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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint #KS00178959. The 2567 was sent electronically on 08/09/23	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/09/2023

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.

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 _____	07/27/2023

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 580	Continued From page 1	F 580		

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 30 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to report blood pressures and fasting blood sugars (a system which measures blood glucose in the body) outside of physician ordered parameters for Resident (R) 8. This placed the resident at risk for complications related to potential delay in physician involvement and/or treatment decisions.

Findings included:

- R8's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and elevated high blood pressure.

The "Annual Minimum Data Set" (MDS), dated

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2	F 580		

10/03/22, documented intact cognition. R8 required supervision with set-up assistance for transfers and was independent with all other activities of daily living (ADL). The assessment further documented R8 received seven days of insulin (a hormone produced in the pancreas by the cells in the pancreas), an antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions), and an antibiotic (medication that inhibits the growth of or destroys microorganisms).

The "Quarterly MDS," dated 06/26/23, documented intact cognition. R8 required supervision with set-up assistance with personal hygiene, and was independent with all other ADLs. The assessment further documented R8 received seven days of insulin, antipsychotic, and a diuretic (medication to promote the formation and excretion of urine).

The "Care Plan," dated 07/14/23, directed staff to monitor R8's blood glucose as ordered by the physician and as needed; monitor for signs of increased blood sugar and report any signs and symptoms to the physician. The care plan further directed staff to administer medications as ordered and report any side effects, effectiveness, and report any abnormal findings to the physician.

The "Physician's Order," dated 10/06/21, directed staff to notify the physician if the fasting blood glucose was over 160 mg/dl (milligrams per deciliter) or under 70 mg/dl.

The "Physicians' Order," dated 01/25/23, directed staff to administer Novolog (fast-acting insulin), 18 units (U), subcutaneous (under the skin) three

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

times a day for diabetes mellitus type 2, which was discontinued on 07/07/23

The "Physician's Order," dated 07/09/23, directed staff to administer Novolog, 25 U subcutaneous three times a day for diabetes mellitus type 2.

The "Medication Administration Record" (MAR), dated May 2023, documented the following fasting blood sugars outside of the physician ordered parameters:
05/08/23-162 mg/dl
05/11/23-183 mg/dl
05/17/23-183 mg/dl
05/23/23-205 mg/dl
05/24/23-265 mg/dl
05/26/23-226 mg/dl

The EMR lacked documentation the physician was notified of blood sugars listed above.

The "MAR" dated June 2023, documented the following fasting blood sugars outside of the physician ordered parameters::
6/12/23-98 mg/dl
6/14/23-176 mg/dl
6/23/23-188 mg/dl
6/26/23-169 mg/dl
6/29/23-172 mg/dl

The EMR lacked documentation the physician was notified of the blood sugars listed above.

The "MAR", dated July 2023, documented the following fasting blood sugars outside of the physician ordered parameters::
7/5/23-232 mg/dl
7/6/23-244 mg/dl
7/12/23-176 mg/dl

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

7/13/23-211 mg/dl
7/19/23-170 mg/dl

The EMR lacked documentation the physician was notified of the blood sugars listed above.

The "Standing Order Special Instructions," dated 10/17/22, directed staff to notify the physician if R8's systolic blood pressure (SBP-the pressure caused by the heart contracting and pushing out the blood) was greater than 160 beats per minute (bpm) or less than 80 bpm and if R8's diastolic blood pressure (DBP-the pressure in the arteries when the heart rests between beats) was greater than 100 bpm or less than 50 bpm.

The "Physician's Order," dated 03/07/23, directed staff to administer Cozaar (medication for elevated blood pressure), 25 mg (milligrams) by mouth daily.

The "Physician's Order," dated 03/09/23, directed staff to administer Norvasc (medication for elevated blood pressure), 5 mg by mouth in the evening.

R8's "Vital Sign Record" for January, February, and July 2023 documented the following SBP outside of ordered parameters which lacked evidence of physician notification:
01/19/23-172/86
01/24/23-178/79
01/31/23-166/82
02/07/23-169/87
02/14/23-164/80
07/01/23-165/81

On 07/26/23 at 11:35 AM, observation revealed R8 in the dining room eating lunch.

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 On 07/26/23 at 03:00 PM, Licensed Nurse (LN) G verified the physician should have been notified of the out of parameter blood sugars and blood pressures. On 07/26/23 at 09:56 AM, Administrative Nurse D stated staff should follow the physician orders and blood sugars and blood pressures outside or ordered parameters should have been called to the physician. The facility's "Clinician Notification" policy, dated 11/28/17, directed staff to notify the physician on a timely basis when a need to alter treatment is required, if there was a significant change in the resident's physical, mental, or psychosocial status and if there was a decision to transfer or discharge a resident from the facility. The policy further documented, decision making regarding notification parameters for clinical signs and symptoms would be based on physician orders and physician specific parameters. The facility failed to report blood sugar and blood pressures which were outside of the physician ordered parameters for R8, placing him at risk for complications related to potential delay in physician involvement and/or treatment decisions.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6	F 657		

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents, with 12 reviewed for bathing. Based on observation, record review, and interview, the facility failed to revise a care plan to reflect Resident (R) 20's shower refusal's and include other alternatives for personal hygiene per the resident's needs and preferences. This placed the resident at risk for poor hygiene due to uncommunicated care or behaviors.

Findings included:

- The Electronic Medical Record (EMR) for R20 documented diagnoses of dementia without

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7	F 657		

behavior disturbance (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and diabetes mellitus type 2 (2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 07/10/23, documented R20 had intact cognition and required supervision and set up assistance for personal hygiene, independent with set-up assistance with eating, and independent with all other activities of daily living (ADL) . The MDS further documented bathing did not occurred during the look back period.

The "Care Plan," dated 07/21/23, documented R20 preferred to take a shower during the night, every other day, and he would get the towels and supplies when he was ready to shower. The care plan directed staff to assist R20 if he asked for help as he would often ask staff permission to take a shower, shave, to toilet and documented R20's skin could get itchy. The care plan lacked documentation of interventions to employ when R20 refused showers.

The "May 2023 Bathing Record" documented R20 refused baths or showers the following days:
05/02/23
05/05/23
05/09/23
05/12/23
05/16/23

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 _____	07/27/2023

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 657	Continued From page 8 05/19/23 05/23/23 05/26/23 05/30/23 The "June 2023 Bathing Record" documented R20 refused baths or showers the following days: 06/07/23 06/09/23 06/13/23 06/16/23 06/20/23 06/23/23 06/27/23 06/30/23 The "July 2023 Bathing Record" documented R20 refused baths or showers the following days: 07/04/23 07/08/23 07/11/23 07/15/23 07/25/23 On 07/27/23 at 09:57 AM, observation revealed R20 had on a orange shirt that had three small stains on it, and red shorts; his hair appeared clean. On 07/26/23 at 09:00 AM, Certified Nurse Aide CNA) M stated R20 used to take his showers regularly but he will at times refuse for about a week ata time. CNA M further stated staff tried to encourage the resident and provide constant reminders during the day if residnets continued to refuse. On 07/27/23 at 0930 AM, Administrative Nurse D stated staff would encourage bathing and would	F 657		

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9 offer washing up at the bathroom sink if the resident did not want to take a shower. The facility's "Care Plan" policy, dated 11/28/17, documented the care plan should reflect individualized problems, goals, and interventions based on the resident's preferences and wishes, and would be updated on an ongoing basis as the resident achieved goals and progresses toward discharge. The facility failed to revise R20's care plan to provide staff direction or interventions related to R20's shower refusals. This placed the resident at risk for poor hygiene due to uncommunicated care needs.	F 657		
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 30 residents. Based on observation, record review, and interview, the facility failed to provide Registered Nurse (RN)	F 727		

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 10 coverage eight hours a day, seven days a week, placing all residents who reside at the facility at risk of lack of assessments and inappropriate care. Findings included: - Upon review of "Payroll Based Journal" (PBJ- a required detail information submitted by nursing homes of staffing required from the Centers of Medicare and Medicaid Services [CMS]) lacked RN eight-hour coverage for the months of May 2022, July 2022, August 2022, September 2022, October 2022, November 2022, December 2022, January 2023, February 2023, and March 2023. On 07/26/23 at 10:00 AM, Consultant GG stated she was unsure if the information on the PBJ report was correct but knew they had difficulty finding an RN to work on weekends. The facility's "Nursing Service" policy, dated 04/27/28, documented the facility would provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to maintain resident safety and assist resident to attain and/or maintain their highest practicable level of physical, mental, and psychosocial wellbeing. The facility failed to provide Registered Nurse coverage eight consecutive hours a day, seven days a week placing the residents who resided in the facility at risk of lack of assessment and inappropriate care.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 11	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 12	F 756		

The facility had a census of 30 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist idenitfied and reported Resident (R) R8's blood pressure and blood sugars (a system which measures blood glucose in the body) were outside of physician ordered parameters. This placed the resident at risk for physical decline.

Findings included:

- R8's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and elevated high blood pressure.

The "Annual Minimum Data Set" (MDS), dated 10/03/22, documented intact cognition. R8 required supervision with set-up assistance for transfers and was independent with all other activities of daily living (ADL). The assessment further documented R8 received seven days of insulin (a hormone produced in the pancreas by the cells in the pancreas), an antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions), and an antibiotic (medication that inhibits the growth of or destroys microorganisms).

The "Quarterly MDS," dated 06/26/23, documented intact cognition. R8 required supervision with set-up assistance with personal hygiene, and was independent with all other ADLs. The assessment further documented R8 received seven days of insulin, antipsychotic, and a diuretic (medication to promote the formation

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 _____	07/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 13	F 756		

and excretion of urine).

The "Care Plan," dated 07/14/23, directed staff to monitor R8's blood glucose as ordered by the physician and as needed; monitor for signs of increased blood sugar and report any signs and symptoms to the physician. The care plan further directed staff to administer medications as ordered and report any side effects, effectiveness, and report any abnormal findings to the physician.

The "Physician's Order," dated 10/06/21, directed staff to notify the physician if the fasting blood glucose was over 160 mg/dl (milligrams per deciliter) or under 70 mg/dl.

The "Physicians' Order," dated 01/25/23, directed staff to administer Novolog (fast-acting insulin), 18 units (U), subcutaneous (under the skin) three times a day for diabetes mellitus type 2, which was discontinued on 07/07/23

The "Physician's Order," dated 07/09/23, directed staff to administer Novolog, 25 U subcutaneous three times a day for diabetes mellitus type 2.

The "Medication Administration Record" (MAR), dated May 2023, documented the following fasting blood sugars outside of the physician ordered parameters:
05/08/23-162 mg/dl
05/11/23-183 mg/dl
05/17/23-183 mg/dl
05/23/23-205 mg/dl
05/24/23-265 mg/dl
05/26/23-226 mg/dl

The EMR lacked documentation the physician

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	17E591	A. BUILDING _____ B. WING _____	07/27/2023

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VALLEY HEALTH CARE CENTER	400 12TH STREET VALLEY FALLS, KS 66088

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F 756	Continued From page 14	F 756		

was notified of blood sugars listed above.

The "MAR" dated June 2023, documented the following fasting blood sugars outside of the physician ordered parameters::
6/12/23-98 mg/dl
6/14/23-176 mg/dl
6/23/23-188 mg/dl
6/26/23-169 mg/dl
6/29/23-172 mg/dl

The EMR lacked documentation the physician was notified of the blood sugars listed above.

The "MAR", dated July 2023, documented the following fasting blood sugars outside of the physician ordered parameters::
7/5/23-232 mg/dl
7/6/23-244 mg/dl
7/12/23-176 mg/dl
7/13/23-211 mg/dl
7/19/23-170 mg/dl

The EMR lacked documentation the physician was notified of the blood sugars listed above.

The "Standing Order Special Instructions," dated 10/17/22, directed staff to notify the physician if R8's systolic blood pressure (SBP-the pressure caused by the heart contracting and pushing out the blood) was greater than 160 beats per minute (bpm) or less than 80 bpm and if R8's diastolic blood pressure (DBP-the pressure in the arteries when the heart rests between beats) was greater than 100 bpm or less than 50 bpm.

The "Physician's Order," dated 03/07/23, directed staff to administer Cozaar (medication for elevated blood pressure), 25 mg (milligrams) by

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F 756	Continued From page 15	F 756		

mouth daily.

The "Physician's Order," dated 03/09/23, directed staff to administer Norvasc (medication for elevated blood pressure), 5 mg by mouth in the evening.

R8's "Vital Sign Record" for January, February, and July 2023 documented the following SBP outside of ordered parameters which lacked evidence of physician notification:
01/19/23-172/86
01/24/23-178/79
01/31/23-166/82
02/07/23-169/87
02/14/23-164/80
07/01/23-165/81

On 07/26/23 at 11:35 AM, observation revealed R8 in the dining room eating lunch.

On 07/26/23 at 03:00 PM, Licensed Nurse (LN) G verified the physician should have been notified of the out of parameter blood sugars and blood pressures.

On 07/26/23 at 09:56 AM, Administrative Nurse D stated, staff should follow the physician orders and the out of the parameter blood sugar and blood pressures should have been called to the physician. Administrative Nurse D stated the pharmacist should inform the facility of any irregularities found during review of the residents' medical record.

The facility's "Drug Regimen Review" policy, dated 11/28/17, documented the pharmacist would complete a review of the resident's clinical chart one time monthly and would report any

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F 756	Continued From page 16 irregularities to the attending physician, the facility's medical director and the director of nursing. The facility failed to ensure the Consultant Pharmacist idenitfied and reported R8's blood pressure and blood sugars (a system which measures blood glucose in the body) were outside of physician ordered parameters. This placed the resident at risk for physical decline.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The	F 757		

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F 757	Continued From page 17	F 757		

sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure adequate monitoring to identify out of parameter blood pressures and fasting blood sugars (a system which measures blood glucose in the body) for Resident (R) 8. This placed the resident at risk for complications related to medications used for high blood pressure and blood sugars.

Findings included:

- R8's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus type 2 (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), and elevated high blood pressure.

The "Annual Minimum Data Set" (MDS), dated 10/03/22, documented intact cognition. R8 required supervision with set-up assistance for transfers and was independent with all other activities of daily living (ADL). The assessment further documented R8 received seven days of insulin (a hormone produced in the pancreas by the cells in the pancreas), an antipsychotic (a class of medication used to treat psychosis and other mental emotional conditions), and an antibiotic (medication that inhibits the growth of or destroys microorganisms).

The "Quarterly MDS," dated 06/26/23, documented intact cognition. R8 required supervision with set-up assistance with personal hygiene, and was independent with all other ADLs. The assessment further documented R8 received seven days of insulin, antipsychotic, and a diuretic (medication to promote the formation

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F 757	Continued From page 18	F 757		

and excretion of urine).

The "Care Plan," dated 07/14/23, directed staff to monitor R8's blood glucose as ordered by the physician and as needed; monitor for signs of increased blood sugar and report any signs and symptoms to the physician. The care plan further directed staff to administer medications as ordered and report any side effects, effectiveness, and report any abnormal findings to the physician.

The "Physician's Order," dated 10/06/21, directed staff to notify the physician if the fasting blood glucose was over 160 mg/dl (milligrams per deciliter) or under 70 mg/dl.

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The EMR lacked documentation the physician

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F 757	Continued From page 19	F 757		

was notified of blood sugars listed above.

The "MAR" dated June 2023, documented the following fasting blood sugars outside of the physician ordered parameters::
6/12/23-98 mg/dl
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F 757	Continued From page 20	F 757		

mouth daily.

The "Physician's Order," dated 03/09/23, directed staff to administer Norvasc (medication for elevated blood pressure), 5 mg by mouth in the evening.

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On 07/26/23 at 11:35 AM, observation revealed R8 in the dining room eating lunch.

On 07/26/23 at 03:00 PM, Licensed Nurse (LN) G verified the physician should have been notified of the out of parameter blood sugars and blood pressures.

On 07/26/23 at 09:56 AM, Administrative Nurse D stated staff should follow the physician orders and blood sugars and blood pressures outside or ordered parameters should have been called to the physician.

Upon request, a policy for blood sugar and blood pressure parameters was not provided by the facility.

The facility failed to ensure adequate monitoring to identify out of parameter blood pressures and fasting blood sugars for R8. This placed the

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F 757	Continued From page 21 resident at risk for complications related to medications used for high blood pressure and blood sugars.	F 757		