STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 A follow-up and complaint investigation survey was conducted from 01/04/23 through 01/06/23. The Event ID# TNIT11. The following intakes were investigated NC00194838, NC00196389, NC00195569, NC00196462, NC001955647, NC00196586 and NC00194838. 1 of 17 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 693	Resident #12 tube feeding syringe,	1/20/23

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

Electronically Signed | 01/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 693	Continued From page 1 interviews the facility failed to store a tube feeding syringe with the plunger separated from the syringe and failed to change the enteral feeding bag and tubing within 24 hours for 1 of 3 residents (Resident #12) reviewed for enteral feeding management, which created a potential for bacterial growth. Findings included: Resident #12 admitted to the facility on 8/30/2019 with diagnoses of stroke and difficulty with swallowing. A quarterly Minimum Data Set assessment dated 11/15/2022 indicated Resident #12 was severely cognitively impaired and received 51% or more or her total caloric intake from enteral tube feedings. On 1/4/2023 at 12:35 pm Resident #12 was observed in bed with the head of the bed elevated and her enteral feeding on hold and the pump beeping. The feeding bag was dated 1/1/2023 and the enteral feeding flush syringe was hanging in a clean plastic bag from the pump stand with the plunger inside the syringe and clear liquid in the tip of the syringe. The plastic bag containing the enteral feeding syringe was not labeled or dated. An interview was conducted with Medication Aide #1 on 1/4/2023 at 12:40 pm and she stated Nurse #1 was responsible for changing the enteral feedings and giving Resident #12 her medications through the gastrostomy tube. She stated Nurse #1 knew when the enteral feeding bags were changed by looking at the resident's Medication Administration Record.	F 693	enteral feeding bag and tubing were replaced on 1/4/2023. On 1/9/2023 the Director of Nursing reviewed the current residents that are receiving enteral feeding to ensure tube feeding syringe was separated after usage, enteral feeding bag and tubing had the correct date. Director of Nursing and designee educated license nurses including agency on separating tube feeding syringe after usage, changing the enteral feeding bag and tubing daily. Completed 1/20/2023. Education will continue in orientation with new hire and any new agency nurses. Licenses nurses, facility and agency will be validated during orientation in-person and/or via phone. Director of Nursing and/or designee will observe tube feeding syringe for separation after usage, enteral feeding bag and tubing has the correct date 3x weekly x 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	**1900 W 1ST STREET WINSTON-SALEM, NC 27104**

(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 693	Continued From page 2	F 693		

On 1/4/2023 at 12:53 pm an interview was conducted with Nurse #1, and she stated the enteral feeding bag and enteral feeding syringe should be changed each shift and sooner if needed, and the enteral feeding bag and enteral feeding syringe storage bag should be dated. She stated the enteral feeding bags should not be refilled. Nurse #1 was asked to observe Resident #12's enteral feeding bag and agreed the enteral feeding bag was dated 1/1/2023. Nurse #1 also stated Resident #12's enteral feeding syringe was stored with the plunger in the syringe; there was liquid in the syringe; and the storage bag was not dated. Nurse #1 stated she was aware the storage bag for the enteral feeding syringe should be dated but was not aware she should store the enteral feeding syringe plunger separate from the syringe to promote drying and decreased the risk for bacterial growth.

During an interview with the Director of Nursing on 1/5/2023 at 4:37 pm she stated the enteral feeding bags, and the enteral feeding syringe should be changed every 24 hours and the syringe and plunger should be stored separately in a bag labeled with the date. The Director of Nursing also stated Resident #12's enteral feeding bag should not be refilled with feeding. The Director of Nursing stated not storing the enteral feeding syringe with the plunger removed and not providing Resident #12 with a new bag and tubing every 24 hours created a potential for bacterial growth.

On 1/5/2023 at 5:14 pm an interview was conducted with the Regional Director of Operations, and she stated the facility should follow the policy as it relates to enteral feedings and the enteral feeding bag should be changed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	**1900 W 1ST STREET WINSTON-SALEM, NC 27104**

(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 693	Continued From page 3 every 24 hours and the enteral feeding syringe should be stored properly with the plunger disengaged.	F 693		