

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Valley Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC Highway 16 South Taylorsville, NC 28681	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538</p> <p>Based on record review, observations, and interviews with the Medical Director, Registered Dietitian, and staff the facility failed to ensure the volume rate settings on the feeding pumps were correct to administer water flushes as ordered by the physician for 2 of 3 residents reviewed for the care of a feeding tube (Resident #1 and Resident #2).</p> <p>Findings included:</p> <p>1. Resident #1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, and placement of gastrostomy tube (a tube placed directly into the stomach for the administration of fluids).</p> <p>An active physician's order dated 7/8/20 instructed the nurse to clear the feeding pump at midnight and document intake one time a day for nutrition.</p> <p>Resident #1's current enteral feed (delivery of nutrients through a feeding tube) physician's order dated 12/12/23 included instructions to receive a nutritional supplement at a volume rate of 45 milliliters (ml) every hour and water flushes at a rate of 60 ml every 2 hours via feeding pump.</p> <p>The quarterly Minimum Data Set, dated dated [DATE] indicated Resident #1 was rarely understood and his cognition was severely impaired. His ability to eat was not assessed and nutrition and hydration were received via tube feeding with no known weight loss or gain. Special treatments included oxygen, suctioning, tracheostomy care, and use of an invasive mechanical ventilator.</p> <p>The care plan last reviewed on 4/15/24 included a focus area that identified Resident #1 was unable to safely tolerate oral intake and required tube feedings and was at risk for dehydration. The care plan goals included flushes would be safely tolerated to prevent dehydration with an intervention to provide tube feedings and flushes as ordered.</p> <p>During an observation on 6/12/24 at 1:47 PM Resident #1 had no signs of dry, peeling, or wrinkled skin and no signs of dry, cracked lips to indicate he was dehydrated. Resident #1's feeding pump was set up with a bag that held 1000 ml of water with approximately 850 to 900 ml in the bag. A bottle of nutritional supplement was set up and labeled with the date and time 6/12/24 at 5:20 AM. The rate of the water flushes was not displayed on the screen of the feeding pump. The nutritional supplement rate was displayed on the screen and read 45 ml every hour.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 6/12/24 at 2:59 PM Nurse #1 revealed she worked from 7:00 AM through 7:00 PM. She checked the feeding pump setting for water flushes that were blank and read ____ ml at ____ hours to indicate Resident #1 did not receive 60 ml of water every 2 hours as ordered. Nurse #1 stated she did not set up the water bag or nutritional supplement that was done by the night shift nurses. Nurse #1 stated she had not checked the water flush settings on feeding pump, and she was unsure how to program the feeding pump for Resident #1 to receive water flushes as ordered by the physician. Nurse #1 stated she did check the feeding pump to ensure it was on and the nutritional supplement was being administered.</p> <p>During an observation and interview on 6/12/24 at 3:01 PM the Director of Nursing (DON) entered Resident #1's room and rechecked the water flush settings on the feeding pump that were blank and read ____ ml at ____ hours. The DON reviewed the physician's order and instructed Nurse #1 to program the feeding pump for Resident #1 to receive 60 ml of water every 2 hours. The DON revealed the nurses documented on the resident's electronic Medication Administration Record (MAR) the amount of the nutritional supplement received using milliliters but did not include the amount of water flushes. She was unable to verify Resident #1 received water flushes as ordered by the physician. The DON assessed Resident #1 for signs of dehydration and stated the skin turgor was plump and there were no signs of dry skin or dry and cracked lips. The DON stated the nurses should check the feeding pump settings including when the volume amounts were cleared. She revealed Resident #1 was dependent on the feeding pump water flushes for hydration and did not receive oral intake. The DON stated she expected the rate settings were checked by the nurses for accuracy and correctly programmed to administer the water flushes as ordered by the physician to prevent dehydration.</p> <p>A phone interview was conducted on 6/14/24 at 2:28 PM with Nurse #2. Nurse #2 confirmed she worked the night shift from 7:00 PM through 7:00 AM and it was her initials on Resident #1's MAR for 6/11/24 to indicate she had documented the volume amounts of nutritional supplement received at 12:00 AM. She confirmed it was her name written on the nutritional supplement bottle dated 6/12/24 at 5:20 AM. Nurse #2 revealed her process for the care of tube feeding was to pause the pump, make a note of the amount of nutritional supplement received then clear those values. She then set up a new bottle of nutritional supplement and restarted the feeding pump and if needed she replaced the water bag. Nurse #2 revealed she did not recall if she checked the water flush settings or volume amounts Resident #1 received since the MAR documentation did not include water flushes. Nurse #2 stated she did check the settings on the feeding pump either when changing the nutrition bottle or during her shift to ensure it was correct. She did not know why or what happened to Resident #1's water flush setting and thought either her or another nurse could have cleared it.</p> <p>During a phone interview on 6/13/24 at 4:47 PM the Registered Dietitian (RD) stated the residents that were unable to receive oral intake were dependent on the feeding pump water flushes for hydration. She stated the water flush rate settings should be correct as ordered by the physician to prevent dehydration.</p> <p>A phone interview was conducted on 6/14/24 at 10:24 AM with the Medical Director. The Medical Director revealed he relied on the RD to make recommendations for residents receiving nutrition and hydration from a feeding tube. The Medical Director stated he expected the nurses to follow physician orders and set the rates on the feeding pump correctly for the resident to receive their water flushes.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #2 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure.</p> <p>Resident #2's current diet order dated 3/15/21 instructed no oral intake.</p> <p>Resident #2's current physician's order dated 3/24/21 instructed the nurse to record the tube feeding amount and clear the feeding pump one time a day. The enteral feed order dated 7/21/23 instructed to provide the nutritional supplement at a volume rate of 40 ml every hour and water flushes at a rate of 90 ml every hour via feeding pump.</p> <p>The annual MDS assessment dated [DATE] revealed Resident #2's cognition was severely impaired. His ability to eat was not assessed and nutrition and hydration were received via tube feeding with no known weight loss or gain.</p> <p>The care plan last reviewed on 4/9/24 included a focus area that identified Resident #2 was unable to safely tolerate oral intake and required tube feedings and was at risk for dehydration. The care plan goals included flushes would be safely tolerated to prevent dehydration with an intervention to provide tube feedings and flushes as ordered.</p> <p>During an observation and interview on 6/12/24 at 3:52 PM with the DON revealed Resident #2 had no signs of dry or peeling skin and no signs of dry and cracked lips to indicate he was dehydrated. Resident #2's feeding pump was set up with a bottle of nutritional supplement and bag of water for flushes with approximately 300 ml remaining. The supplement bottle was labeled with the date and time 6/12/24 at 12:45 AM with Nurse #3's initials to indicate she set up the feeding pump. The DON checked the feeding pump setting for water flushes that showed the rate was set to receive 90 ml of water every 2 hours and the volume amount received was 630 ml. The DON checked the physician's order and stated the water flush settings on the feeding pump were incorrect and should be set to flush every hour. The DON reprogrammed the water flush setting for Resident #2 to receive a 90 ml water flush every hour as instructed on the physician's order.</p> <p>During a phone interview on 6/13/24 at 4:21 PM Nurse #3 confirmed she worked from 7:00 PM to 7:00 AM and her initials were on the bottle of nutritional supplement dated 6/12/24 at 12:45 AM. Nurse #3 revealed what she did to manage Resident #2's feeding pump was to clear the volume amount of the nutritional supplement received and document the result on Resident #2's MAR. She started a new bottle, reloaded the tubing in the pump, and restarted the pump. Nurse #3 stated the rate settings for Resident #2's feeding pump were already setup, and she did not change or adjust it. She confirmed she did not review the physician's order to ensure the rate setting was correct.</p> <p>During a phone interview on 6/13/24 at 4:47 PM the RD stated the residents that were unable to receive oral intake were dependent on the feeding pump water flushes for hydration. She stated the water flush rate settings should be correct as ordered by the physician to prevent dehydration.</p> <p>A phone interview was conducted on 6/14/24 at 10:24 AM with the Medical Director. The Medical Director revealed he relied on the RD to make recommendations for residents receiving nutrition and hydration from a feeding tube. The Medical Director stated he expected the nurses to follow physician orders and set the rates on the feeding pump correctly for the resident to receive their water flushes.</p>		