STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Nursing and Rehabilitation Center	**581 NC Highway 16 South , Taylorsville, North Carolina, 28681**

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F0000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 08/25/25 through 08/26/25. The following intake was investigated 2586356. 1 of 1 complaint allegation did result in deficiency. Event ID: 1D529C.	F0000		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F0627	Unit Manager and Interim Social Work Assistant corrected discharge summary for resident #1 to reflect complete and accurate information in section B and section C, updated assessment was sent to resident's responsible party via mail on 8/28/25 by Interim Social Work Assistant. Administrator, Director of Nursing, and Assistant Director of Nursing completed audit of Discharge Summary assessments for accuracy and completion on all residents discharged from the facility in the last 90 days on 8/27/25. Additional findings noted, corrections were made to discharge summaries noted to be inaccurate or incomplete on 8/27/25. Corrected discharge summaries were reprinted sent to resident or resident responsible party that were identified. Regional Business Development, BSW educated Administrative interdisciplinary team on 8/27/25 regarding accuracy and completion of discharge summary form. Any newly hired administrative staff will be educated by Administrator upon hire. The Administrator or designee will review residents scheduled for discharge for accurate completion of Discharge Summary for 6 weeks. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAP Committee responsible for ongoing compliance. Date of Compliance 8/29/25	08/29/2025

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

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

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F0627 SS = D	Continued from page 1 (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	F0627		

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F0627 SS = D	Continued from page 2 This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F0627		

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F0627 SS = D	Continued from page 3 (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care	F0627		

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F0627 SS = D	Continued from page 4 and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and resident representative interviews, the facility failed to complete a comprehensive discharge summary that included the name of the home health company and their contact information and failed to ensure education regarding catheter care was provided to the Resident Representative prior to discharge for 1 of 3 residents reviewed for discharge (Resident #1). The findings included: Resident #1 was admitted to the facility on 06/07/25 with diagnoses that included stroke and neuromuscular dysfunction of bladder. Review of Resident #1's discharge Minimum Data Set assessment revealed him to be severely cognitively impaired and was coded as having an indwelling urinary catheter. Review of Resident #1's electronic medical record revealed a discharge summary document dated 08/07/25	F0627		

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F0627 SS = D	Continued from page 5 and titled “CCH Bridge to Home Discharge Summary – v2” that it was still “in progress.” Additional review of the document revealed there was no information in the Social Services section regarding home health nor was there documentation that education was provided to either Resident #1 or his responsible party regarding catheter care. Resident #1 was discharged to his home on 08/08/25. An interview with Nurse #1 via telephone on 08/25/25 at 2:26 PM revealed she completed the discharge note and indicated she had completed the nursing section of the discharge summary. She reported the day of Resident #1’s discharge, she had discussed Resident #1’s discharge information with Resident #1’s representative, which included therapy notes, and medications. Nurse #1 stated she also discussed Resident #1’s wound care and asked if Resident #1’s representative had questions regarding his urinary catheter which Nurse #1 reported Resident #1’s representative stated no. Nurse #1 indicated that no official education regarding Resident #1’s urinary catheter care was provided to Resident #1’s representative and also indicated that she should have completed the catheter education on Resident #1’s discharge summary. Nurse #1 reported she provided the discharge summary to Resident #1’s representative. An interview with the Business Office Manager on 08/25/25 at 11:17 AM revealed she was currently serving in a dual role where she completed business office tasks and served as the facility’s social worker. The Business Office Manager reported she had completed the social work section of Resident #1’s discharge summary and stated before Resident #1 had discharged, she thought that Resident #1 would be receiving home health from Home Health Company #1 and had initially placed that information into the discharge summary but was notified on 08/11/25 by Resident #1’s representative that Home Health Company #1 had not shown up to provide home health 5 days post Resident #1’s discharge. The Business Office Manager stated at that time, she set up home health for Resident #1 through Home Health Company #2 and stated she had reopened Resident #1’s discharge summary and removed Home Health Company #1 from the discharge summary and had forgotten to update the discharge summary with Home Health Company #2’s information. She indicated that it should have been updated and the discharge summary “closed.” An interview with Resident #1’s representative via telephone on 08/26/25 at 9:41 AM revealed Resident #1	F0627		

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F0627 SS = D	Continued from page 6 did not have a urinary catheter prior to his hospitalization before being admitted to the facility. She stated she had not received any education upon discharge from any person at the facility regarding how to take care of a urinary catheter and stated she had no prior knowledge on how to care for a urinary catheter. Resident #1's representative stated she had to do her own research on how to care for Resident #1's urinary catheter until Home Health Company #2 began coming out to the home on 08/13/25. Resident #1's representative reported she had not received any paperwork at the time of Resident #1's discharge other than a list of Resident #1's medications and some paper medication prescriptions. Multiple attempts to reach Home Health Company #2 via telephone were unsuccessful. An interview with the Administrator on 08/25/25 at 2:32 PM revealed it was her understanding that Resident #1's discharge summary was completed fully and there was a change in the home health provider, so the discharge summary was reopened to be edited. She reported that, ideally, when a change was made and verification was provided that a new home health provider was going to begin to see Resident #1, that the discharge summary should be updated and completed. She also indicated that if urinary catheter care education was provided, it should be marked in the discharge summary.	F0627		