signature the administrator verbalized to the surveyor that no physician was present at this meeting. No further information regarding this issue was provided to the survey team prior to the exit conference.	F868	4. The QA attendance sheet will be reviewed by the facility Administrator or Designee after each quarterly meeting.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(dX1)(2) §483.BO(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the Immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		3/30/18

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
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F 883	Continued From page 31 (iv)The residenfs medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization: and (B) That the resident either received the influenza immunization or did not **receive** the influenza immunization due to medical contraindicationsor refusal. §483.80(d){2) Pneumococcal **disease**. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the residenfs representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the residenthas already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization: and (iv)The resident's medical record includes documentation that indicates, at a minimum. the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization: and (B) That the resident either received the pneumococcal immunizationor did not receive the pneumococcal immunization due to medical contraindication or refusa.l This REQUIREMENT is not met as evidenced **by:**	F 883		

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(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)	(XS) COMPI..E OATE
F 883	Continued From page 32 **Based** on staff interview and clinical record review, the facility staff failed to obtain the Residents flu and pneumonia vaccine status for two of 19 Residents, Residents #217 and #218. The findings included. 1. For Resident #217, the facility staff failed to obtain the Residents flu and pneumonia vaccine status until asked by the surveyor. The record review revealed that Resident #217 had been admitted to the facility 12/20/17. Diagnoses included, but were not limited to, adult failure to thrive, malignant neoplasm, depressive disorder, gastro-esophageal reflux **disease,** and altered mental status. Section O (special treatments, procedures, and programs) of the Residents admission MOS (minimum data set) assessment with an ARD (assessment reference date) of 12127/17 had been coded "Not offered" for the influenza vaccine. For the questions "Is the resident's Pneumococcal vaccination up to date?" and "If Pneumococcal Vaccine not received. state reason." The facility staff had documented "Not assessed/no information." The facility policy/procedure titled "Immunization Influenza and Pneumococcal" read in part "...The influenza vaccine will be offered annually by the community (facility) during the influenza season, October through March...The Pneumococcal vaccines...will be offered on admission...The community will document the acceptance or refusal of immunization..." The interim DON was asked about the Residents	f 883	1. Resident #217has documentation signed by his responsible party which Indicates refusal of the flu vaccine. Resident#218 has documentation indicating that the resident had received both the flu and pneumonia vaccines during the fall of 2017. 2. Residents already residing in or newly admitted to the facility are at risk of not being provided the opportunity to receive the flu or pneumonia vaccine 3. The Admissions Nurse or designee will interview the residents or the residents responsible party to ask if and when the resident was offered the flu and/or pneumonia vaccines. The Admissions Nurse will document the acceptance or refusal of the vaccines. The DON or Designee will review all new admissions charts for the appropriate immunization documentation 4. The results of the audit will be presented to the QA committee. Additional interventions will be initiated if the audit indicates necessity.	

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. W NG _____	C 02/15/2018

NAM: *OF* PROVIDER OR SUPPLIER	STREET PDDRESS. CIIY. STATE ZIP COOE
OUR LADY OF THE **VALLEY**	**HO NORTH JEFFERSON STREET ROANOKE, VA 24016**

(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)	{XS) COMPLETION DATE
F 883	Continued From page 33 pneumonia/flu vaccine status on 02/13/18. The clinical record included the following nursing progress noted dated 02/13/18 at 6:06 p.m., "Called wife about PNE/Flu immunization. Declined but wanted me to speak to _ (Resident) to see if he agreed. Spoke with ____ (Resident) and he declined to be immunized. Consent form signed by this nurse documenting conversation with both _ (Resident) and (spouse)." During an interview with the interim, DON on 02/14/18 at 9:56 AM the interim DON verbalized to the surveyor that the facility did not know the Residents flu status until yesterday. On 02/15/18 at 1:20 p.m., the interim DON verbalized to the surveyor that the Resident's spouse came in last night and signed consent regarding flu/pneumonia vaccine and declined. The administrative team were notified of the issues regarding the Residents pneumonia/flu vaccine status during a meeting with the survey team on 02/14/18 at 4:25 p.m. and again on 02/15/18 at 5:00 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #218, the facility staff failed to obtain the Residents flu and pneumonia vaccine status until asked by the surveyor. The record review revealed that Resident #218 had been admitted to the facility 02/02/18. Diagnoses included, but were not limited to,	F883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ 8VI/ING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	HO NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'$ PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X51 COMPI.ETION CATE
F 883	Continued From page 34	F883		

essential hypertension, congestive heart failure, gastro-esophageal reflux disease, history of acute myocardial infarction, and anxiety disorder.

There was no completed MDS (minimum data set) assessment for this Resident.

The Residents clinical record included the following documentation dated 02/02/18 (admission date). "...Daughter unsure of flu and pne (pneumonia) vaccination history. VVill need to speak with son regarding history since he has been historic care giver."

The clinical record did not include any further documentation until the Residents flu/pneumonia status was questioned by the surveyor.

02/14/18 at 12:53 p.m., per an interview with the interim DON (director of nursing) in regards to the Resident's flu and pneumonia vaccine/status. The interim DON stated they (the facility) had checked with the Resident's previous facility and the Resident had not been vaccinated there.

On 02/14/18 the facility nursing staff documented "Call placed to POA (power of attorney) this morning to check if she has talked to her brother about immunization status of resident...Message left to call facility..."

The administrative staff were made aware of the concerns regarding the Residents pneumonia and flu vaccine status during a meeting with the survey team on 02/14/18 at 4:25 p.m.

The facility policy/procedure titled "Immunization Influenza and Pneumococcal" read in part "...The influenza vaccine **will be** offered annually by the

STATEMENT OF DEFICIENCIES *NID* PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A BUILDING _____ B VIING _____	C 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	HO NORTH JEFFERSON STREET ROANOKE, VA 24016

(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)	(XS) COMPLETION OAT!:
F 883	Continued From page 35 community (facility) during the influenza season, October through March...The Pneumococcal vaccines...will be offered on admission...The community will document the acceptance or refusal of immunization...• On 02/15/18, the nursing staff documented "PT (physical therapist) to nursing station with message that POA was transferred to their department instead of nursing. Message given this nurse that POA had stated that resident received both PNE/FLU vaccine this fall..." No further infonnation regarding this issue was provided to the survey team prior to the exit conference.	F883		

STATEMENT OF DEFICIENCIES ANO Pt.AN OF CORRECTION	[X1) PROVIOER/SUPPLIER/Cl.IA IO!!NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	[X3) D,\TE SURVEY COMPIETEO
	,95'57	A. BUILDING 02 • MAIN BUILDING 02 8. WING	R 04/Q2/2018

NAMEOFPROVIOERORSUPPUER	STREET ADDRESS, CITY, ST,\TE. ZIP CODE
OUR UOY OF THE VALLEY	150 NORTH JEFFERSON STRIE!IE!T ROANOKE, VA 24016

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICll!NCI!S (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PL.AM OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS EFEFIENCED TO THE APMOPI\IATE DEFICl!iNCYJ	(X5J COMI'I.ETION DATE
{K 000}	INITIAL COMMENTS Description or Structure: This is a 1 story structure, with a partial basement, masonry ex1erior walls, concrete slab floors on steel bar Joist The roof Is constructed with fire rated wood framing. ConstrucUon Type: 11(111) Sprinkler status: Fully Sprinklered An unannounced LSC revisit to the standard survey conducted on 3/15/2018 was conducted on 04/02/2018 In accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care FaclllUes. The facility was surveyed for compHance using the LSC 2012 (Existing) regulations. The facility was in compliance with the Requirements for Participation Medicare and **Medicaid.** Corrected deficiencies are identified on the CMS-25678.	{K 000}		

LABOAATORY DIRECTOR'S OR PRO\IIOER/SUPPl.11:RREPAESENTATIVE'S SIGNATURE | TITLE | ()(SJ DATE

Any deficiency gtatement ending wilh 1111 asterlsll (") d•noles a d ency whleh the institution may be excu.ed from correcting p,ovidlng it Is delarrnlned that Olller safeguards p,ovid• tidicienl pro«ectiotl to **the** palien ta. (See lnatruelions.J Ellcept for nurting homes, the flnd'ings staled abovv are dlscloseble 90 days fo!IQwlng the *date* or **suvey wtletha'** °' not **a pi.n** *ol* convc:tioo l1 provided. For nursing homes, Ille **above** findings and plant of co,reclion ara dls<:losabla 14 days folowlng the dale 1hes• Oocumanla **are made 1valable** lo Iha fU!Uty. If deflcienclJn .. died, **an approved** plan of correction Is requlsle IO conl#IUlld prvglllm participation.

STATEMENT OF DEFICIENCIES ANO PL.4N OI CORRECTION	(X1) PROVIOER/SIJPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
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NAME OF PROVIOER OR SUPPLIER	STREET ADOAESS. CI'TY. STA.TI!, ZIP COOE
OUR LADY OF THE VALLEY	&SO NORTH JEFFERSON STREET ROANOKE, VA 2,016

(X4)1D PREFIX TAG	SUMMARY STATI:MENT OF DEFICIENCIES {EA.CH DEFICIENCY MUST 8E PRECEDED BY FUU REGUIATORY OR LSC IDENTIFYING INFORMATIONI	ID PREFIX TAG	PROVIDER'S PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS•REFERENCEO TO THE APPROPRIATE OEFICIENCY)	I)(S) COMPL!TIOH DAll!i
{K 000}	INITIAL COMMENTS The Rehabi61ation Room is a wing to the buUdlng **accessed** from a doorway on the ground floor corridor. Conslruction Type: 11(111) Sprinkler status: Fully Sprinklered An unannounced LSC revisit to the standard suivey conducted on 3/15/2018 was conducted on 04/02/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requiremenls for Long Term Care Facilities The facility was surveyed for compliance using the LSC 2012 (Existing) regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are Idenlified on the CMS.25678.	{K 000}		

LABORATORY DIRECTOR"S OR PROVIOERISUPI'LIER REPRESENTATIVE'SSIGNATURE | TITLE | ()(&)DATE

Any denciency 1tatament ending wilh an astensk ("I denotes a deficiency which the insUtulion mey be excused from (lOrrec;ting p1ovlding II ie detel'!Tlitled lhat oltlel 1aleguards proYlde sufficient protection to the tients . (See Instrucl!oos.) Except for ninInll homes. It!• find!ngs staled aboYe **are** disclosable 80 days following lhe dale of swvey whelher or not a plan of COfF&Cllon Is pr011lded. For nursing homes, **hi above** findings and plans of (lOlfection are disdosable 14 days following lhe dale IIMHie doclnlanb ere made available to Ille faelity. II deficiencies are died, an approved plan *ot* corradlon Is requisite to contloued pr011ram pa rticipallon.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZI' CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE. VA 24016

(X4)10 PREFIX TAQ	SUMMARY STATEMENT OF OEFICIENQES EACH DEFICIENCY MUST BE PRECEDED fJY FULL REGULA.TOI OR LSC IDENTIFYING **INFORMATION)**	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUI.O BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XSI COMPI.ETION DAY£
K 000I	INtTIAL COMMENTS Surveyor: 34730 Description of Structure: This is a 3 story structure with masonry exterior walls, concrete slab floors on steel bar joist. The nursing unit is on the 1 st floor and is separated from the remainder of the building both horizontally and vertically by a 2 hour rated fire barrier. The 2 hour vertical separation is achieved using a rated drop-In ceilng tile assembly and poured In place concrete floor. Construclion Type: 11(111) Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 03/15/2018 in accordance with 42 Code of Federal Regu1alion, Part 483: Requirements for Long Term Care Facifities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Tille 42 Code of Regulations. 483.70(a) et seq (Life Safety from Fire.)	KOO0		
K 353 SS-F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System • Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard tor the Inspection, Testing, and Maintaining of **Water-based** Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure locatlon and readUy	K 353	11.Backftow testing has been scheduled and will be conducted on going as needed. 2.No other area identified 3.MaIntenance Director/OesIgnee will continue providing required testing to ensure compliance. 4. Maintenance Director/Oesignee will review testing of backflow to ensure compliance.	3/29/18

LABORATORY DIRECTOR'S **OR PROVIDER/SUPPLIER** REPRESENT"-TIVE'S SIGNATURE | TITLE | (X6) DATE

Dr. Ryan Hess | Administrator | 3/28/18

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE MEDICAID SERVICES

Printed: 03/19/2018
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STATEMENT OF DEFICIENCIES AND Pl.AH Of CORRECTION	IXl) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILOING 01 • MAIN BUILOINO 01 B. WING	03/15/2018

NAME OF PROVIOER OA SUPPLIER	STREET ADORESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(X4I 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL AEOULATOR't OR LSC IDENTIFYING INI'ORMAI ION)	10 PREFIX TAG	PfIOVIDER'S Pl.AN Of CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XSJ COMI'\ETION OATi
K 353	Continued From page 1 avallable. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Pfovide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. **9.7.5,** 9.7.7, **9.7.8,** and **NFPA25** This REQUIREMENT is not met **as evidenced** by: Survey01: 34730 Based on observation and Inspection the facility failed to maintain the sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 3-15·18 al approximately 9:45 AM it was observed through ob&ervation and inspection during the records review that documentation could not be provided to show when the last backflow inspec1ion was conducted. The Facility Administrator and Maintenance Director wltnessed this **evidence** by interview and observation.	K353		
K 911 SS..O	Electrical Systems • Other CFR(s): NFPA 101 Electrical Systems • Other list in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed l:>y the provided K-Tags, but are deficient. This Information, along with the applicable Llie Salety Code or NFPA standard citation, should be lncklcled on Form CMS-2567. Chapter 6 (NFPA 99)	K 911		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDI:A/SUPPLIERICUA IOENTIFICATION NUMBER:	(X2) MUI.TIPLE CONSTRUCTION	[X31 DATE SURVEY COMPLETED
	495357	A. BUILOING 01 • MAIN BUILDING 01 IB,WING	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZP COOE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24018

(X4ll0 PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED ev FULL REGUI.ATORY OR LSC IOENTIFVNG INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY}	(XS) COMPLETION DATE
K911	Continued From page 2 This REQUIREMENT Is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the electrical system. This has the ability to affect occupants of a single smoke compartment. Findings include: On 3-15-18 at approxlmateJy 11:09 AM It was observed through observation and inspection one power strip is plugged into another power slrip In the CHC electrical Maintenance Room. The Facility Administrator and Maintenance Director witnessed this evidence by lnlerview and observation.	K 911	1.The power strip In CHC Mechanical room was removed on survey date. 2.Room inspections were conducted bJ maintenance staff for compliance of no other inappropriate **power** strips being utilized. **3.** Maintenance Dlrector/Designee will conduct monthly inspections for inappropriate power strip **usage.** 4. Maintenance Director/Deslgnee wilt review on an on-going **basis** to ensure compliance.	3/27/18
K 9181 SS=F	Electrical Systems• Essential Electric Syste CFR(s): NFPA 101 Electrical Systems • Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion ts *not* met during the monthly test, a process shall be provided to annually confirm this capablllty for the life safety and critical branches. Maintenance and testing of the generator end transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year In 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include acomplete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and lasting of	K 918 I	1.The main and feeder circuit breakers exercising test has been conducted. 2.No other areas identified. 3. Maintenance Director/Deslgnee will ensure that circuit breaker exercising Is conducted as state manufacture requirements. 4. Maintenance Director/Oesignee will review circuit breaker exercising to ensure compliance.	3/23/18

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(XI) PROVIDEAISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X21MULTIPLE CONSTRUCTION	;IX3I DATE SURVEY COMPLETED
	495357	A. BUILDING 01 • **MAIN** BUILDING 01 B. WING _____	**03/15/2018**

NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOe
OUR LADY OF THE VALLEY	**650 NORTH JEFFERSON STREET ROANOKE, YA 24016**

(X4)1D PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMArl]	10 PREFIX TAO	PROVIOEFrS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUI.O BE CAOSS•RE FERENCEO TO THE APPROPRIATE OEFICIENCVJ	[I(St COMPLEIION DATE
K 918	Continued From page 3 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers ere Inspected annually, and a program for periodically exercising the components ls establlshed according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily Identifiable, and separate from normal power circuits. Minimizing the possibilily of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700,10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observalion and inspection the tacility **!ailed** to maintain the generator system. This hes lhe ability to affect all occupants ot the building. Findings include: On 3-15-18 at approximately 10:15 AM it was observed through observation and inspection during the records review that documentation could not be provided to show that a program for periodically exercising the main and feeder circuit breakers is established according to manufacturer requirements. The Facility Administrator and Maintenance Director witnessed this evidence by interview and observation.	K918		

OUR LADY OF 1HE VALLEY

ROANOKE. VA

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Administrator 3/28/18

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other salagua,ds provide sufficient protection to Iha patients. (See lnatnJClions.} Except lor nursi"ll homes, Ihi, findings staled above are disclosable 90 deip following Iha dale ol survey whether or nol a plari ol correci10ri 111 provided. For nurlin9 homes. the above flndl119s and plans of correction are disclosable 14 days following Iha dale theae documents are made 11.vailabla to the laclly. Il deficiencies are died, an approved plan ol correclion is requlsiu, to continued pro.9.ram pal1iclpatlon.

Printed: 03/19/2018
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAIO_S_ERVICES

STATEMENT OF DEFICIENCIES ANO *PLAN* OF CORRECTIOM	(X1) PROVIDERISIJPPIIEA/CLIA IDENTIFICATIONNUMBER:	(X'21 MULTIPLE CONSTRUCTION	(X3J OATE SUFM:V COMPLETEO
	495357	A. SUILOING **03- REHABILITAIDN GYM** 9. WING _____	**03/15/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
OUA LADY OF THE VALLEY	**650 NORTH JEFFERSON STREET ROANOKE, VA 24D1&**

(X.fJ ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES "EACH DEFICIENCY MUST BE PRECEDED 8Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUID BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) C I'U:TION DATE
K 3531	Continued From **page** 1 Provide In REMARKS Information on **coverage** for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA25 This REQUIREMENT is not met **as evidenced** by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the sprinkler system. This has the abifity to affect all occupants of the building. Findings include: On 3-15-18 at approximately 9:45 AM it was observed through observation and inspection during the records **review** that documentation could not be provided to show when the last backflow Inspection was conducted. The Facility Administrator and Maintenance Director **witnessed** this evidence by Interview and observation.	K353	1. Bacidlow testing has been scheduled and will be conducted on going as needed. 2. No other **area** Identified 3. Maintenance Director/Designee will continue providing required testing to ensure compliance. 4. Maintenance Director/Deslgnee will review testing of backflow to ensure compliance.	3/29/18
K 9181 SS-F	Electrical **Systems** • Essential Electric Syste CFA(s): NFPA 101 Electrical Systems • EssentialElectric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 1O seconds. If the 1a-second criterion is not met during the monthly test, a process shall be provided to annually conllrm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance wtth NFPA 11O. Generator sets are inspected weekly, exercised under load 30 minutes 12 limes a year in 20·40 day ervals, and exercised once every 36	K918	1. The main and feeder circuit breakers exercising has been conducted. 2. No other areas identified. 3. Maintenance Oirector/Oeslgnee will ensure that circuit breaker exercislng Is conducted as state manufacture requirements. 4. Maintenance Director/Designee will review circuit breaker exercising to ensure compliance.	3/23/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT Of DEFICIENCIES AND PI.AN OF CORAECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CX2I MULTIPLE CONSTRUCTION	IX31 OATE SURVEY COMPLETED
	485357	A. BUI.OING 02 • MAIN BUILDING 02 B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLER	STREET ADOAESS. CITV, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATE"-'ENT OF DEFICIENCIES EA DEFICIENCY MUST BE PRECEDED av FULL REGULATOR OR LSC IOENTIFY'ING INFOFIMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION !EACH CORAECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IXSJ COMPIETION DATE
K 000l	**INITIAL** COMMENTS Surveyor: 34730 Description ol Structure: This is a 1 story structure, with a partial basement, masonry exterior walls, concrete slab floors on steel bar joist. The roof Is constructed with fire rated wood framing. Construction Type: 11(111) Sprinkler status: FuDy Sprinklered An unannounced recertification Life Safety Code survey was conducted 03/15/2018 In accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Faclitles. The facllity was surveyed for compliance using the LSC 2012 Existing regulations. The facllitywas not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Tide 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	KOOO	,	
K 1611 SS-F	Building Construction Type and Height CFR(s): NFPA 101 Bu ding Construction **Type and** Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1,6.4, 19.t**.6.5** Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered	K 161	1.The unprotected penetration in drywall ceiling assembly was filled with appropriate fire caulking. 2.No other **areas** Identified. 3.Malntenance Director/Designee will conduct **weekly** ,ounds to ensure there are no other unprotected drywall penetrations. 4.Malntenanee Olrector/Designee will review on an on-going basl& to ensure compliance.	3127/1

LABORATORY DIReCTOR'S OR PROVIDEMUPPLIER RfiPAESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3/28/18

Any dellci11ncy 11atamen1-elndng YAlh an aaleriil (') **dellbta** a dellclency which the inatllulion may be excUHd lrom correcting providing ii la delermlned lhat ott,111 saleguerda provide sufficient protection 10 Iha padenlll. (Sn In1tn.1cllone.) Eiu:epl for nursing homaa, the Dndlng, alalad above are dlscfosable 90 day, fallowlng the dale ol survey whlthe, or nol a plan *ot* correction la prOYldecl. For nur1in9 hom111, the above ftndlngs and plana ot cOl'recll0t1 are dlaclolabla I 4 days foRowing the dale these documenta are made available to the cility, II defictencles are cited, an apprCMld plan ol correction is requisite 10 continued pr;ogram panlclpatlan.

ITATEMENT Of DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEAISUPPLIEAICIIA IDENTIl'ICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	[X:J) DATE SURVEY COMPLETED
	495357	A. BUILOINO OS - AEHASILITAION OYN e. WING	03/1S/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, 2P CODE
OUR LADY OF THE VALLEY	650 HORTH JEFFERSON STREET ROANOKE, VA 24016 ,XS,

(X4) 10 PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST ee PRECEDED ev FUll REGULATOm 00 LSC I0ENTIFYIN13 INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ee CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COt,IPLEllON 01\TE
K 91Bl	Continued From page 2 months for 4 continuous hours. Scheduled test under load conditions include a comple1e simulated cold start and automatic or manual transfer of aU EES loads, and are conducted by competent personnel. Malntenance and testing of stored energy power sources (Type 3 EES} are in accordance wilh NFPA 111. Main and feeder circuit breakers are fnspec1ed annuany, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and tes1ing are maintained and readily available. EES electrical panels and circuits are **marked,** readily identifiable, and separate from normal power circuits. Minimizing the possibili1y of **damage** of the emergency power source is a design considerallon for new instaUations. 6.4.4, 6.5.4, **6.6.4** (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the faclli1Y failed to maintain the generator system. This has the ability to affect all occupants of the building. Findings Include: On 3-15-18 at approximately 10.15 AM it was observed through observation and inspection during the records **review** that documenlation could not be provided *to* show that a program for periodically exercising the main and feeder circuit breakers is established accordlng to manufacturer requirements. The FaclHty Administrator and Maintenance Director **witnessed** this **evidence** by interview and observation.	K918		

STATEMENT OF OEFICISNCIES ANO pt.AN OF CORRECTION	XI) PROVIOERISuPPLIERICIIA IDEHTFICATION NUMBER:	IX2J MULTfILE CONSTRUCTION	IX3J DATE SURVEY COMPLETED
	495357	A. BUILDING 02 • MAIN BUILDING 02 B. WING	03/15/2018

NAME OF PROVIDER OR SUPPLER	STREET AOOAESS, CITY, STATE. ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

[X4J to PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FIR.L REGULATOR'\' OR LSC IOENTIFYIHG INFORMATION)	ID PREFIX TAG	PROVIOEA'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5l COMPLETION CATE
K 161	Continued From page 2 FACP Room. The Facility Administrator and Maintenance Director witnessed this **evidence** by Interview and ob$ervatlon.	K 161		
K 353 SSsF	Sprinkler System· Maintenance and Testing CFA(s): NFPA 101 Sprinkler System • Maintenance and Testing Automatic sprinkler and standpipe systems are Inspected, tested, and maintained In accordance with NFPA 25, Standard lor the Inspection, Testing, and Maintaining or Water-based Fue Protection Systems. Records of system design, maintenance, inspection and testing are maintained In a secure location and readUy available. a) Date sprinkler system last checked b) Who provided system test c) Waler system supply source Provide In REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7,7, 9.7.8, and NFPA 25 This REQUIREMENT is not met **as evidenced** by: Surveyor: 34730 Based on obsenialion and inspection the facility failed to maintain the sprinkler system. This has the ability to affect al occupants of the bulldlng. Findings Include: On 3·15-18 at approximately 9:45 AM It **was** observed through observation and inspection during the records review that documentation could not be provided to show when the last	K 353	1. Backftow testing has been scheduled and will be conducted on **going as** needed. 2. No other **area** identified 3. Maintenance Director/Oesignee will continue providing required testing to ensure compliance. 4. Maintenance Oirector/Deslgnee will review testing of backflow to ensure compliance.	3/29/18

Prlnled: 03/19/2018
FORM APPROVED
OM 938·0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID S E AVICES

STATEMENT OF OeFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERISUPPUERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	IX3) DATE SURVEY COMPLETED
	495357	A. BUil.DiNG 02 • MAIN BUILDING 02 8.WING _____	03/15/201B

NAME OF PROVIOER 0A SuPPI.IER	STREET AOORESS, CITY, STATE, Zif> CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 2401&

(X4)I0 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE !>RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PFIOVIOER'S PLAN OF CORRECTION (EACH CORAECTIVE ACTION SHOULD BE CAOSS·REFERENCEDTO THE APPROPRIATE DEFICIENCY)	(JISJ COMPLETKIH OA.TE
K 161	Continued From page 1 2 11(111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not aHowed non-sprinklered 4 Ill (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 Ill (200) Not aaowed non-sprlnklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories musl be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, Including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small noor plan of the building as appropriate. This REQUIREMENT is not met as evidenced **by:** Surveyor: 34730 Based on observation and inspection the ladity failed to maintain building construction. This has the ability lo affect all occupants or the building. Findings include: On 3-15-18 at approximately 11:21 AM it was observed through observation and inspection that lhere is a unprotected through penetralton to the drywal celling assembly In the SuHivan Center	K 161		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	•)(1) PROVIDEFIISUPPLIERICLIA tOENTIFJCATION NUMBER ;	[I<2) M\JLTPIE CONSTRUCTION	[X3) DATE SURVEY COMPLETED
	495357	A. BUii.DiNG 02 • MAIN BUILDING 02 B. WING	**03/1512018**

NAME OF PROVIDER OR SUPPLIEA	STREET ADDRESS, CITY, STATE, ZIP COOE
OUR LADY OF THE VALLEV	**650 NORTH JEFFERSON STREET ROANOKE, VA 24016**

[X4)1D PREFIX TAG	**SI.MMARY** STATEMENT OF DEFICIENCIES [[EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATOAV OR LSC IDENTIFYING **INFORMATION)**	**D** PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CAOSS·REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION [)Alli.
K 353	Continued From page 3 **bacldlow** Inspection we& conducted. The Facility Administrator and Maintenance Director witnessed this evidence by Interview and observation.	K 353		
K 9181 ss-F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The **generator** or other alternate power source and **associated** equipment is capable of supplying service within 10 seconds. It the 10-second criterion ts not met during the monthly tesl, **a** process shall be provided lo annuaUy confirm this capablfily fOf the life safety and critical branches. Maintenance and testing ot the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are Inspected **weekly,** exercised under load 30 minutes 12 times a year in 20-40 day Intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of atl EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy powet sources (Type 3 EES) are In accordance wilh NFPA 111. Main and feeder circuit breakers are Inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Wrlnen records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identlnable, and separate from normal power circuits. Minimizing the possibility of darnage of the emergency power source is a design consideration for new installations.	K 9181	1.The main and feeder circuit breakers exercising was has been conducted 2.No other areas identified. 3. Maintenance DIrector/Detignee will ensure that circuit breaker exercising is conducted aa state manufacture requirements. 4. Maintenance Director/Oeslgnee will review circuit breaker exercising to ensure comptisnce.	3/23/18

DEPARTMENT OF HEALTH ANO HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/19/2018
FORM APPROVED
0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	l(XIJ PROVIOERISUPPLIERICLIA OENTIFICATION NUMBER:	IX2} MULTIPLE CONSTRUCTION	(1(3) DATE SUAVEY COMPLETED
	495357	A. BUILOING 02 • MAIN BUILDING 02 B.WNG _____	03/15/2018

NAME OF PROVIDER 00 SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADV OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

[X) 10 PREFIX TAG	SUMMARY STATEMENT Of DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAO	PROVIDER'S PLAN OF CORRECTION jEACH COARECTIVE ACTION SHOULD 8E CROSS·REFERENCEO TO THE APPROPRIATE DEFICIENCY)	[)(5) COMPLETION o...re
K 91B	Continued From page 4 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT Is not met as evidenced by: Surveyor: 34730 Based on obseJVation and inspection the facility failed to maintain the generator system. This has the ability to affect all occupants of the building. Findings include: On 3·15-18 at approximately 10:15 AM it was observed through observation and Inspection during the records review that documentation could not be provided to show that a program for periodically exercising the main and **feeder** circuit breakers is established according to manufacturer requirements. The Facility Administrator and Maintenance Director witnessed this evidence by inlervlew and observation.	K 918		

State of Vimi11ia

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0183	A. BUILDING _____ B. IMNG _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATEZIP COOE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 2-'016

PREFIX (X-4) ID TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX ID TAG	(EACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPII!TE (XS) DATE
F	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted on 2/13/18 through 2/15/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.

The census in this 70 certified bed facility was 65 at the time of the survey. The survey sample consisted of 16 current Resident reviews and 3 closed record reviews.

F 001! Non Compliance	F 001		3/30/18

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
The licesnure deficiencies are as followed:

12 VAC 5-371-220 (H). Nursing services. Cross reference to F580
12 VAC 5-371-370 (G). Maintenance and housekeeping. Cross reference to F584
12 VAC 5-371-140 (E). Policies and procedures. Cross reference to F607.
12 VAC 5-371-250. Resident assessment and care planning. Cross reference to F641.
12 VAC 5-371-250. Resident assessment and care planning. Cross reference to F655.
12 VAC 5-371-250. Resident assessment and care planning. Cross reference to F657.
12 VAC 5-371-250. Resident assessment and care planning. Cross reference to F740.
12 VAC 5-371-300. Pharmaceutical services. Cross reference to F755.

The filing of this plan of correction does not constitute an admission that deficiencies alleged did in fact exist. This plan of correction is filed as evidence of Our Lady of the Valley's desire to comply with the requirements of participation and to continue to provide high-quality resident care.

12 VAC 5-371-220 (H). Cross reference to F580:
1. The attending MD & RP for resident #266 have been notified of missed dose of medication.

2. Those residents who have experienced

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X610ATE

Electronically Signed — 03/14/18

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PRO DER/SUPPUER/CUA IDENTIFICATION NUM8ER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	VA0183	A. BUL D! NG _____ B. WING _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 2-'016

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F 001	Continued From page 1 12 VAC 5-371-300. Pharmaceutical services. Cross reference to F761. 12 VAC 5-371-140 (D). Policies and procedures. Cross reference to F868. 12 VAC 5-371-110. Management and administration. Cross reference to F883.	F001	achange in condition or a change in prescribed medication or treatment plan are at risk for facility failure to notify the attending MD and/or RP of that change. 3. Staff have been and will continue to be educated on need to notify both the resident ll s attending MD and their RP of any changes in the reslden tos condition, change in prescribed plan or care or treatment. 4. The DON or designee will review the 24-hour report and EMAR daily to ensure licensed nurses have documented that the MD and RP were made aware of changes in the resident>7s condition, prescribed plan of care of treatment. The QA Committee will review the findings of the DON or designee regarding compliance of the notification requirements An amended plan will be initiated if the facility is found to be non-compliant with current plan. 5. Compliance date: 3/30/2018 12 VAC 5-371-370 (G). Cross reference to F584: 1. The dining room window and carpet in room #408 were cleaned. 2. Residents residing in the facility are at risk of being exposed to an environment which falls short of providing a clean, comfortable and homelike environment. 3. Nursing or housekeeping staff will initiate immediate cleanup of spills. Spills	

SJate of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	VA0183	A BUILDING: _____ B WNG_____	02/1512018

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZJP CODE
OUR LADY OF THE VALLEY	850 NORTH JEFFERSON STREET ROANOKE, VA 24011

()(4)1D 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)	(X51 COMPLEIE DATE
F 001	Continued From page 2	F 001	which cannot be contained and deaned property by nursing staff **will be** reported to housekeeping staff who will perform proper sanitation of the area. Housekeeping department will conduct daily rounds on the nursing units to ensure clean and safe areas. 4. Daily roundos observations will be reported to the QA Committee who will review the information. Areas needing improvement in this plan will be amended to promote compliance. 5. Date of compliance: 3/30/2018 12 VAC 5-371-140 (E) . Cross reference to F607: 1. Both CNA licenses were verified as being active. 2. All professional facility staff, who by law are allowed to practice only with proof of certification or licensure, are at risk of allowing their certificate or licensure to expire. 3. Business Office Manager or Designee, will perform an initial 100% audit of all licenses and certifications. Once initial compliance has been established, all new employee s certificates/licenses will be verified at time of hire. A monthly report will be reviewed to identify any license/certificate which must be updated in the employee file to ensure regulatory compliance. 4. Compliance with these audits and their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0183	A.BUILDING _____ B.WING _____	02/15/2018

NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP COOE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

(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)	(X6) COMPLETE OAT!!
F 001	Continued From page 3	F001	findings Will be reported to QA Committee for their review. 5. Date of compliance: 3/30/2018 12 VAC 5-371-250. Cross reference to F641: 1. The MOS for resident #68 was amended to provide accurate place of discharge. 2. All residents requiring MOS assessment are at risk for inaccurate coding. 3. The MOS assessment for residents who are discharged from the facility for the last six months were reviewed for accurate place of discharge. Any corrections needed to be made were corrected at that time. The MOS nurse will review MOS assessments of all residents being discharged for proper coding. Any errors found will be corrected at that time . 4. The MOS nurse will report audit findings to the QA committee. 5. Date of compliance.3/30/18 12 VAC 5-371-250. Cross reference to F655: 1. The baseline care plan for resident #266 was updated to reflect falls and the risk of incontinence. 2. All residents who are admitted to the facility are at risk for not having their needs addressed on the baseline care	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0183	A. BUILDING: _____ B. W NG _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 001	Continued From page 4	F001	plan. 3. Staff have been and will continue to be educated on timely completion of baseline care plan. The DON or designee will audit all new admission baseline care plans weekly to ensure baseline care plans are complete. 4. Baseline care plan audit findings will be reviewed in the quarterly QA committee. 5. Date of compliance: 3/30/18 12 VAC 5-371-250. Cross reference to F657: 1. The care plans for residents #46, 7, 49, 6, 5 and 219 were revised to instruct staff on the new wound care orders, falls, eye treatment orders, inappropriate behaviors and frequency of safety checks. 2. All residents who have new orders for falls, other unusual incidents, behaviors or any other changes in condition are at risk for not having their care plans updated. 3. The 11-7 charge nurse will review new orders for falls and other occurrences as listed on the 24 hour report to check for appropriate entries being entered on the individual care plan. Charge nurses will be educated on the timely documentation of care plan updates. 4. The results of the 11-7 audits will be reviewed and any necessary actions will be taken to ensure compliance. Findings will be reviewed in quarterly QA.	

State Of Vil'!linia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	VA0183	A. BUILDING: _____ B. WNG _____	02/15/2018

NAME OF **PROVIDER** OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
OUR LADY OF THE VALLEY	**850 NORTH JEFFERSON STREET ROANOKE, VA 24016**

()(4)10 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)	()(5) COMPLETE OATE
F 001	I Continued From page 5	F 001	5. Date of compliance: 3/30/2018 12 VAC 5-371-250. Cross reference to F740: 1. Resident #7 will be evaluated and assessed by behavioral health professionals on an as needed basis. 2. Those residents exhibiting behavior signs and symptoms are at risk of not being provided with timely behavioral health care services. 3. An audit will be preformed by the DON or Designee of each residentc s electronic physicianOs orders to ensure that those residents who have orders to be evaluated by behavioral health professional have been seen. New telephone orders indicating the need for behavioral consults **will be** reviewed by 11-7 charge nurse, who will assure that there is documented evidence that a behavioral health professional has been contacted to evaluate residents. 4. The results of the 11-7 shift telephone audits for new behavioral health referrals will be reviewed by the QA committee. 5. Date of compliance: 3/30/2018 12 VAC 5-371-300. Cross reference to F755: 1. The Xifaxan for resident #266 has been administered since the date of the survey exit with no further documented entries of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0183	A.BU L.DNG _____ B \MNG _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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F 001	Continued From page 6	F 001	medication unavailable. 2. Residents receiving any type of medication or medicated treatment are at risk of missing a dose of prescribed medication or treatment 3. If a 4-day supply of pills or capsules are counted as remaining, the licensed nurses will re-order it from the pharmacy. If a medication is not available for administration, the charge nurse will get the medication from the stat box or by stat delivery from the pharmacy. Licensed nurses will be in serviced on the medication reordering policy and procedure. The DON or Designee will audit 10% of the residentlJs medications weekly to ensure that all medications are available for administration per MD orders. 4. The findings of medication availability audit will be reported to the QA committee and the pharmacy for any necessary interventions. 5. Date of compliance: 3/30/2018 12 VAC 5-371-300. Cross reference to F761: 1. The LPN who left the Culturelle on top of the medication cart has been in serviced. 2. Any medications received from the pharmacy could be improperly stored. 3. Administrative staff will note any items stored on top of medication carts during	

State of VirgInlil

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	()(1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	VA0183	A BU|LD| NG _____ B \MNG_____	02/15/2018

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OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

()<4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY}	(X5) COMPLETE DATE
F 001	I Continued From page 7	F 001	their daily rounds. Licensed staff who are noted to be improperly storing mediations on the medication carts will be in-serviced at the time of discovery. The medication will be immediately stored in its proper place. 4. Medication storage compliance will be reviewed with the members of the QA committee. 5. Date of compliance 3/30/2018 12 VAC 5-371-140 {D). Cross reference to F868: 1. The Medical Director has attended all QA meetings In the last six months. 2. The Quarterly QA Meetings cannot effectively identify and address issues when not represented by a physician. 3. The Medical Director was educated on the necessity of her presence at each QA **Meeting.** If she is unable to attend, she will appoint an appropriate representative. 4. The QA attendance sheet will be reviewed by the facility Administrator or Designee after each quarterly meeting. 5. Date of compliance: 3/8/2018 12 VAC 5-371-110. Cross reference to F883: 1. Resident #217has documentation signed by his responsible party which indicates refusal of the flu vaccine.	

State of VirAinia

STATEMENT OF DEFICIENCIES AND **PLAN** OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0183	A. BUILDING _____ B. WING _____	**02/15/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	**850 NORTH JEFFERSON STREET ROANOKE, VA 24018**

(X4)1D 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) COMPLETE DATE
F 001	Continued From page 8	F 001	Resident #218 has documentation indicating that the resident had received both the flu and pneumonia vaccines during the fall of 2017. 2. Residents already residing in or newly admitted to the facility are at risk of not being provided the opportunity to receive the flu or pneumonia vaccine. 3. The AdmissionsNurse or designee will interview the residents or the residents responsible party to ask if and when the resident was offered the flu and/or pneumonia vaccines. The Admissions Nurse will document the acceptance or refusal of the vaccines. The DON or Designee will review all new admissions charts for the appropriate immunization documentation. 4. The results of the audit **will be** presented to **the QA** committee. Additional interventions **will be** initiated if the audit indicates necessity. 5. Date of compliance:3/30/2018	

Commonwealth of Virginia
Virginia Department of Health

Nursing Home License Number: **NH2650**

In accordance with the provisions of Title 32.1. Chapter 5, Article 1, of the Code of Virginia 1950, as amended.

Coordinated Services Management, Inc.

(Operator)

is Authorized to Operate,

Our Lady Of The Valley, Inc.

(Name of Organization)

a Nursing Home, located at:

650 North Jefferson Street, Roanoke, Virginia 24016

Approved Capacity **70** Beds Expiration **12/31/2021**

M. Norman Oliver, M.D. M.A.
State Health Commissioner

Office of Licensure & Certification

(Tags: Trial attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, sepsis, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, Virginia elder abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, , nursing home chains, statistics on nursing home abuse, Our Lady of The Valley, Roanoke Nursing Home Abuse attorney, Roanoke Assisted Living Abuse Attorney, Roanoke personal injury attorney)