

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehabilitation			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street , Winston-Salem, North Carolina, 27104	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/25/25 through 8/29/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D4481-H1.	E0000		
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 8/25/25 through 8/29/25. Event ID # 1D4481-H1. The following intakes were investigated: 2593867, 2597412, 2580630, 2590616, 2575581, 737398, 737394, 737346, 737391, 737389, 737386, 737384, 737380, 737379, 737351, 737377, 737369, 737367, 737361, 737364, 737273, and 737363. 6 of 47 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity J Immediate Jeopardy began on 8/28/25 and was removed on 8/29/25.	F0000		
F0565 SS = D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F0565		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0565 SS = D	<p>Continued from page 1 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council and communicate the facility's efforts to address grievances voiced during Resident Council meetings for 2 of 2 consecutive months: June 2025, and July 2025.</p> <p>The findings included:</p> <p>a. A review of the Resident Council minutes completed by the Activities Director dated 6/24/25 revealed the following grievances were expressed: housekeeping does not take out their trash, nursing assistants take their time putting the residents to bed, 3rd shift nurses are sleeping in the day room and not answering call bells, laundry was not being sent up in a timely manner.</p> <p>A review of the grievances for the month of June 2025 revealed no Resident Council grievances were submitted.</p> <p>b. A review of the Resident Council minutes completed by the Activities Director dated 7/23/25 revealed the following grievances were expressed: second shift does not help residents into bed timely, television time in the day room is not being shared with residents and</p>	F0565		

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F0565 SS = D	Continued from page 2 missing personal items. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of July 2025 revealed no grievances were submitted. A Resident Council meeting was held on 8/27/25 at 11:00 AM with Residents #30, #83, #90 #161, # 189, 217. During the meeting, Resident #90, the resident council president, expressed that the Resident Council had voiced several grievances in the past two months which had not been fully addressed, and the staff have not communicated the facility's efforts in addressing their grievances. An interview with the Activities Director on 8/28/25 at 10:57 AM revealed that he was not aware that he needed to document resident council grievances or to communicate the facility's efforts in addressing the grievances. An interview with the Administrator on 8/29/25 at 12:45 PM revealed that Resident Council grievances should have been documented and the follow up to those grievances should have been provided to the Resident Council members at the next meeting.	F0565		
F0585 SS = B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F0585		

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F0585 SS = B	<p>Continued from page 3</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the</p>	F0585		

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F0585 SS = B	<p>Continued from page 4 resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record reviews, responsible party and staff interviews, the facility failed to provide written conclusions and resolutions of grievances reported by the Responsible Party (RP) for 1 of 1 resident (Resident #225) reviewed for grievances.</p> <p>Findings included:</p> <p>The review of the facility's policy on "Resident and Family Grievances" with a copyright date of 2024 read in part: "It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal." The procedure of the policy included: "In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:</p> <ol style="list-style-type: none"> i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. 	F0585		

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F0585 SS = B	<p>Continued from page 5</p> <p>v. Any corrective action taken or to be taken by the facility as a result of the grievance.</p> <p>vi. The date the written decision was issued.</p> <p>Resident #225 was originally admitted to the facility on 5/17/23 and re-admitted on 3/30/25 with diagnoses which included: end-stage renal disease and diabetes mellitus.</p> <p>The most recent Minimum Data Set assessment dated 6/13/25 indicated Resident #225 was moderately, cognitively impaired.</p> <p>Review of the facility's grievances revealed two grievances (7/8/24 and 1/13/25) reported to the facility's Social Services department by Resident #225's RP. On 7/8/24 the resident's RP reported concerns about the cleanliness of Resident #225's room and concerns about the resident's wound treatment. The investigation and resolution revealed staff from the nursing department spoke with the RP regarding the resident's dressing change and frequency; and the environmental services' supervisor informed the RP the resident's room was deep cleaned. The RP also reported a grievance to the Social Services department on 1/13/25 concerning Resident #225's unclean bathroom. The findings of the investigation by the Environmental Services department and the resolution of the cleaning of the bathtub and floor and the refilled soap dispenser were verbally reported to the RP by the Environmental Services Manager.</p> <p>Each of these grievance forms documented the investigation results and resolution steps were verbally communicated to the RP but no written documentation of the investigations' conclusions and resolutions was sent to the RP as follow-up.</p> <p>During a telephone interview on 8/28/25 at 8:56 a.m., Resident #225's RP indicated the facility frequently did not communicate with him when he had concerns about the resident's care. He had filed grievances with Social Services, but the facility did not follow-up with him.</p> <p>During an interview on 8/29/25 at 1:05 p.m., the facility's Director of Social Services revealed she</p>	F0585		

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F0585 SS = B	Continued from page 6 began working at the facility in January 2025. She stated after reviewing the notebook of copies of Grievance Response Letters maintained by the previous Director of Social Services, the letters sent to the complainants were discontinued after October 2024. She stated that she was not made aware of the federal requirement of notifying a complainant in writing of the conclusion and resolution of his/her reported grievance.	F0585		
F0646 SS = D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to notify the North Carolina Medicaid Uniform Screening Tool (NC MUST), that is the State Mental Health or Intellectual Disability Authority, when a significant change in condition was identified for a resident with a mental disorder and failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation for PASRR Level II for 2 of 3 residents reviewed for significant change in condition (Resident #10 and Resident # 204). The findings included: 1. The resident's electronic medical record (EMR) included information from the North Carolina Medicaid Uniform Screening Tool (NC MUST). This record revealed Resident #10 was evaluated and found to have a PASRR Level I determination with a start date of 10/28/18. The PASRR Level I evaluation assessed the resident for the appropriateness of nursing facility placement and no further PASRR screening was required unless a significant change occurred with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. The Level I designation specified there was no end date and no limitation unless the resident had a change in condition. Resident #10 was admitted to the facility on 4/26/24. His cumulative diagnoses included a diagnosis of	F0646		

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F0646 SS = D	<p>Continued from page 7 schizoaffective disorder, bipolar type and post-traumatic stress disorder.</p> <p>Resident #10's electronic medical record revealed a hospital psychiatric care coordination note dated 7/11/24 which revealed a problem list and noted a diagnosis of other schizophrenia on 8/11/22 and a diagnosis of post-traumatic stress disorder dated 6/7/19.</p> <p>Physician order dated 3/19/25 revealed a new order for .5 milligrams of Ativan three times a day for anxiety. This medication was discontinued on 7/22/25.</p> <p>Physician order dated 7/23/25 revealed an order for quetiapine fumarate 200 milligrams to be administered at bedtime for bipolar disorder.</p> <p>A psychiatric quarterly treatment plan and progress note dated 7/25/25 indicated Resident #10 has had a decline in mental status and anxiety symptoms had worsened since her previous treatment plan.</p> <p>An interview was conducted on 8/28/25 at 9:27 AM with the Director of Social Services and she indicated she did not realize Resident #10 had diagnosis of schizoaffective disorder and post-traumatic stress disorder added to the diagnosis list after the initial level I PASRR screening had been completed. She further revealed that she and the social work assistants were not aware that Resident #10 and a decline in mental status and anxiety symptoms and therefore did not initiate a Level II PASRR screening. The Director of Social Services also indicated that a Level II PASRR screening should have been initiated for Resident #10 due to having a serious mental illness and a noted decline in mental status, anxiety symptoms and changes in treatment.</p> <p>An interview was conducted with the Director of Nursing on 8/28/2025 at 9:41 AM. She indicated that due to Resident #10 having a diagnosis of a serious mental illness with a change in behaviors and treatments he should have been screened for a level II PASRR.</p> <p>2. The review of the PASRR Level 1 determination dated 8/3/23 for Resident #204, read in part: "No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions." Resident #204 was originally admitted to the facility on 2/28/24 with diagnoses</p>	F0646		

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F0646 SS = D	<p>Continued from page 8 which included moderate dementia with mood disturbance, and anxiety.</p> <p>Review of the quarterly Minimum Data Set dated 6/27/25 indicated Resident #204 was moderately, cognitively impaired with the diagnoses of depression, mood disorder, and anxiety.</p> <p>The clinical record revealed Resident #204's diagnoses was updated on 11/4/24 to include bipolar disorder.</p> <p>A review of the Psychiatric Progress Note dated 8/1/25 revealed Resident #204's past medical history included the diagnosis of bipolar disorder for which he was ordered and received Seroquel (an antipsychotic medication) for mood disorder.</p> <p>Review of the facility's records indicated Resident #204 was not referred to the state-designated authority for a Level II PASRR evaluation post his bipolar disorder diagnosis.</p> <p>During an interview on 8/29/25 at 9:49 a.m. the facility's Director of Social Services revealed she began working at the facility in January 2025. She indicated she was not aware Resident #204 had a diagnosis of bipolar disorder added to her list of diagnoses after the initial level 1 PASRR. The Director of Social Services acknowledged a Level II PASRR screening request should have been submitted to the state's mental health authority when Resident #204's mental status changed resulting in the diagnosis of bipolar disorder.</p>	F0646		
F0677 SS = D	<p>ADL Care Provided for Dependent Residents</p> <p>CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and staff interviews, the facility failed to ensure residents were provided clean footwear for 1 of 5 residents dependent on staff for Activities of Daily Living (ADL)</p>	F0677		

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F0677 SS = D	<p>Continued from page 9 care (Resident #4).</p> <p>Findings Included:</p> <p>Resident #4 was admitted to the facility on 6/26/25 with diagnoses that included Dementia and enlarged prostate gland with an indwelling catheter.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 6/28/25 revealed Resident #4 was assessed as severely cognitively impaired with no behaviors or rejection of care. Resident #4 was assessed as requiring substantial / maximum assistance for toileting hygiene and partial / moderate assistance personal hygiene.</p> <p>The care plan dated 7/3/25 revealed Resident #4 was care planned for ADL self-care deficit related to Dementia. The goal indicated Resident #4 will maintain current level of function through the review date. Interventions included provide sponge bath when a full bath or shower cannot be tolerated and make sure shoes are comfortable and not slippery.</p> <p>During an observation on 8/25/25 at 11:20am, Resident #4 was observed walking from his bedroom towards writer. Resident approached writer wearing yellow socks with purple stripes. Both socks were saturated with a liquid substance. Resident #4 wore plaid pajama pants that were saturated with a liquid substance down the back of his right pants leg. Visible wet footprints were coming from the resident's room door. At the foot of the residents' bed on the floor a small wet area was observed with multiple wet footprints surrounding the area.</p> <p>During an observation on 8/26/25 at 9:30am, Resident #4 was observed lying in bed on his left side wearing a hospital gown and yellow socks with two purple stripes with light brown stains on the bottom of both socks.</p> <p>During an observation on 8/26/25 at 11:25am, Resident #4 was observed lying in bed on his back with his legs crossed at the feet wearing yellow socks with two purple stripes with light brown stains on the bottom of both socks.</p> <p>During an observation on 8/27/25 at 8:40am, Resident #4 was observed wearing gray sweatpants with gray nonskid</p>	F0677		

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F0677 SS = D	<p>Continued from page 10 footies.</p> <p>During an interview on 8/27/25 at 9:10am, Nursing Assistant (NA) #1, indicated she was assigned to the resident. NA #1 further indicated she applied the yellow socks with purple stripes on Resident #4 the morning of 8/25/25. She stated she was not assigned to the resident on 8/26/25. NA #1 also indicated she removed the same yellow socks with purple strips she applied to the resident the morning of 8/25/25 the morning of 8/27/25.</p> <p>During an interview on 8/27/24 at 9:20am, Medication Aide (MA) #1, indicated Resident #4 normally lets staff groom him. She indicated the resident wore a leg bag because of his catheter.</p> <p>During an interview on 8/27/25 at 9:40am, the Unit Manager #1 indicated Resident #4 would mess with his leg bag sometimes. She indicated frequent checks were implemented to ensure Resident #4 was not disconnecting his leg bag from the catheter. Unit Manager #1 stated she was not aware the resident wore the same yellow socks with purple stripes from 8/25/25 through 8/27/25. She stated NA #2 told her she changed the residents' socks on 8/26/25.</p> <p>During an interview on 8/27/25 at 10:00am, NA #2 indicated she put gray socks on Resident #4 on 8/26/25. She stated she could not remember what socks he had on prior to her getting him dressed after lunch. She indicated she put the soiled clothing in a bag and placed it in the soil linen room.</p> <p>During an interview on 8/29/25 at 10:17am, the Assistant Director of Nursing (ADON) indicated staff were instructed to replace the resident's socks as needed. The ADON indicated he did not know why Resident #4 would have the same socks on for multiple days in a row. The ADON stated he would follow up with the unit manager and reinforce the importance of proper footwear to the unit staff.</p>	F0677		
F0812 SS = F	<p>Food Procurement,Store/Prepare/Serve-Sanitary</p> <p>CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements.</p>	F0812		

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F0812 SS = F	<p>Continued from page 11 The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to keep food preparation areas, floors and food service equipment clean, free from debris and/or dried spills during two kitchen observations. The facility failed to clean the ceiling vents located over the food preparation and food service areas. These practices had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>During a kitchen tour on 8/25/25 at 10:32 AM, the following observations were made with the Dietary Manager:</p> <p>a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area.</p> <p>b. The 4-plate warmers had 4 rows of clean plates stored inside the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around.</p> <p>c. The 6-compartment steam table had floating food</p>	F0812		

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F0812 SS = F	<p>Continued from page 12 particles in standing water, the lids of the steam table had large volumes of dried food and greasy build up around edges.</p> <p>d. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside and the fryer also had a heavy grease and food build-up inside and outside. Food products were observed behind the fryer and on the floor that included paper products, dried meats and vegetables.</p> <p>e. The floor area under the stoves, oven, preparation tables, steam tables were sticky with old food debris when walking across the floor.</p> <p>f. All 10 meal carts with dry food products stored in them had dried liquids, food crumbs and particles inside. The outside of all 10 carts also had dried liquids running down the fronts/sides of the cart.</p> <p>g. The 3 ceiling vents had large volumes of black dust/debris blowing over the steam table, clean dry dishware storage racks, food service and preparation surfaces.</p> <p>h. The microwave had large amounts of dried food and liquid products on the inside and outside.</p> <p>An interview was conducted on 8/25/25 at 10:30 AM with the Dietary Manager (DM) who stated the dietary staff were required to wipe down kitchen equipment after each meal and deep clean weekly in accordance with the kitchen cleaning checklist. The DM stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly. The DM acknowledged the identified kitchen equipment and ceiling vents had not been cleaned in accordance with the checklist.</p> <p>An interview was conducted on 08/25/25 at 12:24 PM with the Maintenance Assistant who stated that he was unaware of the cleaning process for the kitchen vents or the grease container because he was recently hired.</p> <p>A follow-up observation and interview were conducted on 8/27/25 at 11:27 AM with the Dietary Manager (DM) and Regional Director of Dietary Services who observed the meals were placed in the dirty meal carts and delivered to the main dining rooms and on the halls of 4 floors. The ceiling fans had not been cleaned from the initial tour on 8/25/25. Staff was observed preparing meals with dust particles were blowing overtop of the food prep table and steam table. The steam tables continue to have food particles in water.</p>	F0812		

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F0812 SS = F	Continued from page 13 An interview was conducted on 8/27/25 at 11:27 AM with the Regional Director of Dietary Services who stated the DM and Assistant Dietary Manager (ADM) was responsible for ensuring the kitchen equipment and floors were cleaned in accordance with the kitchen cleaning checklist. The Regional Director of Dietary Services acknowledged the vents needed to be cleaned and stated the dietary staff and maintenance staff were responsible for ensuring the vents were cleaned. An interview was conducted on 8/27/25 at 2:00 PM with the Regional Consultant for Maintenance and Environmental Services. He stated he was unable to confirm when the vents in the kitchen were last cleaned.	F0812		
F0814 SS = F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure the garbage and refuse was disposed of and keep 4 of 4 dumpsters and 1 of 1 grease interceptor container, and surrounding dumpster area clean and free from debris. This practice had the potential to attract pests and rodents. The findings included: During an initial tour observation on 8/25/25 at 10:00 AM, 4 dumpsters and 1 grease interceptor container located near a wooded area at the back of the facility. The dumpsters had several bags of garbage and refuse overflowing from the tops. In addition, there were loose paper products, boxes, food products, mattresses, furniture, old pallets, clothing, and a blanket outside of the dumpster containers littering the ground and surrounding areas. The grease interceptor container was leaking grease on the ground along with the trash onto the parking lot. A follow-up observation and interview were conducted on 8/25/25 at 10:15 AM with the Dietary Manager revealed the trash bags filled with garbage left on the ground had been removed, however the surrounding area had not been thoroughly cleaned evidenced by the remaining paper and food products and grease was still on the ground around the sides and backs of the dumpsters. The Dietary Manager stated the dietary and housekeeping staff were responsible for cleaning the dumpsters	F0814		

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F0814 SS = F	Continued from page 14 daily. An observation and interview were conducted on 8/25/25 at 11:40 AM with the Administrator who acknowledged the condition of the dumpster area and the overflowing grease interceptor container. She stated the dumpster area has been in this condition for some time and stated housekeeping, dietary and maintenance staff were responsible for ensuring the dumpster and surrounding area cleaned and maintained daily. An interview was conducted on 8/25/25 at 3:20 PM with the Regional Consultant for Maintenance and Environmental Services who stated the housekeeping, dietary and maintenance were responsible for ensuring the dumpster area was cleaned daily. He further stated he was unaware of when grease interceptor container had been cleaned. He stated it should have been cleaned monthly. An interview was conducted on 8/27/25 at 11:00 AM with the Dietary Manager (DM) and Regional Director of Dietary Services who both stated the maintenance staff were also responsible to ensure the grease receptor was cleaned daily and free of any long-standing grease or debris. The Regional Director of Dietary Service acknowledged the grease interceptor had not been cleaned consistently for several months.	F0814		
F0880 SS = J	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 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	F0880		

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F0880 SS = J	<p>Continued from page 15 facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP</p>	F0880		

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F0880 SS = J	<p>Continued from page 16 and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record reviews, observations, and interviews with staff and the Medical Director, the facility staff failed to utilize a blood glucose meter (glucometer) assigned to Resident #11 and used a glucometer that was assigned to another resident, Resident #141, to check Resident #11's blood glucose level. In addition, the staff member did not disinfect the glucometer before or after obtaining Resident #11's blood glucose level and would have had no way to know if another staff member had previously disinfected the glucometer assigned to another resident. Glucometers can become contaminated with blood and must be disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens. There were no residents with documented blood borne pathogens in the facility at the time of the observation. The deficient practice occurred for 1 of 2 staff members observed for glucometer use (Nurse #1).</p> <p>Immediate Jeopardy began on 8/28/2025 when Nurse #1 was observed performing a blood glucose level check on Resident #11 using Resident #141's assigned glucometer without disinfecting the glucometer per the glucometer manufacturer's instructions and the disinfectant wipes manufacturer's recommendations before or after using the glucometer on Resident #11. Immediate Jeopardy was removed on 8/29/2025 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems was in place and employee education was completed.</p> <p>The findings included:</p> <p>The facility's policy that was implemented on 12/1/2022 and reviewed on 1/1/2025 indicated glucometers would be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant after each use and according to manufacturer's instructions regardless of whether they were intended for a single resident or multiple use.</p>	F0880		

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F0880 SS = J	<p>Continued from page 17</p> <p>A review of the manufacturer's instructions for the glucometer used when Resident #11's blood glucose level was checked on 8/28/2025 at 9:42 am indicated the glucometer should be cleaned of any dirt, blood, or other bodily fluids from the exterior of the glucometer before performing the disinfecting procedure. The instructions further stated that the glucometer should be cleaned with two disposable, germicidal wipes after each use, one wipe to clean the glucometer and the second to disinfect the glucometer.</p> <p>The manufacturer's instructions for the disposable germicidal wipes used by the facility stated a glucometer should be wiped with a pre-moistened wipe on the surface of the glucometer remaining visibly wet for 2-minutes, additional wipes should be used to maintain wetness for the entire 2-minutes and then allow the surface to air dry after every blood glucose level check.</p> <p>Resident #11 was admitted to the facility on 7/31/2025 with a cumulative list of diagnoses that included diabetes.</p> <p>Resident #141 was admitted to the facility on 8/14/2025 with a cumulative list of diagnoses that included diabetes. Resident #141 did not have a diagnosis of a communicable disease.</p> <p>On 8/28/2025 at 9:42 am an observation and interview were conducted with Nurse #1 during a medication administration observation. During the observation Nurse #1 was observed to look through her medication cart and then removed a glucometer from the medication cart that was in a plastic bag and carried it into the resident's room without cleaning or disinfecting the glucometer. The name on the glucometer was not visible while Nurse #1 obtained Resident #11's blood glucose level. During the observation Nurse #1 checked Resident #11's blood glucose level and then placed the glucometer and storage bag on the table in front of the resident after sticking her finger and the name on the storage bag and glucometer were for another resident, Resident #141. Upon exiting Resident #11's room Nurse #1 stated she could not find Resident #11's glucometer in the medication cart and used Resident #141's glucometer which she stated was new and had not been used before, since the resident had just moved to unit from another unit. Review of the history for Resident #141's glucometer showed several previous blood glucose</p>	F0880		

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F0880 SS = J	<p>Continued from page 18</p> <p>levels recorded. Nurse #1 placed Resident #141's glucometer on the medication cart and stated she would replace Resident #141's glucometer and obtain a new glucometer for Resident #11. Nurse #1 stated there were glucometers in the facility's supply room and she should have called down to get a replacement glucometer for Resident #11 but was anxious because of the observation. Nurse #1 stated she had been educated regarding how to clean the glucometer and stated they should be cleaned with disinfectant wipes after each time they were used. Nurse #1 opened the medication cart and identified the germicidal wipes used to clean the glucometer. She stated the glucometer should be cleaned with one wipe and then another wipe was to be used to disinfect the glucometer by wetting the surface for 2 minutes and then allowing the glucometer to air dry. Nurse #1 gave the Resident #141's glucometer to the Unit Manager and the Unit Manager stated she would dispose of the glucometer and obtain a new glucometer for Resident #141 and a new glucometer for Resident #11.</p> <p>An interview was conducted with the Administrator on 8/28/2025 at 10:39 am in the presence of the Chief of Nursing Operations (a corporate representative. The Director of Nursing was not available at the time. The Administrator and Chief of Nursing Operations were made aware Nurse #1 had used another resident's, Resident #141's, glucometer to check Resident #11's blood glucose level without cleaning and disinfecting the glucometer prior to use on Resident #11. The Administrator stated each resident in the facility had their own personal glucometer, and there were glucometers in the facility's central supply and the medication rooms on each floor to be assigned to any resident whose glucometer was not working or could not be found. The Administrator stated Nurse #1 should have notified the Unit Manager she was not able to find Resident #11's glucometer and a new glucometer should have been assigned to the resident.</p> <p>The Medical Director was interviewed by phone on 8/28/2025 at 1:41 pm and he stated he did not believe there was any harm, or risk, to Resident #11 when the staff used Resident #141's glucometer without cleaning it because there was no blood-to-blood contact. The Medical Director further stated Nurse #1 should have followed the facility's policy and cleaned the glucometer using the manufacturer's instructions for the disinfectant wipes.</p>	F0880		

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F0880 SS = J	<p>Continued from page 19</p> <p>On 8/29/2025 at 8:37 am the Director of Nursing, who was certified as an Infection Preventionist, was interviewed, and she stated Nurse #1 should have immediately stopped what she was doing when she could not find Resident #11's glucometer in the medication cart and obtained a new glucometer from the Medication Room or the Supply Room. The Director of Nursing stated the facility felt it was best practice for residents who required a blood glucose level to have their own glucometer, and the glucometer should be labeled with the resident's name, room number, and the glucometer should be stored in a plastic bag in the medication cart. The Director of Nursing stated even though the facility had personal glucometers for each resident, Nurse #1 should have cleaned and disinfected the glucometer per the facility's protocol. The Director of Nursing stated Nurse #1 should have used one disinfectant wipe to clean the glucometer, another disinfectant wipe to disinfect the glucometer per the manufacturer's instructions and then allowed the glucometer to air dry before and after using the glucometer.</p> <p>The facility's Infection Preventionist was not available during the survey.</p> <p>The Administrator was made aware of the immediate jeopardy on 8/28/25 at 2:47 PM.</p> <p>The facility implemented the following plan for Immediate Jeopardy removal:</p> <ul style="list-style-type: none"> - Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and <p>On 8/28/2025 at 11:00 a.m., Nurse #1 prepared to conduct a fingerstick blood glucose check on Resident #11. The Nurse was unable to locate a glucometer labeled for Resident #11. The Nurse removed a glucometer from the medication cart which had been designated and labeled for Resident #141. The Nurse did not cleanse or disinfect the glucometer designated for Resident #141, according to the glucometer's manufacturer's instructions and germicidal wipe manufacturer's instructions, prior to conducting the fingerstick blood glucose check on Resident #11. The nurse proceeded to conduct the fingerstick blood glucose check on Resident #11 utilizing the glucometer designated for Resident #141, which had not been</p>	F0880		

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F0880 SS = J	<p>Continued from page 20 cleaned or disinfected. Upon completion of the fingerstick blood glucose check on Resident #11 the nurse failed to cleanse and disinfect the glucometer designated for Resident #141 according to the glucometer's manufacturer's instructions and germicidal wipe manufacturer's instructions.</p> <p>All residents that required blood glucose monitoring through the use of a glucometer were identified as having suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance on the 8/28/2025. Through review of the census all residents who required blood glucose monitoring through the use of a glucometer were added to the potentially affected resident list. The facility had 61 residents who received blood glucose checks with a glucometer as of 8/28/2025. During the interview with Nurse #1 she denied using glucometer designated for a different resident on any resident other than when she used Resident #141's glucometer for Resident #11. The facility interviewed current nurses and current med aides and they denied using a glucometer labeled for another resident on a different resident. Residents that were alert and oriented, as determined by a Brief Interview for Mental Status (BIMS) score of 12 and higher, were interviewed and denied observing a glucometer used for checking their finger stick blood glucose with another resident's name.</p> <p>On 8/28/2025 at 11:48 a.m. the Assistant Director of Nursing (ADON) in-serviced Nurse #1 on the manufacturer's recommendations for the disinfectant wipes, and the glucometer's manufacturer's instructions for cleaning and disinfecting glucometers. The ADON then observed a return demonstration of cleaning and disinfecting the glucometer per manufacturer's instructions. Nurse #1 was educated by the ADON on potential consequences of not properly cleaning and disinfecting glucometers which included the potential to infect the resident with bloodborne pathogens. The education included the manufacturer's instructions for the glucometer and the germicidal wipe instructions to clean and then disinfect with two minutes of wet contact time as written in the germicidal wipe manufacturer's instructions.</p> <p>On 8/28/2025 the Unit Manager removed the glucometer of Resident #141 from the cart and discarded it. Resident #11's glucometer was not located. A new glucometer was placed and labeled in the resident's room for Resident #11 and Resident #141.</p> <p>Resident #11 was notified by the Unit Manager on</p>	F0880		

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F0880 SS = J	<p>Continued from page 21 8/28/25 of the incident. Resident #11 had no questions or concerns. Resident #11 was her own responsible party and has a BIMS (Brief Interview for Mental Status) of 15 indicating no impairment in cognition. The BIMS was most recently assessed on 7/23/25. Labs for screening blood borne pathogens were offered to Resident #11 and she refused.</p> <p>- 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.</p> <p>On 8/28/2025 at 11:14 a.m., The Medical Director was notified of the incident by the Director of Nursing. The clinical team discussed education and systems to put into place to prevent future staff competency issues related to infection control of blood glucose monitoring. These systems included education provided by the Director of Nursing and Assistant Director of Nursing started on 8/28/25 to nurses, and medication aides in the facility. Education provided included the manufacturer's recommendations for the disinfectant wipes, and the glucometer's manufacturer's instructions for cleaning, disinfecting glucometers, and system to keep resident glucometer in resident's room labeled. The Director of Nursing, Assistant Director of Nursing, and Unit Managers audited residents that require glucometers and placed them in the resident room labeled with the resident's name. For staff not in the facility the Director of Nursing and Assistant Director of Nursing began making calls to provide education. The education will be monitored by the Assistant Director of Nursing and Director of Nursing and will be included in orientation to newly hired nurses and medication aides. Training will be completed with oncoming staff prior to starting their assignments.</p> <p>On 8/28/2025 at 11:48 a.m. the Assistant Director of Nursing (ADON) in-serviced Nurse #1 on the manufacturer's recommendations for the disinfectant wipes, and the glucometer's manufacturer's instructions for cleaning and disinfecting glucometers. The ADON then observed a return demonstration of cleaning and disinfecting the glucometer per manufacturer's instructions. Nurse #1 was educated by the ADON on potential consequences of not properly cleaning and disinfecting glucometers. The education included the manufacturer's instructions for the glucometer and the germicidal wipe instructions to clean and then disinfect with two minutes of wet contact time as written in the germicidal wipe manufacturer's</p>	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehabilitation			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street , Winston-Salem, North Carolina, 27104	
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F0880 SS = J	<p>Continued from page 22 instructions.</p> <p>On 8/28/2025 at 2:10 p.m. the clinical team reviewed the manufacturer's recommendations for glucose cleansing and disinfecting. The manual under section B read; Testing confirmed the following wipes will not damage the functionality or performance of the meter, this included suggested manufacturer germicidal disposable wipes. The germicidal disposable wipes directions for use read: To disinfect nonporous surfaces use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface of the glucometer. Allow the surface of the glucometer to remain wet for two minutes. Let the glucometer air dry.</p> <p>The Assistant Director of Nursing then began in-servicing nurses and medication aides working on 8/28/2025. The Assistant Director of Nursing then began in-servicing nurses and medication aides not currently working at the facility via the telephone. Nursing staff and medication aides were instructed to see the Director of Nursing (DON) and/or Assistant Director of Nursing before their next shift for a return demonstration of blood glucose monitoring cleansing and disinfection process. The Assistant Director of Nursing will educate newly hired nurses and medication aides regarding cleaning and disinfection of glucometers per manufacturer's instructions during orientation and before receiving an assignment. On 8/28/2024, the Assistant Director of Nursing was notified by Nurse Consultant #1 of his responsibility to conduct education with nurses and medications aides regarding each resident's personal glucometer for individual use, the proper steps to clean and disinfect a glucometer, storage of a glucometer, and where to locate a glucometer when needed. The Assistant Director of Nursing will be responsible for keeping up with the newly hired staff.</p> <p>In the event a nurse or med aide cannot locate a resident's glucometer, education was provided to retrieve a new glucometer from Central Supply. The glucometer will be labeled using a permanent marker with first initial and last name. The Unit Manager will be made aware the glucometer was placed/replaced.</p> <p>On 8/28/2025 the Director of Nursing, Assistant Director of Nursing and Unit Manager, assessed, cleansed, and disinfected all glucometers according to the manufacturer recommendations for glucometer</p>	F0880		

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F0880 SS = J	<p>Continued from page 23 disinfection and per the directions for the germicidal disposable wipes.</p> <p>On 8/28/2025, an audit was conducted by the Unit Managers to verify each resident who required fingerstick blood glucose monitoring had a designated glucometer on the medication carts, and that the designated glucometer was bagged and labeled. The audit revealed 100% of residents who required glucose monitoring had individualized glucometers available including Resident #11 and Resident #141,</p> <p>The Administrator notified Forsyth County Department of Health of the incident on 8/28/2025. The Health Department staff member was not available, but a message was left requesting a return call.</p> <p>The glucometer policy was placed on every medication cart by the Assistant Director of Nursing on 8/28/25 and read:</p> <ol style="list-style-type: none"> 1. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, germicidal disposable wipe (bactericidal, tuberculocidal, and virucidal). 3. Perform Hand Hygiene. 3. Explain the procedure to the resident. 4. Provide privacy. 5. Don gloves. 6. Obtain capillary blood glucose sampling. 7. Remove and discard gloves, perform hand hygiene prior to exiting the room. 8. Retrieve (2) wipes from germicidal (bactericidal, tuberculocidal, and virucidal) disposable wipe container. 9. Using the first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. 10. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the germicidal (bactericidal, tuberculocidal, and virucidal) wipe, 	F0880		

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F0880 SS = J	<p>Continued from page 24 according to the glucometer manufacturer's instructions. Follow the germicidal wipe directions for the dry time. Allow the glucometer to air dry.</p> <p>11. Discard germicidal (bactericidal/tuberculocidal/virucidal) wipes in waste receptacle.</p> <p>12. Perform hand hygiene.</p> <p>On 8/28/2025 the Director of Nursing, Assistant Director of Nursing, Unit Managers, Administrator and Nurse Consultant made the decision to move the glucometers off the medication carts and into each resident's room and will be stored in a pencil box/pouch. Education was provided by the Unit Managers to the nurses and the Medication Aides (MA) working on 8/28/2025 regarding the location of the glucometers in the rooms and this education will be provided to nursing and MA staff prior to working the next shift, by the Unit Managers. Any nurse or medication aide found to be sharing glucometers will be subject to disciplinary action.</p> <p>IJ removal date 8/29/2025</p> <p>Date of Removal of Immediate Jeopardy: 8/29/2025</p> <p>The facility's credible allegation of immediate jeopardy removal was validated on 8/29/2025. A review was conducted of the facility's education for glucometer disinfection with the nursing staff and the education was completed on 8/29/2025. The nursing staff were able to verbalize the education and training provided regarding disinfection of glucometers assigned to the residents before and after use. An observation was conducted on 8/29/2025 when a nurse performed a blood glucose check and there were no issues observed, the assigned glucometer was used on the correct resident, and the assigned nurse disinfected the glucometer before and after use. During the observation, disinfectant wipes were observed in the medication cart. A sample of residents were observed of the residents' personal glucometers in their room and stored in a container with each resident's name and room number on the glucometer and the container. An observation was also made to ensure the facility had replacement glucometers in stock. The immediate jeopardy removal date of 8/29/2025 was validated.</p>	F0880		