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 NPIs. 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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CENTR	S FOR MEDICARE & I	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES	()(1) PRO VIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CC A. BUILDING	DNSTRUCTION	()(3) DATE SURVEY COMPLETED
		496357	B. WING		06/18/2020
	ROVIDER OR SUPPLIER	-	850	EET ADORES\$, CITY. STATE, ZIP CODE NORTH JEFFERSON STREET ANOKE, VA 24016	
(X4)10 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
E 000	Initial Comments		EOOO		
F 000	COVID-19 Focused S on 06/18/2020. Emerg information was revie and 06/22/2020. The compliance with 42 C Requirement for Long INITIAL COMMENTS An unannounced CO Control Survey was c 06/18/2020 and 06/22 information was revie and 06/22/2020. Corr compliance with F-88 Federal Long Term C On 6/18/2020, the cer facility was 55. Of the residents had tested p virus. Five (5) resider	wed off site on 06/18/2020 facility was in substantial CFR Part 483.73 g-Term Care Facilities. VID-19 Focused Infection onducted onsite on nation updated off site on 2/2020. Infection Control wed offsite on 06/18/2020 ections are not required for 0 of 42 CFR Part 483 are requirement(s). nsus in the 70 certified bed 55 current residents, no positive for the COVID-19	FOOO		
_ABORATORY [DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE	(X610ATE
	cally Signed				07/06/2020

Any deficiency statement ending with **an asterisk** (') **denotes a** deficiency which the institution may be excused from **correcting** providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date *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 to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	DF DEFICIENCIES	{X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			ONSTRUCION		SURVEY PLETED	
		495357	B. WNG			04	/08/2019	
	ROVIDER OR SUPPLIER			650	EET ADDRESS. CITY. STATE, ZIP CODE NORTH JEFFERSON STREET ANOKE, VA 24016			
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E 000	Initial Comments		EC	000				
F 000	survey was conducte 04/08/19. The facility compliance with 42 C Requirement for Lon	r was in substantial CFR Part 483.73, g-Term Care Facilities.	FC	OD				
	Survey and State lice conducted 04/07/19 Corrections are requi CFR Part 483 Federa requirements and Vir	through 04/08/19. ired for compliance with 42 al long Term Care ginia Rules and Regulations Jursing Facilities. The life						
F 684 ² SS=D	at the time of the sun consisted of 16 curre closed record reviews Quality of Care) certified bed facility was 65 vey. The survey sample nt Resident reviews and 3 s.	F6	84			5/17/19	
	applies to all treatment facility residents. Bas assessment of a resident that residents receive accordance with profe- practice, the compre- care plan, and the resident	Indamental principle that Int and care provided to used on the comprehensive dent, the facility must ensure treatment and care in essional standards of mensive person-centered						
	Based on observatio record review, the fac	n, staff interview, and clinical cility staff failed to follow 1 of 19 Residents in the		1	F684 Resident #14 has had her TED ho applied and removed as per her N TITLE			

Electronically Signed

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

05/02/2019

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDERISUPPUERICLIA IDENTIFICATION NUMBER:	. ,	X2) MULTIPLE CONSTRUCTION BUILDING		` '	ATE SURVEY OMPLETED
		495357	B V\IING			04/08/2019	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	I	
OUR LAD	Y OF THE VALLEY			650 NORTH JEFFERSON STREET ROANOKE, VA 24016			
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F 684	14 was wearing phys Resident# 14 was an was originally admitted with a readmission da Included but were no failure, type 2 diabeted disorder, and hyperlip The clinical record for reviewed on 417/19 a MDS (minimum data significant change as (assessment reference of the MDS assesses Section C0500, the fa Resident# 14 had a E mental status) score indicated that Reside was moderately impa The current plan of car reviewed and revised documented a focus related to muscle wea chronic medical con assistance with: None assistance with: bed toileting, and persona Requires limited assis Requires set up assis independent with eati	dent# 14. dent# 14. to ensure that Resident # ician ordered TED hose. 86-year-old- female who ad to the facility on 9/20/18, ate of 3/26/19. Diagnoses t limited to, congestive heart es mellitus, major depressive bidemia. r Resident# 14 was at 2:55 pm. The most recent set) assessment was a sessment with an ARD be date) of 4/2/19. Section C cognitive patterns. In acility staff documented that BIMS (brief interview for of 10 out of 15, which nt# 15's cognitive status ired. are for Resident # 14 was 1 on 4/5/19. The facility staff area as, "Self care deficit akness from long standing ditions. Requires total e Requires extensive mobility, transfers, dressing, I hygiene and locomotion. stance with: eating at times. stance with: eating at times. stance with: eating is ng requires hands on ing Required 2 (#) staff th transfers and bed	f	584	orders since 417/19 . The nurse who charted that the TEDS were applie 4n/19 was counseled regarding cha accurately and application of special garments. Any residents with TED orders are a for having them not applied. A 100% audit of the residents MD o will be conducted by the DON or de in order to identify those residents w should have TED hose applied ever Staff will be inserviced on the impor of applying TED hose. The DON, or designee will check th residents having TED orders daily for weeks and then spot check monthly months to make sure the TEDS wer applied. If it is discovered that the ordered TI were not applied, the certified nursin assistant assigned to provide care for resident will receive counseling. The findings of the TED audit will be discussed at the weekly risk meeting weeks. Any findings of the deficient practice will be addressed and reviss made with an action plan. The audit also be reviewed by the quarterly Q. Committee.	arting at risk rders signee rho y AM. cance or 4 for 3 e EDS ig that e g for 4 ions will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Cf.NTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO			()(3) DATE	SURVEY
		495357	B.VIANO	3		04/	/08/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP C HO NORTH JEFFERSON STREET ROANOKE, VA 24016			
()(4)1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREF TAC	IX	PROVIDER'S PLAN OF CORRECTON (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(XS) COMPLETION DATE;
F 684	but were not limited to PM," which was initiat 3/26/19. On 417/19 at 11:06 at Resident# 14's room interview. The survey 14 was fully dressed a The surveyor did not place on Resident# 1 On 417/19 at 2:51 pm Resident #14 sitting ir wheelchair. The surve # 14 was wearing nor hose were in place. On 417/19 at 3:05 pm LPN #1 (licensed prace TED hose for Residen LPN reviewed the phy # 14 and LPN# 1 agree an active order for TE the AM off in PM. The that Resident# 14 was 417119 during observed the surveyor went into observed that Residen TED hose. LPN # 1 as her TED hose were. F are in the drawer." LF if she would like to pu Resident # 14 stated, putting them on, they I would be putting the right back off." The su	e on in am off in pm." urrent orders that included o, "TED hose on in AM, off in ted by the physician on m, the surveyor was in conducting a Resident or observed that Resident# and wearing nonskid socks. observe and TED hose in 4. h, the surveyor observed h her room in wheelchair her eyor observed that Resident askid socks and no TED h, the surveyor spoke with trical nurse) regarding the tt #14. The surveyor and visician's orders for Resident ed that Resident# 14 had D hose to be placed on in e surveyor informed LPN #1 s not wearing TED hose on ations. LPN # 1 along with o Resident# 14's room and nt # 14 was not wearing sked Resident# 14 where Resident# 14 stated, "They PN# 1 asked Resident# 14 t on her TED hose. "I don't see any point in haven't been on all day and m on and have to take them	F	684			

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

Evenl 10 LA7K11 Facility ID VA0183

DEPARTMENT OF HEALTH AND HUMAN SERVICES C. F.NTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3J DAT	E SURVEY IPLETED
		495367			04	/0812019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 560 North Jefferson Street Roanoke, va 24016		
(X4)10 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'SPLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROS-REFERENCEOTO THE APPRO DEFICIENCY)	D BE	CXSJ COMPLETION DATE
	TED hose had been a On 4/8/19 at 3:24 pm director of nursing we findings as stated abo No further information presented to the surv conference on 4/8/18. J sowel/Bladder Incont CFR(s): 483.25(e)(1) §483.25(e) Incontinent §483.25(e)(1) The fac resident who is contin admission receives se maintain continence of condition is or becom- not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was ne (ii) A resident who ent indwelling catheter or is assessed for remov as possible unless the demonstrates that cat and (iii) A resident who is	served documentation that applied at 3:18 am in 4ll/19. , the administrator and are made aware of the ove. In regarding this issue was ey team prior to the exit inence, Catheter, UTI -(3) nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is in. sident with urinary on the resident's asment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder	F684			5/17/19
		treatment and services to nfections and to restore Dete Event IO:LA7		cility ID- VA0183 If cc		eet Page 4 of 13

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER			CONSTRUCTION	(X3J DATE SURVEY COMPLETED		
		496357				04	/0812019	
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS. CITY, STATE. ZIP CODE			
				6	60 NORTH JEFFERSON STREET			
OUR LAD	Y OF THE VALLEY			R	ROANOKE, VA 24016			
(X-4)10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPI.ETIO OATE	
F 690	Continued From page 4		F	690				
1 000	continence to the extent possible.			590				
	§483.25(e)(3) For a r	esident with fecal						
	incontinence, based							
		ssment, the facility must						
	ensure that a resident who is incontinent of bowel							
		treatment and services to						
	restore as much norn	nal bowel function as						
	possible.							
		is not met as evidenced						
	by:	a staff interview, and slinical			5000			
		n, staff interview, and clinical			F690	ident		
	record review, facility staff failed to provide services to prevent urinary tract infections for 1 of				A foley leg strap was procured for res #52. The foley leg strap is changed to			
		urvey sample, Resident #			weekly or as needed. Placement of t			
	52.				leg strap is verified every shift. The n			
					responsible for applying a leg strap w			
	The findings included:				counseled regarding following physic			
					orders.			
		to ensure that Resident #						
	52 Foley catheter wa	s secure with a leg strap.			Residents who have foley catheter of			
	Decident# 52 was an	84-year-old-female who			are at risk for not having leg strap ap to secure foley tubing.	plied		
		to the facility on 417/16,			to secure roley tubing.			
		e of 5/25117. Diagnoses			A 100% audit of physician orders will	he		
		t limited to, obstructive and			conducted by the DON or designee to			
	reflux uropathy, type				identify those residents with orders for			
	dementia with behavi				foley catheter. Staff will be inserviced			
	hypertension.				the policy for care of a foley catheter			
					including the use of a leg strap to pre	vent		
	The most recent MOS				the increased risk of infection.			
		lent # 52 was an annual				,		
		ARD (assessment reference			The DON or designee will check daily	/ tor		
		tion C of the MOS assesses Section C0SO0, the facility			4 weeks, then weekly for 2 months to make sure that a leg strap was applie	d for		
		t Resident # 52 had a BIMS			each resident having a foley catheter.			
		ental status) score of 5 out of			call rook on having a looy batheter.			
		hat Resident # 52's cognitive			The audit results will be reviewed a	t the		
		mpaired. Section Hof the			weekly risk meeting. Deficient finding		1	

FORM CMS-2567(02-99) PreviOus V8<\$ionS Obsolete

If continuation shaet Page 5 of 13

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2021 FORM APPROVED OMB NQ. 0938--0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/ N«I PI.AN OF CORRECTION IDENTIFICA	SUPPUER/CLIA TION NUMBER:	· · /	PLE CONSTRUCTION G	COMF	SURVEY PLETED
	495357	SWNG_		04/	08/2019
NAME OF PROVIDER OR SUPPLIER OUR LADY OF THE VALLEY			STREET ADDRESS, CITY. STATE. ZIP CODE 860 NORTH JEFFERSON STREET ROANOKE, VA 24016		
(X4)10 SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECI TAG REGULATORY OR LSC IDENTIFYING I	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
 F 690 I Continued From page 5 MDS assesses bowel and bladder. H0100, the facility staff documenter # 52 had an indwelling catheter. The current plan of care for Reside reviewed and revised on 4/1/19. Th documented a focus area for Resid "Resident # 52 is at risk for urinary due to chronic Foley cath use and of process." Interventions included bit limited to, "Follow principles of infect and universal precautions." Resident # 52 had current orders th but was not limited to, "Check cathed placement q (every) shift." On 4/8/19 at 9:31 am, the surveyor Resident # 52's room conducting a interview. During the interview, Ress the surveyor her Foley catheter. Th observed that Resident # 52's cathed secured with a leg strap. On 4/8/19 at 10:06 am, the surveyor RN # 1 (registered nurse). The surv with RN # 1 observed that Residen catheter was not secured with a catheter was not	d that Resident In # 52 was he facility staff ent # 52 as, tract infections disease were not ction control hat included eter strap r was in Resident ident showed e surveyor eter was not or along with veyor along t # 52's Foley theter strap. dent # 52's with a strap. ed to have one rator and re of the s issue was	F6	be addressed and an action plan initiate The audit results wm be discussed at the quarterly QA meeting.	e	et Page 6 of 13

PRINTED: 01/29/2021 FORM APPROVED 0MB NO. 0938-0391

CENTERS FOR MEDIC RE & MEDICAID SERVICES						OMB NO. 0938-0391	
	DF OEFICIENCIES	(X1) PROVIOERISUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		495357	.B WNG			04	/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY. STATE, ZIP CODE		
OUR LAD	Y OF THE VALLEY				550 NORTH JEFFERSON STREET ROANOKE, VA 24016		
(X4)1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	to PREF TAG		PROVIOER''S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSSREFERENCEDTO THE APPROPR DEFICIENCY)	BE	(X5) COMP\.ETION DATE
F 690 F 761 SS=O	<pre>}; FR(s): 483.45(g)(h) §483.45(9) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessory instructions, and the e applicable. §483.45(h) Storage of </pre>	9. d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be with currently accepted es, and include the y and cautionary		690			5/17/19
	Federal laws, the fact biologicals in locked of temperature controls, a personnel to have acc §483.45(h)(2) The fact locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 at abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observatio staff failed to securely medication rooms. On 4/07/19, when the facility at 7:45 AM, th	ility must store all drugs and compartments under proper and permit only authorized cess to the keys . cility must provide separately ffixed compartments for drugs listed in Schedule II of Orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced in and staff interview, facility e store medication in 1 of 2			F761 There have been no reports or sightin of the medication room door being left open, any of the medication or treatm carts left unlocked and unattended, or the medication room refrigerator being	ent of	
FORM CMS-256	7(02-991Previous Versions Obs	e's station on Sullivan hall	11	Fa	unlocked.	inuation sh	eet Page 7 of 13

	OF DEFICIENCIES F CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	· · /	PLE CONSTR	(X3) DATE SURVEY COMPLETED		
		495357	B.WNO			04	/08/2019
	ROVIDER OR SUPft.IER Y OF THE VALLEY			860 NORT	DDRESS. CffY, STATEZIP CODE IH JEFFERSON STREET KE, VA 24D16		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPU:TIC DATE
F 761	nursing staff were pr nurse's station nearb medication carts in th supervisor was in th medication refrigerat no controlled substa of the stored medica The door to the med 8:15 <i>AM.</i> The medic observed open and u SUNey. The director of nursin concern during a disa approximately 3 PM.	ment cart was unlocked. No esent in the room or at the by. Two nurses were working he hall and the nursing e dining room. The or was unlocked. There were nces in the refrigerator. None tions were expired. ication room was closed by ation rooms were not unattended again during the	F	Any r media refrig unse Licen sectio Admi the re media contr refrig condu Admi addre treatr Staff keep when prese The f admin the m edia contr refrig condu Admi addre treatr Staff keep when prese The f admin the m edia condu Admi addre treatr Staff keep when prese The f admin the m edia condu Admi addre treatr Staff keep when prese The f admin the m edia condu Admi addre treatr Staff keep when prese The f admin the m media condu Admi addre the f admin the m media refrig locke The f will ba meetia addre the eu breac proce	medication or treatment cart, cation room, and medication perator are at risk for being left acured and unattended. ased nurses will be inserviced on #25 in the Medication nistration policy regarding kee efrigerator locked to prevent a cation security policy breach w rolled substances require eration. The DON or designee uct a review of the Medication nistration Policy, item #19 whi esses keeping the medication ment carts locked when unatte will receive an inservice remin the medication room door lock no licensed nurse is physical ent in that room. facility administrator and other nistrative personnel will daily in nedication and treatment carts, cation room door and the medi- erator to make sure they are a id when unattended. findings of the administrative re e discussed in the weekly risk ing. Any deficient practice will essed at the time of discovery mployee responsible for the sec th and the progressive disciplin ess will be applied. audit results will be discussed erly QA meeting.	on the ping when will ch and nded. der to ked ly nspect the room ill punds be with ecurity hary	

DEPARTMENT OF HEALTH **AND HUMAN** SERVICES CENTERS FOR MEDICARE & MEDICA10 SERVICES

PRINTED: 01129/2021 FORM APPROVED 0MB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495357	B.v.ING		04/08/2019
	RO'\IIDER OR SUPPLIER Y OF THE VALLEY		·	STREET ADDRESS. CITY, STATE, ZIP COOE 850 NORTH JEFFERSON STREET ROANOKE, VA 24016	·
(X4)1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF 0£FICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREFI TAG		SHOULD BE COMPU:TION
F 812	CFR(s): 483.60(i)(1)(2 §483.60(i) Food safety The facility must - §483.60(i)(1) - Procur approved or considered state or local authoriti (i) This may include for from local producers, and local laws or regul (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, f serve food in accorda standards for food set This REQUIREMENT by: Based on observation policy review it was de failed prepare food in manner for facility resi Findings: The facility kitchen sta a clean and sanitary r the kitchen environme AM. The surveyor entor room. A kitchenette at section contained a st A kitchen employee w	 re/Prepare/Serve-Sanitary 2) y requirements. e food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State lations. s not prohibit or prevent roduce grown in facility pmpliance with applicable d-handling practices. es not predude residents s not procured by the facility. prepare, distribute and nce with professional rvice safety. is not met as evidenced h, staff interview and facility termined the kitchen staff a clean and sanitary idents. 		Food temps are being tested a at each meal by the dietary staf Frozen foods are being thawed to the policy. the finding was co when the inspector noted the ch being thawed. Raw chicken was away and all three sinks were w Cooks have been educated ar inserviced on policy and proced Unsanitary environments can al residents and employees if not appropriately maintained. Any residents receiving meals th prepared at the facility are at ris	if. according irrected nicken s thrown vashed out. nd lure. ffect

FORM CMS-2567(02,99) Previous V81'\$ic:,nS Obsol191•

Event 10:LA7K11

Facility 10: VA0183

If oontinualion sheet Page 9 of 13

CENJ"ERS FOR MEDICARE & MEDICAID SERVICES			FORM APPROVED 0MB_NO. 0938-0391		
STATEMENT C N-0 PLAN OF C	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURI/EV COMPLETED
		495357			04/08/2019
NAME OF PR	OVIDER OR SUPPLIER	A	S	TREET ADDRESS. CITY, STATE, ZIP CODE	
OUR LAD	OF THE VALLEY			60 NORTH JEFFERSON STREET OANOKE, VA 24018	
(JU)ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD S CROSSREFERENCEDTO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 812	Continued From page	9	F 812		
-	covered with lids or w			health being compromised with a brea in policy.	ich
		o see the temperature log			
	on the foods contained employee did not und was asking about Wh obtained the tempera kitchen employee hell her head. She did not	ed in the steam table. The lerstand what the surveyor en asked if she had tures on the food, the d up her hands and shook understand when the		Staff personal drinks are not being sto in the food prep area. Staff has been educated and Inserviced on this issue. Food Service Director, or designee will monitor daily.	ŀ
	the food temperaUH'8S	had a thermometer to take s. staff member called down to		Wet baking pans are not being neste and are placed in the appropriate area dry. Food Service Director or designed continue to monitor daily with kitchen	to
		neone to take the food		rounds.	
	appeared with alcoho	I swabs and a thermometer res of the foods ready to be		The gas stove, kitchen floor, kitchen w and fire sprinkler above the stove have been cleaned Food Service Director o designee will monitor daily to keep	e
		the steam table were eal/grits were 130 degrees; 130 degrees; baked apples		burners clean and maintenance will conduct monthly checks on sprinklers.	
	were 140 degrees. Co kept at 145 degrees o removed alt the food a to the kitchen to rehea	ok I said the food had to be n the steam table and and took it back downstairs at.		The sugar in the bin with trash on top a liquid leaking into the bin was discard The bin was cleaned and refilled and v also relocated to another area in the kitchen to prevent debris near the suga	ded. vas
	cart downstairs to the	anied Cook I and the food regular kitchen. Cook I said ed the plastic covers from		bin. Dietary staff will be inserviced on the	
	the foods after placing	g them on the steam table ad cooled down so much.		Dietary Policy for sanitation, food stora food delivery, and the kitchen area and equipment cleaning schedule. The Foo	b
	bay sink with two bay bottom of the basins.	surveyor observed a three s full of raw chicken in the Water was running from the icken and back washing		Service Director, or designee will audi food temp and the cleaning schedule I daily.	t the
	onto the surface of th	he sink before returning to onto the floor. The surface		The Food Service Director, or designe will perform an inspection of the kitche	

FORM CMS-2567(02-99) PnIVIOUS V- ()bsolale

Facilily ID: VA01"3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE MEDICAID SERVICES

CENTER	<u>S FOR MEDICARE_M</u>	EDICAID SERVICES				OMR NO.	09-38-0:391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495357	B WING			04/	/08/2019
NAME OF PI	ROVIDER OR SUPPIIER			S	TREET ADDRESS, CITY, STATE. ZIP CODE	8	
OUR LAD	Y OF THE VALLEY				110 NORTH JEFFERSON STREET		
			10	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PfU:F TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLE.TIOH OA1E
F 812	used, unwashed dishes surrounding the basin was running through/s into the basin. The surveyor asked of policy for thawing out she was supposed to and place it into the si running over it. Cook buckets that were to be They were stored on a Cook I said she was of the trash, since she h appropriate procedure thaw it under running facility administrator w informed of the finding leaving the area. She chicken being thrown Other areas of concer 1. The staff use of sty cups left in various are area. Three white styr one refillable mug-typ table tops in the food staff names/initials on back to one table in the	ved to have food debris and es on the surface is. The back washing water around the dishes and back Cook I about the facility frozen chicken. Cook I said put the chicken into buckets ink to thaw with water I pointed out the two be used in this process. a wire rack in the kitchen. going to throw the chicken in ad not followed the be to place in containers to water In the sink. The vas entering the kitchen and gs prior to the surveyor said she would oversee the	F	812		t ee d sed s	
	•	re observed nested on wire he pans were observed to					
	have moisture between nested prior to drying,						
1		l under food preparation		1			
FORM CMS-256	67(02-99) Previous Vttr\$iol'IS Obso		(11	Fac	cility ID: VA0183 1r cootin	uation shee	t Page 11 or 13

CENTER	S FOR MEDICARE &	MI:DICAID SERVICES				OMS NO	D. <u>0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY
		496357	B VIING	i		04/	/08/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET AOORESS, CITY STATE. ZIP CODE		
	Y OF THE VALLEY				HO NORTH JEFFERSON STREET		
OOK LAD					ROANOKE, VA 24016		
(X⊲I)ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION 0re
F 812	on them. Cook I said washed, and she rem through the dishwash 4. The six burner gas built-up/blackened for burners contained tra said she didn't know v clean it. 5. The fire sprinkler sy the cook stove top. The caked with dust and s pan was placed on the underneath the sprinkler in the pot. 6. The sugar bin on the have trash and debrink the surface of the sugar be splash marks on it yellow had run down f 7. The kitchen floor w This was pervasive the accumulated beside s countertops. Built-up throughout the kitcher On 417/19 at 12:44 PM was interviewed. She surveyor's findings. T chicken in the sink wa measures in place to sanitized prior to the p asked to the see the p sanitation process an inservices that the sta process. (The kitchen little-to-no English and	to have built-up food debris they had already been oved them to run them back er. stove top was crusted with od debris. The eyes of the sh and food debris. Cook I what the schedule was to vstem had four faucets over ne ends of the faucets were mut-taggles. A large open e stove top directly der system with food boiling ne floor was observed to s on the lid which fell onto ar when the lid was opened. ar bin had what appeared to (Drops of something he inside.) as slippery with grease. roughout the kitchen and stoves. sinks and under food debris was observed in at the base of the walls. If the OM (dietary manager) was informed about the he OM said thawing the s appropriate and they had ensure the sink was procedure. The surveyor bolicy and procedure for the	F	812			

FORM CMS-2567(02-99) Previous V8fSions Oosolele

Facility ID VA0183

If oontinuatioo sheet Page 12 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENT I'RS FOR MEDICARE & MEDIC ID SERVICES

PRINTED: 01/29/2021 FORM APPROVED OMB NO. 0938-0391

	3 FUR MEDICARE &	IVIEDIC ID SERVICES			UNIE NO. 0938-0391
	OF DEFICIENCIES	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(XJ) DATE SURVEY COMPLETED
		495357	B. W NG		04/08/2019
	ROVIDER OR SUPPLIER		6110	B. W NG O4/08/2019 STREET ADDRESS, CITY. STATE, ZIP CODE 6110 NORTH JEFFERSON STREET ROANOKE, VA 24016 PROVIDER'S PLAN OF CORRECTION PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE	OULD BE COMPLETION
F 812	them about the proce The DM also told the supposed to have the the food preparation a with a table outside th personal drinks and h dates on them. The facility administra the facility dietary pol and over 200 pages la referenced frozen foo refrigeration or under policy did not reference should be contained i sanitizing the sink bas food. There was no e referred to any trainin sanitize the basins an prior to placing food in	ss.) surveyor the staff were not in personal drinking cups in area. They were provided he food prep area for ad to have their names and tor provided a few pages of icy-which was computerized ong. On page 47 the policy dds being thawed under cold running water. The ce the vessel the food n or the procedure for sins prior to water thawing vidence presented that g the kitchen staff had to ad surround sink surface no it for thawing. the was provided prior to the		ID. VA0183	continuation sheet Page 13 of 13

PRINTED: 01/29/2021 FORM APPROVED

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IOENTI FICATION NUMBER;		TIPLE CONSTRUCTION			TE SURVEY	
		405257		В . WNG			С	
	ROVDER OR SUPPLIER	495357			SS. CIIY. STATE, ZIP CODE	(02/15/2018	
	OF THE VALLEY				FFERSON STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х (Е/	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY}	ULD BE	(X5) Completio Date	
E 000	Initial Comments		EC	000				
F 000	survey was conduct 02/15118. The facility compliance with 42 Requirement for Long	CFR Part 483.73, J-Term Care Facilities. One tigated during the survey.	F	000				
	survey was conducte 2/15/18. Corrections a with 42 CFR Part 48 requirements. The	low. One complaint was						
F 580 SS=0	at the time of the sur consisted of 16 curre closed record review	njury/Decline/Room, etc.)	F٤	580			3/30/18	
	consult with the resid consistent with his o representative(s) wh (A) An accident invo results in injury and physician interventii (B) A significant char mental, or psychoso	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there Is- lving the resident which has the potential for requiring on: nge in the resident's physical,						
	status in either life-th clinical complication	reatening conditions or						

Electronically Signed

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 disdouble 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 correction is requisije to oontinued program participation.

FORM CMS-2567(0'2-99) Previous Venions Obsolete

03/14/2018

	MENT OF HEALTH ANI S FOR MEDICA E &	D HUMAN SERVICES M f:DICAID SERVICE S			PRINTED: 01/29/20 FORM APPROV 0MB NO. 0938- 03
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3J DATE SURVEY COMPLETED
		495357	B WING		C 02/15/2018
NAME Of P	ROVIOER OR SUPPLIER		S	TREET ADDRESS. CITY. STATE, ZIP CODE	
OUR LAD	Y OF THE VALLEY			50 NORTH JEFFERSON STREET	
				OANOKE, VA 24016	
(X4)1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSs-REFERENCEOTO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 580	Continued From page	e 1	F580		
	a need to discontinue		1000		
	treatment due to adve	erse consequences, or to			
	commence a new for (D) A decision to trans				
	resident from the faci				
	§483.15(c)() (ii).				
		fication under paragraph (g)			
		the facility must ensure that on specified In §483.15(c)(2)			
		ded upon request to the			
	physician.	a cra			
		also promptly notify the dent representative, if any,			
	when there is-	dent representative, ir any,			
		or roommate assignment			
	as specified in §483.1	10(e)(6); or ent rights under Federal or			
		ns as specified in paragraph			
	(e)(10) of this section				
		ecord and periodically mailing and email) and			
	phone number of the				
	representative(s).				
	§483.10(9)(15)	- ta dhati a a a a mu			
		osite distinct part. A facility stinct part (as defined in			
		e in its admission agreement			
	its physical configurat	tion, including the various			
		se the composite distinct / the policies that apply to			
		en its different locations			
	under §483.15(c)(9).				
		is not met as evidenced			
	by: Based on staff intervi	iew and clinical record		The filing of this plan of correction do	es
	review the facility staf			not constitute an admission that	~~
		sident's responsible party		deficiencies alleged did in fact exist.	
	(RP) of changes for	of 19 Resident's, Resident		This plan of correction is filed as evide	ence

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

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			0MB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPILIER/CILA IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495357	B. 'MNG_		C 02/15/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				150 NORTH JEFFERSON STREET	
OUR LADY	OF THE VALLEY			ROANOKE, VA 24016	
(X4)10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES YMUST BE PRECED D BY FULL LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
#266. The findings Resident #2 02/06/18. D anemia, syr thrombocyto disease, his pain.	The findings included Resident #266 was a 02/06/18. Diagnoses anemia, syncope an thrombocytopenia, ga disease, history of ur	l: dmitted to the facility staff on included but not limited to	F58	of Our Lady of the Valley's desire comply with the requirements of participation and to continue to p high-quality resident care.	
	to Resident being a n and oriented x 3. Resident #266's clinic 02/13/18. It contained summary for the mon part, "Xifaxan tablet; 4 (diagnosis): personal infections] Twice a da Resident #266's eMA administration record/ contained an entry wi (rifaximin) tablet; 550 1 tab; oral twice a day 4pm was initialed, wit initials. A note in the 02/09/18 read in part administered: Drug/It Surveyor spoke with approximately 1500 m missing a dose of me DON what should be	th of February which read in 550mg; amt: 1 tab; oral [DX history of urinary (tract) ay: 08:00 AM, 04:00 PM". AR (electronic medication) was reviewed and hich read in part, "Xifaxan) mg; Amount to administer: y". The entry for 02/09/18 at h parentheses around comments section for "02/09/18 05:06 PM Not em unavailable".		 The attending MD & RP for realization. Those residents who have expanded a change in condition or a change prescribed medication or treatment are at risk for facility failure to not attending MD and/or RP of that or attending MD and/or RP of that or astending MD and/or RP of that or any changes in the resident Js or change in prescribed plan or care treatment The DON or designee will revie 24-hour report and EMAR daily to licensed nurses have documented the MD and RP were made awar changes in the resident s condition or care of treatment The DON or designee will revie the MD and RP were made awar changes in the resident of the resident of the DON or designee regarding compliance of the notification 	ed dose berienced e in int plan tify the hange. hue to be he eir RP of ondition, e or ew the b ensure d that e of ion, ent. e findings

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

If continuation sheet Page 3 of 38

CINTER\$ FOR MEDICARE & MEDICAID SERVICES

PRINTED 01/29/2021 FORM APPROVED 0MB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405257	8VIIING		С	
NAME OF PI	ROVIDER OR SUPPLIER	495357	Svilling_	STREET ADDRESS, CITY, \$TATE, ZIP CODE	02/16/2018	
	Y OF THE VALLEY			860 NORTH JEFFERSON STREET ROANOKE, VA 24016		
(X4)10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSCIDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COM IC	
F 580	the clinical record that the Resident's RP hat missed dose of medi The concern of not not Resident's RP of a mit was discussed with th	yor could not locate a note in t indicated the physician or ad been notified of the	F58	non-compliant with current plan		
F 583 SS=D	Personal Privacy/Con CFR(s): 483.10(h)(1) §483.10(h) Privacy an The resident has a ri)-(3)(i)(ii)	f 58	13	3/30/18	
	telephone communica and meetings of famil this does not require t private room for each	dical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a n resident.				
	residents right to pers right to privacy in his written, and electronic the right to send and p mail and other letters materials delivered to	the facility for the resident, red through a means other				
	§483.10(h)(3) The res	sident has a right to secure				

	MENT OF HEALTH AN RS FOR MEDICARE &				FORM	D: 01/29/2021 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	()(1) PROVIDER/SUPPLIER/CUA 10£NTIFICATIONNUMBER;	. ,	TIPLE CONSTRUCTION	()(3) DATE	
		495357	B 'MNG_			C / 15/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS. CITY. STATE, ZIP CODE		
	Y OF THE VALLEY			850 NORTH JEFFERSON STREET		
OUK LAD	I OF THE VALLET			ROANOKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYINGINFORMATON)	ID PREFIX TAG) BE	{X) CO MPL£TICN DIITE
F 583	 (i) The resident has the of personal and mediciprovided at §483.70(i) federal or state laws. (ii) The facility must all Office of the State Low to examine a resident administrative records law. This REQUIREMENT by: Based on observation facility staff failed to medicing the care of survey sample (Resident #49 was readown source) survey sample (Resident #49 was readown source) of 1/16/18, the medicing a BIMS (Brief I score of 12 out of a por Resident #49 was also dependent on 1 staff medicing and the following survey or went on to U saw the following note for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #49 must (we be assisted to bed every survey for all staff to see whice Resident #40 must (we be assisted to bed every	anal and medical records. the right to refuse the release cal records except as (2) other applicable How representatives of the ng-Term Care Ombudsman 's medical, social, and in accordance with State is not met as evidenced the and staff interview, the maintain resident privacy of 1 of 19 residents in the dent #49). dmitted to the facility on ng diagnoses of, but not arkinson's disease and harterly MOS (Minimum D (Assessment Reference esident was coded as nterview for Mental Status) ssible score of 15. to coded as being totally member for dressing, bathing. mately 10:30 am, this nit 1 nursing station and the stated: " (name of vith 2 lines underlying must) ery day after lunch & then er. Reposition her to make	F5	 The note regarding resident #49 was posted at the nurses station removed. All residents residing in the facility at risk of experiencing an invasion of privacy. Notes containing residentinforma or communication will not be posted public area unless requested by the resident or RP. Staff will be educate maintaining privacy regarding reques and communications involving the ca a resident Nursing staff will conduct rounds to ensure resident info is not posted in public areas. Findings will reported to the Administrator and/or who will initiate necessary counselind disciplinary actions to ensure compliance. 	vas are their tion n a d on ts re of daily DON g or unce. Il be ill ary	

FORM CMS-2567(02-SIII)Previous Versions Obsolele

Facility ID· VA0183

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PRINTED: 01/29/2021

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATIONNUMBER: COMPLETED A. BUILDING C B.WNG 495357 02/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 650 NORTH JEFFERSON STREET OUR LADY OF THE VALLEY ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (XS) COM PLETION (X4)1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTVE ACTION SHOULD BE PREFIX OATE CROSS.REFERENCEDTO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 583 Continued From page 5 F583 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. Safe/Clean/Comfortable/Homelike Environment F 584 3/30/18 F 5841 SS=D 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.

FORM CMS-2567(02-99) Pnwious VefSions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID VA0183

If continuation sheet Page 6 of 36

PRINTED: 01/29/2021

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

STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIOERISUPPLIER/CLIA IOENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COM	D. 0938-0391 E SURVEY PLETED
		495357	8.WING	. <u> </u>			C / 15/2018
-	ROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 50 NORTH JEFFERSON STREET ROANOKE, VA 24016		
(X4)1D PREFIX TAG	{EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'\$ PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
	homelike environmen use his or her person possible. (i) This includes ensur receive care and serv physical layout of the independence and do (ii) The facility shall et the protection of the r or theft. §483.10(i)(2) Houseke services necessary to and comfortable interi §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private of resident room, as spec §483.10(i)(5) Adequat levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the r sound levels.	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can rices safely and that the facility maximizes resident bes not pose a safety risk. exercise reasonable care for resident's property from loss eping and maintenance o maintain a sanitary, orderly, or; ed and bath linens that are		584	DEFICIENCY)		
	by: Based on observation interview, the facility fa	n, family interview and staff ailed to maintain a clean, lelike environment on one of			1. The dining room window and carpet room #408 were cleaned.	in	

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

Facility ID VA01B3

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION G	(X3) DATE S COMPL	
		495357	B. W NG		C 02/151201	
	ROVIDER OR SUPPLIER			STREET AOORESS. CITY, STATE, ZIP CODE 650 NORTH JEFFERSON STREET		
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F 584	stained by a red subs dining room had a dr bottom pane. During initial tour of t surveyor observed a room 408 this stain w throughout the survey On 02/13/18 at appro- member directed the and stated there was the lower window and time. Immediately afte surveyor went to the was able to observe dried red substance. The surveyor rechect at 7:54 a.m. and aga substance was obser On 02/14/18 at appro- director of environment the surveyor to the di After observing the a environmental servic were red jello. The administrative sta aware of the stain on	d: 08 was observed to be tance and a window in the ied red substance on the he facility on 02/13/18, the red stain on the carpet in vas observed to be present y process. oximately 1:40 p.m., a family surveyor to the dining room a dried red substance on d it had been there for some er this conversation, the first floor dining room and several small areas of a ked this window on 02/14/18 tin at 2:00 p.m. the dried ved at both times. oximately 2:13 p.m., the ntal services accompanied ning area and room 408. reas, the director of es stated maybe these areas aff of the facility were made the carpet and the dried red dowpane in the dining area	F58	 2. Residents residing in the factor risk of being exposed to an environment of providing a comfortable and homelike environment of the area initiate immediate cleanup of specific which cannot be contained and properly by nursing staff will be housekeeping staff who will perpoper sanitation of the area. Housekeeping department will daily rounds on the nursing unensure clean and safe areas. 4. Daily round s observations reported to the QA Committee review the information. Areas r improvement in this plan will be to promote compliance. 	vironment clean, ronment. aff will pills. Spills d cleaned e reported to erform conduct nits to will be who will needing	

FORM CMS-2567(02-991Previous Vers10ns OblOlele

Facility ID. VA0183

	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	. ,		(€3) DATE SURVEY COMPLETED
		495357	B.WING		C 02/15/2018
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE. ZIP CODE	02/10/2010
	Y OF THE VALLEY			650 NORTH JEFFERSON STREET	
				ROANOKE, VA 24016	
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F 584	Continued From pag	e 8	F584	1	
	No further information	n regarding this issue was ey team prior to the exit			
F 607 ⁻ SS=D	Develop/Implement A	Abuse/Neglect Policies I-(3)	F60	7	3/30/18
	§483.12(b) The facili implement written po	ty must develop and licies and procedures that:			
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of re				
	§483.12(b){2) Establi to investigate any su	ish policies and procedures ch allegations, and			
	paragraph §483.95,	e training as required at Γ is not met as evidenced			
	by:	i is not met as evidenced			
	Based on staff interv	view and facility document aff failed to ensure a current		1. Both CNA licenses were verified being active.	d as
	professional license 25 employees (Emplo	was in good standing for 2 of oyee #7 and #16).		2. All professional facility staff, who	
	The findings included	1:		are allowed to practice only with pro certification or licensure, are at risk allowing their certificate or licensure	of
	professional license	aff failed to ensure a current was in good standing for		expire.	
	Employee #7.			3. Business Office Manager or Des will perform an initial 100% audit of	all
		cted an employee record 8:15 am. During this review,		licenses and certifications. Once ini compliance has been established, a	
		urveyor that Employee #7's		employeeos certificates/licenses w	
	-	ng Assistant) license had		verified at tme of hire. A monthly re	
	-	There were no other records		will be reviewed to identify any	
	found in the employe			license/certificate which must be up	
	professional CNA lice	ense for this employee.		in the employee file to ensure regul	atory

FORM CMS-2567(02-99) Ptavious V8t\$ions Obsolete

Facility ID. VA0183

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS F08 MEDIC ARE & MEDICAID SERVICES 0MB N L0936-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATIONNUMBER A BUILOING COMPLETED C B 'MNG 495357 02/1512018 NAME OF PROVIDER OR SUPPLIER STREET.ADDRESS CITY. STATEZIP CODE **150 NORIIi JEFFERSON STREET OUR LADY OF THE VALLEY** ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES PROVIOER'S PLAN OF CORRECTION (X<4)ID ID (X\$) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FUU PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY} F 607 Continued From page 9 F607 compliance. At 8:45 am. the surveyor notified the administrator of the above documented findings. 4. Compliance with these audits and their The administrator stated, "I will go and talk to findings will be reported to QA Committee Human Resources and get back to you for their review. 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.

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

Facility ID VA0183

If oontrnuation sheet Page 10 of 36

PRINTED: 01/29/2021

	OF DEFICIENCIES	(1) PROVIDER/SUPPLIER/CUA	(X2) MULT	PLE CONSTRUCTION		10.0938-039 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		IG		MPLETED
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NAME OF P	ROVIDER OR SUPPLIER	-75557		STREET ADDRESS. CITY. STAT		2/15/2018
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OUR LAD	Y OF THE VALLEY			ROANOKE, VA 24016		
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	review on 2/15/18 at 8 it was noted by the su CNA (Certified Nursin expired on 1/31/18. Tr found in the employee professional CNA lice At 8:45 am, the surve administrator of the at The administrator stat Human Resources an concerning this." The administrator retu approximately 9 am. T "Here is a copy of the this employee." The a copy of the current loc CNA license. The sun the top of the page of "License Lookup Curr " The surveyor requ	nse for this employee. yor notified the pove documented findings. ted, "I will go and talk to				
	the facility's policy title Abuse Neglect and Ex surveyor noted under Abuse and Neglect Pr Screening" which nurses' and certified r on their respective Bo	vided the surveyor a copy of ed "Right to Dignity from eploitation" at 11 am. The the section of "Resident evention Program in stated,"1b. Licensed nurses' aides must be listed ard of Nursing registry as se in good standing"				
		the administrative team of d findings on 2/15/18 at				

Facilily ID. VA0183

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER				E SURVEY IPLETED
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F 607 F 641 SS=D	5:03pm. No further informatio surveyor prior to the Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on staff interv review, the facility sta accurate MDS (minin for one of 19 Residen The findings included For Resident #68, the Resident as being di hospital when in fact home. The record review rev had been admitted to Diagnoses included, psychotic disorder an Section C (cognitive admission MDS asse (assessment reference	n was provided to the exit conference on 2/15/18. ents of Assessments. st accurately reflect the T is not met as evidenced view and clinical record aff failed to ensure an num data set) assessment its, Resident #68. d. e MDS coordinator coded the scharged to an acute he had been discharged vealed that Resident #68 the facility 12/05/17. but were not limited to, id malnutrition. patterns) of the Residents	F64	7	te of tate dents lity for for ere surse will esidents g. Any lat time.	3/30/18
	problems. The Resident had be 12/23/17.	en discharged home on				

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Ewnt ID:R72W11 Facility ID: VA0183

If continuation sheet Page 12 of 36

OF DEFICIENCIES					
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The Residents discha an ARO of 12123/17 the Resident had bee hospital. The clinical record inc	rge MOS assessment with had been coded to indicate n discharged to an acute cluded a physician telephone	F64	1		
On 02/15/18 at 10:43 the discharge MDS w After reviewing the M stated she had marke she would find out how The administrative sta inaccurate MDS asse	a.m., the surveyor reviewed ith the MOS coordinator. DS, the MDS coordinator ed acute hospital in error and v to fix it. aff were notified of the ssment during a meeting				
approximately 5:00 p Prior to the exit confe coordinator provided corrected MDS indica discharged to the "co No further information provided to the survey conference. Baseline Care Plan	m. rence on 02115/18 the MOS the surveyor with a copy of a ting the Resident had been l'Mlunity." n regarding this issue was y team prior to the exit	F65	5	3/30/1	18
Planning §483.21(a) Baseline (§483.21(aX1) The fac implement a baseline that includes the instru-	Care Plans cility must develop and care plan for each resident uctions needed to provide				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGUIATORY OR L Continued From page The Residents discha an ARO of 12123/17 If the Resident had bee hospital. The clinical record indo order dated 12122/17 F Daughter on 12123/17 On 02/15/18 at 10:43 the discharge MDS w After reviewing the M stated she had marked she would find out how The administrative state inaccurate MDS assed with the survey team approximately 5:00 p Prior to the exit confer coordinator provided corrected MDS indica discharged to the "coon No further information provided to the survey conference. Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehenss Planning §483.21(a) Baseline (§483.21(aX1) The factor implement a baseline that includes the instru- effective and person-	ROVIDER OR SUPPLIER Y OF THE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(aX1) The facility must develop and implement 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	A BOILDING 19 OVIDER OR SUPPLIER Y OF THE VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION) PRECEDED BY FULL REGUIATORY OR LSC IDENTIFYING INFORMATION) F64 The Residents discharge MOS assessment with an ARO of 12123/17 had been coded to indicate the Resident had been discharge 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 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. F65 Baseline Care Plan CFR(s): 483.21 (a)(1)-(3) F65 §483.21 (a) Baseline Care Plans §483.21(a) Baseline Care Plans §483.21(a) Baseline Care Plans §483.21(a) Baseline Care Plans §483.21(a) Daseline Care Plans §483.21(be the instructions needed to provide effective and person-centered care of the resident	A BULLING NOVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, 2IP CODE 150 NORTH JEFFERSON STREET ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REGUATORY OR LSC DENTIFYING INFORMATION) D 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. F641 The clinical record included a physician telephone order dated 12122/17 to 'Discharge home with Daughter on 12123/17 at 1:00pm." F641 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. After reviewing the MDS, the MDS coordinator. After reviewing the MDS, the MDS coordinator. After reviewing the MDS acordinator. After reviewing the MDS acordinator. 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." F655 S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(3) S483.21(a)(1)-(4) S483.21(a)(1)-(5) S483.21(a)(1)-(6) S483.21(a)	A BULLING C 2015120 STREET ADDRESS CITY: STATE JP CODE STREET ROADRESS CITY: STATE JP CODE Y OF THE VALLEY ID Continued From page 12 The Residents discharge MOS assessment with an ARO of 1223/17 at 1:00 pm." The clinical record included a physician telephone order dated 12122/17 to 'Discharge home with Daughter on 12123/17 at 1:00 pm." The administrative staff were notified of the inaccurate MDS assessment during a meeting with the survey team on 02115/18 the MOS coordinator provided the survey or than acouge or discharged to the colluminy." No further information regarding this issue was provided to the survey team prior to the exit conference. Baseline Care Plans S483.21(a)X(1) The facitity mustdevelop and implement abseline Care Plans S483.21(a) Base

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PREFX TAG (EACH DEPICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Constraints F655 Continued From page 13 that meet professional standards of quality care. The baseline care plan must. F655 (i) Be developed within 48 hours of a residents admission. F655 F655 (i) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: F655 (i) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: F655 (ii) Detays pervices. (i) Detay services. (i) Detay services. (ii) Social services. (i) Detays pervices. (ii) Social services. (iii) Advective care plan in place of the baseline care plan if the comprehensive care plan. (i) developed within 48 hours of the residents admission. (iii) Meets the requirements set forth in paragraph (b) 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: (iii) As summary of the resident's admissior. (ii) As unmary of the resident's medications and detary instructions. (iii) Any services and treatments to be administread by the facility and personnel acting on behalf of the facility. <td< td=""><td>OUR LAD</td><td>Y OF THE VALLEY</td><td></td><td></td><td>F</td><td>ROANOKE, VA 24016</td><td></td><td></td></td<>	OUR LAD	Y OF THE VALLEY			F	ROANOKE, VA 24016		
that meet professional standards of quality care. The baseline care plan must. (i) Be developed within 48 hours of a residents admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (i) Initial goals based on admission orders. (ii) Detary orders. (iii) Therapy services. (c) Detary orders. (i) Therapy services. (f) 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 residents admission. (ii) Meets the requirements set forth in paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the residents admission. (ii) A summary of the residents medications and diretary instructions. (iii) A summary of the residents medications and diretary 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 <td>PREFIX</td> <td colspan="2">(EACH DEFICIENCY MUST BE PRECEDED BY FULL</td> <td>PREF</td> <td>IX</td> <td>(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR</td> <td>BE</td> <td>COMPLETION</td>	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
	F 655	that meet professional The baseline care pla (i) Be developed with admission. (ii) Include the minimu necessary to properly including, but not lim (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care p care plan if the compr (i) Is developed with admission. (ii) Meets the require (b) of this section (exc this section). §483.21(a)(3) The fact resident and their rep of the baseline care p limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fac on behalf of the facility (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on staff intervi	I standards of quality care. n must- in 48 hours of a residenfs um healthcare information care for a resident ited to- I on admission orders. Hendation, if applicable. Solar in place of the baseline ehensive care plan- in 48 hours of the residenfs ments set forth in paragraph cepting paragraph (b)(2)(i) of Solar that includes but is not the resident. resident set for the details care plan, as necessary. is not met as evidenced ew, Resident interview and	F	655	-		
	FORM CMS-2567		-	11	Fac	·		t Page 14 of 36

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OUR LAD	Y OF THE VALLEY			650 NORTH JEFFERSON STREET ROANOKE, VA 24016			
(X4)1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC OATE	
F 655	 #266. The findings included For Resident #266, the initiate a baseline carrincontinence. Resident #266 was a 02/06/18. Diagnoses anemia, syncope arr thrombocytopenia, gas disease, history of uripain. There is no current M to Resident being a nand oriented x 3. Surveyor spoke with approximately 1400. If allen at previous fact that she was recently urinary tract infection antibiotic. Resident #266's base on 02/15/18. Surveyor plan for falls or risk of spoke to the MOS corapproximately 1335 m baseline care plan. M 	e plan for 1 of 19 Residents, : he facility staff failed to e plan for falls and risk of dmitted to the facility staff on included but not limited to hd collapse, stroesophageal reflux nary tract infection, and IOS (minimum data set) due ew admit Resident is alert Resident on 02/13/18 at Resident stated that she had ility. Resident also stated on contact precautions for and was still taking an eline care plan was reviewed for could not locate a care incontinence. Surveyor ordinator on 02/15/18 at egarding Resident #266's IDS coordinatorstated that if ecent fall, then a baseline e been initiated. MOS ed that a baseline care plan ce should have been	F65	 risk of incontinence. 2. All residents who are admitted to facility are at risk for not having thein needs addressed on the baseline caplan. 3. Staff have been and will continue educated on timely completion of bicare plan. The DON or designee wirall new admission baseline care plar weekly to ensure baseline care plar complete. 4. Baseline care plan audit findings reviewed in the quarterly QA comm 	r are to be aseline Il audit ns ns are will be		

EvenI ID:R72W11

f ac;lity ID VA0183

FORM CMS-2567(02-99) Previous Vers,ans Obsolete

If oon nuation sheet Page 15 of 38

PRINTED: 01/29/2021 FORM APPROVED 0MB NO: 0938-0391

CENTER	<u>S FUR IVIEDICARE &</u>	MEDICAID SERVICES					J. 0938-0391
	DF' DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMER:			CONSTRUCTION	()(3) DATE SURVEY COMPLETED	
		405267	.B IMNG	.B IMNG		C 02/1512018	
		495367				02	/1512018
NAME OF'P	ROVIDER OR SUPPLIER				STREET ADDRESS. CITY. STATE, ZIP CODE		
OUR LAD	Y OF THE VALLEY			6	60 NORTH JEFFERSON STREET		
				F	ROANOKE, VA 24018		
()(4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION OATe
F 655	Resident #266's clinic contained a progress PM which read in part Resident to toilet. Wh away. Resident was I pain and discomfort a head. Able to move a and RP (responsible The concern of not ha care plan was discuss team during a meetin approximately 1700 No further information Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive a (ii) Prepared by an in- includes but is not lim (A) The attending phy (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac the resident and the r An explanation must medical record if the	cal record was reviewed and note dated 02/12/18 1:49 t "CNA was transferring nen Resident legs gave owered to floor. Denies any at this time. Denies hitting Il extremities x 4 well. MD party) made aware". aving a complete baseline sed with the acIrninistrative g on 02/15/17 at m was provided prior to exit. d Revision (i)-(iii) ensive Care Plans brehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that ited to- /sician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined		655			3/30/18
	7(02-99) Previous Varsions Obs0	Diela Ewni ID:R72	2\//11	E-	nility ID: \/A0183	uation at a	of Page 16 of 20
1 OLINI CIVIO-200	(UZ-33) FIEVIOUS VAISIONS ODSU		<u>~vvii</u>	гa	cility ID: VA0183 If contin	ualiuii sne	et Page 16 of 36

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CON	E SURVEY IPLETED C 2/15/2018
475357 0	
OUR LADY OF THE VALLEY 650 NORTH JEFFERSON STREET	
ROANOKE, VA 24016	
(X4)ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX TAG REGULATORY OR LSCIDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
 F 667 1 Continued From page 16 (F) Other appropriate staff or professionals in disciplineasy determined by the resident's needs or as requested by the resident's needs or as requested by the resident's needs or as requested by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REDUREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the person centreed 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. 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 11/4/18, her 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 scilicial record on 2/14 and 2/15/18. During this review, it was noted by the surveyor that Resident #46 had a fail on 117/17. When the surveyor reviewed the care plan, the care plan did not reflect the fail that the resident had on more compliance. Findings will be reviewed in quarterly QA. 	

FORM CMS-2567(02-99) Pre\lious Ve111ions Obsolete

Facility 10: VA0183

If continuation sheet Page 17 of 36

CENTER	S FOR MEDICARE &	MEDICAID \$EiiVICES				OMB NO	0. 0938-0391	
	OF DEFICIENCES CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495357	B. WNG			C 02/15/2018		
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				н	O NORTH JEFFERSON STREET			
OUR LAD	Y OF THE VALLEY			R	OANOKE, VA 24016			
()(4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEDTOTHEAPPRoPRIA DEFICIENCY)		(x&) COMP\.ETION DATE	
	Continued From page 1117/17. On 2/15/18 at 5:03 pr administrative team of findings. No further information surveyor prior to the e 2. The facility stat the person centered of Resident #7. Resident #7 was read 10/16/17 with the follo limited to heart failure disorder, depression at the quarterly MDS (Mit ARD (Assessment Ret the resident was code Interview for Mental S possible score of 15. coded as requiring ex member for dressing at on 1 staff member for The surveyor conduct #7's clinical record on this review, the survey physician had ordered antibiotic twice a day f resident's left lower ex noted that on 2/8118,	e 17 m, the su,veyor notified the of the above documented Was provided to the exit conference on 2115/18. If failed to review and revise comprehensive care plan for dmitted to the facility on owing diagnoses of, but not , dementia, anxiety and psychotic disorder. On inimum Data Set) with an efference Date) of 11/13/17, ed as having a BIMS (Brief Status) score of 5 out of a Resident #7 was also tensive assistance of 1 staff and being totafly dependent bathing. ted a review of Resident 2/14 and 2115118. During yor noted that on 2/8/18 the d the resident to receive an	TAG	557		re	DATE	
	hibaclens cleanser. T Resident #7's care pla	he surveyor also reviewed an. The surveyor noted that an had not be updated to						

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

Facility ID VA0183

Ir oontinualion sheet Paga 18 of 36 $\,$

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

PRINTED 01/29/2021 FORM APPROVED 0MB NO. 0938-0391

STATEMENT OF DEFICIENCES (M) PROVIDERSUPPLIENCULA DETITION MURDERSUPPLIENCULA (OC) MULTPLE CONSTRUCTION (DS) MULTPLE CONSTR		<u>S FUR MEDICARE & I</u>	VILDICAID SERVICES			UND NO. 0938-0391			
495357 In WING 02/15/2018 INME OF PROVIDER OR SUPPLIER STREET ADDRESS. CTT: STATE21PCODE NON ORTH JEFFERSON STREET COUR LADY OF THE VALLEY STREET ADDRESS. CTT: STATE21PCODE NON ORTH JEFFERSON STREET COURS. NOT OF THE VALLEY COURS. NOT COURSECTION (INSTRUCT OF DEFICIENCES AT THE NOT OF COURSECTION INSTRUCT OR LIGO DESTRUCT NOT THE APPROPRIATE COURS. THE NOT OF COURSECTION (INSTRUCT OR LIGO DESTRUCT OR LIGO				. ,					
OUR LADY F THE VALLEY DO NORTH JEFFERSON STREET ROMOKE, VA 2001 PRETEX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY OR LS DEMTIFING INFORMATOR) DB PRETEX TAC DD NORTH JEFFERSON STREET ROMOKE, VA 2001 CONSENTING (EACH CORRECTIVE ACTION BROUGHES IN TAXION (EACH CORRECTIVE ACTION BROUGHES ACTION (EACH C			495357	B WNG					
OUR LADY OF THE VALLEY ROANCKE, VA 24016 Image: Constraint of the constene consthe constraint of the constraint of the consthe constra	NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS. CITY. STATEZIPCODE	-			
PARTD PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES INVEXTORY OR USCIDENTIFYING INFORMATION ICAC CORRECTIVE ACTION SOULD BE REGULATORY OR USCIDENTIFYING INFORMATION REGULATORY OR USCIDENTIFYING INFORMATION No further information was provided to the surveyor prior to the exit conference on 2/15/18 at 5.03 pm in the conference on 2/15/18. F657 3. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #49 was readmitted to the facility on 5/9/14 with the following diagnoses of, but not limited to domentia, Parkinson's disease and depression. On the quarterly MDS (Minimum Data Sei) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Bire Interview of Nertal Status) score of 12 out of apossible score of 15. Resident #49 was also coded as being totally dependent n1 staff member for dressing, personal hygiene and bathing. The surveyor notified the administrative team of the surveyor noted that the physician ordered antibiotis to be placed in the resident #49's clinical record on 2/15/18. During this review, the surveyor noted that the physician ordered these on 2/15/18 The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5.03 pm. Inversion ordered these on 2/15/18 at 5.03 pm. Inversion ordered these on 2/15/18 at 5.03 pm. <td></td> <td></td> <td></td> <td>НО</td> <td>NORTH JEFFERSON STREET</td> <td></td>				НО	NORTH JEFFERSON STREET				
Presix TAG (BACH CORRECT AUTORY OR USC IDENTIFYING INFORMATION) PRE-TX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE COMPLETE ONLY F 657 Continued From page 18 The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm in the conference room. F657 No further information was provided to the surveyor prior to the exit conference on 2/15/18. F657 S. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #49. F667 Resident #49 was readmitted to the facility on 5/9/14 with the following diagnoses of, but not limited to dementia, Parkinson's disease and depression. On the quarterly MDS (Minimum Data Sci with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (Enter Interview of Mental Status) score of 12 out of a possible score of 15. Resident #49 was los 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 bay shampoo a the bedime each night. The physician ordered these on 2/9/18 The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5:03 pm.	OUR LAD	Y OF THE VALLEY		ROA	ANOKE, VA 24016				
The surveyor notified the administrative team of the above documented findings on 2/15/18 at 50.3 pm in the conference room. F657 No further information was provided to the surveyor prior to the exit conference on 2/15/18. F657 3. The facility staff failed to review and revise the person centered comprehensive care plan for Resident #49. F657 Resident #49 was readmitted to the facility on 5/9/16 with the following diagnoses of, but not limited to dementic. Parkinson's disease and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/6/18, 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. Unring this review, the surveyor noted the physician ordered these on 2/9/18. The surveyor that the physician ordered these on 2/8/18. The surveyor note than for dressing, personal hygiene and bathing. The surveyor conducted review of Resident #49's clinical record on 2/15/18. Unring this review, the surveyor note the physician ordered these on 2/9/18. The surveyor note than for dressing, personal hygiene and bathing. The surveyor notified the administrative team of the above documented findings on 2/15/18 at 5/3 pm.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	E COMPLETION			
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. Resident #49. Resident #49. Resident #49. Data Set) with an ARD (Assessment Reference Date) of 1/16/18, the resident was coded as having a BIMS (fired interview of Mental Status) score of 12 out of a possible score of 15. Resident #49 was also code as being totally dependent on 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for dressing, personal hygiene and being totally the evides to be washed with baby shampoo at beditme each night. The physician ordered has one 2/16/18. The surveyor reviewed the care plan for Resident #49's time image and the updated to reflect the physician ordered has one or 2/18/18. The surveyor reviewed the care plan for Resident #49's time source previewed the care plan for Resident #49. The surveyor reviewed the care plan for Resident #49's time source previewed the care plan for Resident #49. The surveyor reviewed the care plan for Resident #49's time source previewed the care plan for Resident #49. The surveyor rowithed the doministrative team of the above documented findings on 2/15/18 at 5.03 pm.	170			inte					
the above documented findings on 2/15/18 at 5:03 pm.	TAG	Continued From page The surveyor notified the above documente 5:03 pm in the confere No further information surveyor prior to the e 3. The facility sta the person centered of Resident #49 was rea 5/9/16 with the followi limited to dementia, P depression. On the qu Data Set) with an ARE Date) of 1/16/18, the personal hygiene and the surveyor conduct clinical record on 2/15 surveyor noted that the antibiotics to be place three times a day for be washed with baby night. The physician of The surveyor reviewe #49. It was noted by t resident's care plan h	SC IDENTIFYING INFORMATION) a 18 the administrative team of ad findings on 2/15/18 at ence room. a was provided to the exit conference on 2/15/18. If failed to review and revise comprehensive care plan for admitted to the facility on ng diagnoses of, but not arterly MDS (Minimum D (Assessment Reference resident was coded as Interview for Mental Status) possible score of 15. o coded as being totally member for dressing, bathing. ed review of Resident #49's 5/18. During this review, the re physician ordered d in the resident's eyes 14 days and the eyelids to shampoo at bedtime each ordered these on 2/9/18. d the care plan for Resident he surveyor that the ad not be updated to reflect	TAG	CROSS-REFERENCED TO THE APPROPRIA				
		the above documente 5:03 pm.	d findings on 2/15/18 at	N44	JD. 140402				

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STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IOENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
		495357				C 02/1512018		
NAME OF P	ROVIDER OR SUPPLIER		- 	STREET ADORES\$, CITY. STATE, ZIP CO	DDE			
				860 NORTH JEFFERSON STREET				
OUR LAD	Y OF THE VALLEY			ROANOKE, VA 24016				
				ROANORE, VA 24010				
(X4)ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	ION SHOULD BE HE APPROPRIA		(X6) COMPLETION DAIE	
F 657	No further informati surveyor prior to the 4. For Resident fl6 the and revise the care p falls. Resident fl6 was adm 05/15/13. Diagnoses depression, osteopord dementia, macular d gastroesophageal refi glaucoma and hyperte The most recent MDS an ARD (assessment coded the Resident a cognitive status. Resident's clinical rec contained nurse's pro part "02/09/18 02:56 A <i>02108</i> no injuries obs AM Resident did have bathroom on the 7 to 3 un-harmed", "1212 was sleeping in her be nurses aid) heard thur room and the bed alar went to check on Res Resident laying on the the floor to get help R rolled out of bed", a Resident fl6's care pla contained a plan for fa The last fall listed on the	on was provided to the exit conference on 2/15/18. e facility staff failed to review plan for falls to include recent hitted to the facility on included but not limited to osis, rheumatoid arthritis, legeneration, lux disease, anemia, ension. 6 (minimi.m data set) with reference date) of 12/17 s 3 of 15 in section C, cord was reviewed and gress notes which read In M Rsd (Resident) had a fall served", "02/04/18 10:28 e a fall today in her 3 shift, Resident was 5//17 03:50 AM Resident ed, the CNA (certified mping coming from her m going off. VJhen the aide ident, she found the e floor banging her hand on esident stated that she and "12101/17 06:15 PM or by CNA, laying on back	F65	7				
L							_	
FORM CMS-2567	(02-991Previous Versions ObsQI	ete Event ID:R72\	V11 F	a Lily 10 VA0183	If oontinu	ation sheet	Page 20 of 36	

PRINTED	: 01/29/2021
FORM	APPROVED
	0038-0301

STATEMENT	OF DEFICIENCIES CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				()(3) DATE SURVIEY COMPLETED	
		(B. W NG					С
	ROVIDER OR SUPPLIER	495357		STRE 650 N	ET ADDRESS. CITY, STATE, ZIP COOE IORTH JEFFERSON STREET NOKE, VA 24016		02/	1612018
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F 657	02/15/18 at approxim plan for Resident 11 that care plans are r quarterly. Also stated and the unit coordina care plans. Surveyor fall, how soon should as possible. Surveyor fall in December, if it now and she stated the The concern of not r care plan was discuss team during a meetir approximately 1700 No further informatio 5.The facility staff fal comprehensive care reflect the resident ref Resident #5, was add 07/12/12, and readm following diagnoses: high blood pressure, arthritis, and hypoth Resident #S's most r set) assessment com an annual assessme reference date) of 11 patterns} of this asse to have both short ar problems. Section B	the MDS coordinator on nately 0910 regarding care 6. MOS coordinator stated eviewed and revised d that the nurses on the floor ators helped out with updating asked if a Resident had a d it be put on the care plan, t she tries to put it on as soon or asked if a Resident had a should be on care plan by that it should. eviewing and updated the seed with the administrative ng on 02/15/18 at 0. n was provided prior to exit. led to review and revise the e plan for Resident #5 to emoves her clothing in public. mitted to the facility on itted on 12/2/13, with the dementia with behaviors, depression,angina pectoris,	F	657				
ORM CMS-256	7(02-99)Pte\IIOUS Versions Obs	solete Even!IO: R72	2W11	Facility	ID- VA0183	If conUnu	ation shee	t Page 21 of 36

	MENT OF HEALTH ANI					FORM	D: 01/29/2021 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	. ,	IPLE CONSTRUCTION		(X3) DATE	
		495357	B. WNG				C /15/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS,	, CITY, STATE, ZIP CODE		
OUR LAD	OF THE VALLEY			650 NORTH JEFFE			
				ROANOKE, VA	24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIOER'S PI.AN OF CORRECTIO I CORRECTIVE ACTION SHOULD REFERENCEDTO THE APPROPR DEFICIENCY)	BE	()(5) COIIFI.£TION DATE
F 657	without her top in the staff replaced it, CNA removes her top wher The surveyor reviewe plan on 2/13/18. The or resident incontinent a all activities of daily liv had behaviors of ware not contain a informat removing her own clot The admmistrator and informed of the finding survey team on 2/14/1 Prior to exit updated or provided to the survey removing her clothes. 6. For Resident #219, review and revise the indicate the Resident The record review rev had been admitted to Diagnoses included, b partial infarct, acute re syndrome, essential Alzheimer's disease. There was no complet set} assessment on th was alert and orientate	also coded requiring sons for bed mobility, thing, and hygiene. esident #5 was observed dining room at lunch. The #1, told the surveyor "she in she gets hot." d the comprehensive care care plan revealed the nd requires assistance with ring. It also indicated she dering. The care plan did ion of the residents thing in public. d director of nursing were gs during a meeting with the 16 at 4:30 p.m. care plan information was yor related to the resident the facility staff failed to Residents care plan to was on 15-minute checks. ealed that Resident #219 the facility 02/09/18. but were not limited to, left enal failure, chronic pain hypertension, and ted MDS (minimumdata nis Resident. The Resident ed to self. Numerous	F6	57			
FORM CMS,2567		ade of the Resident during	V11	Facility 10. VA0183	lf contir	nuation shee	et Page 22 of 36

PRINTED : 01/29/2021 FORM APPROVED

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			0MB NO. 0 0391	
STATEMENT ON N/0 PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(XJ) DATE SURVEY COMPLETED	
		495357	B . W NG		C 02/1512018	
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				650 NORTH JEFFERSON STREET		
OUR LAD	Y OF THE VALLEY			ROANOKE, VA 24016		
(}(4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X&)	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E	E COMPLETION	
TAO	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS.REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE	
				DEFICIENCY		
F 657	Continued From page		F65	7		
		he Resident would present				
	as confused at times					
	Dan that distingt as a solution	naviana (I. Desident mes				
		review, the Resident was				
	attempting to leave the	checks on 02/11/18 after				
	allempling to leave the	e lacinty.				
	A review of the Reside	ents baseline care plan				
		plan had not been revised				
	to include the 15-minu	•				
	-	m., during an interview with				
	the DON (director of r					
		eyor that she would expect				
	to See the 15-minute of	checks ON the care plan.				
	The administrative at	aff were notified that the				
		to review and revise the				
		regards to 15-minute				
		ing with the survey team on				
	02/15/18 at approxima					
	Prior to the exit confer	rence, the DON provided				
	the surveyor with a co	py of an updated care plan				
	that included the 15-m	inute checks.				
		regarding this issue was				
	, ,	team prior to the exit				
	conference.					
F 740	Behavioral Health Ser	VICES	F74	0	3/30/18	
SS=D	CFR(s): 483.40					
	§483.40 Behavioral he	ealth services				
		ceive and the facility must				
		behavioral health care and				
	services to attain or m					
		nental, and psychosocial				
		nce with the comprehensive				
		-				
ORM CM6•2\$7	(02·99) Prellioos Ve <sions obso<="" td=""><td>Event ID:R72W1</td><td>1 F</td><td>acili1y ID VA0183 If contin</td><td>uation sheet Page 23 of 36</td></sions>	Event ID:R72W1	1 F	acili1y ID VA0183 If contin	uation sheet Page 23 of 36	

If continuation sheet Page 23 of 36

PRINTED: 01/29/2021 FORM APPROVED

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	OF DEFICENCIES CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATIONNUMBER	· · /	(X2) MULTIPLE CONSTRUCTION A BUILDING			(XJ) DATE SURVEY COMPLETED	
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		496357	5	-		02/	Ui/2018	
	ROVIDER OR SUPPUER Y OF THE VALLEY			н	TREET ADORESS, CITY. STATE. ZIP CODE IO NORTH JEFFERSON STREET ROANOKE, VA 24016			
(X4)ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED SY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCEDTO THE APPROPRIA DEFICIENCY)		{XS) COMPUITION DATE	
F 740	encompasses a resid mental well-being, wh limited to, the preventi and substance use di This REQUIREMENT by: Based on staff intervi review , the facility staff necessary behavioral attain the highest prace 19 residents in the suf The findings included: Resident #7 was read 10/16/17 with the follo limited to heart failure, disorder, depression at the quarterly MDS (Mi ARD (Assessment Re the resident was code Interview for Mental S possible score of 15. coded as requiring ext member for dressing at on 1 staff member for The surveyor reviewe Resident #7 on 2/15/15 surveyor noted that or the "Nursing Commun physician of Resident to help in decreasing to at night. The surveyop physician order sheet	of care. Behavioral health enfs whole emotional and ich includes, but is not ion and treatment of mental sorders. T is not met as evidenced iew and clinical record ff failed to provide the health care and services to crical of well-being for 1 of rvey sample (Resident #7). Imitted to the facility on wing diagnoses of, but not , dementia, anxiety and psychotic disorder. On inimumData Set) with an efference Date) of 11/13/17, ed as having a BIMS (Brief Status) score of 5 out of a Resident #7 was also tensive assistance of 1 staff and being totally dependent bathing. d the clinical record of 8. During this review , the n 9/27/17 documentation on hication Form" notified the #7 exhibiting increased r at night. The physician o have medication changes hese behaViors and anxiety	F	740	 Resident #7 will be evaluated and assessed by behavioral health professionals on an as needed basis. Those residents exhibiting behavior signs and symptoms are at risk of not being provided with timely behavioral health care services. An audit will be preformed by the DO or Designee of each resident Js electro 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 -7 charge nurse, who will assure that there is documented evidence that a behavioral health professional has bee contacted to evaluate residents. The results of the 11-7 shift telepho audits for new behavioral health referra will be reviewedby the QA committee. 	onic e or / 11 n ne		
FORM CMS-2567	(02.99) PreviOUs Ve <sions obso<="" td=""><td>event ID;R72</td><td>2WI1</td><td>Fac</td><td>d1,ty ID. VA0183 If contin</td><td>uation shee</td><td>t Page 24 of 36</td></sions>	event ID;R72	2WI1	Fac	d1,ty ID. VA0183 If contin	uation shee	t Page 24 of 36	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OATE F 740 Continued From page 24 consult prn (as needed)". The surveyor noted a psychiatric consult that was dated for 11/14/17. F740 F740 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 F740 F740 F740 F740 F740		S FURIVIER.I. UARE &	MEDICAID SERVICES					P. 0938-0391
IMMG				. ,				IPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE OUR LADY OF THE VALLEY Street Address. CITY, STATE, ZIP CODE (X4) ID 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 SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 OATE F 740 Continued From page 24 consult prn (as needed)". The surveyor noted a psychiatric consult that was dated for 11/14/17. F740 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			495357	B. IMNG			02	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIO OATE F 740 Continued From page 24 consult prn (as needed)". The surveyor noted a psychiatric consult that was dated for 11/14/17. F740 F740 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 F740					650 NORTH JEFFERSON STREET			
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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPIETION
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. Pharmacy Strvcs/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	consult prn (as neede psychiatric consult the On 2/15/18 at approx surveyor notified the documented findings. administrator how so for a psychiatric cons behaviors and anxiet resident with a diagna anxiety disorder and stated, "The resident month." The surveyor administrator that Res behaviors and anxiet September, 2017 and for a psychiatric cons The administrator sta have been seen in Od The surveyor notified the above documente 5:03 pm on 2/15/18. No further information surveyor prior to the e Pharmacy Srvcs/Prod CFR(s): 483.45(a)(b) §483.45 Pharmacy S The facility must prov drugs and biologicals them under an agreer §483.70{9}. The facility personnel to administ permits, but only under	ed)". The surveyor noted a at was dated for 11/14/17. imately 10:30 am, the administrator of the above The surveyor asked the on a resident should be seen sult once increased ty has been seen in a osis of psychotic disorder, dementia. The administrator should be seen within a or pointed out to the sident #7 had increased y noted by the staff in d the resident was not seen ult until November, 2017. tted, "That resident should ctober." the administrative team of ed findings by the surveyor at n was provided to the exit conference on 2/15/18. cedures/Pharmacist/Records (1)-(3) ervices ide routine and emergency is to its residents, or obtain ment described in ty may pennit unlicensed ter drugs if State law					3/30/18

FORM CMS-2567(02-99) Pravious Ve<sionl OblOlele

Facility ID: VA0183

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	TERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT O ANO PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2J MUL A. BUILDI		E CONSTRUCTION		SURVEY PLETED	
		495357	B. VVIN G				C /15/2018	
NAME OF PR	OVIDER OR SUPPLIER			5	STREET ADDRESS. CITY. STATE, ZIP CODE			
	OF THE VALLEY			6	660 NORTH JEFFERSON STREET			
OUN LADI				F	ROANOKE, VA 24016			
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F 755∖	Continued From page §483.45(a) Procedure	25 es. A facility must provide	F7	755				
	that assure the acrur dispensing, and admi	es (including procedures ate acquiring, receiving, nistering of all drugs and he needs of each resident.						
	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-							
a tt \$ ru s	§483.45{b)(1) Provide aspects of the provision the facility.	es consultation On all on of pharmacy services in						
		shes a system of records of on of all controlled drugs in ble an accurate						
	order and that an acc is maintained and peri	ines that drug records are in count of all controlled drugs odically reconciled. is not met as evidenced						
	and facility document to ensure medications	iew, clinical record review review the facility staff failed were available for f 16 Residents, Resident			1. The Xifaxan for resident #266 has been administered since the date of the survey exit with no further documented entries of medication unavailable.	-		
	The findings included	:			2. Residents receiving any type of medication or medicated treatment are risk of missing a dose of prescribed	at		
	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				medication or treatment.3. 3. If a 4-day supply of pills or capsules are counted as remaining, the	Ģ		
					licensed nurses will re-order it from the pharmacy. If a medication is not availa for administration, the charge nurse wil	ble		

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	OF DEFICIENCIES F CORRECTON	(X1) PRO\IIDER/SUPPI.IER/CLIA IDENTIFICATION NUMBER:	``'	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495357	B WNG		C 02/15/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY. STATE, ZIP	CODE
OUR LAD	Y OF THE VALLEY			860 NORTH JEFFERSON STREET ROANOKE, VA 24016	
(X4) IO PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	10 PREFI TAG		TION SHOULD BE COPI.ETM THE APPROPRIATE DATE
F 755	Resident #266 was a 02/06/18. Diagnoses anemia, syncope ar thrombocytopenia, gr disease. history of ur pain. There is no current M to Resident being a r alert and oriented x 3 Resident #266's clini 02/13/18. It contained summary for the mor part, "Xifaxan tablet; (diagnosis): personal infections] Twice a da Resident #266's eMA administrationrecord contained an entry w (rifaximin) tablet; 550 1 tab; oral twice a day 4pm was initialed, wi initials. A note in the 02/09/18 read in part administered: Drug, Surveyor spoke with approximately 1500 r missing a medication should be done if a r and DON stated the f	patic encephalopathy. admitted to the facility staff on included but not limited to nd collapse, astroesophageal reflux inary tract infection, and MDS (minimum data set) due new admit. The Resident is a. cal record was reviewed on d a physician's order nth of February which read in 550mg; amt: 1 tab; oral [DX hist()()' of urinary (tract) ay; 08:00 AM, 04:00 PM" . IR (electronic medication) was reviewed and hich read in part, "Xifaxan 0 mg; Amount to administer: y". The entry for 02/09/18 at th parentheses around comments section for "02/09/18 05:06 PM Not /Item unavailable".	F7	 get the medication from the stat delivery from the pharm nurses will be in serviced medication reordering polit procedure. The DON or D audit 10% of the resident. weekly to ensure that all m available for administratio orders. 4. The findings of medicate audit will be reported to the and the pharmacy for any interventions. 	nacy. Licensed on the icy and esignee will s medications nedications are n per MD ion availability e QA committee

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER: 495357	()(2) MULTIPLE CO A BUILDING B. 'MNG		CON	E SURVEY PLETED C 2/15/2018
	ROVIDER OR SUPPLIER Y OF THE VALLEY		НО	EET ADDRESS, CITY, STATĘZIP CODE No RTH JEFFERSON STREET NOKE, VA 24016		
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F755 F 761 SS=D	policy entitled "Admir which read in part, "1 shall be timely to avoid Medications should be pharmacy procedures procedures. If a medi- not arrive as schedul- designee shall be not can be contacted via or follow electronic re- status". The concern of the m- was discussed with during a meeting on (1700. No further information Label/Store Drugs an CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci- biologicals in locked of	and was provided with a histration of Medications" 2. Medication fills and refills id missed dosages. e reordered according to the s or electronic record vendor cation that is ordered does ed, the Director of Nursing or ified so that the pharmacy telephone for a stat deliver cord for policy for checking edication not being available the administrative team 02/15/16 at approximately n was provided prior to exit. d Biologicals (1)(2) of Drugs and Biologicals e with currently accepted es and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and pennit only authorized	f 755			3/30/18

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2021 FORM APPROVED QMB NO B-0391

STATEMENT OF		(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTIPI F	CONSTRUCTION	(X3) OATE	
ANO PLANOF CO		IOENTIFICATION NUMBER:	· ,			LETED
			B WING			С
		495367			02/	15/2018
NAME OF PRC	VIDER OR SUPPLIER			STREET ADDRESS. CITY. STATE, ZIP COOE		
OUR LADY	OF THE VALLEY			50 NORTH JEFFERSON STREET ROANOKE, VA 24016		
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{X4JID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS.REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPUITION DATE
<pre> { } } t f f f f f f f f f f f f</pre>	ocked, permanently a storage of controlled of he Comprehensive D Control Act of 1976 ar abuse, except when the backage drug distribur quantity stored is mini- pe readily detected. This REQUIREMENT by: Based on observation document review, the medications were sto The findings included: The surveyor observe op of the medication of probiotic/dietary supp On 02/13/18 at 3:57 p he unit. Upon entering observe LPN (licensed medications cart. The s hat she would be observed to and LPN #4 both appr Joon reaching this ca observe one box of ci asked LPN #4 if she h medication on top of the stated that she did no medication on top of h	ility must provide separately diffixed compartments for drugs listed in Schedule II of rug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced in, staff Interview, and facility facility staff failed to ensure red securely on 1 of 2 units. d one box of culturelle on cart. Culturelle is a blement. o.m., the surveyor entered g, the unit the surveyor d practical nurse) #4 at the surveyor informed LPN #4 serving her give e administration of ond resident, the surveyor coached the medication cart. rt, the surveyor was able to ulturelle. The surveyor ad intended to leave this he cart to which LPN #4 ot intend to leave the er cart. d a Resident in the vicinity	F 761	 The LPN who left the Culturelle on t of the medication cart has been in se,viced. Any medications received from the pharmacy could be improperly stored. Administrativestaff will note any iten stored on top of medication carts during their daily rounds. Licensed staff who a noted to be Improperly storing mediatio on the medication carts will be in-servic at the time of discovery. The medication will be immediately stored in its proper place. Medication storage compliance will b reviewed with the members of the QA committee. 	ns are ns æd n	
0/10/2007	2-33/ FIEVIOUS VEISIONS UD\$U	Even! ID: R/2W	та га	unity iD. VAUIO.3 If CONTINU	auon sneet	t Page 29 of 36

FORM APPROVED C!=NTERS FOR MEDICARE & MEDICAID SERVICES OMO NO. 0938-0391 STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CIIA (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY ANO Pt.AN OF CORRECTION **IOENTIFICATION NUMBER:** COMPLETED A BUILCNNG С B VI/ING 495357 02/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, ZIP CODE HO NORTH JEFFERSON STREET OUR LADY OF THE VALLEY ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S Pt.AN OF CORRECTION (X5) COMPIETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEDTO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 29 F 761 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 868 OM Committee F868 3/8/18 CFR(s): 483.75(9)(1)(i)-{iii)(2)(i) SS=D §483.75(9) Quality assessment and assurance. §483.75(9)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum 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 1. The Medical Director has attended all review, the facility staff failed to ensure the QA meetings in the last six months. medical director or their designee was present at the QA (quality assurance) meeting In January 2. The Quarterly QA Meetings cannot 2017. effectively identify and address issues when not represented by a physician. The findings included. 3. The Medical Director was educated on The facility failed to ensure the medical director or the necessity of her presence at each QA their designee attended the QA meeting held Meeting. If she is unable to attend, she 01/09/17 {1st quarter). This was the QA meeting will appoint an appropriate representative. held after the FOSS (federal overaight survey)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Facilily ID VA0183

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		MEDICAID SERVICES					M APPROVE 0. <u>0938-03</u>		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPUER/CLIA IOENTIFICATION NUMBER :	(X2) MUL A BUILD		CONSTRUCTION	(X3) DATE	E SURVEY IPLETED		
		495357	B 1∧IING			02	C /15/2018		
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F 868	Continued From page	e 30	F	368					
	completed December			000	4. The QA attendance sheet will be				
					reviewed by the facility Administrator of	or			
		eximately 2:50 p.m., the			Designee after each quarterly meeting				
	surveyor requested o								
		vould indicate the medical							
		nee was present at the s that had been held since							
	the last survey (Dece								
	The administrator pro	vided the surveyor with							
		icate the medical director or							
		resent at all the QA meetings							
		on 01/09/17. When asked							
		nature the administrator eyor that no physician was							
	present at this meetin								
	No further information	n regarding this issue was							
		y team prior to the exit							
	conference.								
	Influenza and Pneum CFR(s): 483.80(dX1	ococcal Immunizations)(2)	F	883			3/30/18		
	§483.BO(d) Influenza	and pneumococcal							
	immunizations								
		za. The facility must develop							
	policies and procedur	es to ensure that- influenza immunization,							
		resident's representative							
		egarding the benefits and							
	potential side effects								
	(ii) Each resident is of								
	immunization Octobe								
	annually, unless the in	mmunization is medically							

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

contraindicated or the resident has already been

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

immunized during this time period;

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Ir continuation sheet Page 31 of 38

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-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER	(X2) MULTI A. BUILCN	IPLE CONSTRUCTION	_	()(3) DATE COMF	SURVEY PLETED
		495367	B. IMNG				C /15/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS. CITY,	STATE. ZIP CODE		
OUR LAD	Y OF THE VALLEY			860 NORTH JEFFERSON R DANOKE, VA 24016			
()(4)10 PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IOENTIFYING INFORMATION)	PREACY		R S PLAN OF CORRECTION 독대산범 슈영 가위험 유부위상 무류류 DEFICIENCY)	TE	(X6) COMBLETION
F 883	 (iv)The residenfs media documentation that in following: (A) That the resident was provided education and potential side effection munization: and (B) That the resident of immunization or did not immunization or did not immunization due to refusal. §483.80(d){2) Pneumore must develop policies that- (i) Before offering the immunization, each refuse and potential immunization; (ii) Each resident is of immunization; (iii) Each resident is of immunization, unless medically contraindication that in following: (A) That the resident or th has the opportunity to (iv)The resident's media documentation that in following: (A) That the resident or the pneumococcal immunization; and (B) That the resident or refusion that in following: (A) That the resident or the pneumococcal immunization; and contraindication or refusion that the pneumococcal immunization and the pneumococcal immunization or refusion o	dical record includes adicates, at a minimum, the or resident's representative on regarding the benefits acts of influenza either received the influenza ot receive the influenza medical contraindicationsor bococcal disease . The facility and procedures to ensure e pneumococcal esident or the residenfs es education regarding the side effects of the fered a pneumococcal the immunization is ated or the residenthas ted; e resident's representative refuse immunization: and dicat record includes dicates, at a minimum. the or resident's representative en regarding the benefits ects of pneumococcal either received the hizationor did not receive munization due to medical	F8				
FORM CMS-256	7(02-99) Previous Versions Obsc	lete Event ID;R72W1	1	Facility ID VA0183	If continu	ation she	et Page 32 of 36

PRINTED : 01/29/2021 FORM APPROVED

0MBNO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANO PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING С B. WN G 495367 02/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 660 NORTH JEFFERSON STREET OUR LADY OF THE VALLEY ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPI..E (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX OATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 883 Continued From page 32 f 883 Based on staff interview and clinical record 1. Resident #217has documentation signed by his responsible party which review, the facility staff failed to obtain the Residents flu and pneumonia vaccine status for Indicates refusal of the flu vaccine. Resident#218 has documentation two of 19 Residents, Residents #217 and #218. indicating that the resident had received both the flu and pneumonia vaccines The findings included. during the fall of 2017. 1. For Resident #217, the facility staff failed to obtain the Residents flu and pneumonia vaccine 2. Residents already residing in or newly status until asked by the surveyor. admitted to the facility are at risk of not being provided the opportunity to receive The record review revealed that Resident #217 the flu or pneumonia vaccine had been admitted to the facility 12/20/17. Diagnoses included, but were not limited to, adult 3. The Admissions Nurse or designee will failure to thrive, malignant neoplasm, depressive interview the residents or the residents disorder, gastro-esophageal reflux disease, and responsible party to ask if and when the resident was offered the flu and/or altered mental status. pneumonia vaccines. The Admissions Section O (special treatments, procedures, and Nurse will document the acceptance or refusal of the vaccines. The DON or programs) of the Residents admission MOS (minimum data set) assessment with an ARD Designee will review all new admissions (assessment reference date) of 12127/17 had charts for the appropriate immunization been coded "Not offered" for the influenza documentation vaccine. For the guestions "Is the resident's Pneumococcal vaccination up to date?" and "If 4. The results of the audit will be presented to the QA committee. Additional Pneumococcal Vaccine not received. state interventions will be initiated if the audit reason." The facility staff had documented "Not assessed/no information." indicates necessity. 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

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Fac ifrty ID- VA01BJ

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U.ENTER	S FOR MEDICARE &	VIEDICAID SERVIC	<u>-0</u>				UNR NO	. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49535	7	B. W NG				C 15/2018
NAM: OF PR	OVIDER OR SUPPLIER	-		S	TREET PDDRESS. CIIY. STATEZIP COO			
				F	IO NORTH JEFFERSON STREET			
OUR LADY	Y OF THE VALLEY				ROANOKE, VA 24016			
	0.0000000000000000000000000000000000000	TEMENT OF REFINENCE	_		·			
(X4)ID PREFIX		ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION			(XS) COMPLETION
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE			DATE
					DEFICIENQ')			
F 883	Continued From page	e 33		F883				
	pneumonia/flu vaccine							
		- sialus 011 02/ 13/ 10	•					
	The clinical record inc	cluded the following	nursing					
	progress noted dated							
		out PNE/Flu immun						
	Declined but wanted r							
	(Resident) to see if he		_					
		id he declined to be	•					
	immunized. Consent f		nurse					
	documenting conversa							
	(Resident) and	(spouse)."	_					
		(00000)						
	During an interview w	rith the interim, DON	on					
	02/14/18 at 9:56 AM t							
	to the surveyor that th							
	Residents flu status u							
		,,						
	On 02/15/18 at 1:20 p	o.m., the interim DO	N					
	verbalized to the surve							
	spouse came in last n							
	regarding flu/pneumoi							
	The administrative tea	am were notified of t	he					
	issues regarding the F	Residents pneumoni	a/flu					
	vaccine status during							
	team on 02/14/18 at 4							
	02/15/18 at 5:00 p.m.							
	-							
	No further information							
	provided to the survey	/ team prior to the ex	kit					
	conference.							
	2. For Resident #218,							
	obtain the Residents f		accine					
	status until asked by the	he surveyor.						
	The record review rev							
	had been admitted to							
	Diagnoses included, b	out were not limited t	0,					
FORM CMS-2567	(02-99) Pre1110Us Vefsl009 Obso	lete	Event IO;R72W11	Fac	sili1y ID VAOt 83	If continua	ation sheet	Page 34 of 36

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391
-	OF DEFICIENCIES	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495357	svi/ing_				C /15/2018
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS. CITY, STATE, ZIP CODE		
OUR LAD	Y OF THE VALLEY				HO NORTH JEFFERSON STREET ROANOKE, VA 24016		
					PROVIDER'S PLAN OF CORRECTION		
(X4)10 PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCEDTO THE APPROPRI DEFICIENCY)			(X51 COMPI.ETION CATE
F 883	Continued From page	e 34	F8	383			
	essential hypertension, congestive heart failure, gastro-esophageal reflux disease, history of acute myocardial infarction, and anxiety disorder.						
	There was no comple set) assessment for t	eted MDS (minimum data his Resident.					
	The Residents clinica following documenta						
		Daughter unsure of flu and					
		ination history. VVill need to					
		ding history since he has					
		d not include any further					
	documentation until the status was questione	ne Residents flu/pneumonia d by the surveyor.					
		n., per an interview with the					
		of nursing) in regards to the eumonia vaccine/status. The					
		ney (the facility) had checked					
		revious facility and the					
	Resident had not bee	n vaccinated there.					
	On 02/14/18 the facili	ty nursing staff documented					
		power of attorney) this					
		ne has talked to her brother					
	about immunization s left to call facility"	tatus of residentMessage					
		aff were made aware of the					
		ne Residents pneumonia					
	and flu vaccine status survey team on 02/14	s during a meeting with the 4/18 at 4:25 p.m.					
		cedure titled "Immunization					
		ococcal" read in part "The I be offered annually by the					
			1		1		

FORM CMS-2567(02-99) PIIIIIiOuS VB<Sions Obsolete

Facility ID VA0183

PRINTED: 01/29/2021 FORM APPROVED 0MB NO. 0938-0391

TATEMENT OF ID PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		495357	B VING				 15/2018
	OVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COD HO NORTH JEFFERSON STREET ROANOKE, VA 24016	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIAT		(XS) COMPLETIO OAT!:
	October through Marc vaccineswill be offer community will docum refusal of immunizati On 02/15/18, the nurs (physical therapist) to message that POA wa department instead of this nurse that POA h received both PNE/FL No further infonnation	uring the influenza season, chThe Pneumococcal red on admissionThe nent the acceptance or ion• sing staff documented "PT nursing station with as transferred to their i nursing. Message given ad stated that resident	F88	3			

DEPARTMENT OF HEALTH AND HUMAN SE FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 [X1) PROVIOER/SUPPLIER/CLIA [X3) D,\TE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION ANO PLAN OF CORRECTION COMPIETEO **IOIINTIFICATION NUMBER:** A.BUILDING 02 · MAIN BUILDING 02 R .95'57 8. WING 04/Q2/2018 NAMEOFPROVIOERORSUPPUER STREET ADDRESS, CITY, ST,\TE. ZIP CODE 150 NORTH JEFFERSON STRIE!IE!T OUR UOY OF THE VALLEY ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIIINCIIS PROVIDER'S PL.AM OF CORRECTION 10 (X5J COMI'I.ETION DATE (X4)10 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGUIATORY OR LSC IDENTIFYING INFORMATION) CROSS EFEFIENCED TO THE APMOPI\IATE TAG TAG DEFICIIiNCYJ INITIAL COMMENTS {K 000} {K 000} Description Of 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: Reguirements for Long Term Care FacIIIUes. 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. LABOAATORY DIRECTOR'S OR PRO\IIOER/SUPPI.11:RREPAESENTATIVE'S SIGNATURE TITLE ()(SJ DATE

Any deficiency gtatement ending wilh 1111 asterIsII (") denotes a d ency while the institution may be excued from correcting providing it is delarmined that Ollier safeguards provide tidicient pro «ection to the palien ta. (See Inatruelions. J Elicept for nurting homes, the findings staled above are discloseble 90 days fo!!Qwing the *date* or suvey wtether' ^{O'} not a pi.n.ol convc:tioo II provided. For nursing homes, Ille **above** findings and plant of correction ara dis<:losabla 14 days following the date 1hes• Oocumania are made 1valable to the fu!Uty. If deficiencJn ... died, an approved plan of correction is regulste IO cont#IUIId prvgllIm participation.

PRINTED: 04126/2018

	OF DEFICIENCIES I CORRECTION	(X1) PROVIOER/SIJPPLIER/CLIA IDENTIFICATION NUMBER.		PLE CONSTRUCTION G 03 • REHASIUTAION GYM	()(3) DATE SURVEY COMPLETED	
		495357	II.WINO		0	R 4/D2/2018
	ROVIOER OR SUPPLIER Y OF THE VALLEY			STREET ADOAESS. CITY. STA.TI!, ZIP COOO &SO NORTH JEFFERSON STREET ROANOKE, VA 2,016		
(X4)1D PREFIX TAG	{EA.CH DEFICIE	STATI:MENT OF DEFICIENCIES ENCY MUST & PRECEDED BYFUU 2R LSC IDENTIFYING INFORMATIONI	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS•REFERENCEO TO THE A OEFICIENCY)	SHOULO BE	l)(S) COMPL!TIOF DAll!i
{K 000}	I INITIAL COMMENT	S	{K 00	0}		
		Room is a wing to the buUdIng orway on the ground floor				
	Conslruction Type: 11(111) Sprinkler status: Fully Sprinklered					
	suivey conducted of on 04/02/2018 in a Federal Regulation Long Term Care Fa surveyed for complia (Existing) regulation compliance with the Participation Medica	SC revisit to the standard on 3/15/2018 was conducted ccordance with 42 Code of , Part 483: Requiremenls for acilities The facility was iance using the LSC 2012 hs. The facility was in a Requirements for are and Medicaid. Corrected enlified on the CMS.25678.				

Any denciency Itatament ending wilh an astensk ("I denotes a deficiency which the insUtulion mey be excused from (IOrrec;ting plovlding II ie detel'!Titled lhat oltel 1aleguards proYlde sufficient protection to the tients. (See Instructions.) Except for ninInII homes. It!• find!ngs staled aboYe are disclosable 80 days following lhe dale of swvey whether or not a plan of COfF&Clion Is pr011lded. For nursing homes, hi above findings and plans of (IOlfection are disclosable 14 days following lhe dale IIMHie docInlanb ere made available to IIIe faelity. II deficiencies are died, an approved plan of corradion Is requisite to contloued pr011ram pa rticipalion.

	MENT OF HEALTH AND HUMAN SERV		_		FORM	03/19/2018 APPROVED 0938-0391
	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIE OF CORRECTION IDENTIFICATION NU			LE CONSTRUCTION Q 01 • MAIN BUIIDING 01	(X3) DATE SU COMPLE	RVEY
	495357	,	B, WING		03/15	512018
	ROVIOER OR SUPPLIER DY OF THE VALLEY	650 NO		STATE, ZI' CODE ERSON STREET 24016		
(X4)10 PREFIX TAQ	SUMMARY STATEMENT OF OEFICIENQI EACH DEFICIENCY MUST BE PRECEDED fJY FULL R OR LSC IDENTIFYING INFORMATION)	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS.REFERENCED TO THE APPRO DEFICIENCY)	JI.O BE	(XSI COMPI.ETION DAY£
K OO0I	INTTIAL COMMENTS		KOO0			
	Surveyor: 34730 Description of Structure: This is a 3 sto structure with masonry exterior walls, co slab floors on steel bar joist. The nursin on the 1 st floor and is separated from t remainder of the building both horizontall vertically by a 2 hour rated fire barrier. hour vertical separation is achieved usin drop-In ceilng tile assembly and poured concrete floor.	ncrete ng unit is he y and The 2 ng a rated				
	Construction Type: 11(111)					
	Sprinkler status: Fully Sprinklered					
	An unannounced recertification Life Safe survey was conducted 03/15/2018 in ac with 42 Code of Federal Regu1alion, Par Requirements for Long Term Care Facifi facility was surveyed for compliance usi LSC 2012 Existing regulations. The fac not in compliance with the Requirements Participation Medicare and Medicaid.	cordance t 483: ties. The ng the ility was				
	The findings that follow demonstrate non-compliance with Tille 42 Code of Regulations. 483.70(a) et seq (Life Safet Fire.)	y from				
к 353] SS-F	Sprinkler System - Maintenance and Tes CFR(s): NFPA 101	sting	к ³⁵³	11.Backftow testing has been sc and will be conducted on going	heduled g as	3/29/18
	Sprinkler System • Maintenance and Te Automatic sprinkler and standpipe system inspected, tested, and maintained in acc with NFPA 25, Standard tor the Inspectio Testing, and Maintaining of Water-based Protection Systems. Records of system maintenance, inspection and testing are maintained in a secure location and read	ms are ordance on, d Fire n design, IUy		needed. 2.No other area identified 3.MaIntenance Director/OesIgn continue providing required test ensure compliance. 4. Maintenance Director/Oesign review testing of backflow to er compliance.	ing to ee will	
	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE	ent"-five's SIGN	NATURE	Ala in christor	3/2	(XG) DATE
Arr, delicien other aaled	ncy slatemeht endild with an astirrik () 'denoloe guards prO\ <lda 1uflc111nt="" padentill<="" protection="" td="" the="" to=""><td>a dallclency wt1</td><td>1ch the Inatitu</td><td>JUon may bit excused from cOfrecrtng prOl</td><td>iding 1111 del</td><td>ermine<i iha!<="" td=""></i></td></lda>	a dallclency wt1	1ch the Inatitu	JUon may bit excused from cOfrecrtng prOl	iding 1111 del	ermine <i iha!<="" td=""></i>

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other aaleguards prO\<Ida luftlcl11nt protection to Iha padenIII, {Seainstructions,) Eicept for nur1ing homes, Iha findings 1tiled above are diacloaable 90 days following the date of survey whether o, not a plan of conection ia pl'ir.ided. For nursing homaa. Iha above findings and plans *d* correction •• dsclosable 14 days foRowing Ihe date Ihe1111 documttt1ta 1111 made available to Iha facility. H deficiencies are cited, an approv!MI plan of cotraction is requiled to continued program participation.

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		AND HUMAN SERV				FORM	03/19/2018 APPROVED 09:ul-0391	
	T OF DEFICIENCIES DF CORRECTION	IXI) PROVIDER/SUPPLIER IDENTIFICATION NUM		· /	PLE CONSTRUCTION G 01 • MAIN BUILOINO 01	(X3) DATE SUI COMPLE		
		495357		B. WING		03/15	5/2018	
	ROVIOER OA SUPPLIER DY OF THE VALLEY	(650 NC	ORESS, CITY, STATE, ZIP CODE ORTH JEFFERSON STREET IOKE, VA 24016				
(X4I 10 PREFIX TAG	EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL A ENTIFYING INI'ORMAI ION)	S AEOULATOR't	10 PREFIX TAG	PfIOVIDER'S PLAN OF CORRECT [EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XSJ COMI\ETION OATi	
K 353	avallable. <u>a) Date sprinkler s</u> <u>b)</u> Who provided s	system last checked		K353				
	<u>c)</u> 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							
к 911 sso	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 witnessed this evidence by interview and observation. 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 I:>y the provided K-Tags, but are deficient. This Information, along with the applicable Llie Salety Code or NFPA standard citation, should be Incklcled on Form CMS-2567. Chapter 6 (NFPA 99)			K 911				

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CENTER		ANO HUMAN SERV & MED.ICAIO SEAV (X1) PROVIDI:A/SUPPLIEF	ICES	(X2) MUI.TIP	PLE CONSTRUCTION	FORM	: 03/19/201 APPROVEI 0938-039	
	OF CORRECTION	IOENTIFICATION NUM		A. BUILOIN	G 01 • MAIN BUILDING 01	COMPLETED		
		495357	_	B,WING_		03/15	5/2018	
	ROVIDER OR SUPPLIER DY OF THE VALLEY	(650 NO	RTH JEFFERSON STREET OKE, VA 24018				
(X4110 PREFIX TAO	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED EV FULL F ENTIFVNG INFORMATION)		IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEDTO THE APPRO DEFICIENCY}	LD BE	(XS) COMPLETION DATE	
K911	This REQUIREMEN by: Surveyor: 34730 Based on observati failed to maintain th the ability to affect compartment. Findings include: On 3-15-18 at appro observed through of power strip is plugge the CHC electrical M The Facility Adminis Director witnessed to observation.	NT Is not met as evi ion and inspection the electrical system. occupants of a single oximateJy 11:09 AM I bservation and inspect ed into another power Maintenance Room. strator and Maintenar this evidence by Inlem	t was t was t srip ln r slrip ln nce view and	K 911	1 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 DIrector/Designee will conduct monthly inspections for inappropriate power strip usage. 4.Maintenance Director/Designee wilt review on an on-going basis to ensure compliance.		3/27/18	
				 The main and feeder circuit breakers exercising test has been conducted. No other areas identified. Maintenance Director/Designee will ensure that circuit breaker exercising Is conducted as state manufacture requirements. Maintenance Director/Oesignee will review circuit breaker exercising to ensure compliance. 				

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		NO HUMAN SERVI				FORI	d: 03/19/2018 M APPROVED O 0938-039i
	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDEAISUPPLIER IDENTIFICATION NUM		`	PLE CONSTRUCTION G 01 • MAIN BUILDING 01	IX3I DATE S; COMPL	SURVEY ETED
		495357		B. WING		03/1	5/2018
	ROVIDER OR SUPPLIER	Y	650 NO		TATE, ZIP COOE ERSON STREET 24016		
(X4)1D PREFIX TAO	EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIE ST BE PRECEDED BY FULL R DENTIFYING INFORMArI]	EGULATORY	10 PREFIX TAO	PROVIOEFrS PLAN OF COR (EACH CORRECTIVE ACTION CAOSS•RE FERENCEO TO THE A OEFICIENCVJ	SHOUI.O BE	[I(St COMPLEIION DATE
K 918	stored energy pow accordance with NF circuit breakers ere program for period components Is esta manufacturer requi maintenance and t readily available. E circuits are marked separate from norm the possibility of dai source is a design of installations. 6.4.4, 6.5.4, 6.6.4 (N 111, 700,10 (NFPA This REQUIREME by: Surveyor: 34730 Based on observal !ailed to maintain t lhe ability to affect Findings include: On 3-15-18 at appr observed through o during the records could not be provic periodically exercis breakers is establi manufacturer requi	er sources (Type 3 E FPA 111. Main and fe e Inspected annually, a dically exercising the bbllshed according to irrements. Written rece esting are maintained ES electrical panels , readily Identifiable, a nal power circuits. Mi mage of the emergen consideration for new NFPA 99), NFPA 110, .70) NT is not met as evic lion and inspection th he generator system. all occupants ot the b roximately 10:15 AM i bservation and inspe review that documer led to show that a pro- ing the main and feed shed according to	eeder and a cords of and and nimizing cy power NFPA lenced le tacility This hes uilding. t was ction ntation ogram for ler circuit	K918			

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Da: <u>ICHINCYIJJSY III</u> , PAECSIB> BYRI.1IEGIU CR <u>LICarmrntG</u> IF <rmido< td=""><td>M fi∐B≝Di</td><td>IIICIIIICII'I AM OFCCIII&CI10N iur_tVVVI•' IIIU_DIIE CAQ8S.REFIIIIB<<u>10 na:</u>APfIAOAMT <u>I&ICIB±'D</u></td><td>CDa'Ui1I0II 'E</td></rmido<>	M fi ∐B ≝ D i	IIICIIIICII'I AM OFCCIII&CI10N iur_tVVVI•' IIIU_DIIE CAQ8S.REFIIIIB< <u>10 na:</u> APfIAOAMT <u>I&ICIB±'D</u>	CDa'Ui1I0II 'E
K 000 INITW. COMMENTS	KOOO		
SUvaJor:84730 Tiit Rd'iatlilatbi Room ii a111'11 ID the buBdIng amtBlldfRIIII a daolway onh GfOl,11d lloor oontmr. eon11ruc1on 1ype: u,111) Spnastatus: Fu'' SprilkJnd An Lllannouncod rocatificallan Ua Saltly Code survey•• mndudad OS11M!Q1a i1 accordance With 42 Godi at Fadri Recented on Patters 7: Kaddrimi,D'tar IJJI'g Fishib C:: o Fatters 7: Kaddrimi,D'tar IJJI'g Fishib C:: o fish	KaBS		
b) <u>Who pniijid</u> aystam tat			
<u>cJwafar iivitem</u> W rm			
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R)RU Cl&S!ll1(11Ma) PlMIIII VtnllGnl OD1a111t		RJ211111!1	auton sheet Page 1 of 3

other salagua,ds provide sufficient protection to Iha patients. (See InatnJClions.) Except lor nursi"II homes, Ihi, findings staled above are disclosable 90 deip following Iha dale of survey whether or nol a plari of correci10ri 111 provided. For nurlin9 homes, the above findI119s and plans of correction are disclosable 14 days following Iha dale theae documents are made 11.vailabla to the lacIIIy. II deficiencies are died, an approved plan of correction is regulsiu, to continued pro.9.ram pal1icipation.

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

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MENT OF HEALTH / S FOR MEDICARE &	AND HUMAN SERVIO & MED!CAIO_S_ERV	CES ICES			FORM	03/19/2018 APPROVED na A 0-391
			(X'21 MULTIPLE CONSTRUCTION A. SUILOING 03- REHABILITAIDN GYM		(X3J OATE SUFM:V COMPLETEO	
	495357		9. WING		03/1	5/2018
	,	650 NC	ORTH JEFF	ERSON STREET		
"EACH DEFICIENCY MUS"	T BE PRECEDED 8Y FULL R		ID PREFIX TAO	(EACH CORRECTIVE ACTION SHOU	JID BE	C I'U:TION DATE
Provide In REMAR for any non-required system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Surveyor: 34730 Based on observati failed to maintain ti the abifity to affect a Findings include: On 3-15-18 at appro observed through o during the records could not be provid backflow Inspection The Facility Adminis Director witnessed observation.	KS Information on co d or partial automatic and NFPA25 NT is not met as evid ion and inspection th he sprinkler system. all occupants of the b oximately 9:45 AM it w bservation and insper review that document ed to show when the mas conducted. strator and Maintenar this evidence by Interv	sprinkler enced he facility This has building. was ction tation last nce iew and	K353	TAO CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)		3/29/18
CFA(s): NFPA 101 Electrical Systems Maintenance and The generator or or and associated equ service within 10 se criterion is not met of process shall be pro- capability for the life Maintenance and te transfer switches a wtth NFPA 110. Generator sets are under load 30 minutes	• EssentialElectric Sy Testing other alternate power ipment is capable of seconds. If the 1a-second during the monthly test ovided to annually co e safety and critical bit esting of the generator are performed in accord e inspected weekly, e utes 12 limes a year	vstem source supplying ond st, a inlirm this ranches. r and ordance exercised in 20-40	K918	breakers exercising has been conducted. 2 No other areas identified. 3.Maintenance Oirector/Oeslo ensure that circuit breaker ex Is conducted as state manufa requirements. 4.Maintenance Director/Desig	n gnee will ercisIng cture gnee will	3/23/18
	S FOR MEDICARE of OF DEFICIENCIES OF CORRECTIOM ROVIDER OR SUPPLIER DY OF THE VALLEY SUMMARY ST "EACH DEFICIENCY MUS' OR LSC IDE Continued From pa Provide In REMAR for any non-required system. 9.7.5, 9.7.7, 9.7.8, a This REQUIREMEN by: Surveyor: 34730 Based on observat failed to maintain t the abifity to affect Findings include: On 3-15-18 at appro observed through o during the records could not be provid backflow Inspection The Facility Admini- Director witnessed observation. Electrical Systems CFA(s): NFPA 101 Electrical Systems Maintenance and The generator or and associated equiservice within 10 se criterion is not met process shall be pr capability for the life Maintenance and to transfer switches a wtth NFPA 110. Generator sets are under load 30 mini-	S FOR MEDICARE & MEDICAIO S ERV OF DEFICIENCIES OF OF CORRECTIOM (X1) PROVIDERISUPPIE/ IDENTIFICATIONNUL 495357 ROVIDER OR SUPPLIER DY OF THE VALLEY SUMMARY STATEMENT OF DEFICIENCIE "EACH DEFICIENCY MUST BE PRECEDED 8Y FULL F OR LSC IDENTIFYING INFORMATION) Continued From page 1 Provide In REMARKS Information on co for any non-required or partial automatic system. 9.7.5, 9.7.7, 9.7.8, and NFPA25 This REQUIREMENT is not met as evid by: Surveyor: 34730 Based on observation and inspection th failed to maintain the sprinkler system. the abifity to affect all occupants of the b Findings include: On 3-15-18 at approximately 9:45 AM it to observed through observation and inspection. the abifity defice all occupants of the b Findings include: On 3-15-18 at approximately 9:45 AM it to observed through observation and inspection. The Facility Administrator and Maintenar Director witnessed this evidence by Interv observation. Electrical Systems • Essential Electric S CFA(s): NFPA 101 Electrical Systems • Essential Electric Sy Maintenance and Testing The generator or other alternate power and associated equipment is capable of service within 10 seconds. If the 1a-second criterion is not met during the monthly terprocess shall be provided to annually cond capability for the life safety and critical b Maintenance and testing of the generato transfer switches are performed in acc with NFPA 110. Generator sets are inspected weekly, equinder load 30 minutes 12 limes a year	OF CORRECTIOM IDENTIFICATIONNUMBER: 495357 IDENTIFICATIONNUMBER: 495357 ROVIDER OR SUPPLIER DY OF THE VALLEY STREET ADL 650 NG ROAN SUMMARY STATEMENT OF DEFICIENCIES "EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 1a-second criterion is not met during the monthly test, a process shall be provided to annually conlirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in acc	S. FOR MEDICARE & MEDICAIO. S. ERVICES OF DEFICIENCIES OF DEFICIENCIES SF CORRECTIOM (X1) PROVIDERISUPPLEX/CLIA IDENTIFICATIONNUMBER: 495357 ROVIDER OR SUPPLIER DY OF THE VALLEY STREET ADORESS, CITY, S 650 NORTH JEFF ROANOKE, VA 2 TEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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 la-second criterion is not met during the monthly test, a process shall be provided to annually conlirm this capability for the life safety and critical branches. Maintenance and testing of the generator	S.FOR MEDICARE & MEDICAID S. FRVICES * OF DEFICIENCIES * AUDITIFICATIONNUMBER: * 495357 ROVIDER OR SUPPLIER DY OF THE VALLEY SUMMARY STATEMENT OF DEFICIENCIES **ACH DEFICIENCY MUST BE RECEDED BY FULL REGULATORY Provide In REMARKS Information on coverage for any non-required or partial automatic sprinkler 9.7.5, 9.7.9, 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. the abifity to affect all occupants of the building. Findings include: On 3-15-18 at approximately 9:45 AM it was observation. Director Witnessed this evidence by Interview and observation. Electrical Systems • Essential Electric System Maintenance and Testing Maintenance and Testing Provided to annually conlim this capability for the life salety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 limes a year in 20.40	MENT OF HEALTH AND HUMAN SERVICES FORM FORMEDICARE & MEDICAIO SERVICES FORM Nn OF DEFICIENCIES MILTIPLE CONSTRUCTION A: SUILOING 03- REHABILITAION GYM X:SI DATE SU PCORECTIOM MILTIPLE CONSTRUCTION A: SUILOING 03- REHABILITAION GYM X:SI DATE SU PCONDER OR SUPPLIER STREET ADDRESS, CITY, STATE: ZIP CODE 650 NORTH JEFFERSON STREET 03/11 POVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE: ZIP CODE PROVIDER'S PLAN OF CORRECTION 03/12 Continued From page 1 FORM PROVIDER'S PLAN OF CORRECTION OR SUBJOINT ACTION OR SUBJOINT ACTION AND SECTION OR SUBJOINT ACTION AND SECTION OR SUBJOINT ACTION ACTION AND SECTION OR SUBJOINT ACTION

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	T OF DEFICIENCIES DF CORAECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			PLE CONSTRUCTION G 02 • MAIN BUILDING 02	IX31 OATE SURVEY COMPLETED	
		485357		B. WING _		03/15	5/2018
	ROVIDER OR SUPPLER DY OF THE VALLEY	7	650 NO		TATE, ZIP CODE ERSON STREET 24018		
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K 000	INITIAL COMMENT	S		K000			
	structure, with a par exterior walls, conc	cture: This is a 1 stor tial basement, maso rete slab floors on ste nstructed with fire rate	nry eel bar	,			
	Construction Type: 1	11(111)					
	Sprinkler status: Fu	Dy 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 facility was surveyed for compliance using the LSC 2012 Existing regulations. The facilitywas not in compliance with the Requirements for Participation Medicare and Medicaid.						
	Fire.)	h Tide 42 Code of D(a) et seq (Life Safe	ty from				
	Table 19.1.6.1, unle 19.1.6.2 through 19 19.1,6.4, 19.t. 6.5 Constructio	n Type and Height on type and stories m ss otherwise permitt 0.1.6.7	ed by nber of	K 161 I	 The unprotected penetration ceiling assembly was filled with appropriate fire caulking. No other areas Identified. MaIntenance Director/Design conduct weekly ,ounds to ens are no other unprotected dryw penetrations. MaIntenanee Olrector/Design review on an on-going basl& to compliance. 	ith nee will ure there all ee will	3127/1
LABORATO		VIDEMUPPLIER RfiPAESEI	NTATIVE'S SIGI	NATURE		12 147123	(X8) DATE
	may 11 atoman 1 alada	VAID an externit () dellate	a dollolonou	which the inotilled	Administrator		128/18

Any delicitincy internet i-einong YAIn an aaleriil () **delibta** a deliclency which the inatilulion may be excUHd from correcting providing ii la defermined that ott,111 saleguerda provide sufficient protection 10 Iha padenIII. (Sn In1tn.1clione.) Europi for nursing homaa, the Dnding, alalad above are disclosable 90 day, fallowing the dale of survey whithe, or not a plan of correction la prOYIdecl. For nur1in9 hom111, the above findings and plana of collection is requisite 10 continued program panicipatian.

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	MENT OF HEALTH					FORM	03/19/2018 APPROVED OA.,'\A-fl.91
	T Of DEFICIENCIES OF CORRECTION	(X1) PROVIDEAISUPPLI IDENTII'ICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILOINO OS - AEHASILITAION OYN		[X:J) DATE SU COMPLE	
		495357	,	e.WING_		03/1	S/2018
	OUR LADY OF THE VALLEY 650 H		650 HO		TATE, 2P CODE ERSON STREET 24016		.XS,
(X4) 10 PREFIX TAO	EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST ee PRECEDED ev FUIREGULATOm 00 LSC I0ENTIFYIN13 INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD ee	COt,IPLEIION 01\TE
К 91В	months for 4 contin under load condition simulated cold star transfer of aU EES I competent personne stored energy powe accordance wilh NF circuit breakers are program for periodi components is esta manufacturer requi maintenance and te readily available. E circuits are marked separate from norm the possibility of da source is a design instaUations. 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This REQUIREMEN by: Surveyor: 34730 Based on observati failed to maintain th the ability to affect Findings Include: On 3-15-18 at appro observed through of during the records r could not be provid periodically exercis breakers is establis manufacturer requi	nuous hours. Schedu as include a complete t and automatic or n oads, and are conduce el. Malntenance and t er sources (Type 3 El PA 111. Main and fe finspec1ed annuany, cally exercising the ablished according to irements. Written rec esting are maintained ES electrical panels , readily identifiable, nal power circuits. M mage of the emergen considerallon for new NFPA 99), NFPA 110 70) IT is not met as evid on and inspection the me generator system all occupants of the te poximately 10.15 AM in observation and inspec- review that documer ed <i>to</i> show that a pro- ing the main and fee shed according to	e hanual cted by resting of ES} are in eeder and a b cords of and and linimizing hcy power , NFPA enced facIII1Y . This has building. was ection lation gram for der circuit	K918			

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						03/15	5/2018
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K 161	Continued From particular FACP Room.	age 2		K 161			
0504	The Facility Adminis Director witnessed t ob\$ervatlon.	strator and Maintenan his evidence by Inter	ce view and				
k 353' SSsF	Sprinkler System M CFA(s): NFPA 101	laintenance and Tes	ting	K 353	 Backftow testing has been s and will be conducted on goin needed. 		3/29/18
	Automatic sprinkler Inspected, tested, a with NFPA 25, Stand Testing, and Mainta Protection Systems maintenance, inspe- maintained In a securation available.	Maintenance and Tes and standpipe system and maintained In acc dard lor the Inspection ining Of Water-based . Records of system ction and testing are ure location and read	ns are cordance n, d Fue design,		 No other area identified Maintenance Director/Oesign continue providing required test ensure compliance. Maintenance Oirector/Design review testing of backflow to end compliance. 	sting to nee will	
	b) Who provided	-					
	for any non-required system. 9.7.5, 9.7,7, 9.7.8, a This REQUIREMEN by: Surveyor: 34730 Based on obseniali failed to maintain th the ability to affect a Findings Include:	KS information on c d or partial automatic and NFPA 25 IT is not met as evid ion and inspection th he sprinkler system. al occupants of the b	sprinkler enced e facility This has ulldlng.				
	observed through o during the records r	oximately 9:45 AM It to bservation and inspe- eview that documenta led to show when the	ction ation				

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DEPART CENTERS	MENT OF HEALTH S FOR MEDICARE &	AND HUMAN SERV MEDICAID S E AVI	CES			FORI	1: 03/19/2018 M APPROVED 938-0391
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		495357		8.WING		03/1	5/201B
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K 161	Continued From page 1			K 161			
	2 11(111) non-sprinklered	One story					
	sprinklered	Maximum 3 stories					
	3 II (000) non-sprinklered	Not aHowed					
	4 III (211) sprinklered 5 IV (2HH) 6 V (111)	Maximum 2 sto	ories				
	7 III (200) non-sprinklered	Not aaowed					
	8 V (000) sprinklered	Maximum 1 sto					
	throughout by an a	s musl be sprinklered pproved, supervised a	utomatic				
	19.3.5)	nce with section 9.7.					
	construction, the nu	otion, in REMARKS, of umber of stories, Inclu	uding				
	location of smoke	on which patients are or fire barriers and da	ates of				
	plan of the building This REQUIREME	e sketch or attach sma as appropriate. ENT is not met as evic					
	by: Surveyor: 34730		L . La alte :				
	failed to maintain b	tion and inspection to building construction. all occupants or the	This has				
	Findings include:						
	observed through of the observed through of the observed through the obs	roximately 11:21 AM observation and inspec- ted through penetral embly In the SuHivan	ction that ton to the				

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DEPART CEI-U'EI	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERVI				FORM	03/19/2018 MAPPROVED 0.0918-03q1
STATEMEN	T OF DEFICIENCIES OF CORRECTION	•)(1) PROVIDEF\ISUPPLIE tOENTIFJCATION NUM	RICLIA		PIE CONSTRUCTION IG 02 • MAIN BUILDING 02	[X3) DATE SU COMPLE	JRVEY
		495357		B. WING_	•,	03/1	512018
	ROVIDER OR SUPPLIEA DY OF THE VALLEV		650 NO		STATE, ZIP COOE ERSON STREET 24016		
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К 353 к 918] ss-F	Continued From pa bacldlow Inspection The Facility Adminis Director witnessed observation. Electrical Systems CFR(s): NFPA 101 Electrical Systems Maintenance and Te The generator or c and associated equ service within 10 se criterion ts not met process shall be prov capablfily fOf the life Maintenance and te transfer switches a with NFPA 110. Generator sets are under load 30 minu day Intervals, and e months for 4 continu under load conditio simulated cold start transfer of atl EES In competent personne stored energy powe accordance wilh NF circuit breakers are program for periodic components is estal manufacturer requir maintenance and te readily available. E circuits are marked,	age 3 h we& conducted. Strator and Maintenar this evidence by Inte - Essential Electric S - Essen	rview and yste ystem source supplying ond sl, a firm this anches. r and rdance tercised in 20-40 y 36 d test e nual cted by esting of S) are In eeder and a rds of and and and and	K 353	DEFICIENCY)	t breakers ducted gnee will ercising is ure gnee will	3/23/18
	the possibility of dar	nage of the emergen consideration for new					

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DEPART CENTEF	MENT OF HEALTH AN	NO HUMAN SERVICE & MEDICAID SERVICE				FORM	: 03/19/2018 / APPROVED) 0938-0391
	T OF DEFICIENCIES OF CORRECTION	1(XIJ PROVIOERISUPPLIEI OENTIFICATION NUM		,	PLE CONSTRUCTION G 02 • MAIN BUILDING 02	(1(3) DATE SU COMPLE	
		495357	,	B.WNG		03/1	5/2018
	ROVIDER 00 SUPPLIER DV OF THE VALLEY		650 NC		TATE, ZIP CODE ERSON STREET 24016		
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K 91B	6.4.4, 6.5.4, 6.6.4 (N 111, 700.10 (NFPA This REQUIREMEN by: Surveyor: 34730 Based on obseJVati failed to maintain th the ability to affect a Findings include: On 3-15-18 at appro observed through of during the records could not be provid periodically exercisin breakers is establis manufacturer requi	NFPA 99), NFPA 110, 70) NT Is not met as evid ton and inspection the regenerator system. all occupants of the b oximately 10:15 AM it pservation and Inspec- review that documer ed to show that a pro- ng the main and feec thed according to	denced e facility This has uilding. was ction tation ogram for ler circuit	K 918			

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State of V	imi11ia				FORMAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0183	B. IMNG		02/15/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. ST	TATEZIP COOE	
OUR LAD	Y OF THE VALLEY	650 NOR1	TH JEFFERSO	N STREET	
		ROANOK	E, VA 2-'016		
PREFIX (X-4) ID TAG	(Y MUST BE PRECEDED BY FULL TATEMENT OF DEFICIENCIES LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD PROVIDER'S PLAN OF CORRECTIO CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F	Initial Comments		F 000		
	survey and biennial S was conducted on 2/1 Corrections are requir CFR Part 483 Federa requirements and Virg for the Licensure of N Safety Code survey/re complaint was investig The census in this 70 at the time of the surve	ginia Rules and Regulations ursing Facilities. The Life eport will follow. One gated during the survey. certified bed facility was 65 ey. The survey sample nt Resident reviews and 3			
F 001	Non Compliance	Z 1 1 1	 F 001	I	 3/30/18
	I he facility was out of following state licensu	of compliance with the re requirements:			
	This RULE: is not met	as evidenced by:			
	The licesnure deficien			I The filing of this plan of correction does not constitute an admission that	5
	reference to F580 12 VAC 5-371-370 (G housekeeping. Cross 12 VAC 5-371-140 (E Cross reference to F6 12 VAC 5-371-250. F care planning. Cross	reference to F584). Policies and procedures. 07. Resident assessment and		deficiencies alleged did in fact exist. This plan of correction is filed as evide of Our Lady of the Valley's desire to comply with the requirements of participation and to continue to provide high-quality resident care.	
	care planning. Cross 12 VAC 5-371-250. Re care planning. Cross 12 VAC 5-371-250. R care planning. Cross	reference to F655. esident assessment and reference to F657. esident assessment and reference to F740. harmaceutical services.		 12 VAC 5-371-220 (H). Cross reference F580: 1. The attending MD & RP for resident #266 have been notified of missed dos medication. 2. Those residents who have experience 	e of
			1		
		JPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X610ATE
	ally Signed				03/14/18

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	/ <u>Irginia</u> FOF DEFICIENCIES DF CORRECTION	()(1) PRO DER/SUPPUER/CUA IDENTIFICATION NUM8ER:			(X3) OATE SURVEY COMPLETED
		VA0183	B. WING		02/15/2018
	ROVIDER OR SUPPLIER Y OF THE VALLEY SUMMARY ST	650 NO	ADDRESS. CITY, ST RTH JEFFERSOI IKE, VA 2-'016		1x,1
PREFIX TAO	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL
F 001	Cross reference to F	Pharmaceutical services. 761. D). Policies and procedures. 868. /Janagement and	F001	 achange in condition or a change in prescribed medication or treatment pla are at risk for facility failure to notify th attending MD and/or RP of that chang 3. Staff have been and will continue to educated on need to notify both the resident. Is attending MD and their RP any changes in the residentos condition change in prescribed plan or care or treatment. 4. The DON or designee will review the 24-hour report and EMAR daily to ensilicensed nurses have documented tha MD and RP were made aware of charr in the residerb∂7 s condition, prescribed plan of care of treatment. The QA Committee will review the find 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 F584: The dining room window and carpe room #408 were cleaned. 2. Residents residing in the facility are risk of being exposed to an environme which falls short of providing a clean, comfortable and homelike environmer 3. Nursing or housekeeping staff will initiate immediate cleanup of spills. Spills. 	e e. o be o f o n, e ure t the oges d lings d ce to t in at nt t.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ECONSTRUCTION	()(3) DATE SURVEY COMPLETED
		VA0183	B WNG		02/1512018
	ROVIOER OR SUPPLIER Y OF THE VALLEY	850 NC	ADDRESS, CITY, ST DRTH JEFFERSON DKE, VA 24011		
()(4)1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLEI
F 001	I Continued From page	e 2	F 001	 which cannot be contained and deane property by nursing staff will be report housekeeping staff who will perform proper sanitation of the area. Housekeeping department will conduct daily rounds on the nursing units to er 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 amend to promote compliance. 5. Date of compliance: 3/30/2018 12 VAC 5-371-140 (E) . Cross reference F607: 1. Both CNA licenses were verified as being active. 2. All professional facility staff, who by are allowed to practice only with proof certification or licensure, are at risk of allowing their certificate or licensure to expire. 3. Business Office Manager or Design will perform an initial 100% audit of all licenses and certifications. Once initia compliance has been established, all the employee is certificates/licenses will to verified at time of hire. A monthly repo- will be reviewed to identify any license/certificate which must be updat in the employee file to ensure regulator compliance. 4. Compliance with these audits and the 	ed to

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0183	SWNG		02/15/2018
	ROVIDER OR SUPPLIER Y OF THE VALLEY	650 NO	ADDRESS. CITY, ST. RTH JEFFERSOI		
			KE, VA 24016		
(X4)ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
F 001	I Continued From page	e 3	F001	 findings Will be reported to QA Commit for their review. 5. Date of compliance: 3/30/2018 12 VAC 5-371-250. Cross reference to F641: The MOS for resident #68 was amended to provide accurate place of discharge. All residents requiring MOS assess are at risk for inaccurate coding. The MOS assessment for residents are discharged from the facility for the six months were reviewed for accurate place of discharge. Any corrections needed to be made were corrected at time. The MOS nurse will review MOS assessments of all residents being discharged for proper coding. Any error found will be corrected at that time. The MOS nurse will report audit find to the QA committee. Date of compliance.3/30/18 VAC 5-371-250. Cross reference to F655: The baseline care plan for resident #266 was updated to reflect falls and the risk of incontinence. 	o ment who last that ors dings
				2. All residents who are admitted to th facility are at risk for not having their needs addressed on the baseline care	

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State of	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		VA0183	B. W NG		02/15/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
OUR LAD	Y OF THE VALLEY	650 NO	RTH JEFFERSO	N STREET	
		ROANC	OKE, VA 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
F 001	Continued From page	e 4	F001		
				plan.	
				3. Staff have been and will continue to	
				educated on timely completion of base care plan. The DON or designee will a	
				all new admission baseline care plans	
				weekly to ensure baseline care plans	
				complete.	
				4. Baseline care plan audit findings wi	ill be
				reviewed in the quarterly QA committe	
				5. Date of compliance: 3/30/18	
				12 VAC 5-371-250. Cross reference to	
				F657:	
				1. The care plans for residents #46, 7,	
				6, 5 and 219 were revised to instruct s on the new wound care orders, falls, ey	
				treatment orders, inappropriate behavi	
				and frequency of safety checks.	
				2. All residents who have new orders f	for
				falls, other unusual incidents, behavior	-
				any other changes in condition are at r	risk
				for not having their care plans updated	
				3. The 11-7 charge nurse will review n	ew
				orders for falls and other occurrences a	as
				listed on the 24 hour report to check for	
				appropriate entries being entered on th individual care plan. Charge nurses wi	
				be educated on the timely documentati	
				of care plan updates.	
				4. The results of the 11-7 audits will be	
				reviewed and any necessary actions wi	
				be taken to ensure compliance. Findin	
				will be reviewed in quarterly QA.	

If continuation sheet 5 ol 9

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	()(3) DATE SURVEY COMPLETED
		VA0183	B. WNG		02/15/2018
	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST		
OUR LAD	OY OF THE VALLEY		OKE, VA 24016		
()(4)10 PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET
F 001	I Continued From pag	e 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 DC or Designee of each residents a electror physicianOs orders to ensure that thos residents who have orders to be evaluate by behavioral health professional have been seen. New telephone orders indicating the need for behavioral const will be reviewed by 11-7 charge nurse, who will assure that there is documente evidence that a behavioral health professional has been contacted to evaluate residents. 4. The results of the 11-7 shift telepho audits for new behavioral health referration will be reviewed by the QA committee. 	DN onic e ated ults ed
				 5. Date of compliance: 3/30/2018 12 VAC 5-371-300. Cross reference to F755: 1. The Xifaxan for resident #266 has be administered since the date of the surv exit with no further documented entries 	een ey

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0183	B \MNG		02/15/2018
	ROVIDER OR SUPPLIER	STREET	ADDRESS. CITY, STA		02/10/2010
OUR LAD	Y OF THE VALLEY	ROANO	OKE, VA 24016		
(X4)1D PREAX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET
F 001	Continued From page	9 6	F 001	medication unavailable.	
				2. Residents receiving any type of medication or medicated treatment and risk of missing a dose of prescribed medication or treatment	e at
				3. If a 4-day supply of pills or capsules counted as remaining, the licensed nu will re-order it from the pharmacy. If a medication is not available for administration, the charge nurse will g the medication from the stat box or by 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 residentIJs medication weekly to ensure that all medications available for administration per MD or of	rses et stat ns are
				 4. The findings of medication availabili audit will be reported to the QA comminand 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 the of the medication cart has been in serviced. 	
				 Any medications received from the pharmacy could be improperly stored. Administrative staff will note any iter stored on top of medication carts durin 	

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State of Vin STATEMENT C AND PLAN OF C	F DEFICIENCIES	()(1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	()(3) DATE SURVEY COMPLETED
		VA0183	B \MNG		02/15/2018
	VIDER OR SUPPLIER	650 NC	ADDRESS, CITY, ST DRTH JEFFERSO DKE, VA 24016		
()<4)10 PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY}	BE COMPLET
F 001 I C	Continued From pag	e 7	F 001	 their daily rounds. Licensed staff who noted to be improperly storing mediation the medication carts will be in-servat the time of discovery. The medicatiwill be immediately stored in its properplace. 4. Medication storage compliance will reviewed with the members of the QA committee. 5. Date of compliance 3/30/2018 12 VAC 5-371-140 {D). Cross referent F868: 1. The Medical Director has attended QA meetings In the last six months. 2. The Quarterly QA Meetings canno effectively identify and address issues when not represented by a physician. 3. The Medical Director was educated the necessity of her presence at each Meeting. If she is unable to attend, sh appoint an appropriate representative 4. The QA attendance sheet will be reviewed by the facility Administrator of 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. 	ons iced on r I be ce to all t s d on QA ie will or g.

STATE FORM

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State of VirAinia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BULD ING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER	850 NC	ADDRESS, CITY, STA DRTH JEFFERSON DKE, VA 24018	ATE, ZIP CODE	02/15/2018
(X4)1D PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DATI DEFICIENCY)	
F 001	I Continued From page	≥8	F 001	 Resident #218 has documentation indicating that the resident had receive both the flu and pneumonia vaccines during the fall of 2017. Residents already residing in or neadmitted to the facility are at risk of n being provided the opportunity to receive the flu or pneumonia vaccine. The AdmissionsNurse or designed interview the residents or the resident responsible party to ask if and when a resident was offered the flu and/or pneumonia vaccines. The AdmissionsNurse will document the acceptance refusal of the vaccines. The DON or Designee will review all new admission charts for the appropriate immunization. The results of the audit will be presented to the QA committee. Addi interventions will be initiated if the audi indicates necessity. Date of compliance:3/30/2018 	ewly ot eive eive e will ts the s or ons on ons on

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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 Öliver, 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)