STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/16/2024 through 10/08/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TEHD11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 9/16/2024 through 9/20/2024. The credible allegation of IJ removal was validated on 9/24/2024 and additional information was obtained on 10/07/24 and 10/08/24. Therefore, the exit date was changed to 10/08/24. Event ID: TEHD11. The following intakes were investigated NC00222047, NC00222048, NC00221886, NC00221692, NC00221135, NC00220591, NC00220579, NC00219769, NC00219449, NC00219421, NC00219344, NC00217792, NC00216946, NC00215665, NC00215043, NC00212046, NC00208807, NC00208614, NC00222114, NC00218077, NC00222240, NC00222322, and NC0022661. Intake NC0021135 resulted in immediate jeopardy. 12 of the 53 complaint allegations resulted in deficiency Immediate Jeopardy was identified at: CFR483.24 at tag F678 at a scope and severity of J CFR 483.25 at tag F684 at a scope and severity of J CFR483.35 at tag F726 at a scope and severity of J The tags F678 and F684 constituted Substandard	F 000		

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

Electronically Signed | 10/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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	Continued From page 1 Quality of Care. Immediate Jeopardy began on 7/18/2024 and was removed on 9/20/2024. An extended survey was conducted.	F 000		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, the facility failed to ensure a staff member had no pending or substantiated allegations of Resident Abuse or Neglect on the North Carolina Nurse Aide Registry for 1 of 5 employees (Dietary Aide #1) reviewed for resident abuse.	F 606	1. Dietary Aide was terminated from employment on 9/12/24. 2. Regional Human Resources Director completed an audit of all current employees on 9/12/24 to ensure no other	10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 606	Continued From page 2 The findings included: Review of Dietary Aide #1's employee file revealed he was hired on 9/6/2024 and was terminated on 9/12/2024. A background check had been completed, and there were no criminal charges. A report from the North Carolina Nurse Aide Registry revealed Dietary Aide #1 had one pending allegation of "Abuse of a Resident." An interview was conducted on 9/17/2024 at 12:49 pm with the Human Resources (HR) Director. The HR Director stated when a person was hired, she completed a background check to ensure there were no criminal charges. The HR Director stated she also searched each new hire employee's name on the North Carolina Nurse Aide Registry to ensure there were no allegations of abuse or neglect. The HR Director stated if either the criminal background check or North Carolina Nurse Aide Registry reports had any charges or allegations, the individual would not be eligible for employment at the facility. The HR Director stated she was made aware by the Administrator on 9/12/2024 that Dietary Aide #1 had 1 pending allegation of abuse on the North Carolina Nurse Aide Registry. The HR Director stated she had not thoroughly looked over the document from the Registry because Dietary Aide #1 was the DON's son. The HR Director stated if she would have seen the pending allegation, she would not have allowed Dietary Aide #1 to work at the facility. The HR Director stated Dietary Aide #1 had not had any resident contact in the facility, had one day of classroom orientation, and two shifts with another Dietary Aide in the kitchen. An interview was conducted on 9/17/2024 at 1:13	F 606	staff members had negative findings on the C.N.A. Registry. No other findings noted. 3. Education provided by Regional Human Resources Director, on 9/12/24, for the HR Director, Administrator, Assistant Administrator and Director of Nursing regarding policy and regulation related to ensuring no one is hired with pending or actual negative findings on the C.N.A. Registry. The Human Resources Director or Administrator will educate all new administrative staff and department managers upon employment and annually thereafter on the policy and regulatory requirement ensuring no one is hired to work in the facility in any department that has pending or substantiated negative findings on the NC NA registry. 4. The Assistant Administrator will review License Checks, Background Checks, and NC N.A. Registry for all potential new hires prior to employment weekly for the next 3 months, then continue to audit one potential new hire weekly X 8 weeks. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 606	Continued From page 3	F 606		

pm with the Director of Nursing (DON). The DON stated any individual can apply to work at the facility by walking in and completing an application. The DON stated whenever someone was being considered for employment, she obtained a copy of their driver's license and current certifications. The DON stated she would then give the copies to the HR Director who completed a criminal background check and set up orientation. The DON stated that Dietary Aide #1 was her son. The DON stated she was aware that her son had pending allegations on the North Carolina Nurse Aide Registry, which is why he was not employed at the facility as a Nurse Aide (NA).

An interview was conducted on 9/17/2024 at 1:27 pm with the Dietary Manager. The Dietary Manager stated Dietary Aide #1 went through one day of in-person general orientation in the front conference room at the entrance of the facility and worked two days alongside another Dietary Aide in the kitchen. The Dietary Manager stated Dietary Aide #1 never had any contact with any residents during his time of employment and only trained on the dishwasher.

An interview was conducted on 9/17/2024 at 1:58 pm with the Administrator. The Administrator stated that anyone can apply for a job at the facility by completing an application in person or over the internet. The Administrator stated after an application was received it was forwarded to the appropriate department manager for employment consideration and to schedule an interview. The Administrator stated if a department manager wished to hire an individual, they would notify the HR Director. The Administrator stated the HR Director completed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 606	Continued From page 4 criminal background check, would run a report on the North Carolina Nurse Aide Registry, and would schedule/set up orientation. The Administrator stated she was contacted by someone outside of the facility on 9/12/2024 that Dietary Aide #1 had pending abuse allegations on the North Carolina Nurse Aide Registry. The Administrator stated she immediately went to the HR Director and had her retrieve Dietary Aide #1's employee file. The Administrator stated in the file was a copy of the report from the North Carolina Nurse Aide Registry that stated Dietary Aide #1 had a pending allegation of abuse. The Administrator stated she immediately terminated Dietary Aide #1. The Administrator stated if she would have known about the pending abuse allegation on his certification, she would not have allowed Dietary Aide #1 to work at the facility.	F 606		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes	F 607		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 5 occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to follow their Abuse, Neglect, and Exploitation policy by failing to screen a new employee and initiate protective measures to safeguard residents from potential abuse and neglect when they hired Dietary Aide (DA) #1 with one pending allegation of "Abuse of a Resident" on the North Carolina Nurse Aide Registry for 1 of 5 employees reviewed for screening of employees (DA#1). The facility also failed to implement their abuse policy and procedures in the areas of reporting by not submitting an initial allegation report to the Division of Health Service Regulation (DHSR) within 2 hours of the facility being made aware of an allegation of abuse (Resident #81) and not notifying local law enforcement of an allegation of neglect (Resident #225) for 2 of 3 sampled residents reviewed for abuse. The findings included: Review of the facility's Abuse, Neglect, Exploitation, and Misappropriation Prevention Program policy reviewed on 3/28/2023 revealed	F 607	1. A) Dietary Aide was terminated from employment on 9/12/24. B) A self-report was sent for allegation of sexual abuse for resident # 81on 8/13/24. C) Administrator notified the police of allegation of neglect on 9/17/24. 2. A) The Regional Human Resources Director completed an audit of all current employees on 9/12/24 to ensure no other staff members had negative findings on the C.N.A. Registry. No other findings noted. B & C) Regional Nurse audited all self-reports for last 90 days to ensure timely reporting and police notification on 9/23/24, with no negative findings noted. 3. A) Education provided by Regional Human Resources Director, on 9/12/24, for the HR Director, Administrator, Assistant Administrator and Director of Nursing regarding policy and regulation related to ensuring no one is hired with pending or actual negative findings on the C.N.A. Registry. The Human Resources	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 6 the facility should "conduct background checks and not knowingly employee or otherwise engage any individual who has a) been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law; b) had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c) a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property." Review of Dietary Aide #1's employee file revealed he was hired on 9/6/2024 and was terminated on 9/12/2024. A background check had been completed and there were no criminal charges. A report from the North Carolina Nurse Aide Registry dated 9/6/2024 revealed Dietary Aide #1 had one pending allegation of "Abuse of a Resident." A review of a September 2024 timecard revealed Dietary Aide #1 worked on 9/6/2024 for 3.75 hours, on 9/8/2024 for 3.25 hours, and on 9/10/2024 for 8 hours. An interview was conducted on 9/17/2024 at 12:49 pm with the Human Resources (HR) Director. The HR Director stated the Director of Nursing (DON) had brought Dietary Aide #1 to her office and introduced Dietary Aide #1 as her son. The HR Director stated the DON and Dietary Aide #1 never mentioned having a pending charges or allegations. She stated that she had printed a report from the North Carolina Nurse Aide Registry on Dietary Aide #1 prior to hiring him. The HR Director stated she had not thoroughly	F 607	Director or Administrator will educate all new administrative staff and department managers upon employment and annually thereafter on the policy and regulatory requirement ensuring no one is hired to work in the facility in any department that has pending or substantiated negative findings on the NC N.A. registry. B &C) Education provided by the Regional Director of Operations to the Administrator , Assistant Administrator and Director of Nursing on requirements/regulation on reporting timely and police notification on 9/23/24. 4. The Assistant Administrator will review License Checks, Background Checks and NC N.A. Registry for all potential new hires prior to employment weekly for the next 3 months, then continue to audit one potential new hire weekly X 8 weeks. The Regional Director of Operations will audit all self-reports weekly for the next 90 days to ensure appropriate timely reporting to DHHS and Police notification. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 7	F 607		

looked over the document from the Registry because it was the DON's son. The HR Director stated if she would have seen the pending allegation, she would not have allowed Dietary Aide #1 to work at the facility. The HR Director stated she was made aware by the Administrator on 9/12/2024 that Dietary Aide #1 had 1 pending allegation of abuse on the North Carolina Nurse Aide Registry. The HR Director stated after she was made aware of the pending allegation, Dietary Aide #1 was immediately terminated. The HR Director stated Dietary Aide #1 had not had any resident contact in the facility, had one day of classroom orientation, and two shifts with another Dietary Aide in the kitchen. The HR Director stated she was responsible for reviewing the registry information prior to employment was offered

An interview was conducted on 9/17/2024 at 1:58 pm with the Administrator. The Administrator stated she was contacted by someone outside of the facility on 9/12/2024 and informed that Dietary Aide #1 had pending abuse allegations on the North Carolina Nurse Aide Registry. The Administrator stated she immediately went to the HR Director and had her retrieve Dietary Aide #1's employee file. The Administrator stated in the file was a copy of the report from the North Carolina Nurse Aide Registry that stated Dietary Aide #1 had a pending allegation of abuse. The Administrator stated she immediately terminated Dietary Aide #1 and spoke with the DON. The Administrator stated she was told by the DON that Dietary Aide #1 had received a letter in the mail that stated the abuse allegation had been cleared. The Administrator stated if she would have known about the pending abuse allegation on his certification, she would not have allowed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 8	F 607		

Dietary Aide #1 to work at the facility. The Administrator stated their system had failed and they had not followed their policies and procedures.

2. The facility policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" with a revised date of September 2022, revealed in part: "Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Policy Interpretation and Implementation: 1) If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. 3) Immediately is defined as a) within two hours of an allegation involving abuse or result in serious bodily injury or b) within 24 hours of an allegation that does not involve abuse or result in serious bodily injury."

Resident #81 was admitted to the facility on 06/17/24.

The admission Minimum Data Set (MDS) assessment dated 06/23/24 assessed Resident #81 with intact cognition.

Review of the initial allegation report submitted by the facility to DHSR via fax transmission on 08/11/24 at 9:33 PM noted an allegation type of resident abuse that the facility was made aware of on 08/09/24 at 4:35 PM. Resident #81 alleged that a young, male staff member had exposed his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 9	F 607		

genitalia to her during care. Law enforcement was notified of the allegation on 08/10/24 at 4:00 PM.

Review of the 5-day investigative report submitted by the facility to DHSR via fax transmission on 08/14/24 at 3:53 PM noted Adult Protective Services (APS) was notified of the allegation on 08/10/24 and an onsite visit by APS was conducted on 08/12/24. Further review revealed the allegation of resident abuse was unsubstantiated.

During an interview on 09/20/24 at 8:51 AM, the Administrator confirmed that she was notified of the abuse allegation reported by Resident #81 the evening of 08/09/24 and an investigation was immediately initiated. The Administrator confirmed that she had not submitted the initial allegation report to DHSR until 08/11/24 and explained she was trying to get statements along with further details of the alleged incident and time just slipped away from her.

3. A review of the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy revised September 2022 revealed: Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Policy Interpretation and Implementation: Reporting Allegations to the Administrator and Authorities: 2. The administrator or the individual making the allegation immediately reports his or her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 10	F 607		

suspicion to the following persons or agencies: 3. Law enforcement officials.

Resident #225 was admitted to the facility on 06/21/24.

A review of the facility's Initial 24-hour Report dated 07/12/24 at 8:50 AM revealed the facility was notified on 07/12/24 by the local county of department of social services (DSS) and adult protective services (APS) of the confirmation of neglect of Resident #225. The report indicated the Resident was currently in the facility and with no harm noted and no concerns noted upon nurse assessment. The Resident remained at baseline with normal psychosocial affect and an investigation was underway. The Report did not indicate the local law enforcement was notified of the allegation. The Report was completed by the Assistant Administrator on 07/13/24.

A review of the Investigation Report dated 07/17/24 and completed by the Administrator revealed the local law enforcement was not notified of the allegation of neglect of Resident #225.

During an interview with the Assistant Administrator on 09/17/24 at 2:02 PM the Assistant Administrator explained that on 07/12/24 the facility was notified by an APS investigator that they were substantiating an allegation of neglect secondary to two omissions of documentation of wound treatments in May 2024. She continued to explain that she completed the Initial Report as Resident Neglect as advised by their corporation but failed to inform the local law enforcement of the allegation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 607	Continued From page 11 An interview was conducted with the Administrator on 09/17/24 at 2:42 PM. The Administrator explained that she was informed by an APS investigator on 07/17/24 that they were substantiating an allegation of neglect of Resident #225 based on one or two omissions of documentation of treatments of pressure ulcers and stated, "if they were not documented, they were not done." The Administrator indicated she was not aware that the reports were submitted to the state agency as Resident Neglect and remarked the local law enforcement should have been notified as well.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 623	Continued From page 12	F 623		

resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 623	Continued From page 13 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff, family member, and regional ombudsman interviews, the facility failed to notify the Regional Ombudsman of a facility initiated discharge for 1 of 4 residents reviewed for dischage (Resident #308).	F 623	1. Resident # 308 was a respite resident that was discharged from the center. Ombudsman was notified of Resident # 308 discharge on 10/07/24. 2. The administrator completed a 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 623	Continued From page 14 The findings included: Resident #308 was admitted to the facility on 08/11/24 with diagnoses that included dementia. A review of Resident #308's discharge Minimum Data Set assessment dated 08/14/24 revealed resident was moderately cognitively impaired. Resident #308 was discharged home on 08/14/24. An interview with Resident #308's Family Member on 10/07/24 at 4:56 PM revealed Resident #308 had been admitted to the facility for a short-term respite period while Resident #308's spouse was having a medical procedure. The Family Member stated he was contacted on 08/14/24 by the Admissions Coordinator and notified that Resident #308 had eloped from the facility. During that phone call, he was notified that the facility could not meet the care needs of Resident #308 but would assist in finding him a secure unit. Resident #308's Family Member reported he came to the facility and picked up Resident #308 and took him home with him while the facility continued to locate a more appropriate placement for Resident #308. Resident #308's family member reported Resident #308 respite care stay was scheduled to be over on 08/15/24. During an interview with the Admissions Coordinator on 10/07/24 at 2:35 PM revealed after Resident #308 was brought back into the facility from his elopement, she was notified by the Administrator to contact Resident #308's family and notify them of the elopement and ask them to come get Resident #308 as the facility	F 623	audit on 10/08/24 of all discharges in the last 30 days to ensure that the Ombudsman was notified of transfer/discharge, noted that Ombudsman had not been notified. Social Service Director provided written notification to Ombudsman of all discharges in the last 30 days. 3. Education provided to the Social Service Director and Business Office Manager by the Administrator on requirements/ regulation on reporting discharges to the Ombudsman on 10/08/24. New Social Services and Business Office employees will be will be educated on this requirement by the Administrator during their facility orientation. 4. Administrator or Assistant Administrator will audit all discharges 5 days per week for next 30 days and then 5 discharges per month for 3 months to ensure that the ombudsman is notified of all discharges. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance: 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 623	Continued From page 15	F 623		

could not meet Resident #308's needs and keep him safe. The Admissions Coordinator reported she typically did not have anything to do with discharging of residents and that discharges were handled by the Social Worker. The Admissions Coordinator reported she did not notify the Regional Ombudsman of the discharge.

During an interview with the Social Worker on 10/07/24 at 3:09 PM revealed she was on vacation during the time that Resident #308 was admitted to the facility and stated while she was away, the Business Office Manager covered her duties. The Social Worker stated that they should have been notified along with the Regional Ombudsman. She reported she did not know if the facility had notified the Regional Ombudsman.

During an interview with the Business Office Manager on 10/07/24 at 3:13 PM revealed she had nothing to do with Resident #308's discharge process.

An interview with the Regional Ombudsman via phone on 10/07/24 at 4:20 PM revealed she was not notified of Resident #308's facility-initiated discharge. She stated she would like to be notified of any facility-initiated discharges so she could reach out to the resident and or family to see if they would like for her to advocate for the discharging resident.

During an interview with the Assistant Administrator on 10/07/24 at 4:40 PM she stated Resident #308 was admitted to the facility for a very short-term respite care stay and while he was admitted, Resident #308 eloped from the facility. She stated after the elopement, the Admissions Coordinator was instructed to contact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 623	Continued From page 16 his family and notify them of the elopement and to tell them that the facility could not meet the care needs of Resident #308 but would assist the family in locating a facility that had a secured dementia-care unit. The Assistant Administrator reported Resident #308's respite care stay was scheduled to end on 08/15/24. She also revealed the facility did not provide any discharge planning or notify the Regional Ombudsman of the facility-initiated discharge of Resident #308. She reported because Resident #308 admitted under respite care, and the facility was only providing room, board, and nursing services, she was under the impression that they did not need to provide notification to the Regional Ombudsman.	F 623		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) 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 that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 655	Continued From page 17 §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 resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) 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: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary 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 record review and staff interviews the facility failed to develop a baseline care plan that addressed a resident's wound or indwelling catheter for 1 of 5 residents reviewed for pressure ulcers (Resident #58). The findings included: Resident #58 was admitted to the facility on 07/09/24 and was discharged on 08/27/24. Resident #58's diagnoses included pressure ulcer of sacral region and neuromuscular dysfunction of the bladder.	F 655	1. Resident # 58 has been discharged from the center on 8/27/24. 2. Director of Nursing and Assistant Director of Nursing completed 100% audit of all admissions in the last 30 days 9/26/24 to ensure that a Baseline Care Plan had been completed and that any wounds and indwelling catheters were included on the Base Line Plan of Care. 3. Education was provided 10/01/24 to the Director of Nursing, MDS Nurses and Licensed Nurses by the Staff Development Coordinator on the process,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 655	Continued From page 18 Resident #58's admission assessment completed on 07/09/24 revealed that she had multiple pressure ulcers and an indwelling catheter. The assessment was completed by Nurse #7. Review of Resident #58's medical record revealed no baseline care plan was completed. The admission Minimum Data Set (MDS) dated 07/15/24 revealed that Resident #58 had an indwelling catheter and one stage 3 pressure ulcer that was present on admission. MDS Nurse #1 was interviewed on 09/19/24 at 4:23 PM who stated that baseline care plans were initiated and completed by the nurse who admitted the resident to the facility. The next shift completed anything that was not done. MDS Nurse #1 added that she did not complete the comprehensive care plan until the initial assessment was done. Nurse #7 was interviewed via phone on 09/19/24 at 5:03 PM. Nurse #7 confirmed that he had admitted Resident #58 to the facility. He stated that he did not have access to the medical record to check but he "was fairly certain he completed the baseline care plan" when he completed Resident #58's admission. The Director of Nursing (DON) was interviewed on 09/19/24 at 6:00 PM who stated that there was no baseline care plan developed for Resident #58. A follow up interview was conducted with the DON on 09/20/24 at 3:11 PM who stated that the nurse that admitted a patient to the facility was expected to develop the baseline care plan.	F 655	policy and regulation to complete a Base Line Care Plan within 48 hours of admission to include treatments and services resident requirements. No licensed staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. MDS Nurses will audit all new admissions X 30 days, then 2 Admissions per week X 3 months to ensure that a complete Baseline Care Plan was completed by the admitting nurse within 48 hours and make any required updates as needed to the baseline care plan or comprehensive care plan. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 655	Continued From page 19 Previous to January 2024 the facility did not utilize the baseline care plan and upon admission developed the comprehensive care plan.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Wound Provider interviews the facility failed to provide a physician ordered treatment to an arterial ulcer (an ulcer due to inadequate blood supply) over a weekend for 1 of 5 residents (Resident #49) reviewed with wounds. In addtion, a nurse did remain at the bedside to confirm a resident had taken his medications for 1 of 1 resident assessed as unable to self administer medications (Resident #44). The findings included: Resident #49 was admitted to the facility on 11/18/19 with diagnoses that included chronic non pressure ulcer of left and right lower leg and stricture of artery. The quarterly Minimum Data Set (MDS) dated 07/24/24 revealed that Resident #49 was moderately cognitively impaired and had 2 venous ulcers, had an infection of the foot, and received a dressing to feet. A physician order dated 08/07/24 read, Dakin's	F 658	1. Resident # 49 is currently receiving all treatments as ordered for her arterial wound Provider notified of missed treatments with no new orders provided. Resident # 44 is currently receiving medications as ordered, Self-Medication Assessment completed on 10/01/24 determined that resident is unable to safely self-administer medications. 2. A) Director of Nursing and Assistant Director of Nursing completed a 100% audit 9/30/24 of all current residents□ treatments to ensure that treatments were provided as ordered including on weekends. The provider was notified of any negative findings with no new orders B) Director of Nursing and Assistant Director of Nursing completed 100% audit on 10/01/24 of all rooms to ensure no medications at bedside, with no negative findings. 3. Education was provided for Nurses by the Staff Development Coordinator on	10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 20 (antiseptic used to clean wound) full strength to right second toe and left third toe daily and cover with a foam dressing. Review of the Treatment Administration Record (TAR) dated September 2024 revealed that Resident #49's treatment had been initialed indicating the treatment had been completed daily except for 09/07/24 (Saturday) and 09/08/24 (Sunday) the treatment was blank and contained no initials indicating the treatment had not been done as ordered. Review of the facility schedule for 09/07/24 revealed that Nurse #10 was caring for Resident #49 on day shift. Further review of the schedule revealed that on 09/08/24 Nurse #11 was caring for Resident #49 on 09/08/24 on day shift. There was no designated staff member for wound care on the schedule. Nurse #10 was interviewed via phone on 09/19/24 at 10:15 AM who stated that she worked at the facility through an agency and was there approximately one to two times a month. Nurse #10 stated she did wound care on the days that she worked if there was no wound nurse assigned to do them. She confirmed that she had worked with Resident #49 on Saturday 09/07/24 and stated that she was told that day there was a wound nurse, so she did not have to complete wound care. Nurse #10 could not recall who told her that there was a wound nurse that day or who the charge nurse was that day but stated that "if I did not do it was because they told me they had a wound nurse." Nurse #10 stated if she had completed the wound care she would have documented it on the TAR.	F 658	ensuring that treatments are completed as ordered 10/01/24. Education was completed 10/01/24 by the Staff Development Coordinator for all nurses and Medication Aides on policy on medication administration to include ensuring residents who are not assessed as safe for self-admin have swallowed all medications prior to leaving resident unattended. No Nurses or Medication Aides shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. Director of Nursing and/or Assistant Director of Nursing to audit treatment administration documentation for compliance with ordered treatments 5 times per week x 2 months, then audit 2 random residents per hall 5 times per week x 8 weeks. Director of Nursing or designee will observe medication pass for 5 nurses weekly X 4 weeks then 2 per week for 4 weeks to ensure proper procedure for medication administration including medications swallowed prior to leaving resident unattended. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 21	F 658		

Nurse #11 was interviewed via phone on 09/19/24 at 10:21 AM who stated that she worked at the facility through an agency and confirmed that she worked on 09/08/24 and was caring for Resident #49. She stated that when she worked at the facility, she did wound care if there was not a wound nurse in the building assigned to do them. Nurse #11 stated she was generally informed in report at the beginning of her shift if there was wound nurse that day or not. Nurse #11 stated if she did not document the dressing change on the TAR then she did not complete the dressing change, "I work a lot of places and don't recall" the specifics.

Wound Nurse #1 was interviewed on 09/17/24 at 11:13 AM who stated recently Wound Nurse #2 had been completing the daily dressing changes Monday through Friday and she had been doing all the paperwork and rounding with the Wound Provider weekly. Wound Nurse #1 stated that they used to have a staff member that was trained in wound care and completed the dressing changes on the weekend but that the staff member had been pulled back to the floor. She further explained that on the weekend the dressing changes were the responsibility of the hall nurse.

The Wound Provider was interviewed on 09/19/24 at 9:34 AM who stated he followed Resident #49 on a weekly basis. He stated that Resident #49 had osteomyelitis (infection of the bone) but had refused treatment options of amputation. He explained that Resident #49 had slightly exposed bone on her affected toes, and she does not refuse daily treatment but does adamantly refuse suggestion of amputation. The Wound Provider stated that he continued to use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 22	F 658		

Dakins solution to the areas to help with the bacteria. The Wound Provider was not aware of any issues with daily dressings being completed as ordered.

The Director of Nursing (DON) was interviewed on 09/20/24 at 1:13 PM who stated that Wound Nurse #1 was responsible for the paperwork and rounded with the Wound Provider and Wound Nurse #2 completed the daily dressings Monday through Friday. The DON stated that on the weekends the hall nurses were expected to complete any ordered wound care during their shift and on a rare occasion they had a staff member trained in wound care that would be assigned to do wound care on the weekend. She stated it would be indicated on the daily schedule if there was someone designated to do wound care.

The Assistant Administrator was interviewed on 09/20/24 at 3:11 PM who stated the facility offered wound care on the weekends and should have been completed as ordered either by the hall nurse or the designated wound care nurse.

2. Resident #44 was admitted to the facility on 07/01/24 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting the left non-dominant side, dependence on renal dialysis, diabetes and pain.

The admission Minimum Data Set (MDS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 23	F 658		

assessment dated 03/26/24 revealed Resident #44 had intact cognition.

A self-medication assessment completed 07/02/24 revealed in part, Resident #44 was unable to administer medications.

An observation on 09/18/24 at 9:06 AM revealed Nurse #1 entering Resident #44's room with a medication cup containing several pills and a cup with an orange-colored fluid substance. Nurse #1 handed the medication cup containing pills to Resident #44 and set the cup containing the orange-colored fluid substance on the overbed table. At 9:07 AM, Nurse #1 was observed exiting Resident #44's room and returned to the medication cart in the hallway.

An observation of Resident #44 on 09/18/24 at 9:07 AM revealed he was sitting up in bed with the medication cup in his hand. There were approximately 2-3 pills left in the medication cup and Resident #44 was taking the medication independently with no nurse present in the room.

During an interview on 09/18/24 at 9:08 AM, Nurse #15 confirmed Resident #44 did not have an order to self-administer medications. Nurse #15 stated she could have sworn Resident #44 took the all the medications prior to her leaving the room because he had put the cup to his mouth. Nurse #15 went back into Resident #44's room and confirmed that he still had some medication left in the medication cup. Nurse #15 asked Resident #44 if he was going to take the medication and he stated yes but he needed some ice-water which Nurse #14 provided. Nurse #15 stated she usually stayed in the room with residents when administering their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 24	F 658		

medications and restated she had thought Resident #44 had taken the medications administered prior to her leaving the room.

Review of Resident #44's September 2024 Medication Administration Record (MAR) revealed the following medications scheduled for 9:00 AM were initialed as administered by Nurse #15 on 09/18/24:

*Cholestyramine oral packet (used to lower cholesterol in the blood) 4 grams (GM)-give one packet by mouth three times a day for loose stools, reconstitute with water.

*Sevelamer Carbonate oral tablet (used to lower phosphorus levels in the blood) 800 milligrams (mg)-give two tablets by mouth with meals for phosphorous binding.

*Lomotil oral tablet 2.2-0.025 mg - give two tablets by mouth four times a day for diarrhea.

During an interview on 09/20/24 at 10:05 AM, Resident #44 stated nurses usually stayed with him in his room while he took his medications but on occasion, they didn't. Resident #44 stated he was capable of taking his medications independently but no one had ever asked if he would like to self-administer his medications. Resident #44 stated he was only asked if he needed help taking medications or if the medications needed to be crushed.

During a joint interview on 09/20/24 at 3:14 PM, both the Director of Nursing and Assistant Administrator stated nurses were expected to stay with residents until they were confident that all medications were taken prior to leaving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 658	Continued From page 25 room.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive discharge summary that included a recapitulation of stay for 1 of 3 residents reviewed for discharge	F 661	1. Resident # 306 discharged to another center. 2. Director of Nursing and Assistant	10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 661	Continued From page 26 (Resident #306). The findings included: Resident #306 was admitted to the facility on 03/26/24. A review of Resident #306's admission Minimum Data Set assessment dated 04/01/24 revealed Resident #306 was cognitively intact. Resident #306 was discharged to her home on 04/05/24. A review of Resident #306's electronic medical record revealed a discharge summary document dated 04/05/24 and titled "CCH Bridge to Home Discharge Summary - v2" that did not have a complete recapitulation of stay. Additionally, the summary was not signed by Resident #306 or her representative and the social services section, nursing services section, the recapitulation of stay, and the discharge instructions/follow-up precaution section were not completed until 04/30/24. An interview with Nurse #6 09/20/24 at 12:53 PM revealed hall nurses opened the discharge summary assessment the day of discharge and filled it out. She stated the other service areas completed their respective sections and then the nurse assigned to the resident at the time of discharge printed the discharge summary, along with the discharge instructions, provided the resident with paper prescriptions for their medications, reviewed their prescribed medications and educated them on how and when to take them.	F 661	Director of Nursing completed an audit 9/26/24 of all discharges in the last 30 days to ensure that discharge summary was completed and shared with the resident/responsible party. The two residents identified as incomplete discharge summaries were called by the Social Worker on 10/7/24 to check on well-being and to see if further services or assistance was needed. 3. Director of Nursing provided education to the Social Service Director on their responsibility to ensure that the Discharge Summary is completed by all disciplines prior to discharge date on 9/26/24. Staff Development Coordinator provided education to licensed nurses on ensuring that the Discharge Summary is complete and printed and given to the resident / responsible party upon discharge from the center. All new social workers, facility nurses, and agency nurses will receive this training on completion of resident Discharge Summary in facility new employee or agency orientation. 4. Assistant Administrator to audit all discharges weekly x 8 weeks and then 2 discharges per week x 4 weeks to ensure that the discharge summary was completed and shared with the resident/family upon discharge from the center. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 661	Continued From page 27 Review of facility provided staffing schedules from 04/05/24 revealed Nurse #9 was Resident #306's hall nurse the day she discharged from the facility. Multiple attempts to reach Nurse #9 by telephone were unsuccessful. An interview with Staff Development Coordinator/Infection Preventionist on 09/20/24 at 2:11 PM revealed she served as the facility's Director of Nursing on the day Resident #306 discharged from the facility. She reported on the day of discharge, a medication list was printed and reviewed with the resident. Paper prescriptions were provided to the resident and a complete and thorough discharge summary was supposed to be completed. She reported that Resident #306's discharge summary did not appear to have been completed at the time she discharged and that it was not thorough. She did not know why the discharge summary was not completed. During an interview with the Director of Nursing on 09/20/24 at 3:53 PM, she reported that Resident #306's discharge summary assessment did not appear to have been completed at the time of her discharge and indicated that she expected the discharge assessment to be completed thoroughly at the time of a resident's discharge. An interview with the Assistant Administrator on 09/20/24 at 4:01 PM revealed she expected discharge summaries be completed at the time of a resident's discharge.	F 661	compliance. 5. Date of compliance: 10/09/24	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR)	F 678		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 28 CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, observation, crash cart checklist, and staff, Respiratory Therapist, and Medical Director (MD) interviews the facility failed to immediately initiate Cardiopulmonary Resuscitation (CPR) when Resident #103, who was a full code had agonal breathing (a state of breathing of gasping for air due to the brain receiving insufficient oxygen) and went pulseless, failed to immediately utilize the overhead paging system to call staff to Resident #103's room (code blue), and failed to immediately active Emergency Medical Servies (EMS). Once the Respiratory Therapy recognized the need for CPR, they failed to implement the use of the Automated External Defibrillator (AED), failed to have available or use an oral airway, and the regulator on the emergency oxygen tank on the crash cart only went to 10 liters. Resident #103 was pronounced deceased and resuscitative efforts were stopped. This affected 1 of 1 resident reviewed for CPR. Immediate jeopardy began on 7/18/2024 when the staff failed to immediately initiate CPR for Resident #103 who was a full code. Immediate jeopardy was removed on 09/20/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and	F 678	1. Resident # 103 expired on 7/18/24. 2. On 9/19/24 the Director of Nursing and the Assistant Director of Nursing completed an audit of the center crash carts to ensure that they were adequately supplied according to the Crash Cart Check List. 3. Education was completed 9/23/24 by the Director of Nursing, Assistant Director of Nursing, and Unit Managers for all licensed staff and Respiratory Therapy on assessing and responding to changes in condition, this education included the center CPR Policy and when to call a Code Blue/ 911 EMS contact, and the location of the centers three crash carts. During this education staff were informed the centers policy does not include use of AED□s and that the AEDs had been removed from the Crash Carts. Education included all staff, FT, PT, PRN and Agency staff. No staff shall work until education completed. Education will be included in all new hire and new agency onboarding. 4. Mock Code Drills will be conducted by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 29 severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: A review of the facility's Emergency Procedure - Cardiopulmonary Resuscitation policy dated 2022 revealed "the facility's procedure for administering CPR shall incorporate the steps covered in the American Heart Association Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care of facility Basic Life Support (BLS) training material." The policy stated the facility should "maintain equipment and supplies necessary for CPR/BLS in the facility at all times" and "if an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: instruct a staff member to activate the emergency response system." Review of the American Heart Association Guidelines for Adult Basic Life Support for Healthcare providers dated 2020 read in part, verify scene, check for responsiveness, shout for help, activate emergency response, get AED and emergency equipment. Start CPR, perform cycles of 30 compressions and 2 breaths, and use AED as soon as it is available. A review of the standard Crash Cart checklist located on top of the crash cart, not dated, revealed a full tank of oxygen with a 15-liter regulator, oxygen wrench, sharps container, backboard, suction machine with tubing, bag-valve mask, and clipboard with paper should be kept outside of the cart. Gauze, a flashlight, a	F 678	the Administrator and Director of Nursing monthly to ensure compliance with response time and location of crash carts. The Crash Carts will be audited by the Assistant Director of Nursing or designee 5 X week for 8 weeks and then 1 time weekly X 8 weeks to ensure appropriately stocked. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 30	F 678		

roll of tape, alcohol pads, safety needs, CPR kit, Narcan, 3-milliliter (ml) syringe, 10 ml syringe, pulse oximetry device, lubricant, tongue blades, saline bullets, and needles should be kept in the top drawer of the crash cart. A non-rebreather face mask, simple face mask, oxygen tubing, suction catheter kits, nasal cannula, oral airway (a devise used to keep the tongue from covering the airway), suction, and sterile water should be kept in the second drawer of the crash cart. A saline flush, intravenous (IV, needle or catheter placed in the vein to deliver medications/fluids) kits, IV cap, IV connector, Huber needle (used to access ports), Normal Saline, central line dressing change kit, and IV tubing should be kept in the third drawer of the crash cart. Various sizes of gloves, a stethoscope, blood pressure cuff, spill kit, and AED with 2 sets of pads should be kept in the bottom drawer of the code cart.

Resident #103 was admitted to the facility on 6/26/2024 with a diagnosis of a fracture (break) of the right femur (long bone located at the top of the leg) and post right periprosthetic hip fracture (a broken bone that occurs around the implant of a total hip replacement).

Review of an admission Minimum Data Set (MDS) dated 6/30/2024 revealed Resident #103 was moderately cognitively impaired.

Review of a physician's order dated 7/5/2024 revealed Resident #103 was a full code and wanted to receive cardiopulmonary resuscitation (CPR).

A review of the July 2024 Medication Administration Record (MAR) revealed Resident #103 was documented as having received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 31	F 678		

ondansetron (medication used to treat nausea and vomiting) 4 milligrams (mg) by mouth on 7/18/2024 at 5:21 pm.

A review of a nursing note dated 7/18/2024 and the time of entry was 8:43 PM, authored by Nurse #3, revealed Resident #103's family requested ondansetron for nausea for Resident #103. The dose was given at 5:21 pm. Resident #103 had returned from a doctor's appointment vomiting green fluid with no food particles per Resident #103's family. Resident #103 refused supper and ondansetron was effective. The family later came to the nurses' station and stated Resident #103 was not responding. A sternal rub was performed by Nurse #3 with minimal response from Resident #103. Vital signs were taken, and the resident had a blood pressure of 49/33 (normal range is 90/60 to 120/80), heart rate of 90 beats per minute (normal range is 60 to 100 beats per minute), respiration rate of 18 breaths per minute (normal range is 12 to 20 breaths per minute), and a temperature of 96.7 degrees (normal is 98.6 degrees Fahrenheit). Resident #103's oxygen saturation level dropped into the 70's (normal range is greater than or equal to 92%) and Resident #103 was placed on oxygen (unspecified amount). 911 was called and CPR was started on Resident #103. Resident #103 was pronounced deceased at 7:50 pm.

Nurse #3 was unavailable for an interview.

Review of a telephone statement dated 7/19/2024, taken by the former Director of Nursing (DON), who was the Assistant Director of Nursing at the time) on behalf of Nurse #3, revealed at approximately 4:00 pm on 7/18/2024, Resident #103 returned to the facility from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 32	F 678		

doctor's (orthopedic) appointment with green bile on him that he had vomited in the car with his family. Resident #103's family had assumed Resident #103 had gotten car sick. The family came to the nurses' station around 5:15 pm and requested ondansetron (medication used to treat nausea and vomiting) for Resident #103. Ondansetron was administered at 5:21 pm. The family came and got Nurse #3 around 6:30 pm and Nurse #3 went into Resident #103's room and assessed him. Nurse #3 checked Resident #103's vital signs, and his blood pressure was low, "pulse and respirations were good," and he did not have a fever. Nurse #3 performed a sternal rub on Resident #103, and he opened his eyes. The family thought Resident #103 was sleepy. Nurse #3 reported she was going to send Resident #103 to the hospital but did not know where the on-call provider number was and then the second shift (7:00 pm to 7:00 am) nurse came in. Nurse #3 stated she informed Nurse #8 that Resident #103 was "not doing well" and they proceeded to go to Resident #103's room. Nurse #3 reported she called 911 and told EMS it was emergent, and someone had paged a Code Blue. Nurse #3 reported Nurse #8 performed CPR until EMS got there and took over. Nurse #3 reported Resident #103 was pronounced dead at 7:50 pm.

An interview was conducted on 9/19/2024 at 9:32 am with Nurse Aide (NA) #2. NA #2 stated she worked on 7/18/2024 during second shift (3:00 pm to 11:00 pm) and was assigned Resident #103. NA #2 stated she was in the process of taking her lunch break, around 7:00 pm, and was approached by Nurse #3 in the hall. NA #2 stated that Nurse #3 "panicked and did not know what to do" and stated that Resident #103 had "coded." NA #2 stated she showed her where the crash

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 33	F 678		

cart was at the nurses' station and instructed Nurse #3 to call 911. NA #2 stated Nurse #3 did not initiate CPR and had someone use the overhead paging system to call a Code Blue. NA #2 stated several minutes passed by when she was assisting Nurse #3 locate the crash cart and directing her to call 911 for EMS. NA #2 stated she stood at Resident #103's door with the family until the nurses and Respiratory Therapist entered the room, CPR was then initiated several minutes later. NA #2 stated she stayed out in the hall with Resident #103's family.

A review of a typed statement dated 7/19/2024, authored by Nurse #9, revealed the staff told her a resident was gone (had expired). Nurse #9 ran down to the 600 hall and told staff to call a Code Blue over the intercom. Nurse #9 arrived at the room around 7:00 pm after she received report from the 200-hall nurse. Nurse #3 was sitting at the nurses' station on the phone with Emergency Medical Services (EMS). Nurse #9 documented the crash cart was in the room and Nurse #8 was monitoring the situation. Nurse #9 documented Resident #103 had a pulse, but did not look good, and noticed his fingers were blue. Nurse #9 checked on the family member in the hallway and informed her Resident #103 was still alive, at which time staff called out of the room that they had started chest compressions. Nurse #9 documented Nurse #14 started compressions, and the RT began bagging (ventilating) Resident #103. Nurse #3 remained on the phone with EMS. EMS arrived in the room and placed a CPR vest (mechanical chest compression device that goes around the resident's chest) on Resident #103.

An interview was conducted on 9/18/2024 at 3:46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 34	F 678		

pm with Nurse #9. Nurse #9 stated she worked second shift (3:00 pm to 11:00 pm) on 7/18/2024 and was not assigned Resident #103. Nurse #9 stated an NA (name unknown) came to her and told her to go to Resident #103's room because they needed help. Nurse #9 stated when she arrived at Resident #103's room, Nurse #3 was calling EMS from the nurse's station and the family was in the hall. Nurse #9 stated she spoke with Nurse #8 and was told by Nurse #8 Resident #103 was not breathing well. Nurse #9 stated she went into the room and yelled for someone to get the crash cart and call a Code Blue. Nurse #9 stated she did not perform CPR and comforted the family member in the hall.

A review of a Report on a Code Blue event dated 7/18/2024, authored by the agency RT and submitted to her supervisor, revealed that at approximately 7:15 pm, an overhead announcement for a Code Blue was called for Resident #103. The RT responded to Resident #103's room at which time she observed Resident #103 was unresponsive, with an oxygen saturation level at 76% and dropping, CPR had not been initiated. The RT instructed staff to begin CPR and requested a bag-valve mask (mask used to give breaths during CPR using positive pressure, squeezing bag). Resident #103 was observed with a simple mask on with insufficient oxygen flow, which she documented as likely causing carbon dioxide retention. The bag-valve mask did not inflate properly which indicated inadequate oxygenation. Challenges faced were documented as a "delay in CPR initiation: initial hesitation and lack of coordinated effort from the team delayed effective CPR. The resident's pupils were fixed and dilated, indicating a critical need for timely intervention. Equipment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 35	F 678		

and flow issues: the bag-valve mask did not inflate properly, raising concerns about oxygen delivery. The outcome was documented as "despite multiple efforts, including epinephrine administration and advanced airway management attempts, the patient remained unresponsive. After approximately 25 minutes of high-performance CPR, the resident was pronounced dead at 7:50 pm." Post-event reflection documentation revealed the RT had spoken with Nurse #3 at which time Nurse #3 reported she was called to check on Resident #103, who had agonal breathing, however, CPR was not started promptly. The RT emphasized the importance of initiating CPR immediately upon finding a resident without a pulse and ensuing continuous efforts are made until help arrives, as per the American Heart Association (AHA) guidelines. The conclusion documentation stated "This event highlights the critical need for prompt and coordinated response during Code Blue situations. Immediate initiation of CPR and effective team communication are essential to improve resident outcomes. Further training and drills are recommended to ensure all staff are prepared to respond effectively to similar emergencies in the future." The report was electronically signed by the RT.

An interview was conducted on 9/18/2024 at 10:24 am with the agency Respiratory Therapist (RT). The RT stated she worked as an RT on night shift 7:00 pm to 7:00 am and responded to the Code Blue called on 7/18/2024 for Resident #103. The RT stated she was in the RT office when she heard a Code Blue paged overhead on the intercom for Resident #103's room around 7:15 pm and immediately responded (The RT's office was approximately 400 feet from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 36	F 678		

resident's room). The RT stated upon entering the room, there was a nurse and an NA standing beside the resident's bed, Resident #103 was hooked up to a vital sign machine, was on oxygen via face mask, and had an oxygen saturation of 76% (normal oxygen saturation range is >92%). The RT stated that she immediately assessed Resident #103 at which time he had no carotid pulse (pulse in the neck), fixed/dilated pupils, and agonal breathing, but was warm to touch. The RT stated other nurses had arrived in the room behind her and she instructed them to initiate CPR. The RT stated during the code the oxygen tank on the crash cart would only go up to 10 liters of oxygen per minute (instead of 15 liters per minute) and that the pressure that came out of the oxygen tank was not enough to inflate the bag on the bag-valve-mask, there was no oral airway in the cart, and she was unsure if there was an AED in the crash cart. The RT stated chest compression and ventilation were performed by a nurse (name unknown) until EMS arrived on scene. The RT stated CPR continued until EMS called a time of death. After the Code Blue the RT approached Nurse #3 and asked her why she had not initiated CPR and was told by Nurse #3 it was because she was alone and did not have any shoes on.

An interview was conducted on 9/18/2024 at 1:35 pm with Nurse #8. Nurse #8 stated she was an agency nurse, and was scheduled to work from 7:00 pm to 7:00 am on 7/18/2024. Nurse #8 stated on 7/18/2024 she arrived at work late around 7:15 PM and was met in the hall by staff and was told Resident #103 "did not look well." Nurse #8 stated she asked Nurse #3 about Resident #103 and urgently grabbed the vital sign equipment and ran into the room. Nurse #8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 37	F 678		

stated when she arrived in Resident #103's room the resident had difficulty breathing and he was unable to get a pulse oximetry reading. Nurse #8 stated the RT entered the room; she could not feel a pulse and began CPR. Nurse #8 stated the RT ran the code and instructed staff. Nurse #8 stated 2 other nurses arrived at the room and they rotated chest compressions every two minutes and one nurse called 911. Nurse #8 stated 2 to 3 rounds of CPR were performed and the RT remained at the head of the bed prior to EMS arrival, ventilating (supplying breaths) the resident, Nurse #8 stated when EMS arrived, they placed a defibrillator (an electrical shock across the chest used to treat life-threatening arrhythmias such as ventricular tachycardia and ventricular fibrillation) on Resident #103 and the chest compression device. Nurse #8 recalled EMS defibrillating (shocking) Resident #103 after he was placed on the cardiac monitor. Nurse #8 stated EMS spoke with the family, and the family wanted to stop chest compressions, and the time of death was called. Nurse #8 stated the AED was not on the crash cart which is why it was not placed on Resident #103 prior to EMS arrival.

An observation of the crash cart on 09/18/24 at 10:43 AM along with the Unit Manager revealed there was an Automated External Defibrillator (AED) in the bottom drawer of the cart.

A review of an EMS report dated 7/18/2024 revealed EMS call was received at 7:22 PM, the call was reported as "emergent with lights and sirens" for cardiac arrest. EMS arrived on scene at 7:28 PM, and arrived at Resident #103 at 7:36 PM at which time CPR was being performed by facility staff on Resident #103. CPR had been performed for approximately 10 minutes prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 38	F 678		

EMS arrival. Resident #103 had a shockable rhythm and was manually defibrillated at 7:41 pm and again at 7:43 pm. Time of death was documented at 7:50 pm.

An interview was conducted on 9/19/2024 at 9:37 am with DON. The DON stated on 7/18/2024 she was in the position of Assistant Director of Nursing (ADON). The DON stated after the Code Blue on 7/18/2024 which involved Resident #103, she was asked by the Former DON, to gather written statements from Nurse #3 and Nurse #8. The DON stated she was told by Nurse #3 that Resident #103 had gone to a doctor's appointment and when he returned to the facility, he stated having nausea. The DON stated the family had later approached Nurse #3 and said that "something was not right." DON was told by Nurse #3 that Nurse #3 and Nurse #8 had gone to the room to assess Resident #103 at which time they called a Code Blue and initiated CPR. The DON stated Nurse #3 was terminated following the Code Blue incident on 7/18/2024.

A telephone interview was conducted on 9/19/2024 at 10:31 am with the Former DON. The Former DON stated she was not able to recall much about the Code Blue event which involved Resident #103.

An interview was conducted on 9/24/2024 at 10:04 am with the Medical Director (MD). The MD stated Resident #103 had been admitted to the facility following a hip fracture. The MD was made aware of Resident #103 requiring CPR and later deceased. The MD stated he was not aware that the AED had not been applied prior to EMS arrival at the facility and was not aware that EMS had defibrillated Resident #103 two times after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 39	F 678		

their arrival on scene. The MD stated the application "would have not hurt his chance of survival" had it been applied by facility staff and said that it was "hard to say" if it would have changed the outcome of the situation. The MD stated he suspected Resident #103 may have died of a pulmonary embolism (a blood clot that stops the flow of blood to an artery in the lungs). The MD stated that if a resident was a full code and in distress, he would expect them to initiate EMS and CPR if indicated.

An interview was conducted on 9/19/2024 with the Administrator. The Administrator stated she was familiar with Resident #103 and recalled that on 7/18/2024 Resident #103 had gone out of the facility to a doctor's appointment and passed away later that night. The Administrator stated she was informed about the Code Blue during the morning meeting on 07/19/24. The Administrator stated she had read some statements from facility staff regarding the Code Blue. She had not been made aware the RT's written statement had been emailed to the Respiratory Therapy Supervisor who was an administrative staff member at the facility. Had she been made aware that the email which outlined a delay in response and initiation of CPR and equipment failure she would have immediately addressed the issues.

The Administration was notified of Immediate Jeopardy on 9/19/2024 at 3:33 pm.

The facility provided the following credible allegation of Immediate Jeopardy Removal:

Identify those recipients who have suffered and those who are likely to suffer a serious adverse outcome as result of the noncompliance:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 40	F 678		

Beginning on 7/18/24 on the 3-11 shift, Resident #103 had a change in condition which led to resident becoming unresponsive and went into Cardiopulmonary arrest. The staff failed to respond timely to initiate CPR and delayed in calling 911. The facility staff failed to implement the use of the AED. The center failed to have available or use an oral airway during event and the emergency tank on crash cart had a regulator which only went to 10 liters.

On 9/19/2024 at approximately 4:00 p.m. the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed an audit of the centers three Crash Carts to ensure that they were adequately supplied, all carts noted to be supplied with all required supplies/equipment in working order (Full O2 tank with 15-LPM Regulator, Suction machine and tubing, Oxygen wrench, sharps container, backboard, clipboard with paper, ambu bag, gauze 4x4, flashlight, tape, alcohol pads, Huber needle, 3cc syringe, 10cc syringe, safety needles, Surgi lube, tongue blades, saline, pulse oximeter, IV start kits, IV cap, IV tubing, IV connector, 20, 22 & 24G Jelco catheters, non-rebreather face mask, face mask, oxygen tubing, suction cath kit, nasal cannula, oral airway, Yankaur, gloves, stethoscope, BP cuff, Spill kit).

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The center has a policy that has been reviewed by the IDT and medical director, the policy indicates that the center will perform BLS level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 41	F 678		

CPR. Policy states a licensed staff member is responsible for providing BLS CPR. Policy review dated 9/19/24.

On 9/19/24 the Director of Nursing validated that all three crash carts have emergency oxygen tanks that go to 15 liters.

On 9/19/24 the Administrator and Medical Director decided to remove the AED's from the center. A note was place on each crash cart indicating that the AEDs are no longer in use at the center.

On 9/19/24 center HR Director reviewed all current staff and agency staff cpr certification and they were current.

The center HR Director and /or the Assistant Administrator verifies agency staff are cpr certified upon their assignment to the center.

On 9/19/24 the center Administrator notified the Director of Nursing of immediate implementation of Mock Code Drills increasing from Quarterly to Monthly. Mock Code Drills are conducted by the DON or ADON.

On 9/19/2024 at approximately 5:00 p.m. the Director of Nursing and Nursing Leadership Team which includes ADON, Unit Managers, Wound Nurse, initiated education for all licensed nurses and Respiratory Therapy on Assessing and Responding to Changes in Condition to include abnormal vital signs. Education also included review of the center CPR policy and how and when to call a Code Blue and when to call 911, immediate initiation of CPR in cardiopulmonary arrest and the Location of Crash

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 42	F 678		

Carts/Emergency Supplies. During education staff have been informed that the AEDs have been removed from the center. On 9/19/2024 at approximately 5:00 pm the Regional Nurse initiated education with all staff to include, Administrative Staff, Maintenance, Dietary, Laundry, Housekeeping, Licensed staff, Nurse Aides, and Therapy Staff on the Location of the Crash Carts/Emergency Supplies, how to call Code Blue and to notify a nurse with any noted change in a resident condition. This education included the Nurse's Aides responsibility in alerting licensed staff immediately of abnormal vital signs and/or unresponsive residents. Education includes per policy that the licensed staff will call 911 for Cardiorespiratory events. This education includes Full-Time, Part Time, PRN and Agency Staff.

No staff shall work until they receive this education. Director of Nursing is responsible for making sure all receive the above education. Director of Nursing informed the Staff Development Coordinator on 9/19/2024 that she would be responsible for new hire and new agency education on the above, to include assigning supervisory staff members to provide the education in her absence. Education will be included in new hire orientation and new agency orientation via in person review or a written education packet by a member of the Nurse Management Team (DON, ADON, SDC, Unit Managers, Shift Supervisors). Training to occur prior to the beginning of an unsupervised shift.

Night shift charge nurses are responsible for checking the crash carts nightly to ensure appropriately stocked, licensed nurses re-educated to this process as of 09/19/2024 by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 678	Continued From page 43 director of nursing or other member of nurse leadership team. Beginning 9/19/24 ADON or DON will check the crash carts weekly to ensure that they are appropriately stocked and in working order. Alleged date of IJ removal: 9/20/24. A validation of IJ removal was conducted on 09/24/24. All three facility crash carts were observed to have the needed emergency supplies and were in working order. Each cart contained a sign alerting the staff that the AED machines had been removed and contained a checklist that had been initialed nightly by the night shift nurse. The facility's CPR policy was reviewed as was the center's list of CPR certified staff. Nursing staff interviews revealed that they had received the education on CPR, responding to emergencies, location of crash carts, calling EMS services and the overhead page of Code Blue when an emergency was identified. Interviews with non-nursing departments revealed that they were aware of their role during an emergency and were able to verbalize tasks that they could do in the event of a Cod Blue. The facility conducted a mock Code Blue drill on 09/24/24 which was also observed without concerns. The nursing staff secured the crash cart, notified emergency personnel, and all staff including the RT responded and began performing CPR on the victim. The IJ removal date of 09/20/24 was validated.	F 678		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 44 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, Nurse Practitioner (NP), Medical Director (MD), and Pharmacist interviews the facility failed to assess a resident and initiate the sepsis protocol when Resident #96, who was continuously ventilator dependent, was found by Nurse #1 between 8:00 and 9:00 pm on 9/16/2024 to have a fever of 100.4 degrees Fahrenheit (F) (normal is 98.6 degrees), a heart rate of 116 beats per minute (normal is 60-100 beats per minute), and a respiratory rate of 24 breaths per minute (normal is 12-20 breaths per minute). Nurse #1 did not initiate the sepsis protocol when Resident #96 met two criteria on the Ventilator Unit Sepsis Protocol (a heart rate greater than 90 beats per minute and a respiration rate of greater than or equal to 20 breaths per minute), failed to re-check Resident #96's temperature for the remainder of the shift, and did not administer fever reducing medication. Then on 09/17/24 at approximately 6:30 AM to 7:00 AM Nurse Aide (NA) #1 obtained another set of vital signs that revealed a temperature of a 103 degrees Fahrenheit, a heart of rate of 121, and respiratory rate of 22 breaths per minute and reported the vital signs to Nurse #1 (who was the night shift nurse) that was reporting off to Nurse #2. Resident #96 was given Acetaminophen (medication used to reduce fever) 650 milligrams	F 684	1. Nurse Practitioner updated of resident # 96 condition and resident transferred to hospital on 9/17/24. Resident #96 returned from hospitalization on 9/30/24 and continues to reside at the center. 2. On 9/19/24 the Director of Nursing, Assistant Director of Nursing, Unit Manager and Wound Nurse obtained vital signs on all current residents and assessed for a change in condition. No other residents were identified as having abnormal vital signs. 3. The Staff Development Coordinator completed education 9/18/24 for all licensed nurses and respiratory therapists on the Facility Sepsis Protocol, Assessing and responding to resident□s change in condition to include abnormal vital signs, notifying provider of changes and reassessing residents for efficacy after interventions. Education was provided to nurse aides by Staff Development Coordinator and Administrative Nurses on 9/18/24 for recognizing and reporting immediately abnormal vital signs. No licensed staff shall work until education is received. This education will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 45 (mg) and Ibuprofen (medication used to reduce fever) 400 mg between 9:00 am and 11:00 am by Nurse #2. Nurse #2 failed to recheck Resident #96's temperature until approximately 3:00 pm at which time it was 102.3 degrees Fahrenheit after being prompted by the Unit Manager. The Unit Manager reported a temperature should have been obtained between 30 minutes to an hour after the administration of fever-reducing medication. At 3:00 pm, the Unit Manager contacted the NP and initiated the Sepsis Protocol (set of orders to follow when a resident has signs/symptoms of infection). Resident #96 was sent to the Emergency Department at approximately 4:15 pm and was later admitted to the Intensive Care Unit (ICU) with sepsis (life-threatening infection), urinary tract infection (UTI), an infected sacral (buttocks) wound, and dehydration. The deficient practice occurred for 1 of 3 residents (Resident #96) reviewed for change in condition. Immediate jeopardy began on 9/16/2024 when Resident #96 was found by Nurse #1 to have a change in condition and did not reassess Resident #96 after he was found to have a temperature of 100.4 degrees F, a heart rate of 116 beats per minute, and a respiration rate of 24 breaths per minute, which met the facility's sepsis criteria. Immediate jeopardy was removed on 09/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included:	F 684	in new hire and new agency staff orientation. 4. The Director of Nursing or designee will monitor the Vital Signs Exception report and eInteract Changes of Condition along with the 24 hour report as part of the Clinical Morning Meeting 5 days per week to ensure that all changes in condition and abnormal vital signs have appropriate follow up, interventions and provider notification, any discrepancies will result in immediate re-education and or disciplinary action. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 46	F 684		

The Ventilator Unit Sepsis Protocol revealed it was to be initiated if a patient exhibits two or more of the following Systemic Inflammatory Response Syndrome (SIRS, exaggerated defense response) criteria: temperature greater than 100.4 degrees or less than 96.8 degrees, heart rate greater than 90 beats per minute, respiratory rate greater than or equal to 20 breaths per minute, or a white blood count greater than or equal to 12,000 cubic millimeters (mm3) or less than or equal to 4,000 (mm3) and suspected or proven infection. Protocol interventions included staff were to obtain immediate labs, a chest x-ray, and begin cefepime 2 grams intravenously (IV) every 12 hours for 7 days or doxycycline 100 mg IV every 12 hours for 7 days. If the systolic blood pressure (top number on a blood pressure reading) was less than 100, staff should administer normal saline IV at 100 milliliters (ml) per hour for 48 hours. Staff should monitor intake and output for 48 hours for residents with a catheter. Staff should notify the MD or NP during their next visit to the facility. The protocol had an area for the nurse who initiated the protocol to sign.

Resident #96 was admitted to the facility on 6/17/2024 with diagnoses which included chronic respiratory failure (lungs are unable to exchange oxygen and carbon dioxide), ventilator associated pneumonia (a lung infection that develops when a person is on a ventilator), quadriplegia (inability to move all four extremities), unstageable pressure wound of the sacral region, gastrostomy tube (tube inserted through the stomach used to provide nutrition and medications), and dependence on a respiratory ventilator (machine used for breathing).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 47	F 684		

A review of a care plan dated 8/2/2024 revealed Resident #96 was at risk for respiratory complications related to ventilator (a machine used to help breathe) and tracheostomy (an opening in the neck to facilitate breathing). Staff were to monitor for signs and symptoms of pneumonia (an infection of the lungs), bronchitis (inflammation of the linings of the lungs), etc. and advise the medical provider of any abnormal findings.

A review of an annual Minimum Data Set (MDS) dated 8/19/2024 revealed Resident #96 was severely cognitively impaired, required extensive assistance for mobility and was coded for a tracheostomy mechanical ventilator, suctioning (used to remove secretions from the respiratory tract), oxygen, and intravenous (IV, given through the veins) medications.

A physician's order dated 9/9/2024 revealed Resident #96 was ordered ceftazidime (an antibiotic used to treat bacterial infections) injection 1 gram intravenously (IV, infused through the vein) every 8 hours for 10 days for a urinary tract infection and ciprofloxacin (an antibiotic used to treat infections) 500 milligrams (mg) via gastrostomy tube twice a day for 10 days for pseudomonas (an infection that can affect your skin, blood, lungs, and gastrointestinal tract) in the sputum.

The Medication Administration Record (MAR) revealed documentation that Resident #96 had received ceftazidime on 9/9/2024 (2:00 pm and 10:00 pm) , 9/10/2024 (6:00 am, 2:00 pm, and 10:00 pm), 9/11/2024 (6:00 am, 2:00 pm, and 10:00 pm), 9/12/2024 (6:00 am, 2:00 pm, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 48	F 684		

10:00 pm), 9/13/2024 (6:00 am, 2:00 pm, and 10:00 pm), 9/14/2024 (6:00 am, 2:00 pm, and 10:00 pm), 9/15/2024 (6:00 am, 2:00 pm, and 10:00 pm), 9/16/2024 (6:00 am, 2:00 pm, and 10:00 pm), and 9/17/2024 (6:00 am) and ciprofloxacin on 9/9/2024 (9:00 am), 9/10/2024 (9:00 am and 6:00 pm), 9/11/2024 (9:00 am and 6:00 pm), 9/12/2024 (9:00 am and 6:00 pm), 9/13/2024 (9:00 am and 6:00 pm), 9/14/2024 (9:00 am and 6:00 pm), 9/15/2024 (9:00 am and 6:00 pm), 9/16/2024 (9:00 am and 6:00 pm), and 9/17/2024 (9:00 am).

An observation was conducted on 9/16/2024 at 10:43 am of Resident #96. Resident #96 was observed lying in bed. Resident #96 had a tracheostomy and was on the ventilator. Ventilator settings were the following: oxygen at 5 liters per minute, respiration rate of 18 breaths per minute, Resident #96 was able to open his eyes and mouthed that he was "hot." The Surveyor notified Nurse Aide (NA) #3. Resident #96's ventilator was set on Assist Control/Volume Control (AC/VC, the ventilator produces a fixed tidal volume, the amount of air that moves in and out of the lungs with each breath, that is delivered at set time intervals or when the individual initiates a breath).

A review of vital signs on 9/16/2024 at 11:18 pm revealed Resident #96 had a temperature of 100.4 degrees (normal temperature is 98.6 degrees), heart rate of 116 beats per minute (normal heart rate is 60-100 beats per minute, respiration rate of 24 breaths per minute (normal respiration rate is 12-20 breaths per minute), a blood pressure of 113/62, and an oxygen saturation of 96% (normal is greater than 92%). The vital signs were documented by Nurse #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 49	F 684		

and were not reported to the physician.

An interview was conducted on 9/18/2024 at 4:49 pm with Nurse #1. Nurse #1 stated she had worked on the ventilator unit on 9/16/24 from 7:00 pm until 9/17/2024 at 7:00 am and was assigned Resident #96. Nurse #1 stated Resident #96 had a low-grade fever of 100.4 degrees Fahrenheit when she checked his vital signs close to the start of her shift somewhere between 8:00 pm and 9:00 pm. Nurse #1 stated she had not thought to re-check it until she had been informed around 7:00 am while giving report to Nurse #2, that Resident #96 had a temperature of 103 degrees. Nurse #1 stated Resident #96 met criteria for the Sepsis Protocol during her shift but stated she usually did not initiate the protocol if a resident was already on antibiotics. Nurse #1 stated Resident #96 met sepsis criteria because he had high heart rate of 116 beats per minute and an elevated respiratory rate of 24 breaths per minute. Nurse #1 stated the nurse could implement the Sepsis Protocol if a resident met two or more criteria, however, she was not sure how that worked since Resident #96 was on antibiotics. Nurse #1 stated staff typically only checked vital signs once a shift. Nurse #1 stated did not notify the provider because Resident #96 was already on antibiotics.

A review of vital signs on 9/17/2024 at 6:30 am revealed Resident #96 had a temperature of 103 degrees F, heart rate of 121 beats per minute, respiratory rate of 22 breaths per minute, and a blood pressure of 106/63. The vital signs were documented on a vital sign report sheet completed by NA #1.

An interview was conducted on 9/17/2024 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 50	F 684		

10:35 am with Nurse Aide (NA) #1. NA #1 stated she was assigned Resident #96 and had arrived on shift at 6:00 am on 9/17/2024. NA #1 stated shortly after she arrived, she obtained Resident #96's vital signs and recalled Resident #96 having an elevated temperature. NA #1 stated she wrote down Resident #96's vital signs and gave them to Nurse #1. NA #1 documented Resident #96's vital signs on a vital sign report sheet.

An interview was conducted on 9/17/2024 at 10:45 am with Nurse #2. Nurse #2 stated she was assigned Resident #96 and arrived on shift at 7:00 am. Nurse #2 stated she was told in report that Resident #96 had a temperature of 103 degrees Fahrenheit, heart rate of 121 beats per minute, respiration rate of 22, and a blood pressure of 106/63. Nurse #2 stated she had just received orders for Acetaminophen and Ibuprofen but had not given them yet. Nurse #2 had no response for why Acetaminophen and Ibuprofen had not been administered earlier. Nurse #2 stated she was not sure if the facility had a Sepsis Protocol and was unsure where the standing orders were.

A physician's order dated 9/17/2024 at 8:45 am revealed Resident #96 was ordered ibuprofen 400 mg via gastrostomy tube one time only for hyperthermia (increased body temperature).

A physician's order dated 9/17/2024 at 9:00 am revealed Resident #96 was ordered prednisone (steroid used to decrease inflammation) 60 mg via gastrostomy tube once a day for seven days for ventilator associated pneumonia.

An observation was conducted on 9/17/2024 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 51	F 684		

9:07 am of Resident #96. Resident #96 would not make eye contact or mouth any words. Resident #96's lips were dry and cracked. Ventilator settings were the following: oxygen at 10 liters per minute, respiration rate of 18 breaths per minute.

An interview was conducted on 9/17/2024 at 10:45 am with Nurse #2. Nurse #2 stated she was assigned Resident #96 and arrived on shift at 7:00 am. Nurse #2 stated she was told in report that Resident #96 had a temperature of 103 degrees Fahrenheit, heart rate of 121 beats per minute, respiration rate of 22, and a blood pressure of 106/63. Nurse #2 stated she had just received orders for Acetaminophen and Ibuprofen but had not given them yet. Nurse #2 had no response for why Acetaminophen and Ibuprofen had not been administered earlier. Nurse #2 stated she was not sure if the facility had a Sepsis Protocol and was unsure where the standing orders were.

An interview was conducted on 9/18/2024 at 5:19 pm with Wound Care Nurse #2. Wound Care Nurse #2 stated she had changed Resident #96's dressing around lunch time on 9/17/2024. Wound Care Nurse #2 stated at that time Resident #96's skin felt warm, and she told Nurse #2, and was told by Nurse #2 she was going to give him acetaminophen.

An interview was conducted on 9/18/2024 at 5:01 pm with the Wound Care Nurse #1. Wound Care Nurse #1 stated she had been told by Wound Care Nurse #2 that Resident #96 had a fever, because he felt warm, when she had changed his dressings on 9/17/2024 around lunchtime. Wound Care Nurse #1 stated she had walked to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 52	F 684		

Resident #96's room to check on him around 3:30 pm at which time he appeared "terrible and grayish blue in color." Wound Care Nurse #1 stated RT #1 was in the room with Resident #96 at that time giving him a nebulizer treatment and she left the room to inform the DON.

An interview was conducted on 9/17/2024 at 2:47 pm with Respiratory Therapist (RT) #1. RT #1 stated Resident #96 had been on antibiotics for pneumonia and was ventilator dependent. RT #1 stated Resident #96 had his oxygen level desaturate (get lower) on 9/16/2024 and had to have his oxygen requirements increased from 5 liters to 10 liters. RT #1 stated that was not uncommon for Resident #96. RT #1 stated nursing staff had not made him aware that Resident #96 had an elevated temperature and heart rate and stated that could be an indication of sepsis.

A physician's order dated 9/17/2024 at 3:20 pm revealed Resident #96 was ordered a sputum culture one time only for a fever, a urinalysis with culture and sensitivity one time only for a fever, and blood cultures/comprehensive blood count (CBC, used to evaluate for infection)/platelets (help blood to clot). A sputum sample was documented as collected on 9/17/2024 at 3:29 pm.

A physician's order dated 9/17/2024 at 3:37 pm revealed Resident #96 was ordered Ibuprofen 400 mg via gastrostomy tube one time only for hyperthermia (fever).

A physician's order dated 9/17/2024 at 3:45 pm revealed Resident #96 was ordered tobramycin nebulizer treatments 300 mg via tracheostomy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 53	F 684		

two times a day for pneumonia for 13 administrations to be nebulized with oxygen and 150 mg via tracheostomy one time for hyperthermia for one day.

A physician's order dated 9/17/2024 at 4:00 pm revealed Resident #96 was ordered meropenem (antibiotic) 1 gram/100 milliliters (ml) every 8 hours for hyperthermia for 7 days.

An interview was conducted on 9/17/2024 at 3:41 pm with the Unit Manager. The Unit Manager stated the ventilator unit utilized a Sepsis Protocol. The Unit Manager stated that the sepsis protocol typically applied to residents that were not currently on antibiotics and had experienced brand new sepsis symptoms. The Unit Manager stated she had not initiated the Sepsis Protocol for Resident #96 earlier in the shift because he was already on two different antibiotics. The Unit Manager stated she had contacted the NP earlier in the shift around 8:30 am and received orders to administer acetaminophen and ibuprofen at the same time. The Unit Manager stated she had to go to the store to get ibuprofen and when she returned, she gave it to Nurse #2 and told her to administer it with the acetaminophen. The Unit Manager stated she asked Nurse #2 around 3:00 pm what Resident #96's temperature was, at which time she had not checked it. Resident #96's temperature was 102.3 degrees Fahrenheit at that time. The Unit Manager stated that a temperature was typically rechecked between 30 minutes and 1 hour after the administration of medication for a fever. The Unit Manager stated she was unsure why Nurse #2 had not rechecked Resident #96's temperature sooner stated she contacted the NP at 3:20 pm and was told to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 54	F 684		

alternate Acetaminophen and Ibuprofen and initiate the Sepsis Protocol.

A review of a physician's order dated 9/17/2024 at 4:05 pm revealed Resident #96 was to be transferred to the hospital for evaluation and treatment for respiratory distress and fever.

Review of an Emergency Medical Services (EMS) report dated 9/17/2024 at 4:04 pm revealed that EMS had been dispatched to the facility in reference to Resident #96 having a fever. Upon arrival documentation revealed Resident #96 presented with septic shock. Facility staff had stated Resident #96's mental status was abnormal. Resident #96's skin was warm and diaphoretic. Resident #96's initial vital signs were a blood pressure of 94/60, heart rate of 118 beats per minute, and an oxygen saturation level of 100% on the ventilator. Resident #96 was given a normal saline fluid bolus (fluid administered through the vein to increase blood pressure) of 500 ml enroute to the hospital.
Review of an Emergency Room note dated 9/17/2024 at 5:48 pm revealed Resident #96 presented to the ER with a concern for sepsis (life-threatening infection). Resident #96's initial blood pressure was 83/58, heart rate of 101 beats per minute, respiration rate of 18, an oxygen saturation level of 97%, and a temperature of 98.4 degrees Fahrenheit. Resident #96 had extremely dry mucous membranes and a large, stage 3 sacral wound that was foul-smelling. Resident #96 went into ventricular tachycardia (irregular heart rate that can be life-threatening) and required an amiodarone (medication used to treat ventricular tachycardia) drip and continued to have worsening blood pressures which required a dose of epinephrine and initiation of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 55	F 684		

norepinephrine (medication used to increase blood pressure) drip. Resident #96 was admitted to the Critical Care Unit and remained in the hospital.

An interview was conducted on 9/17/2024 at 12:05 pm with the Pharmacist. The Pharmacist stated Resident #96 was on ciprofloxacin for a gram-negative bacterium, pseudomonas, and was also on ceftazidime, a third-generation cephalosporin, that was broader spectrum. The Pharmacist stated Resident #96 had been on antibiotics for several days and stated if Resident #96 had a fever of 103 degrees the facility should reinitiate the Sepsis Protocol to determine which bacteria was causing the elevation and adjust antibiotics as necessary.

An interview was conducted on 9/18/2024 at 2:16 pm with the Medical Director (MD). The MD stated the Sepsis Protocol was developed by the NP. The MD stated the Sepsis Protocol had to be initiated by himself, the Pulmonologist, or the NP, not the nursing staff. The MD stated the nursing staff at the facility should call the MD when a resident experienced signs or symptoms of sepsis before initiating the Sepsis Protocol. The MD stated Resident #96 had pneumonia in the past and had been on a couple of broad-spectrum antibiotics. The MD stated Resident #96 was on antibiotics which would typically start working within 3 to 5 days. The MD stated he would not be concerned about a fever of 103 degrees Fahrenheit not being treated unless the resident experienced symptoms of discomfort. The MD stated a fever was only dangerous when it reached 105 degrees, which could cause seizures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 56	F 684		

An interview was conducted on 9/18/2024 at 4:11 pm with the Director of Nursing (DON). The DON stated on 9/17/2024 around 3:30 pm that she was approached by the Wound Care Nurse that Resident #96 "did not look good," at which time she and the ADON started to the ventilator unit. The DON stated she stopped by the Unit Manager's office and asked how Resident #96 had been doing and was told he had been running a fever and orders had been obtained from the NP to initiate the Sepsis Protocol. The DON stated when she entered the room Resident #96 looked malaise, was warm to the touch, had a bounding heart rate, and looked like he needed to be transferred. The DON stated acetaminophen should have been administered by Nurse #2 per standing order when Resident #96 had a fever of 103 degrees, and stated she was unsure why there was a long delay in the administration of acetaminophen and ibuprofen. The DON was unsure why the Sepsis Protocol was also not initiated when Resident #96 had an elevated temperature and heart rate at the beginning of shift and agreed it should have been. The DON also reported Nurse #1 should not have waited multiple hours to recheck a temperature after the administration of antipyretics (fever-reducing medications).

An interview was conducted on 9/19/2024 at 10:04 am with the NP. The NP stated that she had created the Ventilator Unit Sepsis Protocol specifically for residents in the ventilator unit to prevent frequent hospitalizations. The NP stated that any nurse in the facility could initiate the Sepsis Protocol, and the nursing staff would inform her when she was in the building the next day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 57	F 684		

An interview was conducted on 9/18/2024 at 5:37 pm with the Administrator. The Administrator stated that she had been informed that Resident #96 had a fever of 103 degrees and that the Unit Manager had went to the store to get ibuprofen. The Administrator stated she was under the impression that Nurse #2 had given Resident #96 ibuprofen and acetaminophen. The Administrator stated the Sepsis Protocol could be initiated by any hall nurse and that the nurse did not have to call the MD or NP prior to initiating it. The Administrator reported Nurse #2 should have performed continuous assessments, including vital sign checks, until the resident had stabilized or was transferred to a higher level of care.

The Administrator was notified of Immediate Jeopardy on 9/18/2024 at 6:06 pm.

The facility provided the following credible allegation of Immediate Jeopardy Removal:

Identify those recipients who have suffered and those who are likely to suffer a serious adverse outcome as result of the noncompliance:

Beginning on 9/16/24 on 3-11 shift, resident # 96 met criteria to implement the center's sepsis protocol. Facility failed to implement the sepsis protocol and failed to reassess resident timely after administration of acetaminophen and ibuprofen on 9/17/24.

On 9/18/2024 at approximately 7:00 p.m. the Director of Nursing (DON) and Nursing Leadership team which includes the Assistant Director of Nursing (ADON), Unit Managers, and Wound Nurse obtained vital signs, to include temperature, respirations, pulse, oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 58	F 684		

saturations and blood pressure, of all current residents in the center to ensure that no other resident was experiencing an acute change in condition. No other residents were identified as having abnormal vital signs.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 9/18/2024 at approximately 7:00 p.m. the Staff Development Coordinator (SDC) initiated education for all licensed nurses and Respiratory Therapists on the Facility Sepsis Protocol (Sepsis Protocol to be initiated when the patient exhibits two or more symptoms), Assessing and Responding to Changes in Condition to include abnormal vital signs, notifying the provider and re-assessment for efficacy after initial intervention (residents should be reassessed one hour after intervention). Licensed nurses also educated at this time to new process for monitoring vital sign exception report at end of every shift and that nurses are to enter their vital signs every shift as ordered (The Vital Signs Exception Report is a report that is ran from the electronic health record that shows any vital signs that are abnormal) The Nurses' Aides were educated on Vital Signs and reporting abnormal results immediately to the charge nurse. This education includes Full-Time, Part Time, PRN and Agency Staff. No licensed staff shall work until they have received this education. Director of Nursing is responsible for making sure all receive the above education. Director of Nursing informed the Staff Development Coordinator on 9/18/2024 that she would be responsible for new hire and new agency education on the above. Education will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 59	F 684		

included in new hire orientation and new agency orientation via in person review or a written education packet by a member of the Nurse Management Team (DON, ADON, SDC, Unit Managers, Shift Supervisors). No Licensed Nurses, Respiratory Therapists or Nurses Aides shall work until they have received the above education.

On 9/18/24 at 7:00 p.m. a new process implemented by the Director of Nursing that begins having the Director of Nursing, Assistant Director of Nursing, Unit Manager, or charge nurse monitor resident vital signs exception report at end of shift daily to ensure that abnormal vital signs were addressed timely. The Unit Managers will round on their residents daily to ensure that there is no evidence of change in condition, to include abnormal vital signs, for any resident. If Unit Manager is not present the ADON, DON or Shift Supervisor will complete the rounds on that unit.

Alleged date of IJ removal: 9/19/24.

A validation of IJ removal was conducted on 09/24/24. A review of the initial audit completed on 09/18/24 revealed all resident vital signs were obtained to ensure no other change in condition was identified. Staff interviews revealed that they had received the education on identifying a change in condition, abnormal vital signs, and initiating the Sepsis protocol. The nursing staff were also able to verbalize the new process of running a vital sign exception report at the end of their shift to ensure that all abnormal vital signs had been acted upon appropriately and nothing had been missed. Interviews with the Unit Manager/Charge Nurse revealed that they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 684	Continued From page 60 rounded daily on their units to look for any change in condition and ensuring that none were missed or overlooked including reviewing vital signs for the shift. The IJ removal date of 09/19/24 was validated.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and Wound Provider interviews, the facility failed to provide a physician ordered treatment to a pressure ulcer over a weekend for 1 of 5 residents reviewed for pressure ulcers (Resident #76). The findings included: Resident #76 was admitted to the facility on 08/25/23 with diagnosis that included pressure ulcer of the sacrum stage 3.	F 686	1. Resident # 76 is currently receiving all treatments as ordered for her pressure ulcer. Provider notified of missing treatments on 9/30/24 with no new orders provided. 2. Director of Nursing and Assistant Director of Nursing completed a 100% audit of all current residents treatments 9/30/24 to ensure that treatments were provided as ordered including on weekends. Provider was notified 9/30/24 of other treatment omissions, with no new	10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 686	Continued From page 61 A physician order dated 07/02/24 read, Dakins (antiseptic used to clean wounds) full strength apply to sacral wound topically every day shift then cover with calcium alginate (absorbent product) and cover with foam dressing. The quarterly Minimum Data Set (MDS) dated 08/18/24 revealed that Resident #76 was severely cognitively impaired and required extensive to total assistance with activities of daily living. The MDS further revealed that Resident #76 had a stage 4 pressure ulcer not present on admission and received pressure ulcer care. Review of the Treatment Administration Record (TAR) dated September 2024 revealed that Resident #76's treatment had been initialed indicating the treatment had been completed daily except for 09/07/24 (Saturday) and 09/08/24 (Sunday) the treatment was blank and contained no initials indicating the treatment had not been done as ordered. Review of the facility schedule for 09/07/24 revealed that Nurse #10 was caring for Resident #76 on day shift. Further review of the schedule revealed that on 09/08/24 Nurse #11 was caring for Resident #76 on 09/08/24 on day shift. There was no designated staff member for wound care on the schedule. Nurse #10 was interviewed via phone on 09/19/24 at 10:15 AM who stated that she worked at the facility through an agency and was there approximately one to two times a month. Nurse #10 stated she did wound care on the days that she worked if there was no wound nurse assigned to do them. She confirmed that she had worked with Resident #76 on Saturday 09/07/24	F 686	orders given. 3. Education was provided for Licensed Nurses by the Staff Development Coordinator on ensuring that treatments are completed as ordered 10/01/24. No licensed staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. Director of Nursing and/or Assistant Director of Nursing to audit treatment administration documentation for compliance with ordered treatments 5 times per week x 2 months, then audit 2 random residents per hall 5 times per week x 8 weeks. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 686	Continued From page 62	F 686		

and stated that she was told that day there was a wound nurse, so she did not have to complete wound care. Nurse #10 could not recall who told her there was a wound nurse that day or who the charge nurse was that day but stated that "if I did not do it was because they told me they had a wound nurse." Nurse #10 stated if she had completed the wound care she would have documented it on the TAR.

Nurse #11 was interviewed via phone on 09/19/24 at 10:21 AM who stated that she worked at the facility through an agency and confirmed that she worked on 09/08/24 and was caring for Resident #76. She stated that when she worked at the facility, she did wound care if there was not a wound nurse in the building assigned to do them. Nurse #11 stated she was generally informed in report at the beginning of her shift if there was wound nurse that day or not. Nurse #11 stated if she did not document the dressing change on the TAR then she did not complete the dressing change, "I work a lot of places and don't recall" the specifics.

Wound Nurse #1 was interviewed on 09/17/24 at 10:45 AM who stated recently Wound Nurse #2 had been completing the daily dressing changes Monday through Friday and she had been doing all the paperwork and rounding with the Wound Provider weekly. Wound Nurse #1 stated that they used to have a staff member that was trained in wound care and completed the dressing changes on the weekend but that the staff member had been pulled back to the floor. She further explained that on the weekends the dressing changes were the responsibility of the hall nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 686	Continued From page 63	F 686		

The Wound Provider was interviewed on 09/19/24 at 9:15 AM who stated that he evaluated Resident #76 on a weekly basis and stated initially the wound had a lot of necrotic tissue but after debridement (manual removal of dead tissue) the wound cleaned up nicely and was stable and had improved a small bit from last week. The Wound Provider was not aware of any issues with daily dressings being completed as ordered.

Nurse Aide (NA) #5 was interviewed on 09/19/24 at 10:35 AM who stated that she was trained in wound care and used to do treatments in the facility through the week and sometimes on the weekend. She stated she had not done treatments in the facility since July 2024 because they had pulled her back to the floor to provide direct patient care.

The Director of Nursing (DON) was interviewed on 09/20/24 at 1:13 PM who stated that Wound Nurse #1 was responsible for the paperwork and rounded with the Wound Provider and Wound Nurse #2 completed the daily dressings Monday through Friday. The DON stated that on the weekends the hall nurses were expected to complete any ordered wound care during their shift and on a rare occasion they had a staff member trained in wound care that would be assigned to do wound care on the weekend. She stated it would be indicated on the daily schedule if there was someone designated to do wound care.

The Assistant Administrator was interviewed on 09/20/24 at 3:11 PM who stated the facility offered wound care on the weekends and should have been completed as ordered either by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 686	Continued From page 64 hall nurse or the designated wound care nurse.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to supervise a cognitively impaired resident who exited the facility through a sliding window in his room which resulted in a skin abrasion on the resident's knee for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #308). The findings included: Resident #308 was admitted to the facility on 08/11/24 with diagnoses that included dementia without behaviors, hypertension, history of falling, and restlessness and agitation. A review of Resident #308's admission wandering assessment dated 08/11/24 revealed he had a history of wandering, Resident #308's wandering placed him at significant risk of getting to a dangerous place and identified Resident #308 as being able to ambulate independently. A review of Resident #308's physician orders revealed the following orders:	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 65	F 689		

- Wanderguard to right ankle - Every shift for wandering [behavior] dated 08/13/24
- [Check] wander guard function to right ankle - every shift, tester in the treatment cart dated 08/13/24

A review of Resident #308's discharge Minimum Data Set assessment dated 08/14/24 revealed resident was moderately cognitively impaired with no delirium, behaviors, or rejection of care. Resident #308 was coded as having wandering behaviors 1-3 days during the assessment period.

Review of Resident #308's progress notes revealed a physician encounter note dated 08/14/24 at 1:00 PM that indicated Resident #308 had eloped from the facility and was found outside. Per the physician note, Resident #308 was noted to have an abrasion to his right knee, was agitated and demanded to be taken home. The physician noted Resident #308 had a diagnosis of dementia and was confused. The note was signed by the Nurse Practitioner.

A review of historical weather data from 08/14/24 for the area the facility was located in revealed at the time Resident #308 eloped from the facility that the temperature was between 83 and 84 degrees Fahrenheit, with partly cloudy skies.

An interview with the Activities Assistant on 10/07/24 at 11:39 AM revealed on 08/14/24 she was sitting in the day room assisting a resident with their lunch meal when a family member of the resident she was assisting, alerted her that Resident #308 was walking around in the unenclosed courtyard outside of the day room. The Activities Assistant stated she found Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 66	F 689		

#308 in the grassy area approximately 20-30 feet from a driveway and parking lot behind the facility. She stated she immediately exited the exterior door in the dayroom and went to Resident #308. She reported Resident #308 appeared to be walking away from the facility towards the paved drive that ran behind the facility. She reported Resident #308 was wearing a t-shirt, a bathrobe and socks. She stated he was carrying his shoes and a plastic bag that contained his belongings. She could not recall what he was wearing on his lower half. When she got to Resident #308, she asked him what he was doing, and he stated that he was going home. She replied to Resident #308 that was ok but she needed him to return to the facility so he could sign out and that she would like for the nurse to look at what appeared to be a small abrasion to Resident #308's right knee. The Activities Assistant stated Resident #308 agreed to return to the facility and she escorted him back into the facility and had him sit down in a chair. She reported she called for assistance and the Wound Nurse came to assess Resident #308. She stated she then went to the hall where Resident #308 resided and notified the nurse and followed up by alerting the Assistant Administrator and the Wound Nurse of where she had found Resident #308.

An observation of the area Resident #308 was located on 10/07/24 at 2:21 PM revealed it was a well-maintained grassy area with a concrete sidewalk that followed along the back of the facility. At the time of the observation, there were no vehicles located in the parking lot and no traffic observed traveling down the driveway.

During an interview with Wound Nurse on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 67	F 689		

10/07/24 at 11:45 AM she revealed she remembered Resident #308's elopement on 08/14/24 and stated she was called to assess and treat a small skin abrasion to one of Resident #308's knees. She stated she treated the wound with wound cleanser and a bandage. She reported Resident #308 was a very short stay respite resident and that her treatment of the knee abrasion was the only interaction she had with Resident #308 during his admission but stated he did appear to be confused. Wound Nurse also reported she believed that Nurse Practitioner also came and assessed Resident #308 after the elopement.

Review of facility provided staffing schedules revealed Nurse #1 and Nurse Aide #1 (NA #1) were assigned to provide Resident #1's care on 08/14/24.

Multiple attempts to reach NA #1 via telephone were unsuccessful.

Nurse #1 was an agency nurse, and a telephone call was placed to the agency on 10/07/24 at 1:21 PM for which she worked who reported they would forward a request for Nurse #1 to return the phone call. Nurse #1 never returned the requested phone call.

During an interview with Unit Manager #1 on 10/07/24 at 11:49 AM revealed she was the unit manager on the rehabilitation hall where Resident #308 was residing during his admission. She reported Resident #308 was admitted to the facility for a short respite stay and was confused. She stated after admission, Resident #308 started exhibiting exit seeking behaviors, so the facility placed a wander guard alarm on 08/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 68	F 689		

on his ankle but that the wander guard alarm only prevented Resident #308 from exiting through the facility's doors.

During an interview with the Assistant Administrator on 10/07/24 at 10:49 AM, she reported she remembered Resident #308 and that he was a respite care resident who was admitted to the facility (08/11/24) for a 5 day respite stay. The Assistant Administrator reported the facility staff noted some wandering behaviors, so they placed a wander guard alarm on his ankle on 08/13/24 to prevent him from being able to elope from the facility. She continued, and stated despite the facility's effort, Resident #308 opened the window in his room, pushed out the screen and exited the facility through the window. She reported it was her understanding that the Activities Assistant was feeding a resident in the day room when she saw Resident #308 walking through the grass by the day room. She reported that Activities Assistant immediately retrieved Resident #308 and brought him back inside the facility and notified herself and the Administrator. She stated she believed that Resident #308 had an abrasion to one of his knees but no other injuries.

During a follow-up interview with the Assistant Administrator on 10/07/24 at 4:40 PM revealed Resident #308 was confused and had a diagnosis of dementia. She reported about 20 minutes before Resident #308 was found outside of the facility, she had helped him pull a sock up because she had walked by Resident #308's room and saw him struggling to pull it up and was sitting on the edge of the bed and she was afraid he may fall. She reported she assisted with pulling his sock up and asked him how he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 69	F 689		

doing and he reported he was doing well. She insisted that he made no mention to her at the time that he needed to find his family or that he wanted to go home. She reported he had asked about his family earlier in his stay and appeared to be looking for them, so the facility placed a wander guard alarm on his ankle.

During an interview with Nurse Practitioner on 10/07/24 at 2:22 PM she revealed Resident #308 was admitted to the facility as a respite care admission, and she technically was not allowed to see or treat them but stated she did see Resident #308 on 08/14/24 because he had eloped from the facility by crawling out of a window. She stated she assessed Resident #308 and treated him for an abrasion to his right knee that was cleaned and covered by Wound Nurse. She stated while she assessed Resident #308, he appeared confused and demanded that someone take him home. She reported she was not aware of any previous wandering or exit seeking behaviors.

During an interview with the Director of Nursing on 10/07/24 at 11:10 AM, she reported she remembered Resident #308 and stated he had exited the building by opening a window and pushing out the screen (08/14/24). She stated she was initially alerted when the Nurse Practitioner came and told her that Resident #308 had been found outside of the facility. She stated she followed the Nurse Practitioner to Resident #308's room, assessed him, and the staff completed a full head to toe assessment. She stated the only injuries Resident #308 was noted to have, was a small abrasion to his knee which was treated with wound cleanser and a bandage. She reported the staff had noted some hall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 70	F 689		

wandering behaviors soon after his admission and a wander guard alarm was placed on his ankle on 08/13/24 but indicated the alarm would not prevent a resident from exiting through a window.

The facility provided the following corrective action plan with a compliance date of 08/15/24:

CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED

On 08/14/24, resident assisted back into facility by activity staff and assessed by licensed nurse for injury.

On 08/14/24, resident placed with one-on-one staff supervision until window secured.

On 08/14/24, notified resident's responsible party and physician.

On 08/14/24, screw placed on resident's window by Maintenance Director and Maintenance Assistants to prevent opening greater than six inches.

On 08/14/24, all windows were checked by Maintenance Director and Maintenance Assistants to ensure proper securement to prevent opening greater than six inches.

On 08/14/24, all exit doors were checked by Assistant Administrator to ensure proper functioning and alarm.

On 08/14/24, resident's wandering assessment updated in medical record by licensed nurse to reflect current risk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 71 IDENTIFICATION OF OTHER RESIDENTS On 08/14/24, licensed nurses conducted a 100% audit of current residents to validate all were present and accounted for. On 08/14/24, licensed nurses conducted an audit of all residents with current wander guard alarms to ensure proper function and placement, with no concerns noted. On 08/14/24, licensed nurses reviewed care plan for all residents currently identified at risk for elopement to ensure appropriate interventions were place. On 08/14/24, licensed nurses conducted wandering assessments for all current residents to ensure no other newly identified residents with no new residents identified as at risk for elopement. MEASURES FOR SYSTEMIC CHANGE On 08/14/24, Facility Administrator educated by Regional Director of Operations regarding requirement to maintain security of windows on all resident rooms. On 08/14/24, Maintenance Director educated by Nursing Home Administrator regarding scheduled routine window and door checks to ensure they are properly secured to prevent exiting by exit seeking residents or other residents at risk for wandering or elopement. On 08/14/24, the SDC [Staff Development Coordinator] and designee completed education	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 72	F 689		

for all staff regarding identification and response to residents with exit seeking behaviors, missing residents, proper functioning of window and locked doors. Absent staff, or newly hired or contracted personnel will be educated prior to beginning their next shift.

HOW CORRECTIVE ACTION WILL BE MONITORED

The DON [Director of Nursing], ADON [Assistant Director of Nursing], or nursing unit coordinators will review progress notes, wandering assessments and 24-hour reports 5 days a week for 4 weeks, and then 3 days a week for 2 months to identify residents with exit seeking behaviors or wandering, and to ensure that appropriate interventions are in place.

The Maintenance Director will check facility windows 5 days a week for 4 weeks, then weekly for 2 months to validate that they are secure and will document checks in the [maintenance] system

The Administrator will audit maintenance documentation weekly for 4 weeks, and then monthly for 2 months to validate that window checks are documented.

The Director of Nursing or Administrator will review the plan during the monthly QAPI [quality assurance and performance improvement] meeting and the audits will continue at the discretion of the QAPI committee.

The alleged dated of compliance is 08/15/24.

The corrective action plan was validated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 689	Continued From page 73 10/08/24. Review of facility provided monitoring tools revealed the facility had ongoing checks to ensure the windows remained secure and that the wander guard alarm system was operating adequately. Observations made of windows throughout the facility revealed limiters to be in place that prevented them from being opened further than 6 inches. There was evidence of in-services with sign-in sheets, care plan audits, and other interventions that were mentioned in the corrective action plan. Interview with staff revealed they were able to verbalize the education regarding elopement policies and procedures, locating a missing resident, and how to respond when residents exhibited wandering behaviors. The completion date of 08/15/24 was validated.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 692	Continued From page 74 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Registered Dietitian and staff interviews, the facility failed to administer a high protein, fiber fortified nutritional supplement per the physician's order for 1 of 3 residents reviewed for tube feeding (Resident #94). Findings included: Resident #94 was admitted to the facility on 07/01/24 with multiple diagnoses that included dysphagia (difficulty swallowing) and dependence on respirator [ventilator] status. The admission Minimum Data Set (MDS) assessment dated 07/07/24 revealed Resident #94 was severely impaired with cognitive skills for daily decision making and was dependent on staff assistance for all self-care tasks, bed mobility and transfers. Resident #94 received tube feeding while a resident and received 51% or more of total calories and 501 cubic centimeters (cc) or more of fluid intake via tube feeding. A care plan, initiated on 07/09/24, revealed Resident #94 was unable to safely tolerate PO (by mouth) intake requiring tube feeding and he was at risk for weight changes and dehydration. Interventions included providing tube feeding and flushes as ordered. A physician order dated 08/18/24 for Resident #94 read in part, fortified nutritional supplement 1.5 [calories/cc] at 60 milliliters (ml)/hr.	F 692	1. Resident # 94 is currently receiving his tube feeding according to physician□s orders. The Registered Dietitian and the Nurse Practitioner were notified of the order issue on 9/19/24. The RD reviewed the resident□s nutritional parameters and entered new enteral feeding order on 9/19/24. The nurse then changed the pump settings to reflect the new order on 9/19/24. 2. Director of Nursing and Assistant Director of Nursing completed 100% audit 9/18/24 of current residents with orders for enteral nutrition to ensure that they were receiving their tube feeding according to order. No discrepancies noted. 3. Staff Development Coordinator completed education on for nurses on 9/19/24 on the Enteral Feeding Policy to include ensuring that the enteral feeds are running according to physician□s orders. No licensed staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. Assistant Director of Nursing will audit 5 residents with enteral feed orders 5 X week for four weeks, then once per week X 8 weeks to ensure enteral tube feeding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 692	Continued From page 75 continuous via pump to deliver 1440 ml in 24 hours. Flush feeding tube with 20 cc of water every one hour to deliver 480 ml in 24 hours and with 30 cc water before and after meals. A nursing admission/re-admission assessment dated 09/11/24 revealed in part, Resident #94 received tube feeding at a rate of 60 ml/hr. and 20 cc/hr. water flushes. A Registered Dietician (RD) progress note dated 09/15/24 revealed in part, Resident #94 was seen for readmission following a hospitalization and use of tube feeding for nutrition support and wounds. The RD noted Resident #94's tube feeding was resumed with a fortified nutritional supplement 1.5 at 60 ml/hr. with 20 ml/hr. water flushes. Review of Resident #94's September 2024 Medication Administration Record (MAR) revealed tube feedings were initialed as completed per physician order. An observation of Resident #94 on 09/16/24 at 11:20 AM revealed his tube feeding was running through the pump at 55 ml/hr. with water flushes at 30 ml/hr. The bottle of tube feeding was dated 09/16/24 at 7:00 AM. A second observation of Resident #94 on 09/18/24 at 8:50 AM revealed his tube feeding was running through the pump at 55 ml/hr. with water flushes at 30 ml/hr. The bottle of tube feeding was dated 09/18/24 at 4:30 AM and initialed by Nurse #1. An observation and interview were conducted with Nurse #12 on 09/18/24 at 2:20 PM. Nurse	F 692	is running at ordered rates. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 692	Continued From page 76	F 692		

#12 confirmed that Resident #94's tube feeding was set at 55 ml/hr. and should have been set at 60 ml/hr. Nurse #12 stated Nurse #1 changed Resident #94's tube feeding that morning and normally she (Nurse #12) would check the tube feeding during her shift to make sure the settings were correct but a lot had been happening on the unit and she had not had time.

During an interview on 09/18/24 at 2:20 PM, the Director of Nursing (DON) reviewed Resident #94's physician orders and confirmed his tube feeding should be set at 60 ml/hr. with 20 cc water flushes. The DON stated nursing staff should be checking the settings when changing tube feedings to ensure the settings were accurate per the physician order.

During a telephone interview on 09/18/24 at 4:46 PM, Nurse #1 confirmed she had changed Resident #94's tube feeding earlier that morning (09/18/24) before the end of her shift. Nurse #1 stated typically she checked the tube feeding settings when changing out the tube feeding but she was a little distracted because Resident #94 was trying to crawl out of bed and she was trying to make sure he stayed still. Nurse #1 stated she had not noticed his tube feeding was not set at the correct settings.

During an interview on 09/19/24 at 10:53 AM, the RD revealed when she reviewed the hospital records for Resident #94, he was receiving tube feedings at a rate of 55 ml/hr. which was different from what he had received at the facility prior to his hospitalization. The RD explained when Resident #94 was readmitted to the facility, nursing staff reinstated the previous physician order which was at a rate of 60 ml/hr. but used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 692	Continued From page 77 the tube feeding settings of 55 ml/hr. based on what he had received while at the hospital and just didn't update the physician order when he returned to the facility. The RD stated when the hospital order for tube feeding was different from the facility's order, nursing staff should reach out to her to clarify the order for her to determine the tube feeding rate needed. During an interview on 09/20/24 at 3:14 PM, the Assistant Administrator explained nursing staff likely received Resident #94's tube feeding settings that were used (55 ml/hr.) in report from the hospital and then when the order was entered, it was reinstated at the previous order (60 ml/hr.) which conflicted with the hospital order. The Assistant Administrator stated nursing staff should have clarified Resident #94's order for tube feeding settings.	F 692		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 78 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that a nurse was competent in responding to medical emergencies and activating emergency procedures with emergency medical services (EMS). Resident #103 was a Full Code and experienced sudden cardiac arrest on 7/18/2024. Nurse #3 was unable to locate the crash cart, the automated external defibrillator and did not immediately call 911. Resident #103 was pronounced deceased by EMS on 7/18/2024 at 7:50 pm. The deficient practice was identified for 1 of 5 nurses (Nurse #3) reviewed for competency and had the high likelihood for causing serious harm to other residents. Immediate jeopardy began on 7/18/2024 when Nurse #3 did not demonstrate competency in responding to a medical emergency. Immediate jeopardy was removed on 9/20/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity	F 726	1. Nurse # 3 resigned from her position without notice on 7/18/24. 2. On 9/19/24 the Regional Nurse and Staff Development Coordinator reviewed and validated that all new hired staff and new agency staff since 7/18/24 had received training on location of emergency equipment, emergency procedures, how to respond in case of an emergency. 3. Director of Nursing, Assistant Director of Nursing, Unit Managers and Wound Nurse completed education for all staff on location of crash carts/ emergency supplies and how to call a Code Blue on 9/18/24. No staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. Director of Nursing or HR will audit all new hires and new agency staff weekly X	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 79 level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put into place are effective. The findings included: This tag is cross referred to: F678: Based on record review, observation, crash cart checklist, staff, Respiratory Therapist, and Medical Director (MD) interviews the facility failed to immediately initiate Cardiopulmonary Resuscitation (CPR) when Resident #103, who was a full code had agonal breathing (a state of breathing of gasping for air due to the brain receiving insufficient oxygen) and went pulseless, failed to immediately utilize the overhead paging system to call staff to Resident #103's room (code blue), and failed to immediately active Emergency Medical Servies (EMS). Once the Respiratory Therapy recognized the need for CPR, they failed to implement the use of the Automated External Defibrillator (AED), failed to have available or use an oral airway, and the regulator on the emergency oxygen tank on the crash cart only went to 10 liters. Resident #103 was pronounced deceased and resuscitative efforts were stopped. This affected 1 of 1 resident reviewed for CPR. A review of Nurse #3's Nurse Orientation Checklist dated 7/10/2024 revealed Nurse #3 had knowledge of the location of the crash cart and emergency procedures. The Checklist was signed as completed by Nurse #3 and the Staff Development Coordinator (SDC). The Checklist ensured that staff members knew where the	F 726	8 weeks and then monthly thereafter, for knowledge of onboarding education on emergency equipment location, emergency procedures and how to respond in an emergency by completing a post test on emergency response training. Mock Code Drills will be conducted by the Administrator and Director of Nursing monthly to ensure compliance with response time and location of crash carts. The Crash Carts will be audited by the Assistant Director of Nursing or designee 5 X week for 8 weeks and randomly thereafter to ensure appropriately stocked. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 80	F 726		

crash cart and emergency procedures were located.

A review of a Termination/Discipline Notice dated 7/26/2024 revealed Nurse #3 was terminated for not adequately responding to a resident with a change in condition. The notice was signed by the Administrator and Human Resources (HR) Director.

Nurse #3 was not available for an interview.

An interview was conducted on 9/19/2024 at 4:39 pm with the Staff Development Coordinator (SDC). The SDC stated all staff were required to attend in-person orientation which lasts several hours. The SDC stated during orientation all staff were given a facility tour and shown the location of the crash carts. The SDC stated there were three crash carts in the facility, and each crash cart contained an AED. The SDC stated she did not open crash carts to go over the components and location of supplies and stated that there was a list on top of the cart that explained where to find needed items because the cart was locked with a plastic tag. The SDC stated all nursing staff in the facility were required to be CPR certified and should have received training on the usage of an AED during their certification course. The SDC stated Nurse #3 received a facility tour, was shown the location of the crash cart, and where to find the on-call provider contact information at the nurse's station. The SDC stated she was unsure why Nurse #3 could not locate the crash cart, find information to notify the on-call provider, or what to do when Resident #103 experienced sudden cardiac arrest on 7/18/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 81	F 726		

An interview was conducted on 9/19/2024 at 9:37 am with the Director of Nursing (DON). The DON stated there were concerns after the Code Blue on 7/18/2024 that involved Resident #103 and Nurse #3 "not acting sooner and recognizing things." The DON stated 7/18/2024 was the last shift that Nurse #3 worked at the facility and stated staff received education on 7/19/2024 regarding notification and to respond when a change in condition occurred to prevent a Code Blue situation.

An interview was conducted on 9/19/2024 at 2:21 pm with the Administrator. The Administrator stated she had not been previously made aware of Nurse #3 not knowing where the crash cart was, when to initiate CPR, or when to activate 911 during the Code Blue event involving Resident #103. The Administrator stated she would have expected Nurse #3 to remain with Resident #103, perform ongoing assessments/vital signs, call 911, and initiate CPR if the resident did not have a pulse.
The Administration was notified of Immediate Jeopardy on 9/19/2024 at 3:33 pm.

The facility provided the following credible allegation of Immediate Jeopardy Removal:

Identify those recipients who have suffered and those who are likely to suffer a serious adverse outcome as result of the noncompliance:

Nurse # 3 was hired as a full time RN to the center on 7/08/24. She completed the center's orientation process on 7/10/24, which included location of crash cart. Nurse # 3 did not have training on emergency process. Nurse # 3 failed to follow process and stated she did not know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 82	F 726		

where crash cart was located on 7/18/24. Nurse # 3 failed to respond appropriately in an emergency for resident # 103. Nurse # 3 failed to locate the emergency equipment and did not know how/when to respond in an emergency.

On 9/19/24 the Regional Nurse reviewed new hire and new agency staff orientation from 7/18/24 to current for validation of training and location on emergency equipment, procedures, and how to respond in case of emergency with attestation provided on 09/19/2024 by staff development coordinator that all new and agency hires were trained on emergency equipment, crash cart location, emergency procedures and how to respond to emergencies at the time of orientation.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 9/19/24 the center Administrator notified the Director of Nursing of immediate implementation of Mock Code Drills increasing from Quarterly to Monthly. Mock Code Drills are conducted by the DON or ADON.

Agency staff receive an abbreviated orientation that includes location of crash carts and emergency process. The center orientation process includes emergency equipment location and emergency process. On 9/19/24 the Director of Nursing informed the Staff Development Coordinator that it is her responsibility to orient new hires and new agency staff.

On 9/19/2024 at approximately 5:00 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 83	F 726		

Director of Nursing and Nursing Leadership Team which includes ADON, Unit Managers, Wound Nurse, initiated education for all licensed nurses and Respiratory Therapy on Assessing and Responding to Changes in Condition to include abnormal vital signs. Education was completed for all staff on how and when to call a Code Blue, Calling 911, and the Location of Crash Carts/Emergency Supplies. This education includes Full-Time, Part Time, PRN and Agency Staff.

On 9/19/2024 at approximately 5:00 pm the Regional Nurse initiated education with all staff to include Administrative Staff, Maintenance, Dietary, Laundry, Housekeeping, Nurses' Aides and Therapy Staff on the Location of the Crash Carts/Emergency Supplies, how to call Code Blue.

No staff shall work until they have received this education. The Director of Nursing is responsible for making sure all receive the above education. Director of Nursing informed the Staff Development Coordinator on 9/19/2024 that she would be responsible for new hire and new agency education on the above, as well as responsible for verifying competencies and understanding of training. Education will be included in new hire orientation and new agency orientation via in person review by a member of the Nurse Management Team (DON, ADON, SDC, Unit Managers, Shift Supervisors). No Licensed Nurses, Respiratory Therapists shall work until they have received the above education. SDC will verify the competency and understanding of emergency procedures and emergency procedures and their role in an emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 726	Continued From page 84 On 9/19/24 at 6:00 p.m. a new process was implemented by the Director of Nursing that will include validation of new hire and new agency staff orientation to emergency procedures, crash cart locations, and procedures for calling Code Blue and 911 via a post test administered following orientation. Alleged date of IJ removal: 9/20/24. A validation of IJ removal was conducted on 09/24/24. The initial audit of staff hired since 07/18/24 was reviewed to ensure that they had received the necessary orientation including location of emergency supplies and crash carts, how to activate EMS, when to initiate CPR and how to respond in a Code Blue situation. The facility conducted a mock Code Blue drill on 09/24/24 which was also observed without concerns. The nursing staff secured the crash cart, notified emergency personnel, and all staff including the RT responded and began emulating CPR on the victim. Nursing staff interviews revealed that they had received the education on CPR, responding to emergencies, location of crash carts, calling EMS services and the overhead page of Code Blue when an emergency was identified. Interviews with non-nursing departments revealed that they were aware of their role during an emergency and were able to verbalize tasks that they could do in the event of a Code Blue. The IJ removal date of 09/20/24 was validated.	F 726		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 85 §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(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to keep an accurate account of controlled substances (Resident #90 and Resident #110), failed to remove discontinued controlled substances from the medication cart (Resident	F 755	1. Resident # 90□s discontinued medications were removed from the medication cart by the unit manager on 9/19/24 and returned to the pharmacy for appropriate disposal. Resident # 113 was a respite resident and was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 86 #90), and administered medications to Resident #113 from a bottle that was labeled for another person. This affected 3 of 3 residents reviewed for pharmacy services. The findings included: 1. Resident #90 was admitted to the facility on 03/18/24 with diagnosis that included pain. A physician order dated 03/18/24 read, hydrocodone/acetaminophen (controlled pain medication) 5/325 milligrams (mg) by mouth every 6 hours as needed for pain for 5 days. The Medication Administration Record (MAR) dated March 2024 revealed the order was present from 03/18/24 through 03/23/24 and Resident #90 had received none of the hydrocodone/acetaminophen during those 5 days. The control drug record dated 03/18/24 contained a label with Resident #90's name and dosing instructions for the hydrocodone/acetaminophen and revealed that 20 tablets were sent to the facility. The declining count went down from #20 tablets but skipped #12 and went from #13 to #11. The card of tablets in the medication cart had 11 tablets of the hydrocodone/acetaminophen and all doses administered were accompanied by a staff signature. The quarterly Minimum Data Set (MDS) dated 06/22/24 revealed that Resident #90 was moderately cognitively impaired and received no scheduled or as needed pain medication. No pain was reported during the assessment reference	F 755	discharged home with all of the medication bottles that had been in the center. The Medication with another person□s name on label was removed from the medication cart and returned to the family who provided medication in a bottle with resident□s name on label. Resident # 110 declining inventory record for Tramadol was reviewed and verified by the DON on 9/19/24. 2. Director of Nursing, Assistant Director of Nursing, Unit Managers and MDS Nurses completed 100% audit of all medication carts on 9/19/24 to ensure that all discontinued medications were removed from the medication carts and that there were no medications brought from home that had labels for other persons. No discrepancies noted. 3. Education was provided for all licensed staff and medication aides by the Staff Development Coordinator on the 10 Rights of Medication Administration, the policy on discontinued medications, and medication administration policy. This education also included Controlled Substance administration policy related to ensuring the declining inventory logs are correct. No licensed staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. The Director of Nursing or designee will audit the Declining Inventory Sheet for controlled substances Monday-Friday 5 times per week for eight weeks to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 87 period. An observation and interview were conducted with Resident #90 on 09/20/24 at 11:16 AM. Resident #90 was up in his wheelchair in the day room appropriately dressed and well groomed. Resident #90 stated he was waiting on lunch; he denied any pain and stated, "I only have an occasional headache." The Consultant Pharmacist was interviewed via phone on 09/19/24 at 9:43 AM. The Pharmacist stated that she visited the facility monthly and went through the medication carts "usually every other month and sometimes every month" just depended on the time constraints she had. The Pharmacist further explained that sometimes she would review each medication cart and sometimes she would review a sample of them and added that it was a big building and that she tried to sample each medication cart every other month so that she saw each cart at least every 3 months. Her medication cart review included reviewing the controlled drug records and she "will scan a sample of several different records" to ensure that the math and count were correct. The Pharmacist explained that her review included looking for any signs of diversion and she encouraged the staff to be diligent in what they put down on the controlled drug record. The Pharmacist was not aware of any controlled drug record discrepancies but stated that the Director of Nursing (DON) may need to talk to the nurses and educate them on documenting on the controlled drug record. Nurse #4 was interviewed on 09/19/24 at 10:56 AM who confirmed that she was responsible for Resident #90 and his controlled medications.	F 755	proper procedure followed current orders and no discrepancies noted. The Director of Nursing of designee will audit all medication carts 3 times per week for eight weeks to ensure that discontinued medications have been removed from carts and that there are no medications on the cart that belong to persons who are not residents of the center. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 88	F 755		

Nurse #4 also confirmed that she had counted all the controlled substances in her medication cart at the beginning of her shift with the off going nurse that day and all were correct. Nurse #4 was questioned about the declining control drug record and why #12 was skipped on the record. Nurse #4 replied, "I am agency staff and none of those are my signatures" and threw her hands up in the air. Nurse #4 stated that when she counted the controlled substances earlier that morning, she did not look at the controlled drug record (off going nurse did) she was counting the actual medications in the cart and could not explain the discrepancy on the control drug record again stating she was agency staff. Nurse #4 was asked what she was supposed to do if she had a discrepancy with her controlled medication and she stated to report to the DON. Nurse #4 was asked to please alert the DON of the discrepancy.

The DON was interviewed on 09/19/24 at 11:15 AM. The DON observed the control drug record for Resident #90 and could not explain the discrepancy on the record. She stated she would have to look into the situation.

A follow up interview was conducted with the DON on 09/20/24 at 10:43 AM. The DON stated that she needed to do some re-education with the staff because the nurses should be going through their medication carts and removing any discontinued controlled substances so that they were not remaining on the medication carts for months and months. The DON stated that there was no reason why the medication remained on the medication cart 6 months after it had been discontinued and added she was not aware of the issue until brought to her attention by the surveyor. The DON stated she knew that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 89	F 755		

Resident #90 did not take pain medication, and she would have to open an investigation to see where the medication went.

2. Resident #110 was admitted to the facility on 09/12/24 with diagnosis that included pain.

A physician order dated 09/12/24 read, Tramadol (controlled substance) 50 milligrams (mg) by mouth every 6 hours as needed for pain.

The control drug record dated 09/13/24 revealed that the pharmacy sent 30 tablets. The declining count went down from 30 tablets, 29, 28, 27 then repeated 28, 27, 26, 25, and so on. The record indicated that Resident #110 had received 7 doses from the card of 30 which should leave 23 tablets, but the card contained 25 tablets.

Nurse #5 was interviewed on 09/18/24 at 4:50 PM who confirmed that she was working with Resident #110. Nurse #5 also confirmed that she had counted her controlled substances at the beginning of her shift that day. She explained that when she counted the controlled substances she was standing at the cart and then compared the number of medications to the controlled drug record that the off-going nurse was calling out to her and ensured that they matched. Nurse #5 stated she had not noticed the discrepancy on the controlled drug record. Nurse #5 notified the Unit Manager (UM) of the discrepancy.

The UM was interviewed on 09/18/24 at 4:58 PM. The UM was unable to explain the discrepancy on Resident #110's-controlled drug record and stated she would have to report it to the Director of Nursing (DON).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 90	F 755		

The Consultant Pharmacist was interviewed via phone on 09/19/24 at 9:43 AM. The Pharmacist stated that she visited the facility monthly and went through the medication carts "usually every other month and sometimes every month" just depended on the time constraints she had. The Pharmacist further explained that sometimes she would review each medication cart and sometimes she would review a sample of them and added that it was a big building and that she tried to sample each medication cart every other month so that she saw each cart at least every 3 months. Her medication cart review included reviewing the controlled drug records and she "will scan a sample of several different records" to ensure that the math and count were correct. The Pharmacist explained that her review included looking for any signs of diversion and she encouraged the staff to be diligent in what they put down on the controlled drug record. The Pharmacist was not aware of any controlled drug record discrepancies but stated that DON may need to talk to the nurses and educate them on documenting on the controlled drug record.

A follow up interview was conducted with the UM on 09/19/24 t 11:19 AM who stated that she went through the controlled drug records and looked for any discrepancies weekly but had not noticed the discrepancy with Resident #110.

The DON was interviewed on 09/20/24 at 10:43 AM reviewed the controlled drug record and was unable to explain the discrepancy and stated she would have to do some education with the nurses on signing out controlled drugs correctly. She further explained that the controlled medications were counted with the off-going and on-coming nurses at every shift change or when a change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 91	F 755		

staff was necessary. If there was any discrepancies noted during the shift to shift count they were to immediately report them to the DON.

3. Resident #113 was re-admitted to the facility on 09/14/24 with diagnosis of vascular dementia.

A physician order dated 08/18/24 read; Donepezil 10 milligrams (mg) by mouth one time a day related to vascular dementia.

No Minimum Data Set (MDS) information was available for Resident #113.

An observation of Resident #113's medication was made on 09/18/24 at 4:50 PM along with Nurse #5. The observation revealed a large bag containing bottles of medications prescribed for Resident #113. In the bag of medication, the bottle that was labeled Donepezil 10 mg had a different person's name on the bottle. Nurse #5 explained that Resident #113 had recently admitted from home with respite (a period of rest) care and so his family brought his medication from home in a bag, and they had been administering the medications Resident #113 had an order for from that bag. Nurse #5 stated that the name on the bottle of Donepezil 10 mg was not a resident at the facility and she had no idea who it was but stated that Resident #113 did have an order for Donepezil, but she had not noticed the medication was labeled for someone else when she administered it earlier on her shift.

Nurse #6 was interviewed via phone on 09/19/24 at 12:05 PM. Nurse #6 stated she worked at the facility via an agency and stated that she had never done an admission until 09/14/24 when Resident #113 unexpectedly readmitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 92	F 755		

facility from home. Nurse #6 stated she had no idea what the admission process was as she had not received any orientation to the facility. She stated she did a portion of the admission process as directed by other staff members and she took the bag of medication that Resident #113's family brought in with him and put them in the medication cart. Nurse #6 stated she did not review or look at the medication she just put the bag on the medication cart until it was time to administer his medications then she went through the bag and got the medications she needed out of the bag. Nurse #6 stated she was unaware that there was a bottle of medication in the bag that was not labeled for Resident #113.

The Unit Manager (UM) was interviewed on 09/18/24 at 4:58 PM. The UM stated that Resident #113 came from home with respite care, so they were unable to order any medications from their pharmacy and had to use what the family had supplied. She stated that the admission nurse should have gone through the bag of medications supplied by the family and ensured all were correctly labelled for Resident #113 and not someone else. The UM stated that the name on the bottle of Donepezil was not the name of anyone that had been a resident at the facility before so it must have been someone in Resident #113's family.

The Consultant Pharmacist was interviewed via phone on 09/19/24 at 9:43 AM. The Pharmacist stated that she assumed the nurses would be ensuring that Resident #113's medications were present if brought in from the family so there would be no availability issues. She added the nurses should be looking at the orders on the medication administration record and verify that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 755	Continued From page 93 they were giving the correct dose of medication to the correct resident. The Pharmacist stated that the staff should not be using someone else's medication to medicate Resident #113 but if the Resident had an order for the medication, then she was less concerned. The Director of Nursing (DON) was interviewed on 09/20/24 at 10:43 AM who confirmed that the admission Nurse should have ensured the medications that the family brought in matched the orders for Resident #113 and ensured that they were properly labeled for Resident #113 and not someone else.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(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	F 761		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 761	Continued From page 94 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: Based on observations, record reviews, and staff interviews, the facility failed to: 1) dispose of loose and unidentified tablets of various shapes and sizes from medication cart (300 Hall Bottom), 2) discard expired medications from medication cart (600 Hall), 3) store medications in accordance with the manufacturer's storage instructions (300 Hall Bottom and 100 Hall), and 4) properly store and date a open vial of Tuberculin Purified Protein Derivative (PPD) (600 hall) for 3 of 8 medication carts reviewed for medication storage. The findings included: 1. On 09/20/24 at 9:20 AM an observation was made of the 300 Hall Bottom medication cart accompanied by Medication Aide (MA) #1. The observation yielded 5 loose and unsecured tablets of varying shapes and sizes in the bottom of the middle drawer. When the MA was asked about the loose tablets, she replied she did not work the 300 hall Bottom medication cart often, but it was the third shift nurses' responsibility to clean the medication carts. The MA could not identify the loose tablets. 2a. The manufacturer's storage instructions printed on the box of 0.5 milligrams (mg) / 3 mg ipratropium bromide / albuterol sulfate inhalation solution read in capital letters: "Store in pouch until time of use."	F 761	1. Unit Managers removed and discarded all loose pills in all medication carts, and expired medications, albuterol foil packs and TB solution were disposed of by the Unit Manager on 9/20/24 2. Director of Nursing, Assistant Director of Nursing, and Unit Managers completed 100% audit of all medication carts on 9/20/24, for expired medications, appropriate storage of medications and for loose pills, any discrepancies were immediately corrected. 3. Staff Development Coordinator completed education for all nurses and medication aides on medication storage policy. No licensed nurses or Medication Aides shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. Nursing Leadership including, Director of Nursing, ADON, Unit Manager and MDS Nurses will audit all Med Carts 3 X week X 4 weeks, then weekly X 8 weeks, and then monthly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 761	Continued From page 95 On 09/20/24 at 9:20 AM an observation was made of the 300 Hall Bottom medication cart accompanied by MA #1. The observation yielded 2 boxes of open foil pouches of ipratropium bromide / albuterol sulfate inhalation solution that were available for use. One box had one vial not stored in the foil pouch and one box of 2 vials not stored in the foil pouch. When the MA was asked about how the ipratropium bromide / albuterol sulfate inhalation solution should be stored the MA stated she did not know and explained it was the third shift nurses' responsibility to clean and organize the medication carts. 2b. On 09/20/24 at 9:40 AM an observation was made of the 100 Hall medication cart accompanied by MA #2. The observation yielded 1 open box of ipratropium bromide / albuterol sulfate inhalation solution that was available for use. The box had 5 vials of the ipratropium bromide / albuterol sulfate inhalation solution lying loose in the bottom of the box and not stored in the foil pouch. The MA was asked about how the ipratropium bromide / albuterol sulfate inhalation solution should be stored and the MA stated she was unsure, but it was every nurses' responsibility to keep the medication cart clean and organized. At 3:30 PM on 09/20/24 an interview was conducted with both the Director of Nursing (DON) and the Assistant Administrator. The DON explained she educated the staff just that week on cleaning and organizing the medication carts. She indicated she would need to do more education. 3. A document provided by the facility with no date revealed that Tuberculin PPD was to be stored in the refrigerator and should be discarded	F 761	5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 761	Continued From page 96	F 761		

thirty days after opening.

An observation of the 600-hall medication cart with Nurse #5 on 09/18/24 at 4:37 PM revealed the following expired medications in the medication cart and available for use:

*Opened bottle of Divalproex 500 milligrams (mg) that indicated the medication should be discarded after 01/17/24.

*Opened bottle of Atorvastatin 80 mg that indicated the medication should be discarded after 08/27/24.

* Opened bottle of Ascorbic Acid 250 mg that indicated the medication should be discarded after 11/30/22.

*Opened bottle of Donepezil 10 mg that indicted the medication should be discarded after 04/27/22.

* Opened bottle of Venlafaxine 75 mg that indicated the medication should be discarded after 11/02/23.

* Opened and undated vial of Tuberculin Purified Protein Derivative (PPD).

Nurse #5 was interviewed on 09/18/24 at 4:50 PM revealed that the medications in the bottom drawer of her medication cart were brought from home because the resident was there for respite care (period of rest). She explained that they were not able to order any of those medications from the pharmacy and had to use the medications from home but stated she had not realized that some of those medications were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 761	Continued From page 97	F 761		

expired. She stated that she would sort through the bag to administer the resident's ordered medication but did not check the expiration dates on them. Nurse #5 stated she had noticed the Tuberculin PPD vial in her cart earlier that morning and should have thrown it away because she knew that it was supposed to be kept in the refrigerator.

The Unit Manager (UM) was interviewed on 09/18/24 at 4:58 PM. The UM stated that the resident came from home with respite care, so they were unable to order any medications from their pharmacy and had to use what the family had supplied. She stated that the admission nurse should have gone through the bag of medications supplied by the family and ensured all were within date and not expired. The UM added that the Tuberculin PPD serum should be stored in the refrigerator and discarded thirty days after being opened.

The Consultant Pharmacist was interviewed via phone on 09/19/24 at 9:43 AM. The Pharmacist stated that she visited the facility monthly and went through the medication carts "usually every other month and sometimes every month" just depended on the time constraints she had. The Pharmacist further explained that sometimes she would review each medication cart and sometimes she would review a sample of them and added that it was a big building and that she tried to sample each medication cart every other month so that she saw each cart at least every 3 months. Her medication cart review included looking for expired medications. She stated that she usually did not have issues with expired medications. The Pharmacist stated that the vial of Tuberculin PPD should be stored in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 761	Continued From page 98 refrigerator and discarded after thirty days of opening. Nurse #6 was interviewed via phone on 09/19/24 at 12:05 PM. Nurse #6 stated she worked at the facility via an agency and stated that she had never done an admission until 09/14/24 when she unexpectedly readmitted a resident to the facility from home. Nurse #6 stated she had no idea what the admission process was as she had not received any orientation to the facility. She stated she did a portion of the admission process as directed by other staff members and she took the bag of medication that the resident's family brought in with him and put them in the medication cart. Nurse #6 stated she did not review or look at the medication. She just put the bag on the medication cart until it was time to administer his medications then she went through the bag and got the medications she needed out of the bag. Nurse #6 stated she was unaware that there was expired medication in the bag. The Director of Nursing (DON) was interviewed on 09/20/24 at 10:43 AM who stated that the nurses should be going through their medication carts daily to take out expired medications or anything that had been discontinued. She added that the pharmacy staff was there earlier in the week and did a cart audit of some of the medication carts and she did not believe that any issues were identified.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		10/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 99	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 100 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to don Personal Protective Equipment (PPE) before entering a resident's room and failed to doff PPE after exiting a resident's room under transmission-based precautions for COVID-19. The facility also failed to utilize hand hygiene after removing gloves during a wound dressing change for 2 of 3 residents reviewed for infection control (Resident #46 and Resident #76). The findings included: A review of the facility's policy for SARs-CoV-2 (COVID-19) dated 04/2024 indicated strategies	F 880	1. Resident # 46 Covid Infection has resolved. Resident # 76 was assessed by the Director of Nursing on 9/30/24 and noted to have no signs or symptoms of infection in their wound. 2. Director of Nursing and Assistant Director of Nursing completed 100% audit of all current residents with wounds to ensure no signs and symptoms of infection in wounds related to potentially improper infection control practices during wound care. No infections noted. Staff Development Coordinator observed staff assigned to the Covid Positive Residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 101 used for the rapid identification and management of SARS-CoV-2 infected residents are consistent with current recommendations from the Centers for Disease Control and Prevention. Infection Prevention and Control for Residents with Suspected or Confirmed COVID-19 infection: Personal Protective Equipment: 13. Staff who enter the room of a resident with suspected or confirmed COVID-19 infection will adhere to Special Droplet Precautions and don PPE of gown, gloves, protective eyewear (goggles or face shield) and N95 or higher level of respirator before entering the room. 1. On 09/16/24 at 12:28 PM a continuous observation was made of Nurse Aide (NA) #4 donning PPE to enter Resident #46's room who tested positive for SARS-CoV-2 infection. The room was designated as "Special Droplet Precautions" which indicated PPE of gowns, gloves, face mask of N95 or higher, and eye protection of goggles or face shield. NA #4 donned the gown and gloves she removed from the PPE tower mounted on the Resident's door then took Resident #46's meal tray to her over bed table next to the window. She then went back to the door and removed a N95 mask from the tower and put it on over her personal face mask that she was already wearing. The NA went back to Resident #46 and attempted to feed her the meal, but the Resident only took a couple of bites then refused the meal. At 12:38 PM the NA removed her gown and gloves and washed her hands then while still wearing the N95 mask over her personal face mask, she walked up the hall to the shower room to dispose of the trash bag in the trash bin. NA #4 then walked back down the hall to Resident #46's room not wearing the N95 mask but still wearing her personal face mask.	F 880	on 10/01/24 for appropriate donning and doffing of PPE for all Covid Positive residents with no discrepancies noted. 3. Education provided to the Staff Development Coordinator by the Director of Nursing on 10/01/24 to ensure her understanding of the policy and procedure for Donning and Doffing PPE for Covid Positive Residents to include use of eye protection. Staff Development Coordinator completed education for all staff 10/01/24 on PPE use in Covid Positive Rooms to include appropriate use of eye protection. Education provided 10/01/24 for the wound nurses and all licensed nurses by the Staff Development Coordinator on appropriate hand hygiene during wound care. No staff shall work until education received. This education will be reviewed in new hire and new agency staff orientation. 4. The Assistant Director of Nursing and Unit Manager will monitor 5 staff donning and doffing PPE weekly X 8 weeks to ensure appropriate procedure followed, then 2 staff weekly for 8 weeks. The Assistant Director of Nursing and Unit Manager will observe 3 wound treatments per week X 8 weeks then 1 wound treatment weekly X 8 weeks to ensure appropriate hand hygiene is completed. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 102 On 09/16/24 at 12:39 PM an interview was conducted with NA #4 as she stood outside Resident #46's door. The NA was asked why she had to wear PPE when she went into the Resident's room and the NA explained that Resident #46 was positive for COVID and required Special Droplet Precautions before staff entered the room. When the NA was asked to explain the signage on the door, the NA stated she had to don the PPE of gown, gloves and N95 face mask but she realized she forgot to don the N95 face mask after she went to the Resident's bed and had to come back to don the appropriate face mask. When asked about the protective eye wear (goggles/face shield) the NA remarked the Infection Control Nurse told her that if she already wore personal glasses that she did not have to don protective eye wear. The NA remarked there were no face shields or goggles in the tower, but she knew where to obtain the PPE when she needed to get it. The NA was asked why she did not remove her face masks before she exited the room, and she replied she forgot to until she got to the shower room and then she removed the outer face mask. When asked why she did not remove both masks the NA replied it was her personal face mask. 2. A continuous observation was made on 09/19/24 at 8:55 AM of the Activity Assistant passing out ice water. The Activity Assistant approached Resident #46's room which was posted with the signage of Special Droplet Precautions. She donned a gown, gloves and N95 mask over her personal face mask. After she took both residents their ice water, she removed the gown and gloves and washed her hands before she exited the room. The Activity Assistant	F 880	5. Date of Compliance 10/09/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 103	F 880		

then walked across the hall and into a room that was occupied with two residents before she went back into the hall.

On 09/19/24 at 9:00 AM the Activity Assistant was asked about the Special Droplet Precautions posted outside Resident #46's door. She explained that she had to don the specific PPE before she entered the room because the Resident tested positive for COVID. When asked why she did not don the eye protection like the goggles or face shield the Activity Assistant stated the Infection Control Nurse told her that if she wore glasses that she did not have to don the goggles or face shield part of the PPE. When asked why she did not remove the N95 mask before she exited the room, she replied that she forgot and that she could have spread COVID when she went into the other residents' room across the hall. The Activity Assistant then removed the face mask and washed her hands.

An interview was conducted with the Infection Control Nurse on 09/19/24 at 5:08 PM. The Nurse explained that the staff was educated on hire and yearly on the different types of precautions and she gave a "crash course" on the Special Droplet Precautions when they had an active case of COVID. The Nurse stated all staff knew where they could obtain PPE if the towers were short. The Infection Control Nurse remarked she had never told any staff member that they did not have to wear the face shield or goggles if they wore personal glasses. She indicated the two staff members would be reeducated on PPE.

On 09/20/24 at 3:30 PM during an interview with the Director of Nursing (DON), the DON was informed of what both the Activity Assistant and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 104	F 880		

NA #4 stated about the PPE of face shield or goggles and the DON replied that the staff should follow the Special Droplet Precautions outlined on the sign. She indicated the staff would be educated again on the appropriate PPE usage.

3. Review of the facility's handwashing/hand hygiene policy revised October 2023 read, indications for hand hygiene: immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching a resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal.

An observation of wound care was conducted on 09/17/24 at 10:31 AM with Wound Nurse #1. Wound Nurse #1 was observed to use hand sanitizer and don the appropriate personal protective gear and removed the dressing from Resident #76's sacral area. Once she had the old dressing removed, Wound Nurse #1 removed her gloves and applied new gloves without performing hand hygiene and proceeded to clean the wound. After Wound Nurse #1 cleaned the wound, she removed her gloves and washed her hand with soap and water and applied new gloves before applying the Dakins soaked gauze to the wound bed. Then Wound Nurse #1 covered the wound with calcium alginate and covered it with a foam dressing. The wound was a large opening that was clean, without odor, and with very little drainage noted.

Wound Nurse #1 was interviewed on 09/17/24 at 10:45 AM who stated Resident #76 had a history of irritable bowel and colitis and had constant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	C 10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

(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 880	Continued From page 105	F 880		

diarrhea (loose/water stools). The Nurse Practitioner attempted lots of different treatments to stop or slow the diarrhea and nothing worked, and she developed a wound to the sacral area. Wound Nurse #1 stated that the Nurse Aides were excellent in keeping Resident #76 clean and turned and her wound today was very clean and was without odor. Wound Nurse #1 stated that when she removed her gloves the first time her hands were still clean and that was why she had not used hand sanitizer or washed them. She added that the other times during the observed wound care she had washed her hands appropriately.

The Infection Preventionist was interviewed on 09/18/24 at 4:06 PM who confirmed that hand hygiene should be done before and after contact with a resident, before and after providing care, anytime there were visibly soiled, and before and after applying gloves. The Infection Preventionist stated that when Wound Nurse #1 removed her gloves she should have performed hand hygiene before applying clean gloves.

The Director of Nursing (DON) and Assistant Administrator were interviewed on 09/20/24 at 3:11 PM. The DON stated that anytime the staff removed their gloves they should be using hand sanitizer or washing their hands. The Assistant Administrator added that the Center for Disease Control and Prevention recommended using hand sanitizer as opposed to washing with soap and water and she would expect her staff to do the same.