STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/10/24 through 6/18/24. Additional information was obtained on 07/02/24 . Therefore, the exit date was changed to 07/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CGH811.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/10/24 to conduct a recertification and complaint survey and exited on 06/14/24. Additional information was obtained on 07/02/24 . Therefore, the exit date was changed to 07/02/24. The following intakes were investigated Intake Numbers: NC00208320, NC00208697, NC00208779, NC00208929, NC00209344, NC00209581, NC00210062, NC00210512, NC00210684, NC00211181, NC00212215, NC00212754, NC00213554, NC00213967, NC00214119, NC00215133, NC00215379, NC00215416, NC00215748, NC00216224, NC00216666, NC00217068, NC00218115, NC00218181. 51 of the 95 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		7/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/13/2024

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

(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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews the facility failed to protect a resident's dignity (a) when the resident was left with 3 briefs on that were soiled and saturated	F 550	Without admitting or conceding either the existence or scope or severity of the deficiencies, Willow Valley Center for Nursing and Rehabilitation submits this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling "dirty" "angry" and "neglected." This occurred for 1 of 1 resident (Resident #209) reviewed for incontinence care. Findings included: 1 (a) Resident #209 was admitted to the facility on 5-14-24 with multiple diagnoses that included enterocolitis (inflammation in the intestines) and diabetes. The 5-day Minimum Data Set (MDS) dated 5-14-24 revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting. The MDS documented Resident #209 with adequate vision and no issues with communicating. The MDS also documented Resident #209 was frequently incontinent of urine and always incontinent of bowel. Resident #209's care plan dated 5-23-24 revealed the resident had an activities of daily living (ADL) deficit due to enterocolitis and diabetes. The goal for Resident #209 was to improve the current level of ADL function. The interventions were one staff assist for personal hygiene and toileting. Resident #209 also had an intervention for two staff to assist the resident with transfers. Resident #209 was interviewed on 6-10-24 at 11:25am. Resident #209 was observed to be tearful and stated she was "angry" because she had been laying in a soiled and urine saturated brief since 8:15am. The resident explained she had put her call light on at 8:15am (stated she	F 550	plan of correction to be in compliance with the regulations. F550 Resident #209 brief was changed on 6/10/24 and a single brief was placed on. Residents requiring incontinence care have the potential to be affected by the deficient practice. Unit Managers completed an audit of residents requiring incontinence care. Residents were interviewed to ensure their dignity was protected during perineal care. Clinical staff were educated on protecting a resident's dignity, privacy, and ensuring optimal care and services with perineal care. Education was also provided with the clinical staff on promoting dignity with toileting and prompt incontinent care despite the time of day or night to render care and services to the resident. Staff members that do not receive the education by July 17, 2024, will not be able to work until the education is completed. New hires will receive education during the orientation process by the assigned manager and/or Staff Developer Coordinator. The Unit Managers or designee will conduct an audit of 10 incontinent residents weekly for four weeks, then 5 incontinent residents weekly for eight weeks to ensure the resident's dignity is being protected and that there is no multiple briefing in place. If the resident request multiple briefs this will be care planned.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 knew it was 8:15am because she looked at the clock on the wall) and asked NA #8 to be changed. She stated NA #8 told her she had to wait because the breakfast trays were arriving on the unit. Resident #209 said she told NA #8 again when she delivered her tray that she needed changed and stated NA #8 told her she would get changed after breakfast. Resident #209 said "It is not right that I had to eat in this dirty brief" and expressed this made her feel "neglected" and "dirty." She stated she still had not been changed. The resident was observed to put her call light back on for assistance. Observation of incontinence care occurred on 6-10-24 at 11:33am with NA #4. During the observation, Resident #209 was observed to have 3 briefs and another brief was laid flat under her. When asked if she requested 3 briefs, Resident #209 stated "no, the aide (NA #9) told me I had to have them on because I was a heavy wetter." It was observed that Resident #209's bowel movement and urine had seeped through all 3 briefs, the draw sheet, the cotton pad, and the fitted sheet. There were areas on the draw sheet, cotton pad, and fitted sheet that had dark yellow rings and on Resident #209's skin there were areas where her bowel movement had dried to her skin. The resident's skin was intact with no redness. NA #4 was interviewed on 6-10-24 at 11:44am. The NA explained she had come into work late, so she had not completed initial rounds on her assigned residents. She confirmed Resident #209 was assigned to her. NA #4 stated NA #8 had not informed her when she arrived that Resident #209 needed to be changed. When discussing the condition of Resident #209, NA #4	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 discussed that it was not normal practice to see 3 briefs on a resident and that due to the drying of urine and dried feces, NA #4 said she did not think the resident had been changed since the night before. NA #4 explained staff could change residents even when trays were being delivered and did not know why Resident #209 had not received incontinence care. During an interview with NA #8 on 6-10-24 at 11:50am, NA #8 explained the NA assigned to Resident #209 had come to work late so initial rounds were not completed on the resident. She stated at 8:15am, Resident #209 had put her call light on but said the resident never informed her she needed to be changed. When asked, NA #8 could not state what activity she provided the resident or what the resident wanted at 8:15am when she answered her call light. She also stated when she provided Resident #209 with her breakfast tray, the resident never told her she needed to be changed. A telephone interview occurred with NA #9 on 6-12-24 at 7:30am. The NA confirmed she had been assigned to Resident #209 on 6-9-24 during the 11:00pm to 7:00am shift. NA #9 explained she had usually changed Resident #209 every hour because "she urinates a lot." She stated she had last changed Resident #209 between 6:00am and 6:30am on 6-10-24. NA #9 discussed Resident #209 asking for 2 briefs, but the NA stated she placed one brief on the resident and laid another one down flat under the resident. NA #9 stated she had not placed 3 briefs on the resident. A follow up interview occurred with Resident #209 on 6-12-24 at 10:33am. Resident #209 again stated she had not asked for extra briefs to be	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

placed on her. She explained that NA #9 had told her she had to have 3 briefs on because she was a "heavy wetter."

(b) Observation and interview occurred with Resident #209 on 6-12-24 at 10:33am. The resident was observed wiggling in her bed. When questioned, Resident #209 stated she had to urinate. She explained she had put her call light on and when Nursing Assistant (NA) #10 arrived she had told the NA she had to urinate. Resident #209 explained NA #10 adjusted her brief and told her "If you get the fitted sheet wet you will have to lay on just the mattress because we don't have any other fitted sheets." The resident said she has been holding her urine because she does not want to get her sheets wet. Resident #209 voiced feeling "angry" and "neglected" having to go to the bathroom in her brief when she could use a bed pan. When asked, Resident #209 stated she did not know why she was not taken to the bathroom or provided a bed pan. This surveyor left Resident #209's room and requested the unit manager come to the resident's room.

Interview with the unit manager occurred on 6-12-24 at 10:37am. This surveyor explained Resident #209's situation and the unit manager questioned why NA #10 did not provide a bed pan. The unit manager was observed going to Resident #209's room where Resident #209 explained the situation. The unit manager provided Resident #209 a bed pan. The unit manager stated any resident who was able to use a bed pan should be provided a bed pan and that it was not dignified to expect a resident to urinate in a brief when they are able to use the restroom or bed pan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

During an interview with NA #10 on 6-12-24 at 10:41am, the NA confirmed she had answered Resident #209's call light. She explained the resident had informed her she needed to urinate, and that the resident had asked her to adjust her brief. NA #10 stated she adjusted the resident's brief and walked out. NA #10 discussed not thinking about giving the resident a bed pan, because she was wearing a brief, and the resident did not specifically ask for a bed pan or to go to the bathroom.

The Director of Nursing was interviewed on 6-12-24 at 2:37pm. The DON discussed staff receiving yearly training on incontinence care, dignity, and resident rights. She stated staff were able to provide incontinence care if the meal trays were on the unit but that she would expect them to wash their hands prior to passing the trays. The DON discussed Resident #209 and stated no resident should have to eat their meal in a soiled and wet brief. She also stated it was not the facilities policy to apply more than one brief to a resident. The DON explained if the resident requested more than one brief, the resident would be care planned for more than one brief. She stated since Resident #209 was cognitive enough to know when she needed to use the restroom, she would have expected NA #10 to offer Resident #209 to go to the bathroom or a bed pan.

The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed it not being appropriate for a resident to have on more than one brief but also said she felt this may have been a one-time occurrence. She stated if Resident #209 urinated frequently, then she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7 would expect the resident to be care planned for more frequent visits. The Administrator also discussed if a resident was aware enough to say they needed to use the bathroom, then NA #10 should have offered this to Resident #209 instead of expecting the resident to use the bathroom in a brief.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to honor a resident's request to be assessed for smoking for 1 of 3 sampled residents (Resident #128) reviewed for choices. Findings included: Resident #128 was admitted to the facility on 4/9/24 with diagnoses which included osteomyelitis of vertebra, lumbosacral region, Parkinson's disease, and congestive heart disease. The admission Minimum Data Set dated 4/23/24 indicated Resident #128 was cognitively intact. Review of the facility's Safe Smoking Screening dated 4/30/24 included Resident #128 did not currently smoke. During an interview on 6/11/24 at 1:09 p.m., Resident #128 revealed she was a smoker and since she was admitted to the facility had requested to be assessed to smoke. The resident stated smoking calmed her and she frequently "begged" staff (unable to name staff) to be assessed for smoking but was always told that staff did not have time to assess her for smoking. On 6/14/24 at 2:10 p.m. Nurse #2 revealed she completed the Smoking Assessment on Resident #128 during the admission process and documented the resident as not being a smoker. Nurse #2 was unable to recall if she asked the resident if she smoked. She insisted the resident never requested to smoke until she had a	F 561	F561 Resident #128 smoking assessment was completed on 6/14/24. Residents that have the desire to smoke have the potential to be affected by the deficient practice. Unit Managers completed an audit of all residents and their smoking preference. On July 8, 2024 staff members were educated on the resident right to smoke if they so desire. Education will be ongoing and staff members that have not been educated by July 17, 2024 will be unable to work until the education has been completed with them. The education regarding smoking preferences will be added to the new hire orientation. The Unit Managers or designees will conduct audits on 10 new admissions weekly for four weeks, then 5 new admissions weekly for eight weeks to ensure that residents that desire to smoke have been addressed The Director of Nursing or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 9 roommate who smoked. Nurse #2 stated she spoke with the nurse practitioner who felt the resident would not be a safe smoker. The resident must be able to hold a cigarette without burning herself, sit upright without increase in pain for more than a few minutes because of chronic pain related to a sacral wound and rheumatoid arthritis. The nurse practitioner offered nicotine patches which the resident refused. Nurse #2 admitted that once facility staff became aware Resident #128 requested to smoke, an updated smoking assessment should have been completed at that time.	F 561		
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	F 569		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on staff interviews, family interview and record review of resident trust account, the facility failed to convey funds within 30 days to a discharged resident and failed to forward the balance of funds to the estate of an expired resident for 2 of 3 residents reviewed for personal funds (Resident #619 and 620). The findings included: 1. Resident #619 was admitted to the facility on 7/11/23 and expired on 1/2/24. Review of the resident trust account for Resident #619 revealed the amount of $984.79 was not conveyed to the resident estate within 30 days of his death. The facility did not send the check to the Clerk of Court until 4/24/24. A telephone interview was conducted on 6/11/24 at 2:20 PM with Resident #619's family member who stated that Resident #619 died on 1/2/24 and when she contacted the facility regarding the remaining funds, she was given the run around that the money had been returned to the Medicaid office. She stated the previous Business Office Manager (BOM) continued to report the check would be sent to her being that she was the responsible person. She further stated the funds had not been sent to her and she had not received any correspondence from the facility about where the monies had been sent as of 6/11/24. No one from the facility had informed her of the actual amount that would be refunded. An interview was conducted on 6/11/24 at 3:00 PM, in conjunction with a record review with the	F 569	F569 Resident #619 received funds on 4/24/24 and resident #620 received funds on 6/14/24. Residents that discharge or expire while in the facility could be affected by the deficient practice. An audit was conducted on discharged residents with resident trust funds. Individuals found to have balances had checks issued to their estate. The business office managers were educated by the Administrator regarding issuing resident trust funds for discharged residents within 30 days. New hired business office associates will be educated during orientation The Business Office Manager or designee will audit five discharged/expired residents a week for 12 weeks to ensure that refunds are requested and will be issued within 30 days. The Business Office Manager or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 11 Business Office Manager who revealed the previous Business Office Manger had not sent out the check to the Clerk of Court within the designated 30 days. The Business Office Manager stated that it was not discovered until an audit was done at the end of March 2024 that the funds had not been forwarded to the Clerk of Court . The check was sent to the Clerk of Court on 4/24/24. The Business Office Manager further stated after the completion of the audit and mailing of the check, the facility did not communicate or correspond with the family that the money in the amount of $984.79 had been forwarded to the Clerk of Court. An interview was conducted on 6/12/24 at 9:15 AM, in conjunction with a record review with the Regional Business Office Director revealed the previous Business Office Manager failed to complete an audit and forward the funds to the Clerk of Court. The Regional Business Office Director stated the money should have been sent to the Clerk of Court within 30 days of death per policy. The discrepancy was not discovered until an audit was done at the end of March 2024 and the monies were sent in April following the audit. An interview was conducted on 6/12/24 10:21 AM with the Administrator who stated the Regional Business Office Director and Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days. 2. Resident #620 was admitted to the facility 10/13/22 and discharged home 3/1/24.	F 569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 12	F 569		

Review of the resident trust account for Resident #620 revealed the amount of $1, 984.13, had not been refunded to the resident within 30 days of discharge.

An interview was conducted on 6/11/24 at 3:00 PM, in conjunction with a record review with the Business Office Manager who revealed the previous Business Office Manager failed to send the refund within the designated 30 days. She stated the facility system failed due to the billing system not responding or providing monies to refund the resident in the amount of $1, 984.13. The request was made on 4/3/24 to the home office for the funds however, no one responded as of 6/11/24. Based on the audit and financial review, the previous Business Office Managers had not submitted a request for the refund when the resident was discharged. She further stated per policy discharged and expired residents' accounts should be reviewed and closed out and refunded to the resident or agency within 30 days per the conveyance policy.

A telephone interview was conducted on 6/12/24 at 7:45 AM, with Resident #620's family member who stated she had requested from the previous Business Office Manager and assistant the return of funds from Resident #620's social security check be returned to her when she was discharged on 3/1/24. She reported the previous Business Office Manager stated the check had been returned to the social security office and Medicaid, when the family contacted the social security office, they stated they had not received any correspondences from the facility about the discharge or the request for the social security check to be returned to the home address. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 13 stated she again spoke with the previous BOM about the billing and address change for the check and he continued to give her the run around. She reported Resident #620 had several bills that were not paid for the month of April resulting in the delay of bills. She did not receive the reinstatement of the social security check until May. The family member further stated Resident #620 had not received any refund from the facility for the April check. She reported she had spoken with the current Business Office Assistant to resolve the issue and was told the money would be refunded in April and as of 6/12/24 she had not received any money. An interview was conducted on 6/12/24 10:21 AM, with the Regional Business Office Manager who shared the Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations. An interview was conducted on 6/12/24 10:21 AM with the Administrator who stated the Regional Business Office Director and Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days.	F 569		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone,	F 576		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _______ B. WING _______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576	Continued From page 14 including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident council	F 576	F576	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 576	Continued From page 15 interview, the facility failed to deliver mail to residents on Saturdays for 211 Residents. The findings included: During an interview with 6 members of the Resident Council (Resident #20, Resident # 111, Resident #148, Resident #156, Resident #190 and Resident #365 on 6/13/24 at 9:30 am revealed they did not receive mail on Saturdays and the facility only delivered mail Monday through Friday. Interview with the Activities Director on 6/13/24 at 10:09 am revealed mail was sorted by the Business Office then given to the Activities Department to be delivered to residents. Activities delivered mail to residents 5 days a week, Monday through Friday. She stated mail was delivered to the facility on Saturdays, but the Business Office received the mail first. Interview with the Business Office Manager and Business Office Manager Assistant on 6/13/24 at 10:50 am revealed residents would receive packages on Saturday but not mail because the business office was closed. Mail was sorted and then given to the Activities Department to be delivered Monday through Friday when the business office was open. Mail was sorted to ensure the facilities mail was removed before giving mail to the Activities Department for delivery. Interview with the Director of Nursing on 6/13/24 at 3:18 pm revealed the Activities Department was responsible for delivering mail to residents. Mail should be delivered to residents on Saturdays.	F 576	Residents residing in the facility that receive mail have the potential to be affected by the deficient practice. Business Office Managers and Activities staff were educated regarding resident's right to receive their mail when delivered during the week of July 12, 2024. The facility has "managers on duty" and they will assist with the mail delivery to residents on the weekend with mail delivery to residents. "Managers on Duty" have received education on this process during the week of July 12, 2024. New hired Business Office Managers and Activities staff will be educated during the orientation process. The Administrator or designee will conduct an audit with 10 residents weekly for four weeks, then 5 residents weekly for eight weeks ensuring they have received their mail timely. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to maintain	F 583	F583 Resident #168 door was repaired.	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 17 personal privacy by failing to prevent exposure of a resident's body parts during incontinence care for 1 of 3 residents (Resident #168) reviewed for personal privacy. The reasonable person concept was applied to this deficiency as individuals have the expectation of privacy during incontinence care. The findings included: Resident #168 was readmitted to the facility on 09/26/23. The quarterly Minimum Data Set (MDS) assessment dated 06/05/24 revealed Resident #168 was severely cognitively impaired for daily decision making and required extensive to total assistance by 1 staff for toileting needs. On 06/12/24 at 2:17 PM, an observation was conducted of the 500 hall. This surveyor, the Maintenance Director, and the Environmental Services Director observed Nurse Aide #1 (NA) provide incontinence care to Resident #168. The Resident's door was open, and the privacy curtain was not fully pulled around the bed to ensure his privacy. His bare buttocks were visible from the open doorway. NA #13 entered the room to assist NA #1 and did not close the door or pull the curtain fully around the bed to ensure privacy. An interview was conducted with NA #2 on 06/12/24 at 2:45 PM and she stated it was not standard procedure for the door and curtain to be open during incontinence care. She stated she did not think to close it as she walked into the room. She explained the door should have been closed and the privacy curtain should have been pulled. NA #2 stated the door latch was broken on	F 583	All residents have the potential to be affected by the deficient practice. Clinical staff were educated on providing privacy for the residents. Staff members that have not received education by July 17, 2024, will not be able to work until educated. Newly hired clinical staff will be educated in orientation. The Unit Managers or designees will conduct an audit of 10 residents weekly for four weeks, then 5 residents weekly for eight weeks ensuring privacy is being provided to residents during care. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 18 Resident #168's room and that was why the door was open. She stated she had not put in a work order or report it to Maintenance. During an interview with Nurse #1 on 06/12/24 at 2:54 PM she stated the door and curtain should be closed in residents' rooms during incontinence care. An interview was conducted with NA #1 on 06/12/24 at 3:01 PM and she stated she knew the door was broken and usually propped something against it to keep it closed to provide privacy when giving care to the resident. She further stated she thought the privacy curtain was pulled far enough around the bed to block visibility from the hall. She added she should have made sure the door stayed shut and pulled the curtain further around the bed before incontinence care was provided to Resident #168. An interview was conducted with the Administrator on 06/14/24 at 2:37 PM and she stated NA #1 should have fully drawn the privacy curtain whether the door was in working order or not. She further stated if the resident had a roommate, the curtain afforded a second layer of privacy in case the roommate wanted to enter the room.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain clean and sanitary floors and walls (bathroom of rooms #321 and #509), maintain clean and sanitary shower curtains	F 584	F584 The floor and walls were cleaned in the bathroom of room #321 and #509, completed by July 12, 2024. New shower	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 584

Continued From page 20
(rooms #503, #509, #512, and #525), maintain clean and sanitary privacy curtains (rooms #302, #321, #503, #504, and #506), ensure the toilet was clean and in good repair (room #212), maintain doors and walls in good repair (rooms #424, #517, #525, and #528), maintain privacy curtain ceiling tracks in good repair (rooms #504 and #506), maintain bathtubs/showers clean and in good repair (rooms #506, #507, #516, #517, and #525), maintain furniture in good repair (rooms #409, #513), and maintain the ceiling and polyvinyl chloride pipe (PVC) in good repair (room #503) for 4 of 4 halls (200 hall, 300 hall, 400 hall, and 500 hall) reviewed for safe, clean, and homelike environment.

The findings included:

1. (a). Observations of room #503 on 06/10/24 at 11:45 AM and 06/11/24 at 10:00 AM revealed dried brown matter scattered across the bottom of the shower curtain. The observation further revealed the bracket from which the polyvinyl chloride pipe (PVC) hung was dislodged from the ceiling.

(b). Observations of room 504 on 06/10/24 at 11:50 AM and 06/11/24 at 10:05 AM revealed stained privacy curtains hung loosely off the eyelet hooks on the left side of 504 A bed and the left side of 504 B bed due to not being properly attached to the ceiling tracks.

(c). Observations of room 321 on 06/10/24 at 12:00 PM and 06/12/24 at 11:18AM revealed hundreds of small pieces of shredded purple confetti paper and a sticky residue under the bed of 321 B. Stained privacy curtains hung on the left side in the bed of 321 A bed and the left side

F 584

curtains were hung in room #503, #509, #512 and #525 completed by July 12, 2024. The privacy curtains in room #302, #321, #503, #504 and #506 were washed and rehung, completed by July 12, 2024. The toilet is room #212 was cleaned and repaired, completed by July 12, 2024. The doors and walls were repaired in room #424, #517, #525 and #528, completed by July 12, 2024. Privacy curtain tracks were repaired for rooms #504 and #506 completed by July 12, 2024. The bathtubs in rooms #506, #507, #516, #517 and #525 have been repaired, completed by July 12, 2024. The ceiling and PVC pipe in #503 has been repaired, completed by July 12, 2024.
Current residents residing in the facility have the potential to be affected.
Maintenance director and Environmental Director made facilities rounds, identified concerns and put a plan into place to resolve. Initial audits were conducted with solutions sustained on July 12, 2024.
Staff members were educated on a safe/clean/comfortable/homelike environment during the week of July 8th through the 12th. Staff that have not received education by July 17, 2024, will not be allowed to work until educated.
Newly hired staff will receive the education in orientation.
The Administrator or designee will conduct an audit of 10 resident room per week for twelve weeks to ensure a safe/clean/comfortable/homelike environment is being maintained ensuring compliance with resolution.
The Administrator or designee will review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 21 in the bed of 321 B bed. (d). Observations of room 506 on 06/10/24 at 12:17 PM and 06/11/24 at 10:07 AM revealed stained privacy curtains privacy curtains on the left side, by the door, of 506 A bed and the left side of 506 B bed due to not being properly attached to the eyelet hooks in the ceiling tracks. The privacy curtain rod for 506 B bed was dislodged from the drywall. Observation of the shared bathroom revealed the tiles around bathtub faucet had been removed and the plumbing pipes inside of the wall were exposed. (e). Observations of room 507 on 06/10/24 at 12:19 PM and 06/11/24 at 10:17 AM revealed the shower head was broken off from the shower fitting and was lying in the tub. (f). Observations of room 509 on 06/10/24 at 12:49 PM and 06/11/24 at 9:39 AM revealed a stained privacy curtain on the window side of the room was not attached well and the bracket was loose from wall. The privacy curtain near resident's bed was soiled with brown stains along the bottom and sides of the curtain. There were brown splatters and streaks on the wall behind the toilet in the bathroom and on the shower curtain. (g). Observations of room 525 on 06/10/24 at 1:18 PM and 06/11/24 at 10:24 AM revealed a stained shower curtain and dried smears of brown matter in the bathtub. There was a specimen collection container in the bathtub with dark amber matter in bottom. During the room observation on 06/10/24 the Resident's family member stated the brown matter on the wall, privacy curtain, shower curtain, and behind the	F 584	the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 22	F 584		

toilet were from an episode of diarrhea the resident had experienced two weeks ago. She stated she had not expected there to still be feces on the wall when she arrived on 06/10/24.

(h). Observations of room 409 on 06/12/24 at 8:46 AM and 06/12/24 at 4:00 PM revealed the vinyl wood grain veneer had peeled off the 3-drawer dressers on both resident's dressers. The middle drawer of 409 A's 3-drawer nightstand was missing and the bottom drawer of the nightstand had all the vinyl wood grain covering peeled off (exposing a plain yellow under surface).

An interview was conducted with Housekeeper #2 on 06/11/24 at 10:07 AM while he cleaned room 514. He stated the 500 hall was his assigned area for cleaning. He stated he swept and mopped each room daily. He further stated he disinfected the bathroom sink, toilet and bathtub in every resident room on the 500 hall daily. He said he had just completed his housekeeping duties for all rooms from 501through 514. When asked if he had swept, mopped, and disinfected the bedrooms and bathrooms for rooms 501through 514 he stated "yes, completely."

An interview and walking round were conducted with the Environmental Services Director and the Regional Director of Dietary and Environmental Services on 06/11/24 at 4:55 PM. Observations included the floors and walls of the bathrooms in rooms #321 and #509, the shower curtains in rooms #503, #509, #512, and #525, the privacy curtains in rooms #302, #321, #503, #504, and #506, the toilet in room #212, and the bathtubs/showers in rooms #506, #507, #516, #517, and #525. The Environmental Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 23	F 584		

Director stated routine cleaning of resident rooms included disinfecting all flat surfaces, sweeping and mopping the floor and bathroom floor, cleaning the bathroom sink, toilet, shower, and removing the trash. The Environmental Services Director stated all resident rooms were to be cleaned daily and as needed if the rooms needed further attention. The Environmental Services Director stated he expected bathrooms and resident rooms to be clean. He stated nursing staff were responsible for cleaning up any body fluids on the floor (blood, vomit, urine, and feces) and then environmental services staff disinfect the area after it has been cleaned. The Environmental Services Director and the Regional Director of Dietary and Environmental Services stated in-services on cleaning up body fluids on the floor will start immediately. They stated the stained shower curtains were being replaced.

On 06/11/24 at 5:05 PM an interview was conducted with Nurse #1and she stated if a resident had diarrhea and it got on the floor, walls, or curtains the nursing staff cleaned visibly soiled areas and then housekeeping cleaned the rest. She stated this pertained to all other body fluids as well.
An interview and walking round were conducted with the Maintenance Director on 06/12/24 at 2:11 PM. During observations of the rooms on the 500 hall he stated he was not aware of the condition of the rooms including the toilet in room #212, the doors and walls in rooms #424, #517, #525, and #528, the privacy curtain ceiling tracks in rooms #504 and #506, the bathtubs/showers in rooms #506, #507, #516, #517, and #525, the furniture in rooms #409, #513, and the ceiling and polyvinyl chloride pipe (PVC) in room #503. He stated any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 584 Continued From page 24 F 584

staff could and should put in a work order through the computer-based maintenance reporting program. He stated when a member of staff observed broken equipment or furniture in disrepair it should be reported through a work order. He stated information would be placed at the nursing station to remind staff to enter work orders promptly. He stated the furniture in disrepair would be replaced. He stated he and his assistant made weekly rounds to prioritize repairs. He stated repairs that impacted resident safety were completed first.

On 06/14/24 at 2:00 PM an interview was conducted with the Administrator, and she stated she was trying to get all needed repairs and cleaning up to date. She stated she had removed a lot of the broken furniture and prioritized replacements. She stated there were more needed repairs. She said staff should enter needed repairs in the computer-based maintenance reporting program but if it is an item that could impact resident safety it would need to be removed immediately.

2. Initial tour and subsequent follow up tours of hall 300 revealed the following.

(a) Room 300 was observed on 6-10-24 at 9:57am. The floor was noted to be dirty with brown and orange particles and pieces of paper.

On 6-11-24 at 8:32am, room 300 still had brown and orange particles as well as paper on the floor.

Housekeeper #1 was interviewed on 6-11-24 at 8:34am. The housekeeper confirmed hall 300 was her assignment and explained she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 584 Continued From page 25 F 584

working yesterday (6-10-24). She explained when she was not working, management should assign another person to clean the hall. The housekeeper stated there were housekeeping staff on the weekends and should be emptying trash, cleaning the tables, sweeping, mopping and cleaning the bathrooms as she stated she completed each day.

Observation of room 300 occurred on 6-11-24 at 8:38am directly after housekeeper #1 finished cleaning the room. The room was observed to still have brown and orange particles as well as paper on the floor.

Housekeeper #1 observed room 300 with surveyor on 6-11-24 at 8:42am. The housekeeper stated, "what did not come up needs to be scrapped and I do not have a scrapper." When showed the debris was not stuck to the floor, housekeeper #1 had no response.

A fourth observation of room 300 occurred on 6-12-24 at 1:24pm with the Environmental Service Manager and the Maintenance Director. The room continued to have debris (brown/orange particles, paper) under the over the bed table, around the trash can, next to/under the bed, and in the corners.

The Environmental Service Manager was interviewed on 6-12-24 at 1:25pm. The Environmental Service Manager stated the housekeepers are responsible for sweeping and mopping the floors. He explained his assistant conducted room to room morning rounds and if there were issues, he would speak to the housekeeper assigned to that room. When discussing the issues found, the Environmental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 26	F 584		

Service Manager stated he did not believe his assistant was performing the rounds as he was supposed to.

(b) During an initial observation of room 301, the room was observed to have an orange substance down the front of the heat/air unit, the floor had a yellow/orange substance that was sticky by the bathroom door, and there was debris on the floor that included food particles, paper, medicine cups, and dust.

Another observation of room 301 occurred on 6-12-24 at 1:27pm with the Environmental Service Manager and the Maintenance Director. The room had orange substance down the front of the heat/air unit, the floor had a yellow/orange substance by the bathroom door, and there was debris on the floor that included food particles, paper, medicine cups, and dust.

The Environmental Service Manager was interviewed on 6-12-24 at 1:28pm. The Environmental Service Manager stated the housekeepers are responsible for cleaning the front of the air/vent units. He stated he did not know why this had not been cleaned.

(c) Room 302 was observed on 6-10-24 at 10:42am. The privacy curtains in the room were observed to have 4 areas of a brown substance smeared on the curtain.

On 6-12-24 at 1:30pm, a second observation was made of room 302 with the Environmental Service Manager and the Maintenance Director. The privacy curtains were observed to have 4 areas of a brown substance smeared on the curtain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 27 The Environmental Service Manager was interviewed on 6-12-24 at 1:31pm. The Environmental Service Manager explained that HK was supposed to check the curtains for cleanliness and tell him if they needed to be cleaned. He also stated if staff saw the curtains were dirty, they could inform housekeeping so they could get them clean. The Environmental Service Manager stated he did not know why this was not completed. (d) An initial observation of room 309 occurred on 6-10-24 at 1:11pm. The room was observed to have paper, food particles, and an orange substance on the floor and a brown substance caked on the side rails of the resident's bed. A second observation of room 309 occurred on 6-11-24 at 11:09am. The room was observed to have been swept and mopped as the floor was still wet. However, the brown substance remained caked on the resident's side rails. During a third observation of room 309 occurred on 6-11-24 at 2:59pm. The observation revealed the caked on brown substance on the resident's side rails were still present. A fourth observation of room 309 occurred on 6-12-24 at 1:33pm with the Environmental Service Manager and the Maintenance Director. The observation revealed the caked on brown substance on the resident's side rails were still present. The Environmental Service Manager was interviewed on 6-12-24 at 1:34pm. The Environmental Service Manager explained that	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 28	F 584		

housekeeping would not clean up urine or feces. He explained nursing staff would perform the initial cleaning of the feces and then housekeeping would follow by disinfecting the area. The Environmental Service Manager stated he did not know if the brown substance was feces so housekeeping should have wiped down the resident's side rails.

(d) Room 312 was observed on 6-10-24 at 12:36pm. The observation revealed metal showing where the plaster and paint had been stripped away, the floor had a yellow/clear substance on the floor that was sticky, and there was a hole approximately 1 inch by 1 inch in the middle of the bathroom door.

A follow up observation of room 312 occurred on 6-12-24 at 1:36pm with the Environmental Service Manager and the Maintenance Director. The observation revealed the yellow/clear substance had been cleaned however the metal was still showing where the plaster and paint had been stripped away and there was a hole approximately 1 inch by 1 inch in the middle of the bathroom door.

The Environmental Service Manager was interviewed on 6-12-24 at 1:37pm. The Maintenance Director discussed having one person assigned to plaster and paint but said he did not know if he was aware of the issues in room 312.

(e) During a resident interview and observation of room 315 on 6-10-24 at 10:13am, the resident stated he was able to use the bedside commode but on Saturday (6-8-24) he stated he had a bowel movement on the floor by the bedside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 29 commode. Upon observing the room, the bowel movement was present under/behind the bedside commode. The resident stated staff were aware because he told them but said he could not remember who he told. Another observation of room 315 on 6-11-24 at 8:16 revealed there was still feces on the resident's floor under/behind the bedside commode. NA #18 was interviewed on 6-11-24 at 8:20am. The NA confirmed she had worked the weekend with the resident but stated she was not aware he had a bowel movement on the floor. A third observation on 6-11-24 at 11:00am, after the housekeeper was seen cleaning the resident's room, revealed remanence of feces under/behind the bedside commode. A fourth observation of room 309 occurred on 6-12-24 at 1:39pm with the Environmental Service Manager and the Maintenance Director. The observation revealed a brown/orange area where the feces had been under/behind the resident's bedside commode as well as red/orange debris under his bed and food particles on the floor. The Environmental Service Manager was interviewed on 6-12-24 at 1:40pm. The Environmental Service Manager discussed starting training with the housekeeping staff on how to properly clean a resident's room. He stated the training started yesterday (6-11-24) but that the housekeeper for hall 300 was not present.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 30	F 584		

(f) Room 317 was observed on 6-10-24 at 11:02am. The room was observed to have an approximately 2 foot wide by 2.5-foot-long area of a yellow dry sticky substance at the head of the bed. There were also brown and orange substances on the resident's wall next to her bed.

A follow up observation of room 312 occurred on 6-12-24 at 1:41pm with the Environmental Service Manager and the Maintenance Director. The follow up observation revealed remanence of the yellow substance and the brown and orange substances on the resident's wall next to her bed remained present.

The Environmental Service Manager and the Assistant Administrator were interviewed on 6-12-24 at 1:43pm. The Environmental Service Manager discussed that housekeeping was supposed to be checking the walls for any spills or dirt and cleaning any area that contained an issue. The Environmental Service Manager stated he had not been aware of the issues discussed during the observations. The Assistant Administrator stated she believed there was a disconnect between what the facility felt was clean and what the Environmental assistant believed to be clean.

The Director of Nursing (DON) was interviewed on 6-12-24 at 3:04pm. The DON stated she could not speak to the environment but stated the Environmental Service Manager was new to the building. The DON also stated the nursing staff were aware they were responsible for cleaning any urine or feces first then contacting housekeeping to disinfect. She stated she did not know why feces had stayed on the resident's floor for days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 31	F 584		

The Administrator was interviewed on 6-12-24 at 5:09pm. The Administrator discussed housekeeping staff needing to identify those residents who require more frequent cleaning and develop a cleaning schedule. She also discussed that there were assigned staff to perform "ambassador" rounds each morning in the resident rooms and stated if the ambassador was not catching the issues, then staff or housekeeping should. The Administrator explained If a staff member (ambassador, nursing, maintenance) saw any issues, she would expect them to report the issue to the proper staff so the issue can be resolved.

3.a. Observation was conducted on 6/11/24 at 12:42 PM, Room 517 there were several pieces of tile missing from the back wall in the bathtub.

b. Observation was conducted on 6/11/24 at 12:47 PM, Room 516 there was no drain faucet in the bathtub.

c. Observation was conducted on 6/11/24 at 12:48 PM, Room 513, the closet doors and drawers were broken apart. The floor was very sticky, heavily stained and a very strong urine odor was present. There was stained dried liquids and old food under resident beds and around dresser and closet area.

An interview was conducted on 6/12/24 at 2:27pm, the Maintenance Director stated work orders are put into the maintenance work order program which generated a work list. He further stated he did not have a complete list of repairs that needed to be done throughout the facility. The assigned maintenance staff for each of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 32	F 584		

floors were responsible for doing rounds and completing the needed repairs in resident rooms such as shower heads, tiles in bathrooms should be reported to maintenance the work order system. He indicated he did not have a system in place to monitor the repairs.
4. An observation was conducted on 6/11/24 at 12:30 PM, Room 424 showed 5 feet of baseboard trim lying on the floor and not attached to the drywall. The inside of the bathroom door had deep, large scrapes dug into the bottom quarter of the door exposing rough wood door grain. There were also deep, large gouges into the wall just inside of the bathroom on the right-hand side exposing the drywall. Further inspection of the bathroom revealed the faucet in the bathtub was running. The faucet handles were in the off position.

During an interview with the resident in bed A, whose quarterly Minimum Data Set assessment dated 5/2/24 had him as cognitively intact, on 6/11/24 at 12:40 PM, he stated that maintenance had fixed the trim on the baseboard several weeks ago, but it didn't stay that way for long before it fell off again. He also stated that the bathtub faucet had been running for several days. He stated that he mentioned it to several aides, but nothing had been done to fix it.

An interview and observation were conducted with the Administrator on 6/11/24 at 1:24 pm in Room 424. She stated that she was unaware of the issues in that room and was also unaware that the resident in bed A had attempted to bring it to the attention of staff multiple times. She stated that she would see to it that maintenance was made aware of the issues immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 33 An interview was conducted on 6/13/24 at 3:34pm, the Maintenance Director stated the nursing staff would enter needed repairs into the computerized system that would notify him and his staff. He stated they would print out the work repair requests and assign the tasks to maintenance staff assigned to each floor who were supposed to be doing weekly rounds for all areas including resident rooms. He stated he was not aware of the issues in Room 424 and was also not aware that the bathtub faucet was running. He stated that the system currently in place was for maintenance workers to check their assigned floor for any issues.	F 584		
F 585 SS=D	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.	F 585		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 34 §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: (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; (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; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 35 investigated; (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; (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 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; (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 (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. This REQUIREMENT is not met as evidenced by: Based on record review, family interviews, and staff interviews the facility failed to record a grievance and to make efforts to resolve the grievance for 1 of 3 residents reviewed for grievances (Resident #36). Findings include:	F 585	F585 Resident #36 guardian's grievance was resolved. Residents currently residing in the facility have the potential to be affected by the deficient practice. Grievances for the past 30 days were reviewed for resolution. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 36 Resident #36 was readmitted on 02/21/24. Review of Resident #36's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 04/19/24. The resident was coded as having severe cognitive impairment. During a phone interview with the guardian of Resident #36 on 06/13/24 at 11:43 AM she stated she had visited Resident #36 on 06/07/24 and observed that Resident #36's roommate removed his brief and shredded the brief into many pieces. She stated she observed the roommate masturbate and "play" in the feces from the shredded brief during her visit. The guardian stated she sent an email to Social Worker (SW) Assistant #1 to inform her of Resident #36's roommate's behavior and to request moving Resident #36 to another room. The guardian stated on 06/10/24 she received an email from SW Assistant #1 informing her she (SW Assistant #1) would let the Director of Nursing (DON) and the Unit Manager (UM) know of the concern. The guardian stated she replied to SW Assistant #1's email and asked for a response on how the concern would be resolved. The guardian said she received to no further written or oral communication from the facility regarding the result of the investigation from her grievance. An interview was conducted with SW Assistant #1 on 06/13/24 at 2:11 PM. SW Assistant #1 stated she received an email from Resident #36's	F 585	grievances found not resolved were corrected. Staff were educated in the grievance process. Staff that have not been educated by July 17, 2024 will not be able to work until education is completed. Newly hired staff will be educated in orientation. The Administrator or designee will conduct an audit of 10 grievances a week for four weeks, then 5 grievances a week for eight weeks to ensure the grievance has been followed up and resolved. The Administrator or designee will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 37 guardian on 06/07/24. She said she responded to the email on 06/10/24 and forwarded the email to the DON and UM. She stated she sent a response to the guardian that she would inform the DON and UM of the guardian's concerns. She stated she and the UM were brainstorming to figure out which residents would be compatible to switch. She stated there was not an unoccupied bed to which Resident #36 could be moved. She stated she did not have a resolution at this time unless the guardian wished to move Resident #36 to another floor if they could find another resident with whom to switch rooms. When asked if she had consulted with the guardian regarding a solution she stated "no". She said she thought the DON or UM would complete the grievance, resolve the guardian's concern and follow up with the guardian. She added anyone can fill out a grievance form, but she did not on this occasion. An interview was conducted with the DON on 06/13/24 at 2:30 PM. The DON stated she had not read her emails since 06/10/24 due to the recertification survey. She stated she did have an unread forwarded email from SW Assistant #1 dated 06/07/24. The DON stated she was not verbally informed of the guardian's concern. She stated a Grievance/Concern form should have been initiated by SW Assistant #1 on the day the email was received. She stated SW Assistant #1 should have followed up with the guardian by email and via telephone immediately on 06/10/24 to let her know the concern was being addressed. Review of the facility grievances on 06/14/24 at 2:30 PM revealed no recorded grievance for Resident #36 had been completed.	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 38 An interview was conducted with the Administrator on 06/14/24 at 2:45 PM. The Administrator stated SW Assistant #1 should have immediately completed a grievance form when she received the email from the guardian on 06/10/24. She stated grievances/concerns needed to be documented on the Grievance/Concern form and followed through upon as part of the grievance process, which includes providing a copy of the Grievance/Concern Form to the resident/resident representative upon resolution of the grievance/concern.	F 585		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and resident interviews, the facility failed to protect a resident's right to be free from neglect when Resident #209 was (a) left with 3 briefs on that	F 600	F600 Resident #209 received peri care and one brief was put in place. CNA was suspended pending investigation.	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 39 were soiled and saturated with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling "dirty" "angry" and "neglected." This occurred for 1 of 1 resident (Resident #209) reviewed for neglect. Findings included: This tag is cross referenced to: F550: Based on record review, observation, resident, and staff interviews the facility failed to protect a resident's dignity (a) when the resident was left with 3 briefs on that were soiled and saturated with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling "dirty" "angry" and "neglected." This occurred for 1 of 1 resident (Resident #209) reviewed for incontinence care. The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator stated NA #8 had answered Resident #209's call light at 8:15am but had not changed the resident but said if Resident #209 needed incontinence care provided at that time NA #8 should have provided the care.	F 600	Residents requiring incontinent care have the potential to be affected by the deficient practice. Residents with a BIMs of 12 or greater were interviewed for feelings of neglect. Residents of 11 and below had skin sweeps conducted. There were also audits performed with those resident with BIMS of 11 and below of how they "feel" with either themselves and/or RR validating any concerns. There were no issues identified. The initial audits were concluded and validated during the week of July 12, 2024. Staff were educated in abuse and neglect. Any staff not receiving the education by July 17, 2024, will be unable to work until the education has been completed. Newly hired staff will receive an education in orientation. The Administrator or designee will conduct an audit of (10) random residents a week for four weeks, then 5 residents a week for eight weeks for feelings of neglect. The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 40 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to complete and submit an Initial Allegation Report within 2 hours to the State Regulatory Agency for 1 of 1 resident (Resident #209) reviewed for neglect. Findings included: Resident #209 was admitted to the facility on 5-14-24.	F 609	F609 An Initial Allegation Report was sent to the State Agency regarding the neglect allegation made by resident #209. Initial Allegation Reports for the last 30 days were reviewed for submission in the allotted time. The Administrator and Director of Nursing were educated on reporting allegations in the proper timeframe.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 41 The 5-day Minimum Data Set (MDS) dated 5-14-24 revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting. Upon interviewing Resident #209 on 6-10-24 at 11:25am, the resident voiced feeling "dirty, "neglected", and "angry" being left in 3 briefs that were soiled and urine soaked while she ate her breakfast meal. The Administrator was informed on 6-12-24 at 4:32pm by this surveyor of Resident #209's feelings of "neglect", "angry", and "dirty' when the resident was left in 3 briefs, that were soiled, and urine soaked while she ate breakfast. A telephone interview on 6-18-24 at 11:17AM with the Administrator stated she had not completed an Initial Allegation Report and they had investigated the situation. She stated there had not been a resolution to the investigation as to why Resident #209 had on 3 briefs and not provided incontinence care. She stated she had not reported the allegation as neglect to the state agency.	F 609	The Administrator or designee will audit three Initial Allegation Reports of neglect a week for four weeks, then two a week for eight weeks for reporting completed in the two-hour window. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	
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	F 623		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 42 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 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	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 43	F 623		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 44 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(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and Ombudsman and staff interviews, the facility failed to provide written notification to the ombudsman of the transfer of 1 of 3 sampled residents (Resident #265) to the hospital. This practice had the potential to affect other residents discharged. Findings included: Resident #265 was originally admitted to the facility on 3/25/22. The annual minimum data set dated 3/26/24 indicated Resident #265 was cognitively intact. Review of the clinical records revealed Resident #265 was transferred to the hospital on 5/10/24 per his request and physician's order related to pain and discomfort in his bilateral lower extremities. The resident was subsequently admitted to the hospital. There was no documentation indicating a written notice of transfer was provided to the ombudsman. A telephone interview with the Ombudsman on 6/13/24 at 9:24 a.m. revealed she had not received any of the facility's May 2024's discharge summaries, including Resident #265's discharge to the hospital on 5/10/24.	F 623	F623 Facility submitted the list of discharges for May to the Ombudsman on June 13, 2024. Social Workers were educated on reporting discharges to the Ombudsman monthly on July 12, 2024, by the Administrator. This report must include resident name, date of transfer, and location. The Administrator will be copied on the monthly email to the Ombudsman. The Administrator or designee will audit the submission to the Ombudsman monthly for three months. This audit will allow the Administrator to confirm the discharge list was sent to the ombudsman timely and allow to confirm the list of discharges is accurate/complete. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 45 During an interview on 6/13/24 at 9:39 a.m., the facility's Director of Social Work stated that it was her responsibility to send the Ombudsman a monthly list of discharged residents with their locations. She explained she usually emailed the list on the last day of every month or the beginning of the next month. After reviewing her emails, the Director of Social Work acknowledged she had not sent the Ombudsman the list and notices of residents when discharged from the facility in the month of May 2024. The most recent email the Director of Social Work sent to the Ombudsman was on 4/11/24 of a list of residents discharged in March 2024.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to the Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 4 residents (Resident #174) reviewed for PASRR. The findings included: Resident #174 was admitted to the facility on 3/18/23 with a cumulative diagnosis which included paranoid schizophrenia. Resident #174's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 3/4/24. The Identification	F 641	F641 Resident #174's MDS assessment related to the Preadmission Screening and Resident Review Level II was amended. Residents residing in the facility that have a Level II PASRR have the potential to be affected. Social Services conducted an audit of residents with Level II diagnosis. MDS verified the MDS assessment was accurate based on PASSR level. These audits were conducted on July 12, 2024. On July 12, 2024, the MDS Coordinators were educated on accurately coding PASSR level II on the MDS assessment by the Regional Nurse Consultant. Any newly hired MDS staff will receive an	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 46 Information section of this MDS assessment did not report Resident #174 had a PASRR Level II determination. Further review of the resident's electronic medical record (EMR) revealed Resident #174's care plan included the following area of focus, in part: The resident has a Level II PASRR related to serious mental illness (Initiated 8/3/23; Revised 4/2/24). An interview was conducted on 6/13/24 at 10:35 AM with the facility's Director of Social Work (SW). Upon request, the Director of SW reviewed Resident #174's medical record and provided a copy of the resident's PASRR Level II Determination Notification letter dated 4/17/23. This letter confirmed Resident #174 was determined to have PASRR Level II status. An interview was conducted on 6/13/24 at 3:25 PM with the facility's on-site MDS Nurse (MDS Nurse #1). During the interview, the MDS Nurse reported she was only responsible to conduct the MDS assessments on newly admitted residents. She also stated the facility utilized remote nursing staff to complete the remainder of the residents' MDS assessments. An unsuccessful attempt was made on 6/14/24 at 9:40 AM to conduct an interview with the remote MDS Nurse (MDS Nurse #2) identified as having completed the Identification Information Section on the 3/4/24 MDS related to PASRR status for Resident #174. An interview was conducted with the facility's Director of Nursing (DON) on 6/14/24 at 12:55 PM. During the interview, the inaccurate reporting of Resident #174's PASRR status on	F 641	education in orientation by the Regional MDS Consultant. The Administrator or designee will audit 5 residents a week for twelve weeks ensuring that Level II PASSR has been captured on the MDS assessment. The Administrator will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 47 her 3/4/24 annual MDS assessment was discussed. In response, the DON indicated the resident's MDS assessment needed to be coded accurately.	F 641		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to submit a request for an evaluation for an updated Preadmission Screening and Resident Review (PASRR) determination 3 of 4 residents (Resident #37, Resident #102 and Resident #103) reviewed for PASRR. Resident #37, Resident #103 and Resident #102 received a new mental health diagnosis following admission.	F 644	F644 Resident #37, #102 and #103 PASSR Level II evaluation was completed. Social Services completed an audit of residents with Level II diagnosis on July 12, 2024. Anyone found requiring a Level II PASSR was submitted for evaluation. On July 11, 2024 Social Services was educated by the Administrator on submitting a request for evaluation for an	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 644

Continued From page 48

The findings included:

1. Resident #37 was originally admitted to the facility on 3/29/23 and re-admitted on 8/25/23 with diagnoses that included traumatic brain injury (TBI), dementia with agitation and major depressive disorder. Upon re-admission, Resident #37 had a Level I PASRR number.

Review of Quarterly Minimum Data Set (MDS) assessment dated 8/30/23 revealed Resident #37 was cognitively intact. The MDS further revealed the resident had no behaviors during the look back period.

Nursing note dated 10/19/23 and authored by Nurse # 11 revealed Resident #37 had increased agitation. Further review of the nursing note revealed Situation, Background and Assessment (SBAR) for providers. The situation stated a change in condition were behavioral symptoms to include agitation and psychosis.

Nursing progress note dated 11/8/23 and authored by Nurse #2 revealed Resident #37 was having behaviors of hallucination and being aggressive because of the hallucinations. The note continued with orders to refer the resident to psychiatry, give 1 time dose of Haldol (an anti-psychotic medication) 1 milligram (mg) and lab work to include complete blood count (CBC), comprehensive metabolic panel (CMP).

Physician order dated 11/8/23 stated Haloperidol tablet 1mg. Give 1 tablet by mouth one time only for mood/aggressive behaviors until 11/8/23.

Behavior note dated 2/19/24 and authored by Nurse #6 revealed Resident #37 was noted being

F 644

updated Preadmission Screening and Resident Review. Social Workers are responsible for obtaining and initiating the PASSR evaluation.
The Administrator or designee will conduct an audit of 10 residents with mental health diagnosis weekly for eight weeks to ensure the PASSR Level II has been submitted for evaluation.
The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 49 aggressive with a visitor. Physician order dated 2/19/24 revealed Haloperidol lactate injection solution 5mg/ml (milliliter). Inject 2.5mg intramuscularly (IM) one time only for agitation and aggressiveness for 1 day. Care Plan dated 3/4/24 revealed Resident #37 had the potential to be verbally aggressive (resident hit/punching others) related to dementia, ineffective coping skills, mental/emotional illness, poor impulse control and resident had a history of Post Traumatic Stress Disorder (PTSD). The goals included Resident #37 would demonstrate effective coping skills and Resident #37 would verbalize understanding of need to control verbally abusive behavior. The interventions included psychiatric/psychogeriatric consult as indicated and when the resident became agitated intervene before agitation escalates; bide away from source distress, engage calmly in conversation; if response is aggressive staff to walk calmly away and approach later. Behavior note dated 3/3/24 and authored by Nurse #9 revealed the Resident #37 made inappropriate sexual remarks to the Medication Aide and verbalized delusional thoughts regarding implants in his ear and being ambushed by a family member. Quarterly MDS assessment dated 3/14/24 indicated Resident #37 was cognitively intact, had no behaviors during the look back period and had a diagnosis that included Post Traumatic Stress Disorder. Behavior note dated 5/24/24 and authored by	F 644		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 50 Nurse #10 revealed Resident #37 went into two resident rooms and demanded the residents turn their tv's off. Resident #37 was educated that he could not go into other residents' rooms. The note continued with Resident #37 began swinging his cane in the hallway towards the resident in one of the rooms. Resident #37 was informed he could not use his cane to hit another person or swing it toward anyone in the facility. Resident #37 then called the nurse a racial slur and began swinging his cane towards the nurse. The nurse was able to get the cane and escorted Resident #37 back to his room. The Assistant Director of Nursing (ADON) was made aware. Nursing note dated 5/28/24 and authored by Nurse #2 started the nurse had spoken with Resident #37's family about his verbal and physical aggression towards staff and resident. A new order was received for Ativan 3 times a day (TID). Patient centered care follow note dated 5/28/24 revealed Resident #37 was seen for an acute visit due to nursing staff complaint of agitation. Resident #37 stated he had been feeling more agitated lately. There were no new recommendations identified on the follow up note. Review of SBAR Summary for providers dated 6/2/24 and authored by Nurse #4 indicated a change in condition that was identified as behavioral symptoms to include agitation and psychosis. The note continued with nursing observations, evaluation and recommendations were Resident #37 was observed being verbally aggressive with staff. Charged staff member resulting in loss of balance and fall without injury. Resident continued verbally aggression shortly	F 644		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 51	F 644		

after occurrence. The on-call Nurse Practitioner (NP) indicated to send resident to emergency room (ER) for evaluation. The recommendations stated send Resident #37 to ER for evaluation following combative/aggressive behavior.

Review of Resident #37's medical record revealed a new application for PASRR had not been completed after the resident was diagnosed with PTSD and demonstrated a change in behaviors.

Interview with the Social Worker on 6/13/24 at 11:00 am revealed she was responsible for submitting information to North Carolina Medicaid Uniform Screening Tool (NC MUST-an online platform used to complete PASRR applications) when a resident experienced a change in condition regarding behaviors that may be associated with mental illness. She further indicated she had a number of residents during her audit that were in need of being screened or re-screened. She indicated she was aware of an increase in behaviors with Resident #37 and indicated with his change in condition he would need to be screened to determine if there would be a change in his PASRR I status.

In a continued interview with the Social Worker on 6/13/24 at 11:20 am indicated Resident #37 was not identified during her audit and had not had a request for screening by PASRR. She further stated she must have missed him during her audit.

Interview with the Director of Nursing (DON) on 6/13/24 at 3:18 pm revealed the Social Woker was responsible for notifying NC MUST of residents that had a change in condition to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 52	F 644		

establish a new PASRR level.

2. Review of Resident #102's medical record revealed documentation of a Level I PASRR determination dated 6/22/18 prior to his admission on 11/8/21. His admission diagnoses included dysphagia and hypertension.

A diagnosis of schizoaffective disorder was added on 11/1/23. Further record review did not indicate a referral for a Level II PASRR review had been made.

An interview with the Social Worker on 6/13/24 at 2:01PM revealed that she was not aware of Resident #102 had a change of diagnosis.

An interview with the Administrator on 6/14/24 at 10:40 AM revealed a new diagnosis of paranoid schizophrenia or schizoaffective disorder should be triggered for a new PASRR evaluation. She indicated that she had started an audit to make sure that the PASRR was getting done by the Social Worker. She stated maybe the audit was not as effective as she thought since one of the residents was missed by the audit.

3. Review of Resident #103's medical record revealed documentation of a Level I PASRR determination dated 7/21/17 prior to his admission on 12/17/21. His admission diagnoses included anxiety, depression, respiratory failure and diabetes mellitus.

A diagnosis of paranoid schizophrenia was added on 8/1/23. Further record review did not indicate a referral for a Level II PASARR review had been made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 53 An interview with the Social Worker on 6/13/24 at 2:01PM revealed that Resident #103 had the new diagnosis of paranoid schizophrenia and corporate had directed her to refer for a new PASRR. She revealed that the new diagnosis was on 8/1/23 and it should have already been referred. She indicated that she had the stack of referrals on her desk, she was the only person with the PASRR logon, and she was behind. An interview with the Administrator on 6/14/24 at 10:40 AM revealed a new diagnosis of paranoid schizophrenia or schizoaffective disorder should be triggered for a new PASRR evaluation. She indicated that she had started an audit to make sure that the PASRR was getting done by the Social Worker. She stated maybe the audit was not as effective as she thought since one of the residents was missed by the audit.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 657

Continued From page 54

medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews the facility failed to involve the resident and/or resident representative in the care planning process for 1 of 1 sampled resident (Resident #94) reviewed for care plan participation.

The findings included:

Resident #94 was admitted on 2/14/24 with diagnoses in part, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and major depression.

Review of the admission Minimum Data Set (MDS) assessment dated 2/21/24 revealed Resident #94 was assessed as cognitively intact

Review of the Social Worker Note dated 2/21/24 and authored by Social Worker Assistant #2 indicated Resident #94 was assessed as alert and oriented to self, place, time and situation. The resident was able to make needs known to staff without issue. Resident #94 was assessed as cognitively intact. The resident would remain in the facility for Long Term Care (LTC) Services.

F 657

F657
Resident #94's care plan meeting was completed.
All residents have the potential to be affected by the deficient practice.
Education was completed with the Social Services staff on scheduling and inviting residents and/or responsible parties to care plan meetings.
The Administrator will conduct an audit with 10 residents for 4 weeks, then 5 residents for 8 weeks to ensure care plans are being conducted and the resident and/or responsible party has been invited.
The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 55	F 657		

SW will continue to monitor.

Review of the resident's care plan (completion date) 3/18/24 revealed the resident was care planned for activities of daily living (ADLs), nutrition, falls, risk for pressure ulcers, discharge planning and other medical conditions.

A record review of the Quarterly MDS assessment dated 5/14/24 revealed Resident #94 was assessed as cognitively intact and was dependent on staff for ADL care.

During an interview on 6/10/24 at 10:09 AM, Resident #94 indicated he was not invited to participate in the care plan meeting for the past 4 months. He further indicated he had not recalled participating in developing his plan of care.

During an interview on 6/12/24 at 11:00 AM, the Social Worker Assistant #2 stated the resident's base line care plan was completed on the phone with the resident's representative on 2/16/24. The resident's representative was the responsible party and emergency contact #1. The resident was also present and requested his representative for attendance. Resident #94's discharge planning was discussed, and he was a long-term care resident. The Social Worker Assistant #2 stated usually after the base line care plan meeting, a comprehensive care plan meeting was completed in 5 days. During the comprehensive care plan meeting team reviewed the care plan to see if there were any changes. The resident and/or resident representative was invited to participate in the care plan. The Social Worker Assistant #2 further stated that the resident's comprehensive care plan meeting with the resident and/or resident's representative was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 56	F 657		

missed and there was no care plan meeting completed. The Social Worker Assistant #2 stated she was in contact with Resident #94's representative regarding the care plan meeting for the quarterly MDS assessments. The care plan meetings were done face to face or Virtual (over phone or online) based on their preferences and convenience.

During an interview on 6/12/24 at 11:10 AM, the Social Worker Director stated the resident's admission MDS assessment was completed on 2/21/24. The resident's quarterly assessment was completed on 5/14/24. She indicated the Social Worker Assistant #2 was in the process of scheduling the quarterly assessment care plan meeting with Resident #94's representative. The Social Worker Director stated she goes by the date of MDS assessment and the letters to residents and resident's family members were sent out based on the MDS calendar. The Social Worker Director further stated she usually mailed out the care plan meeting letters. She indicated she had not recollected sending out the letter for comprehensive care plan meeting to the family or the resident. Social Worker Director stated the admission staff scheduled the baseline care plan meeting for the resident and/or representative. She further stated the Social Worker department was responsible for scheduling and conducting the comprehensive and other care conferences.

During an interview on 6/12/24 at 4:09 PM, the Administrator stated the expectation was that care plan meetings and notifications were completed per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 57 and quarterly assessments. She further stated residents and/or resident representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out by social services for care plan meeting and accommodate the meeting based on families' convenience as much as possible.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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; This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, and resident interviews, the facility failed to provide (1) incontinence care to a resident dependent on staff. The facility also (2) failed to provide nail care to a resident who was dependent on staff. This occurred for 2 of 2 residents (Resident #209 and Resident #14) reviewed for activities of daily living (ADL) care. Findings included: 1. Resident #209 was admitted to the facility on 5-14-24 with multiple diagnoses that included enterocolitis and diabetes. The 5-day Minimum Data Set (MDS) dated 5-14-24 revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting. The MDS also documented Resident #209 was frequently incontinent of urine and always incontinent of bowel.	F 677	F677 Resident #209 had peri care performed and was placed in a brief. Resident #14 had their nails cleaned. All residents have the potential to be affected by the deficient practice. Unit Managers conducted audits on incontinent residents for peri care. Unit Managers also conducted audits on residents for nail care and linens. Residents with a preference of long nails were care planned. The nursing clinical staff including but not limited to the certified nurses aides, certified medication aides, were educated by the Nursing Administrative leadership team regarding "ADL care for dependent residents". The nursing clinical staff including but not limited too the certified nursing aides, certified medication aides, that do not receive education by July 17,	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 677

Continued From page 58

Resident #209's care plan dated 5-23-24 revealed the resident had an activities of daily living (ADL) deficit due to enterocolitis and diabetes. The goal for Resident #209 was to improve the current level of ADL function. The interventions were one staff assist for personal hygiene and toileting. Resident #209 also had an intervention for two staff to assist the resident with transfers.

Resident #209 was interviewed on 6-10-24 at 11:25am. Resident #209 was observed to be tearful and stated she had been laying in a soiled and urine saturated brief since 8:15am. The resident explained she had put her call light on at 8:15am (stated she knew it was 8:15am because she looked at the clock on the wall) and asked NA #8 to be changed. She stated NA #8 told her she had to wait because the breakfast trays were arriving on the unit. Resident #209 said she told NA #8 again when she delivered her tray that she needed changed and stated NA #8 told her she would get changed after breakfast. Resident #209 discussed not receiving incontinence care since the night before. She stated she still had not been changed. There was a strong urine odor observed in Resident #209's room. The resident was observed to put her call light back on for assistance.

Observation of incontinence care occurred on 6-10-24 at 11:33am with NA #4. During the observation, Resident #209 was observed to have 3 briefs and another brief was laid flat under her. It was observed that Resident #209's bowel movement and urine had seeped through all 3 briefs, the draw sheet, the cotton pad, and the fitted sheet. There were areas on the draw sheet,

F 677

2024, will not be able to work until the education is complete. Newly hired nursing clinical staff including but not limited to certified nurses aides, certified medication aides, will receive an education in orientation.
The Director of Nursing or designee will conduct audits on 10 dependent residents for four weeks, then 5 residents for eight weeks to ensure incontinent care and nail care has been provided.
The Administrator will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

F 677 Continued From page 59 F 677

cotton pad, and fitted sheet that had dark yellow rings and on Resident #209's skin there were areas where her bowel movement had dried to her skin. The resident's skin was intact with no redness.

NA #4 was interviewed on 6-10-24 at 11:44am. The NA explained she had come into work late, so she had not completed initial rounds on her assigned residents. She confirmed Resident #209 was assigned to her. NA #4 stated NA #8 had not informed her when she arrived that Resident #209 needed to be changed. When discussing the condition of Resident #209, NA #4 discussed that it was not normal practice to see 3 briefs on a resident and that due to the drying of urine and dried feces, NA #4 said she did not think the resident had been changed since the night before. NA #4 explained staff could change residents even when trays were being delivered and did not know why Resident #209 had not received incontinence care.

During an interview with NA #8 on 6-10-24 at 11:50am, NA #8 explained the NA assigned to Resident #209 had come to work late so initial rounds were not completed on the resident. She stated at 8:15am, Resident #209 had put her call light on but said the resident never informed her she needed to be changed. When asked, NA #8 could not state what activity she provided the resident or what the resident wanted at 8:15am when she answered her call light. She also stated when she provided Resident #209 with her breakfast tray, the resident never told her she needed to be changed.

A telephone interview occurred with NA #9 on 6-12-24 at 7:30am. The NA confirmed she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 60 been assigned to Resident #209 on 6-9-24 during the 11:00pm to 7:00am shift. NA #9 explained she had usually changed Resident #209 every hour because "she urinates a lot." She stated she had last changed Resident #209 between 6:00am and 6:30am on 6-10-24. NA #9 discussed Resident #209 asked for 2 briefs, but the NA stated she placed one brief on the resident and laid another one down flat under the resident. NA #9 stated she had not placed 3 briefs on the resident. The Director of Nursing was interviewed on 6-12-24 at 2:37pm. The DON discussed staff receiving yearly training on incontinence care. She stated staff were able to provide incontinence care if the meal trays were on the unit but that she would expect them to wash their hands prior to passing the trays. The DON discussed Resident #209 and stated no resident should have to eat their meal in a soiled and wet brief and should have been provided incontinence care when requested. She also stated it was not the facilities policy to apply more than one brief to a resident. The DON explained if the resident requested more than one brief, the resident would be care planned for more than one brief. The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed it not being appropriate for a resident to have on more than one brief but also said she felt this may have been a one-time occurrence. She stated if Resident #209 urinated frequently, then she would expect the resident to be care planned for more frequent visits. The Administrator stated Resident #209 should have been provided incontinence care when requested and not have to eat her meal in a soiled, wet brief.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 61	F 677		

2. Resident #14 was admitted to the facility on 8-17-23 with multiple diagnoses that included hemiplegia and hemiparesis affecting non-dominant side.

The quarterly Minimum Data Set dated 5-3-24 revealed Resident #14 was moderately cognitively impaired and was dependent on staff for bathing and personal hygiene. The MDS did not document any rejection of care.

Resident #14's care plan dated 5-11-24 revealed an ADL deficiency related to hemiplegia. The goal for Resident #14 was to maintain her current level of function. The interventions for the goal included total staff participation in personal hygiene and bathing.

Resident #14 was observed and interviewed on 6-10-24 at 1:12pm. Resident #14 discussed having a bath this morning by staff however during the observation of the resident, her fingernails were observed to have a brown substance caked under her nails, her gown had dried food particles, and her fitted sheet had holes and dried food.

Observation and interview with Resident #14 occurred on 6-11-24 at 11:09am. Resident #14 discussed hospice providing her a bath this morning. Upon observation, Resident #14 was observed to have a brown substance caked under her fingernails.

An observation of ADL care with Resident #14 occurred on 6-12-24 at 9:41am with Nursing Assistant (NA) #11. Resident #14's skin was observed to be intact with no redness. NA #11 was observed not to clean Resident #14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 62 fingernails. NA #11 was interviewed on 6-12-24 at 9:57am. NA #11 discussed the steps she took providing a bath to a dependent resident. The NA stated she usually provided nail care to her dependent residents, but she had become nervous and forgot to perform nail care on Resident #14. The Director of Nursing (DON) was interviewed on 6-12-24 at 2:37pm. The DON discussed the training for the NAs regarding bathing and stated nail care was part of the bathing process. She stated between the facility staff and hospice, Resident #14 should not have gone without her nails being cleaned for 2 days. The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed staff having "tunnel vision" when they are bathing a resident and forget that nail care was part of a bath. She stated she expected staff to look at the whole resident not just limbs and torso.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 695	F695	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 63 interview the facility failed to have cautionary signage for oxygen (O2) use for 1 of 2 residents (Resident #176) reviewed for respiratory care. The findings included: Resident #176 was admitted to the facility on 4/9/24 with a diagnosis that included chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) assessment dated 4/15/24 revealed Resident #176 was cognitively intact. She was further coded as receiving oxygen therapy. Review of Resident #176 physician order dated 4/10/24 stated oxygen continuously at 3 liters per minute (lpm) via nasal cannula for COPD. Observation on 6/10/24 at 10:29 am revealed Resident #176 to be in her room with O2 being delivered via nasal cannula. There was no cautionary signage observed to the entrance of Resident #176's room indicating the use of O2. Observation on 6/11/24 at 4:26 pm revealed Resident #176 to be in her room with O2 being delivered via nasal cannula. There was no cautionary signage indicating the use of O2. Interview and observation with Nurse #8 on 6/11/24 at 4:30 pm revealed she was assigned to Resident #176. She stated that Residents that received O2 were to have signage that identified O2 was in use on the outside of the their bedroom door. Upon observation of Resident #176's room door she confirmed it did not have O2 signage. She further stated that she was unsure if it was maintenance department or the	F 695	Cautionary signage for oxygen was placed on the door of resident #176 room on June 14, 2024. Residents receiving oxygen therapy have the potential to be affected by the deficient practice. Unit Managers completed an audit of residents with orders for oxygen therapy and ensured a sign was placed on the door. The initial audit was performed during the week of July 12, 2024. Education was completed with nursing staff regarding the requirement of oxygen signage on the door of residents receiving oxygen therapy. Any nursing staff that does not receive the education by July 17, 2024, will not be able to work until education is completed. Newly hired clinical staff will receive the education in orientation. Any "newly admitted" residents requiring oxygen will be reviewed by the clinical IDT team and at this time, auditing for oxygen signage will be reviewed and compliance checked. This will be performed within 24/48 hours of admission to the facility. The respiratory therapist or designee will audit 10 residents for four weeks, then 5 residents for 8 weeks that require oxygen therapy to ensure oxygen signage is in place. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 64 Unit Supervisor who would place cautionary signage indicating the use of O2. Interview with Unit Supervisor on 6/12/24 at 11:45 pm revealed there was no cautionary signage on Resident #176's door indicating the use of O2 until she had noticed the signage was missing on 6/12/24. She stated she was told by the Director of Nursing (DON) 6/12/24 to check for cautionary signage for O2 which was when she identified Resident #176's was missing. The Unit supervisor indicated Resident #176 had been recently moved to room 208 from 212 about a month ago. Interview with the Director of Nursing (DON) on 6/13/24 at 3:18 pm revealed cautionary signage regarding the use of O2 should be placed on residents' doors that require O2. Resident #176 was on O2 and should have had cautionary signage. It was the responsibility of the admissions nurse or the floor nurse to ensure cautionary signage was posted for residents who utilized O2.	F 695	needed.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to ensure a resident attended an infectious disease clinic appointment at an outside facility for 1 of 1 sampled resident reviewed for medically related social services	F 745	F745 Resident #616 has been discharged from the facility. Residents requiring appointments outside the facility have the potential to be	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 65	F 745		

(Resident #616).

The findings included:

Resident #616 was admitted on 02/29/24 with diagnoses that included pneumonia, diabetes, latent tuberculosis, and chronic kidney disease.

Review of Resident #616's hospital discharge summary 02/29/24 revealed an infectious disease clinic appointment scheduled for 03/11/24.

Resident #616's admission Minimum Data Set (MDS) assessment dated 03/13/24 revealed she was cognitively intact.

There was no evidence in the medical record that Resident #616 attended her 03/11/24 infectious disease clinic appointment scheduled for 03/11/24 as noted on the hospital discharge summary.

The medical record indicated Resident #616 was discharged from the facility on 03/13/24.

A phone interview was conducted on 06/10/24 at 10:20 AM with Resident #616 and she stated she was informed the transportation van was not working the morning of 03/11/24 and her appointment would be rescheduled. She stated she was not rescheduled for her infectious disease clinic appointment prior to her discharge to the hospital on 03/13/24.

An interview was conducted with the Resident Appointment Coordinator on 06/13/24 at 3:00 PM. She stated Resident #616's appointment was on her transportation schedule for 3/11/24 and she verified the infectious disease clinic appointment

affected by the deficient practice.
Resident records were reviewed for the last 30 days to verify appointments were scheduled and completed.
Appointment scheduler, social services and unit managers were educated on scheduling medically related social services appointments and ensuring the resident makes it to the appointment if they so wish. Newly hired appointment schedulers, social services and unit managers will be educated during their orientation.
The Director of Nursing or designee will conduct an audit three times a week for four weeks, then twice a week for eight weeks to ensure that residents are scheduled for appointments as ordered. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 66 was missed. She reported the transportation van wheelchair lift malfunctioned the morning of 03/11/24 and they could not use it to transport residents. She stated the other transportation van was being used to transport dialysis residents that morning. The Resident Appointment Coordinator stated she usually called the same day or next day to reschedule a missed appointment. She explained sometimes she was not able to reschedule within a day or two because she helped escort residents to appointments. The Resident Appointment Coordinator said Resident #616 was not rescheduled for her infectious disease clinic appointment before she was discharged to the hospital on 3/13/24. An interview was conducted with the Administrator on 06/14/24 at 2:00 PM. The Administrator stated the Resident Appointment Coordinator should have rescheduled the appointment in a timely manner.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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(g). 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.	F 755		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 67 §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, interviews with a representative from the dispensing pharmacy and facility staff, and record reviews, the facility failed to ensure a medication (a topical anti-fungal powder) was available for application as ordered by a physician, resulting in multiple doses of the prescribed medication being missed for 1 of 4 residents (Resident #416) observed during the medication administration observation. The findings included: Resident #416 was discharged from a hospital to the facility on 5/30/24 with a diagnosis which included cirrhosis of the liver. His hospital Discharge Medication List (dated 5/30/24) indicated Resident #416 should discontinue use of 250 milligram (mg) terbinafine (an oral antifungal medication) previously taken and initiate the use of 2 percent (%) miconazole	F 755	F755 Resident #416 miconazole was discontinued on 6/12/24. No new order was issued by the provider. Residents residing in the facility have the potential to be affected by the deficient practice. Unit Managers audited medication marked as not available and placed the order on July 11, 2024. The physician was made aware. Nurses and med aides were educated on medication availability by the Staff Development Coordinator, Director of Nursing and Unit Managers. Nurses or med aides that have not received the education by July 17, 2024, will not be able to work until they have received the education. Newly hired nurses and med aides will receive the education in orientation by the Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 755

Continued From page 68

powder (a topical antifungal medication) to be applied topically two times daily.

The resident's admission orders to the facility included a medication order dated 5/30/24 for 2% miconazole powder to be topically applied to folds of the skin twice daily for dry skin (Start Date 5/31/24). The order was created and confirmed by Nurse #3 on 5/30/24. Further review of Resident #416's electronic medical record (EMR) included a 5/30/24 Admitting Daily Skin Assessment which reported the resident had "Dry skin to feet..." An Admission Data Collection Note (also dated 5/30/24) included a notation which indicated the resident had "Bruising to arms and hands, dry skin all over."

On 6/12/24 at 9:53 AM, Nurse #3 was observed as she prepared and administered five oral medications to Resident #416. At that time, the nurse reported she knew this resident's miconazole powder was not available on the medication (med) cart for administration because it had not yet been delivered by the pharmacy. A follow-up interview was conducted on 6/12/24 at 10:10 AM with Nurse #3. During the interview, the nurse further explained that since she could not apply the miconazole powder as ordered for Resident #416, she made notations on the resident's Medication Administration Record (MAR) to indicate the medication was not available.

A review of Resident #416's May 2024 and June 2024 MARs revealed the resident's miconazole was scheduled to be applied at 9:00 AM and 9:00 PM each day in accordance with the physician's orders. However, the MARs also documented the miconazole was not applied as ordered on 20

F 755

Coordinator.
The Unit Managers or designee will conduct an audit of 10 residents for four weeks, then 5 residents for eight weeks to ensure medications are available and not being marked as unavailable.
The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 69 occasions between 5/31/24 and 6/12/24. The resident's EMR and pharmacy orders were reviewed on 6/12/24 at 10:48 AM. At that time, the physician's order for 2% miconazole topical powder was listed as an "Active" order for Resident #416 and its status was reported as "On Order." An interview was conducted on 6/12/24 at 4:05 AM with the facility's Central Supply clerk. During the interview, the Central Supply clerk reported she was not aware that an over the counter antifungal powder was ordered for Resident #416 until that morning (6/12/24) when the Unit Manager (Nurse #2) came to the Central Supply to request it. The Central Supply clerk confirmed the medication requested was an over the counter (OTC) medication and reported she had a similar antifungal powder in stock that may be used as an alternative (with a physician's order). An inquiry was made as to what the facility's process was for an OTC medication to be sent up to the floor. In response, the Central Supply clerk stated as soon as the order was received for an OTC medication, the nursing staff was supposed to notify her so she could have it brought up to the floor. If that medication was not in the Central Supply stock, the clerk stated she would attempt to acquire it from a local retail pharmacy. However, the clerk reiterated that she relied on the nursing staff to notify her of the need for an OTC medication so she could be certain the product was available for the resident. A telephone interview was conducted on 6/14/24 at 10:10 AM with a representative from the facility's contracted dispensing pharmacy. During the interview, the representative reported, "All	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 70 facilities know we do not provide OTC medications." The representative added that normally the facilities knew what they had in stock and stated, "They should know what is OTC." She reported the dispensing pharmacy would not call a facility to remind them that an OTC medication was not going to be provided by the pharmacy. However, the representative added, "We would document if there had been an inquiry by the facility" about whether a medication would be sent out by the pharmacy. Upon request, the representative checked to see if the facility had made an inquiry about Resident #416's miconazole not being delivered since it was ordered on 5/30/24. She stated there was no documentation of an inquiry being made by the facility. An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. At that time, the DON and Administrator were also informed of the facility's failure to obtain an OTC antifungal product ordered by the physician for a newly admitted resident (Resident #416). A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. During the interview, the DON stated she would expect nursing staff to call the dispensing pharmacy if a medication ordered was not received so if that medication was an OTC product, the facility could acquire it on their own.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 71 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff and consultant pharmacist interviews and record reviews, the facility failed to	F 756	F756 Resident #97's prn diazepam was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 72 act on recommendations made by the consultant pharmacist and retain documentation of the physician's review and response to the pharmacist's findings / recommendations in the resident's medical record for 1 of 7 residents whose medications were reviewed (Resident #97). The findings included: Resident #97 was admitted to the facility on 10/26/21. Her cumulative diagnoses included an adjustment disorder with anxiety. A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for diazepam (an antianxiety medication). Diazepam is a psychotropic medication and a controlled substance medication. --A physician's order was received on 11/10/23 for 5 milligram (mg) diazepam to be given as one tablet by mouth every 8 hours as needed (PRN) for anxiety. The order was discontinued on 12/6/23. --On 12/12/23, 5 mg diazepam was ordered to be given by mouth every 8 hours PRN for anxiety and/or muscle relaxant. This order was discontinued on 12/19/23. --A physician's order was received on 12/19/23 for 5 milligram (mg) diazepam (an antianxiety medication) to be given as one-half tablet (2.5 mg) by mouth scheduled twice daily for anxiety. --On 2/23/24, an order was received for 10 mg diazepam to be given as one tablet by mouth every 8 hours as needed for crying and/or anxiety. There was no end date or rationale documented for this PRN diazepam order to be extended beyond 14 days.	F 756	discontinued on 6/13/24. Residents residing in the facility have the potential to be affected by the deficient practice. Unit Managers completed an audit of pharmacy recommendations for the last 30 days for follow through/completion. Initial audit was completed during the week of July 12, 2024 and validated. The director of nursing provided education to the nurse management team regarding acting on recommendations made by the pharmacist and retaining the documentation. Any newly hired nurse management will be educated during the orientation process. Monitoring to ensure the deficient practice does not reoccur: The Director of Nursing or designee will audit 20 residents monthly for three months to validate pharmacy recommendations have been completed and uploaded to EHR. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 73	F 756		

--The order for the 2.5 mg of scheduled diazepam given twice daily was discontinued on 3/22/24 and another order was received on 3/22/24 for 5 mg of diazepam to be given as one tablet by mouth scheduled twice a day for anxiety.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/16/24. Resident #97 was reported to have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #97 received an antianxiety medication during the 7-day look back period.

Resident #97's EMR indicated the physician's orders for both the scheduled diazepam (ordered on 3/22/24) and the PRN diazepam (ordered on 2/23/24) continued as active orders up through the date of the review on 6/12/24. A review of Resident #97's Medication Administration Records (MARs) revealed eight (8) doses of PRN diazepam were administered to the resident from 2/23/24 through the date of the review (6/12/24). The last dose of PRN diazepam was documented as having been administered on 6/7/24.

The resident's EMR also included Pharmacist Reviews / Visit Progress Notes completed by the consultant pharmacist each month from August 2023 to May 2024 on the following dates: 8/31/23; 9/30/23 10/30/23; 11/29/23; 12/30/23; 1/30/24; 2/29/14; 3/30/24; 4/30/24; and 5/31/24. Each of these monthly notes read: "MRR [Medication Regimen Review] completed: Medical Record Reviewed including: orders, available labs, progress notes. See consultant pharmacist report for consult on any noted irregularities and/or recommendations."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 74 A request was made for the facility to provide the consultant pharmacist reports with the noted irregularities and/or recommendations made for Resident #97 from August 2023 up to the date of the review (6/12/24). The facility provided two pharmacist reports (Consultant Pharmacist Medication Regimen Reviews) for Resident #97. Only one report (dated 2/29/24) was related to the PRN diazepam ordered for Resident #97. The Consultant Pharmacist Medication Regimen Review dated 2/29/24 noted the pharmacist made a recommendation to Psychiatry which read, "PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order." This recommendation was signed by a Nurse Practitioner (NP) on 3/21/24 with a response that read: "Continue current dose of diazepam 10 mg q 8 hrs (every eight hours) PRN for anxiety." Neither the duration of the order nor the clinical rationale for continuation of the PRN diazepam were addressed in the provider's response. The NP who responded to the pharmacist's 2/29/24 recommendation related to PRN diazepam use for Resident #97 was not available for an interview and no longer worked at the facility. A telephone interview was conducted on 6/13/24 at 3:23 PM with the facility's consultant pharmacist. During the interview, the pharmacist confirmed she had made multiple recommendations to address the use of Resident #97's PRN diazepam over the last several months. The pharmacist was also informed of a concern regarding the facility's failure to retain the	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 75	F 756		

pharmacist's Consult Reports and/or provider responses. She stated that all the pharmacist's recommendations (without the physician's responses) were available for review within the facility via a connection with the pharmacy's software. The pharmacist reported she typically encouraged each of her facilities to give one copy of the pharmacy recommendations to the provider while they kept a second copy in a binder. After the provider returned a signed response for the recommendation, one copy should be scanned into the resident's permanent medical record with another copy replacing the unsigned recommendation in the binder.

On 6/14/24 at 9:14 AM, additional documentation was provided by the consultant pharmacist for review. The documents included three (3) Consultant Pharmacist Medication Regimen Reviews with recommendations related to Resident #97's PRN diazepam. These three Consultant Pharmacist Medication Regimen Reviews had not been previously provided by the facility. Neither the resident's EMR nor the facility provided documentation to show Resident #97's physician reviewed or responded to the following Consultant Pharmacist Medication Regimen Reviews:
--On 11/30/23, the pharmacist made a physician recommendation which noted, "PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order."
--On 1/31/24, a recommendation was made to Psychiatry which read, "PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 76 to continue, please document a clinical rationale and a duration for the PRN order." --On 5/31/24, a recommendation was again made to Psychiatry which read, "PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order." An interview was conducted on 6/14/24 at 12:50 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she was aware that orders for PRN psychotropic medications required a stop date. The DON also stated that she was now aware that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic meds) for an extended duration.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 77 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN	F 758	F758 Resident #97 currently has an order for Diazepam 5mg given twice daily for anxiety on 3/22/24. Resident #28's prn haloperidol has been discontinued on 6/13/24. Residents receiving psychotropic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 78 order to be extended beyond 14 days, when appropriate. This occurred for 2 of 7 residents whose medications were reviewed (Resident #97 and Resident #28). The findings included: 1. Resident #97 was admitted to the facility on 10/26/21. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and adjustment disorder with anxiety. A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for diazepam (an antianxiety medication). Diazepam is a psychotropic medication and a controlled substance medication. --A physician's order was received on 11/10/23 for 5 milligram (mg) diazepam to be given as one tablet by mouth every 8 hours as needed (PRN) for anxiety. The order was discontinued on 12/6/23. --On 12/12/23, 5 mg diazepam was ordered to be given by mouth every 8 hours PRN for anxiety and/or muscle relaxant. This order was discontinued on 12/19/23. --A physician's order was received on 12/19/23 for 5 milligram (mg) diazepam (an antianxiety medication) to be given as one-half tablet (2.5 mg) by mouth scheduled twice daily for anxiety. --On 2/23/24, an order was received for 10 mg diazepam to be given as one tablet by mouth every 8 hours as needed for crying and/or anxiety. There was no end date or rationale documented for this PRN diazepam order to be extended beyond 14 days. --The order for the 2.5 mg of scheduled diazepam given twice daily was discontinued on 3/22/24 and	F 758	medications on a as needed basis have the potential to be affected by the deficient practice. Unit managers audited residents with as needed psychotropics to ensure a stop date was in place on July 12, 2024. Education was provided to the nurses regarding the need for prn psychotropics to have a 14-day duration unless there is indication and documentation by the NP/MD to extend beyond 14 days. This education was provided by the Staff Development Coordinator, Unit Managers and Director of Nursing. Education was conducted during the week of July 12, 2024. All newly hired nursing personnel will also receive education upon hire during orientation. Unit Managers or designee will audit 10 residents a week for four weeks, then 5 residents a week for eight weeks to ensure psychotropics ordered on a as needed basis are limited to 14 days or indicate the rationale for the PRN order to be extended beyond 14 days, when appropriate. The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 79	F 758		

another order was received on 3/22/24 for 5 mg of diazepam to be given as one tablet by mouth scheduled twice a day for anxiety.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/16/24. Resident #97 was reported to have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #97 received an antianxiety medication during the 7-day look back period.

Resident #97's EMR indicated the physician's orders for both the scheduled diazepam (ordered on 3/22/24) and the PRN diazepam (ordered on 2/23/24) continued as active orders up through the date of the review on 6/12/24. A review of Resident #97's Medication Administration Records (MARs) revealed eight (8) doses of PRN diazepam were administered to the resident from 2/23/24 through the date of the review (6/12/24). The last dose of PRN diazepam was documented as having been administered on 6/7/24.

A telephone interview was conducted on 6/13/24 at 3:23 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she had made multiple recommendations to address the use of Resident #97's PRN diazepam on each of the following dates: 11/30/23, 1/31/24, 2/29/24, and 5/31/24. Each recommendation read, in part, "PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order."

An interview was conducted on 6/14/24 at 12:50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 80	F 758		

PM with the facility's Director of Nursing (DON). During the interview, the DON reported she was aware that orders for PRN psychotropic medications required a stop date. The DON also stated that she was now aware that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic meds) for an extended duration.
2. Resident #28 was admitted to the facility on 7/7/23 with diagnoses including dementia, repeated falls, major depressive disorder, and chronic diastolic heart failure.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/24/24. Resident #28 was severely cognitively impaired and there were no behavior concerns during the 7-day look back period. The medication section showed that she received an antipsychotic medication (type of psychotropic medication).

A review of Resident #28's electronic medical record (EMR) revealed a physician's order dated 5/8/24 for Haloperidol oral tablet 2 mg, give 1 tablet every 6 hours as needed for agitation. Haloperidol is a psychotropic medication. There was no end date documented for this medication. The Nurse Practitioner wrote this order.

A review of Resident #28's May and June 2024 medication administration records revealed she had received a dose of Haloperidol 2 mg on 5/9, 5/11, 5/13, 5/15, 5/16, 5/19 (3doses), 5/20, 5/21, 5/22, 5/24, 5/30, 6/1, 6/5, 6/8, and 6/12.

During an interview with Nurse #4 on 6/13/24 at 2:25 pm, he stated that he entered Resident #28's order for Haloperidol into the system and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 81 was unaware that prn psychotropics had to have a 14 day stop date. During an interview with the Nurse Practitioner on 6/14/24 at 1:25 pm, she confirmed she wrote the Haloperidol order dated 5/8/24 without the 14-day stop date and stated that she was aware that all prn psychotropics had a 14 day stop date and that was how she intended the order to be entered. During an interview on 6/14/24 at 3:34 PM with the Director of Nursing (DON), she stated she was aware that orders for PRN psychotropic medications required a stop date. She stated that the Nurse Practitioner came in that morning and noticed there was no stop date for Resident # 28's PRN Haloperidol. The Nurse Practitioner discontinued the current order and placed a new order with a 14-day stop date.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 4 residents (Resident #74 and Resident #416) observed during the medication administration observation.	F 759	F759 Medication errors for residents #74 and #416 were reported to the physician. Unit Managers audited the medication carts to make sure the medications were in place on July 10th and 11th. They also audited medications with parameters at the same time. Nurses and med aides were educated on	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 759

Continued From page 82

The findings included:

1. Resident #74 was admitted to the facility on 8/30/19. Her cumulative diagnoses included hypertension and a history of cerebrovascular accident (stroke) with dysphagia (difficulty swallowing).

On 6/12/24 at 8:28 AM, Nurse #4 was observed as he prepared to administer medications to Resident #74. The nurse collected blood glucose (sugar) monitoring supplies, checked Resident #74's blood glucose, and administered 4 units of Humalog insulin (a rapid-acting insulin) to the resident in accordance with her physician's orders.

At 8:39 AM on 6/12/24, Nurse #4 was observed as he completed his preparation of five (5) medications for administration via a percutaneous endoscopic gastrostomy (PEG tube) to Resident #74. A PEG tube is a feeding tube surgically inserted into the stomach. The medications administered to the resident included one tablet of 25 milligrams (mg) carvedilol (a blood pressure medication). Each medication was observed to be crushed individually, mixed with water, and administered separately into the PEG tube with 5-10 milliliters (ml) of water instilled between each medication. No vital signs were obtained for Resident #74 prior to the medication administration.

On 6/12/24 at 8:56 AM, Nurse #4 completed the medication administration for Resident #74 and returned to the medication cart. A review of the resident's current medication orders was completed at that time. The orders included 25 mg carvedilol to be given as one tablet via PEG

F 759

medication availability to include notifying the physician and obtaining a hold order if necessary while the medication is obtained. Education also included following parameters on medications that have them ordered prior to administration. The education was provided by the Staff Development Coordinator, Director of Nursing and Unit Managers. Any nurses or med aides that do not receive the education by July 17, 2024, will be unable to work until receiving it. Newly hired employees will receive the education in orientation by the Staff Development Coordinator or Director of Nursing in her absence.
The Director of Nursing or designee will conduct 10 medication administration observations for four weeks, then 5 medication administration observations for eight weeks for medication administration errors. The observations will be conducted randomly on all shifts and weekends.
The Administrator will also review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 83 tube two times a day for hypertension. In capital letters, the order also included parameters which read: "Hold for SBP [systolic blood pressure] less than 110 or HR [heart rate] less than 55." Systolic blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading. An interview was conducted on 6/12/24 at 8:58 AM with Nurse #4. During the interview, the nurse was asked when the resident had her vital signs last checked. Nurse #4 reviewed Resident #74's electronic medical record and reported her blood pressure and heart rate were last checked on 6/11/24 (yesterday) at 11:37 AM. The nurse acknowledged he did not notice the resident's orders indicated her vital signs needed to be taken prior to administering the carvedilol. An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. During the interview, the DON stated she needed to review physician orders with parameters attached to them so supplemental documentation could be added to the Medication Administration Record (MAR) when parameters were indicated for a resident. She explained that adding the supplemental documentation on the MAR would trigger obtaining vital signs so the parameters ordered would be observed prior to a medication's administration. A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. At that time, the DON reported she would expect vital sign parameters to be observed and obtained in accordance with the physician orders (if written) prior to administering a medication.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 84	F 759		

2. Resident #416 was admitted to the facility on 5/30/24 with a diagnosis which included cirrhosis of the liver.

On 6/12/24 at 9:53 AM, Nurse #3 was observed as she prepared and administered five (5) oral medications to Resident #416. At that time, the nurse reported this resident's miconazole powder (a topical antifungal powder) was not available on the medication (med) cart for administration because it had not yet been delivered by the pharmacy.

A review of Resident #416's current orders revealed a medication order was received on 5/30/24 for 2% miconazole powder to be topically applied to folds of the skin twice daily for dry skin (Start Date 5/31/24). This order was created and confirmed by Nurse #3 on 5/30/24. The miconazole powder was scheduled to be applied at 9:00 AM and 9:00 PM each day in accordance with the physician's orders.

A follow-up interview was conducted on 6/12/24 at 3:00 PM with Nurse #3 in the presence of the Unit Manager (Nurse #2). During the interview, the omission of a medication (such as miconazole powder) ordered for administration (or application) was discussed. The nurses reported they understood that because miconazole powder was ordered but not given during the medication administration observation, the omission was determined to be a medication error.

An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. At that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 85 time, the DON and Administrator were informed of the facility's failure to obtain 2% miconazole powder (an over the counter or OTC medication) ordered by the physician for a newly admitted resident (Resident #416). A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. During the interview, the DON stated she would expect nursing staff to call the dispensing pharmacy if a medication ordered was not received. She reported that if the medication was an OTC product, the facility would need to acquire it on their own.	F 759		
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 abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 86 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Label medications (meds) with the minimum information required, including the name of the resident, on 1 of 5 medication (med) carts observed (300 Short Med Cart); 2) Discard expired medications and/or meds without a legible expiration date on 4 of 5 medication carts observed (300 Short Med Cart, 300 Long Med Cart, 200 Long Med Cart, and 200 Short Med Cart); 3) Discard opened single-dose vials (SDV) after their initial use on 2 of 5 medication carts observed (300 Short Med Cart and 300 Long Med Cart); 4) Store medications in accordance with the manufacturer's storage instructions on 2 of 5 medication carts observed (300 Long Med Cart and 200 Long Med Cart). The findings included: 1. An observation was conducted on 6/11/24 at 4:00 PM of the 300 Short Med Cart in the presence of Nurse #9. The observation revealed the following medications were stored on the med cart: a. According to the manufacturer, in-use insulin glargine prefilled pens should be stored at room temperature of less than 86 Fahrenheit (oF) and used within 28 days. One (1) opened insulin glargine pen was observed to be stored on the medication cart. The pen was not labeled with a resident's name or the date it had been opened. When asked,	F 761	F761 Unit Managers audited the medication carts for expired or unlabeled medications on July 10th and 11th. This audit included checking to see if medications were stored in accordance with manufacturers recommendations. Any issues identified were remedied. Nurses and medication aides were educated on proper labeling of medications in the cart to include name of resident, discarding expired medications, discarding single use vials after initial use, and storage. This education was provided by the Staff Development Coordinator, Director of Nursing and Unit Managers. Any nurse or med aide that did not receive the education by July 17, 2024 will not be able to work until the education is complete. Newly hired nurses and medication aides will receive education in orientation from the Staff Development Coordinator or Director of Nursing in her absence The Unit Managers or designee will conduct an audit twice a week for twelve weeks of each medication cart to ensure that there are no expired medications on the cart. This audit will also include proper labeling to include name of resident, discarding single use vials after initial use, and storage according to manufacturers recommendations. The Administrator will also review the data for patterns and trends and will take this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 87 Nurse #9 examined the insulin pen and confirmed it was not labeled with a resident's name or date it was opened. The nurse stated the pen would need to be discarded. b. According to the product manufacturer, in-use insulin lispro prefilled pens should be stored at room temperature of less than 86 oF and used within 28 days. One (1) opened insulin lispro prefilled pen was observed to have an illegible name written in a blue marker on the pen. Initially, Nurse #9 stated she thought the insulin pen belonged to Resident #84. However, the pen was stored inside a plastic bag labeled with Resident #103's name. The pen was not labeled as to when it had been opened or put on the medication cart. Upon further inquiry, the nurse stated the pen would need to be discarded. c. According to the product manufacturer, in-use insulin aspart prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days. One (1) opened insulin aspart prefilled pen with Resident #185's name hand-written on the pen was stored on the med cart. The pen was also labeled with a handwritten (but illegible) date as to when it had been opened. An interview was conducted with Nurse #9 at the time of the observation. When the nurse was asked whether she could read the date the pen had been opened, she reported she could not. d. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include	F 761	information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 88	F 761		

information on when single-dose vials (SDVs) should be discarded. The Guidelines state, "Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection ... Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient."

One (1) opened 1 milliliter (ml) vial of 1000 micrograms (mcg) / ml of cyanocobalamin (Vitamin B12) for injection was observed stored on the med cart. The vial was labeled as a single dose vial (SDV). At the time of the observation, Nurse #9 was asked what her thoughts were about the opened SDV being stored on the med cart. The nurse responded by stating she would typically discard a SDV after it had been opened.

An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired. With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.

2. An observation was conducted on 6/11/24 at 11:38 AM of the 300 Long Medication (Med) Cart in the presence of Nurse #5. The observation revealed the following medications were stored on the med cart:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 89	F 761		

a. According to the product manufacturer, in-use insulin lispro prefilled pens should be stored at room temperature of less than 86 degrees Fahrenheit (oF) and used within 28 days.

An opened insulin lispro pen dispensed for Resident #1 was stored on the medication cart. An illegible date was written on a yellow auxiliary sticker placed on the pen to indicate when the pen was opened. No expiration date was noted on the sticker. The yellow auxiliary sticker read, "Discard after 28 days." The mini sticker on the pen included a date as to when the pen was dispensed from the pharmacy, but that date was also illegible. At the time of the observation, Nurse #5 was asked what her thoughts were about the dates on the insulin pen. The nurse stated she could not read them.

b. According to the product manufacturer, in-use insulin aspart prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.

One (1) opened insulin aspart pen dispensed for Resident #209 on 5/13/24 was stored on the med cart. The yellow auxiliary sticker placed on the pen by the pharmacy had two blanks (one blank was for the Date Opened and one for the Date Expired). Neither date was filled out. The auxiliary sticker read, "Discard after 28 days." Upon review, it was determined 29 days had elapsed since the insulin pen had been dispensed from the pharmacy.

c. According to the manufacturer, in-use insulin glargine prefilled pens should be stored at room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 90	F 761		

temperature (less than 86 oF) and used within 28 days.

One (1) opened insulin glargine pen dispensed from the pharmacy on 5/9/24 for Resident #190 was stored on the med cart. A yellow pharmacy auxiliary sticker placed on the pen had one date written on the "Date Expired" line which read, "6/9." Upon inquiry, Nurse #5 stated that most staff usually wrote the opened date on the insulin pens. However, she added that they probably should also write the shortened expiration date on the auxiliary sticker so there would be no confusion. The nurse confirmed it could not be determined for certain whether the insulin pen was past its expiration date.

d. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when single-dose vials (SDVs) should be discarded. The Guidelines state, "Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection ... Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient."

1) Two (2) opened 10 milliliter (ml) single-dose vials (SDV) of sterile water for injection was stored on the med cart. The vial of sterile water for injection was labeled for single use only.

2) One (1) opened 5 ml SDV of 1% lidocaine for injection was stored on the med cart. The vial of lidocaine was labeled for single use only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 91	F 761		

At the time of the observation, Nurse #5 was asked what her thoughts were about the opened SDV being stored on the med cart. The nurse reported the vials needed to be discarded.

e. According to the product manufacturer, an unopened Humalog KwikPen should be stored under refrigeration between 36 oF and 46 oF until the expiration date or at room temperature (less than 86 oF) and used within 28 days.

One (1) unopened Humalog Kwikpen dispensed from the pharmacy on 6/10/24 for Resident #159 was stored on the med cart. No date was written on the pen as to when it had been put on the med cart. When Nurse #5 was asked, she reported the unopened pen should have been stored in the med room refrigerator until it needed to be opened.

An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.

3. An observation was conducted on 6/11/24 at 3:30 PM of the 200 Long Med Cart in the presence of Nurse #6.
The observation revealed the following medications were stored on the med cart:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 92	F 761		

a. The manufacturer's storage instructions printed on the box of 0.5 milligrams (mg) / 2 milliliters (ml) budesonide inhalation suspension read, in part: "...Store unopened ampules in the foil envelope placed upright in the carton ...Once the foil envelope is opened, use the ampules within two weeks."

1) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed from the pharmacy on 4/23/24 for Resident #415 was stored on the med cart. The box contained one opened envelope with 4 ampules stored inside. The opened envelope was not dated as to when it was opened.

2) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed on 4/30/24 for Resident #197 was stored on the med cart. The box contained one opened envelope with 2 ampules stored inside and one ampule placed outside of the foil envelope and lying on the bottom of the box. The opened envelope was not dated as to when it was opened.

3) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed on 5/11/24 for Resident #150 was stored on the med cart. The box contained 3 unopened pouches and one opened pouch with 1 ampule stored inside. The opened pouch was not dated as to when it was opened.

b. The manufacturer's storage instructions printed on the box of 0.25 mg / 2 ml budesonide inhalation suspension read, in part: "...Store unopened ampules in the foil envelope placed upright in the carton ...Once the foil envelope is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761		F 761		

Continued From page 93
opened, use the ampules within two weeks."

One (1) manufacturer's box of 0.25 mg/ 2 ml budesonide inhalation suspension ampules dispensed from the pharmacy on 4/23/24 for Resident #415 was stored on the med cart. The box contained three unopened envelopes and one opened envelope with 1 ampule stored inside. The opened envelope was not dated as to when it was opened.

c. The manufacturer's storage instructions printed on the box of 0.5 mg / 3 mg ipratropium / albuterol inhalation solution read in capital letters: "Store in pouch until time of use."

One (1) manufacturer's box of 0.5 mg / 3 mg ipratropium / albuterol inhalation solution dispensed from the pharmacy on 4/25/24 for Resident #143 was stored on the med cart. Two vials were stored in the manufacturer's box (not inside of a pouch). No pouch was in the box.

An interview was conducted with Nurse #6 at the time of the medication cart observation. During the interview, the nurse acknowledged the envelopes (or pouches) containing inhalation solution or suspension ampules needed to be dated when opened.

An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 94	F 761		

concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.

4. An observation was conducted on 6/11/24 at 3:05 PM of the 200 Short Med Cart in the presence of Nurse #8. The observation revealed the following medications were stored on the med cart:

a. According to the manufacturer, in-use Fiasp insulin prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.

One (1) opened Fiasp insulin pen dispensed from the pharmacy on 4/29/24 for Resident #78 was dated to indicate it was opened on 5/5/24. Upon review, it was determined 37 days had elapsed since the insulin pen had been opened and it was kept past its shortened expiration date. During an interview conducted with Nurse #8, the nurse was asked what her thoughts were with regards to this insulin pen. She confirmed the insulin pen was expired.

b. According to the manufacturer, in-use Lantus insulin vials should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.

One (1) opened Lantus insulin vial dispensed from the pharmacy on 4/18/24 for Resident #177 was stored on the med cart. A yellow pharmacy auxiliary sticker placed on the vial containing the insulin had two blanks (one blank for the Date Opened and one for the Date Expired). Neither of the dates were filled out. The auxiliary sticker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 95 also read, "Discard after 28 days." When Nurse #8 was asked how she would know whether the insulin vial had been kept past its shortened expiration date, she stated, "I wouldn't." An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a meal test tray observation and interviews with the Dietary Manager (DM), the facility failed to serve food that was palatable and at temperatures acceptable to 1 of 5 Halls (200 Hall). This practice had the potential to affect other residents.	F 804	F804 Doors to existing tray carts were placed on carts July 12, 2024. New meal carts were ordered for the facility on Tuesday July 9, 2024. Additional plates for meal service with correct size plates were ordered on June 14, 2024. Initial audits for	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 96	F 804		

Findings included:

An observation of the meal tray line service in the kitchen was conducted on 6/12/24 at 1:15 p.m. The temperatures of the food items on the steamtable were taken by the DM using a calibrated stem thermometer. The temperatures of the food items of regular consistency were greater than the acceptable 135 degrees Fahrenheit. The top of the plated meals was protected with lid covers, but no insulated bottoms due to the large plate size. The meals were placed in a stainless-steel meal delivery cart. The delivery cart was filled with plated meals for the residents on the 200 hall was missing the doors. The cart left the kitchen at 1:23 p.m. and arrived on the 200 long hall at 1:25 p.m. where the nursing staff immediately began serving the residents. A test meal tray of the regular textured foods was included in the meal delivery cart.

6/12/24 at 2:05 p.m., the DM revealed that the doors to 4 of the 10 meal delivery carts have needed repair for approximately three months. She also revealed there were not enough insulated bottom plate covers to fit the large plates used for the residents' meals. She stated smaller plates were ordered several months ago but had not been delivered. The DM indicated she had not conducted any meal test trays surveys.

On 6/12/14 at 2:32 p.m., after serving the residents of the 200 short halls, the DM and this Surveyor observed the test meal tray for palatability. The shepherd's pie was lukewarm and bland to taste. The greenbeans with corn was lukewarm to taste, flavorless and not thoroughly cooked. The DM participated in the

compliance were conducted and solutions sustained on July 12, 2024
All current dining staff were educated on food palatability, plate size, food cart delivery, and temperature on July 12, 2024.
The Dietary manager or designee will start to conduct an audits of (10) ten meal trays for temperature/palatability (5) five times a week for (1) month, then (3)three times a week for (1) month and (2)two times a week for (1) month.
The dietary manager or designee will conduct an audit during various mealtimes ensuring tray cart doors are closed during delivery to units (2)x weekly x1 month, then (1)x weekly x1 month.
The Administrator or designee will be responsible for bringing these audits to the Quality Assurance Committee meeting for 3 consecutive months. The Quality Assurance Committee will determine the need for continued monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 97 testing of the meal tray and acknowledged these findings.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to ensure the sanitizing solution (chlorine) was maintained at the required concentration of 50 ppm (parts per million) during the final rinse cycle according to manufacturer's instructions in the low temperature dish machine; failed to maintain the food service equipment clean, free from debris and in good working condition; failed to ensure leftover food items stored for use in the walk-in cooler and walk-in freezer were sealed, dated and labeled; and failed to ensure facial hair was	F 812	F812 The sanitizing solution was added to the dish machine to maintain 50ppm on June 14, 2024. The doors to the meal carts were added to the meal carts on 7/12/2024. The facility purchased new meal carts on 7/9/24. Equipment in the kitchen was cleaned on 7/12/24 as well as the floor surrounding the equipment. The stand-alone fans have been removed from food preparation areas on 7/12/24. The plate warmer has been cleaned as of	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 98 covered by dietary staff during food preparation. These practices had the potential for cross-contamination of food served to residents. Findings included: 1a. During the initial tour of the kitchen on 6/10/24 at 10:40 a.m., the operation of the low temperature dishwasher of the soiled breakfast dishware by dietary staff was observed. The sanitizing solution (chlorine) for the low temperature dishwasher did not register on the chlorine testing strips provided by the dietary staff. After retesting the concentration of the chlorine solution in the dishwasher with the same results, this surveyor informed the DM (Dietary Manager) the observed dishware would have to be rewashed and sanitized: 1-rack of plates, 3-racks of lid covers, 2-racks of meal trays, and 1-rack of silverware. During an interview on 6/10/24 at 10:45 a.m., the DM revealed that earlier that morning she tested the chlorine sanitizer in the dishwasher, and it read 50 ppm. The DM directed the 2-dietary staff to discontinue using the dishwasher and transfer the dishware to the three compartment sink to be rewashed and sanitized. 1b. During an observation of the kitchen on 6/12/24 at 1:15 p.m., there were no doors attached to the door hinges of 4 of the 10 meal delivery carts. On 6/12/24 at 2:05 p.m., the DM revealed the doors to 4 of the 10 meal delivery carts had been in disrepair for approximately three months.	F 812	7/12/24. Food and drink items in storage and freezer/refrigerator areas have been labeled and dated appropriately and verified on 7/12/24. Hair nets and/or beard guards have been provided and instilled with the dietary staff verified on 7/12/24. Initial audits for compliance were conducted and solutions sustained on July 12, 2024 All current dining staff were educated on food procurement, Store/prepare/serve-sanitary 7/12/24. Any new employees for the dietary department will receive education upon hire prior to starting as part of orientation. The Dietary manager or designee will conduct an audit of the dish machine showing compliance with sanitation solution. This audit will be performed 3x weekly x 1 month and then 2x times weekly for 1 month. The dietary manager or designee will perform an audit on the cleaning check list provided to the dietary personnel. This audit will be performed 4x weekly for 1 month, then 3x weekly for 1 month, then 1x weekly for 1 month. The dietary manager or designee will audit the labeling/dating of all food and drink items within the kitchen for compliance. This audit will be performed 5x a week for 1 month, then 4x a week for 1 month. The Administrator or designee will be responsible for bringing these audits to the Quality Assurance Committee meeting for 3 consecutive months. The Quality Assurance Committee will determine the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 99	F 812		

2a. On 6/10/24 at 10:46 a.m., during the initial tour, the floor of the kitchen had food particles scattered throughout and the floor area near the stove was slippery with grease. The lower wall behind the stove and convection ovens was also littered with dark grease spots. There was black grease and dried food crumbs on the inside and outside of the two convection ovens and the deep fryer. The inside of the two plate-warmers contained food debris and bread slices. Also, next to a food preparation table a stand-alone fan with dry, gray lint covering the protective grid while in use.

2b. A follow up visit to the kitchen on 6/12/24 at 2:05 p.m. revealed the lint covered standing fan was in operation while directed at the preparation table where dietary staff was preparing sandwiches. The two plate-warmers contained food debris and plastic gloves in the bottom and clean plates. The filter on the outside of the ice machine contained thick gray lint.

During an interview on 6/12/24 at 4:56 p.m., the DM stated dietary did not have a cleaning policy but had a sanitation inspection policy checklist. The checklist the DM presented for review did not document the dietary staff assigned to any of the cleaning tasks. She revealed the dietary department did not maintain the completed sanitation checklists.

3. During the initial tour of the kitchen on 6/10/24 at 10:45 a.m., there was 1-unsealed and not dated box of rice on the shelf beneath the food preparation table. An observation of the walk-in cooler revealed 1-opened box with an opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 100 bag of pork loin that was not dated; 1-resealed plastic bag of boiled eggs that was not dated, on the floor beneath the shelf; and 1-opened container of pasteurized liquid egg that was not dated. The walk-in freezer consisted of 10-plastic bags of unidentifiable frozen items, not dated or labeled (8-resealed and 2-not sealed). 4. During a kitchen observation on 6/12/24 at 1:15 p.m., 2 of 5 dietary staff were observed with exposed/uncovered facial hair ranging from ½ inch to 1 inch in length. The two staff were noted to perform various food service tasks including meal production and service without hair coverings over their facial hair.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 101 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document providing education of the influenza vaccine pneumococcal vaccine and the resident's or resident representative's refusal	F 883	F883 Resident #182 (RP) was provided education on the influenza and pneumococcal vaccine on 7/10/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 883

Continued From page 102
to receive the pneumococcal vaccine for 1 of 5 residents reviewed for immunizations (Resident #182).

Findings included:

Resident #182 was admitted to the facility on 7/27/2023.

The quarterly Minimum Data Set (MDS) assessment dated 5/8/2024 indicated Resident #182 was severely impaired cognitively.

There was no documentation in the electronic medical record (EMR) Resident #182 had received the pneumococcal vaccine at the facility. There was also no reported history of Resident #182 receiving a pneumococcal vaccine outside of the facility prior to being admitted.

The facility was unable to provide written documentation Resident #182 or Resident #182's Representative had received education to consent to receive or refusal of administration of pneumococcal vaccine.

Attempts to interview Resident #182's Responsible Party were unsuccessful.

During an interview with the Infection Preventionist on 6/14/24 at 9:12am, she stated that she had worked in that role since July 2023 and was currently also acting as the Staff Development Coordinator. She stated that she had been working on making sure all residents had an updated Covid vaccine and a yearly influenza vaccine and had not focused as much on their pneumococcal status. She added that, previously, an agency nurse filled in the position,

F 883

House audit was conducted to identify those lacking documentation of education and refusals. The audit began on July 10, 2024, and has been ongoing. A plan was formulated amongst the SDC and Unit Managers to resolve issues identified. Education was provided to the SDC regarding the requirements for immunization administration, documentation, and education. The education included how to look up the CDC guidelines and recommendations on the Advanced Committee for Immunization Practices (ACIP), where to locate the ACIP recommendations, and how to share the recommendations with providers. Furthermore, education included obtaining consent and documentation in the electronic medical record. Any newly hired SDC's will receive the education in orientation.
The Director of Nursing or designee will audit five admissions a week for four weeks, then three admissions a week for eight weeks for documentation of influenza and pneumococcal education and consent/refusal of the vaccination.
The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 103 and she had been unable to locate several refusal forms for vaccines. During an interview with the Corporate Nurse Consultant on 6/14/2024 at 10:15am, she stated that she was also unable to locate any documentation of consent or refusal of the pneumococcal vaccine by Resident #182 or Resident #182's representative. She added the facility should have obtained written consent or refusal for all vaccines and that should have been a permanent part of their medical record.	F 883		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure the handrails in the facility corridors were properly secured to the walls, repaired and free from sharp edges on 3 of 4 floors where handrails were present. The findings included: An observation was conducted on 6/11/24 at 12:42 PM to 1:00 PM, revealed on the 500 floor the handrails were detached from the walls and needed repairs due to broken/cracked support backets and missing end caps in the corridor joining rooms 503, 507, 511, 514, 5/19, 520, 526, 527 on the hallways. The end of the handrails had sharp edges that were not covered by the endcaps. Staff and residents were observed using the handrails in the current condition.	F 924	F924 The handrails were assessed and addressed for sharp edges and proper securement to the wall. The Maintenance department was educated in identifying and addressing the hand rails for securement and sharp edges. The staff were educated to report any findings to the maintenance department for repair. Any staff member that has not received the education by July 17, 2024, will be unable to work until education is completed. Any newly hired staff member will receive an education in orientation. The Maintenance Director will conduct an audit 3 times a week for twelve weeks of the handrails looking for sharp edges and secureness.	7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

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

F 924 Continued From page 104

An observation was conducted on 6/11/24 at 1:30 PM to 1:45 PM on the 300 floor, revealed the unit handrails in the corridor joining the rooms 321, 326, 327 and near the janitor hall closet close to the dining room were loose, detached from the walls and needed repairs due to broken/cracked handrails and support brackets that had sharp or exposed edges without endcaps.

An observation was conducted on 6/11/24 at 2:00PM to 2:16 PM on the 200 floor revealed the handrails in the corridor joining the rooms 200, 202, 204, 208, 210 and 226, the handrails were loose and detached from the wall with small unpatched holes in the wall. There were several broken/cracked support brackets that had exposed sharp edges and exposed screws. The end caps were missing on the handrail at room 226 near the elevators.

A follow-up observation was conducted on 6/12/24 at 2:10 PM to 2:25 PM, revealed the identified handrails in the 200 floor 300 floor and 500 floor remained in the same condition and had not been repaired. Staff and residents continued to use the handrails for support during mobilization on the units.

An interview was conducted on 6/12/24 at 2:27pm, the Maintenance Director stated he was aware of the condition of the handrails and the repairs or replacement of the broken handrails. He stated he had submitted an invoice for replacement parts for the handrails for some of the handrails that have already been replaced a few months ago. However, he further stated he did not have a system in place to monitor, replace or recheck any of the newly broken handrails.

F 924

The Administrator or designee will review the data for patterns and trends and will take this information to the Quality Assurance Performance Improvement Committee monthly x 3 months. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the above plan and will add interventions or continued monitoring as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING ______ B. WING ______	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 924	Continued From page 105 The Maintenance Director presented an invoice for new handrail parts effective on 6/14/24. An interview was conducted on 6/14/24 at 8:00 AM, the Administrator who stated the facility Environmental Service Director and Maintenance Director were responsible for ensuring the facility was clean and structural repairs were completed for the safety of all the residents. She included a handrail and resident room audits would be done for repairs and replacement immediately based on the recent invoice dated 6/14/24.	F 924		