STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E591	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 01/12/2022.	F 000		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to use the services of a registered nurse for at least eight consecutive hours a day, seven days a week, as the charge nurse for the 26 residents who resided in the facility. This placed the facility and residents at risk for inadequate nurse guidance and leadership. Findings included: - Review of the "Registered Nursing Staffing Schedule" for October, November, December 2021 and January 2022, recorded the facility	F 727		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/12/2022

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

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F 727	Continued From page 1 lacked a registered nurse on the following days: Ten days in October (10/02/21, 10/03/21, 10/09/21, 10/10/21, 10/18/21, 10/19/21, 10/25/21, 10/26/21, 10/30/21, 10/31/21) Eight days in November (11/06/21, 11/07/21, 11/13/21, 11/14/21, 11/20/21, 11/21/21, 11/27/21, 11/28/21) Eight days in December (12/04/21, 12/05/21, 12/11/21, 12/12/21, 12/18/21, 12/19/21, 12/25/21, 12/26/21) Four days in January (01/01/22, 01/02/22, 01/08/22 and 01/09/22) On 01/04/22 at 08:30 AM, observation revealed 26 residents resided in the facility. On 01/06/22 at 11:00 AM, Administrative Nurse D verified the facility did not have a registered nurse in the building or working as a charge nurse for the above documented dates. The facility's "Nursing Services" policy, dated 04/27/18 recorded the facility would provide nursing services to maintain resident safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. The policy recorded a registered nurse (RN) would be present in the facility for 8 consecutive hours a day. The facility failed to provide a registered charge nurse for the 26 residents who resided in the facility for at least eight consecutive hours a day, seven days a week, when the DON was not available, placing the facility and residents at risk for inadequate nurse guidance and leadership.	F 727		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 2 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure expired medications were removed from a narcotic (medication used to treat moderate to severe pain and/or sleep management, and can lead to addiction) emergency kit in one medication cart. This placed the affected residents at risk for decreased or ineffective therapeutic results.	F 761		

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F 761	Continued From page 3	F 761		

Findings included:

- On 01/04/22 at 09:11 AM, observation revealed the narcotic emergency kit in the medication cart contained the following expired medications:
Tramadol (narcotic pain medication used for moderate to severe pain) 50 milligrams (mg), expired 10/15/21
Lortab (narcotic pain medication used for moderate to severe pain) 5 mg/325 mg, expired 10/15/21
Xanax (antianxiety medication used for agitation and anxiety) 0.25 mg, expired 10/15/21
Ambien (narcotic medication used to treat severe sleep problems) 5 mg, expired 10/15/21

On 01/04/22 at 09:11 AM, Licensed Nurse (LN) H verified the medications in the narcotic emergency kit were expired, and staff should notify the facility's pharmacist for the disposal of the expired narcotic medications.

On 01/04/22 at 03:34 PM, Administrative Nurse D stated staff should monitor medication expiration dates, and remove expired medications from the medication cart to prevent administration to the residents.

The facility's undated "Storage of Medications and Biologicals" policy documented staff should remove expired medications from stock, and dispose of expired medications according to the facility's protocol and procedures.

The facility failed to ensure expired medications were removed from a narcotic emergency kit, placing residents who required those medications at risk for receiving ineffective therapeutic results.

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F 812	Continued From page 4	F 812		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 26 residents. Based on observation, record review, and interview the facility failed to provide a backflow device (unwanted flow of water in the reverse direction) or a two-inch air gap for the drainage system of the kitchen ice machine used by the 26 residents who resided in the facility. This placed the affected residents at risk to receive contaminated ice. Findings Included: - On 01/05/22 at 11:46 AM, observation revealed a flex drainage hose (a flexible water supply tube that connects plumbing fixtures and appliances to	F 812		

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F 812	Continued From page 5 the plumbing system) from the back of the ice machine was inserted into a plastic drainpipe, that extended approximately 15 feet, and connected to a sink drainpipe. Continued observation revealed the ice machine drainage system had no backflow device or two-inch air gap. On 01/05/22 at 02:48 PM, Administrative Staff A verified the ice machine drainage system did not have a backflow device, or two-inch air gap to prevent possible backflow contamination into the ice supply. The facility's "Ice Handling and Cleaning," policy, dated 04/27/20, directed staff to ensure the ice machine had an appropriate drainage system to prevent contamination of the ice supply. The facility failed to provide a backflow device or two-inch air gap for the drainage system of the kitchen ice machine, placing the 26 residents who resided in the facility at risk for contaminated ice.	F 812		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(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	F 868		

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F 868	Continued From page 6	F 868		

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:
The facility had a census of 26 residents. The sample included 12 residents. Based on observation, record review and interview the facility failed to ensure their Quality Assessment and Assurance (QAA) Committee met quarterly. This placed the 26 residents who resided in the facility at risk for lack of quality care.

Findings included:

- The facility provided QAA committee attendance rosters for 06/24/21 and 10/28/21 in which the medical director had been present. The facility only provided documentation for two quarters of the four required for the year 2021.

On 01/10/22 at 01:30 PM, Administrative Staff A verified the QAA meetings should be held quarterly and were to include the medical director. Administrative Staff A verified the lack of quarterly meetings, stated it was hard to get the medical director to come to the facility and the medical director had not utilized computer technology to attend the meetings. Administrative Staff A verified the facility had meetings on 06/24/21 and 10/28/21.

The facility's "Quality Assurance and Performance Improvement" policy, dated 04/27/18, documented the facility would develop, implement, and maintain an effective, comprehensive, date driven QAPI program that

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F 868	Continued From page 7 focuses on indicators of the outcomes of care and quality of life. The QAPI program included documentation of systems and reports demonstrating systematic identification, reporting, investigating, analysis, and prevention of adverse events. Documentation demonstrates the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility failed to ensure the QAA committee met quarterly, placing the 26 residents who resided in the facility at risk for lack of quality care.	F 868		