| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted on 4/18/23 through 4/27/23. Event ID #DJ5G11. The following intakes were investigated NC00199021, NC00199478, NC00199490, NC00199515, NC00199712, NC00199824, NC00199863, NC00200008, NC00200125, NC00200655, NC00200854, NC00201099, NC00201169, NC00201489, NC00201542.<br><br>Intake NC00201169 resulted in immediate jeopardy.<br><br>10 of the 35 complaint allegations resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.24 at tag F678 at a scope and severity K<br>CFR 483.25 at tag F689 at a scope and severity K<br>CFR 483.45 at tag F760 at a scope and severity J<br>CFR 483.70 at tag F835 at a scope and severity K<br><br>The tags F678, F689, F760 constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 7/20/2022 and was removed on 4/26/2023. A partial extended survey was conducted. | F 000 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized | F 636 | | 5/21/23 |

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

Electronically Signed | 05/21/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 636 | Continued From page 1 | F 636 | | |

reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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|---|---|---|---|---|
| F 636 | Continued From page 2<br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to complete an admission Minimum Data Set (MDS) assessment within the required 14 days for 1 of 4 residents (Resident #5) reviewed for admission MDS.<br><br>The findings included:<br><br>Resident #5 was admitted to the facility on 03/10/23. Resident #5 expired on 04/10/23.<br><br>A review of Resident #5's Minimum Data Set (MDS) assessments revealed the admission assessment was incomplete and marked as "in progress".<br><br>On 04/26/23 at 9:45 AM an interview was conducted with the former Minimum Data Set (MDS) Nurse who stated that she was aware that the MDS assessments were not completed and explained that all the MDS assessments were | F 636 | Resident #5 expired in the hospital<br>New admissions have the potential to be affected by deficient practice. The Minimum Data Set coordinator or designee will complete a 100% audit of the Minimum Data Set admission assessments for completion for the new admissions in the last 30 days. This audit was completed 5/20/23 The Minimum Data Set coordinator will address any concerns and notify the Director of Nursing of any concerns.<br>A full time MDS coordinator has been hired and will start at the end of May, in addition a second PRN MDS coordinator was hired to assist with timely MDS completion.<br>Education will be provided to the interdisciplinary team on timely MDS completion. This education will be completed by 5/19/23. New members of | |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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|---|---|---|---|---|
| F 636 | Continued From page 3<br>behind, and she was not able to get them caught up before she left her employment with the facility.<br><br>During an interview with Director of Nursing (DON) #1 on 04/26/23 at 10:25 AM she acknowledged that the admission MDS assessment on Resident #5 was not completed as it should have been. The DON explained that they had obtained assistance with the MDS process from sister facilities to help them get caught up.<br><br>An interview was conducted with Administrator #2 on 04/26/23 at 3:05 PM who confirmed that she was aware that the MDS process was behind and informed that the facility had hired a new MDS Nurse who would be starting soon. | F 636 | IDT will be educated upon hire.<br>Audits of new admissions will occur on a weekly basis x4 weeks and then monthly x two months<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of Compliance: 5/21/23 | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg<br>CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a significant change | F 637 | Resident expired in facility on 3/3/2023.<br>Residents admitted to hospice have the | 5/21/23 |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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|---|---|---|---|---|
| F 637 | Continued From page 4<br>Minimum Data Set assessment within 14 days of the determination of Hospice services for 1 of 1 resident (Resident #6) for Hospice.<br><br>The finding included:<br><br>Resident #6 was admitted to the facility on 01/15/23 with diagnoses that included thoracic aortic aneurism.<br><br>A review of Resident #6's physician orders revealed Hospice Services were ordered on 02/14/23.<br><br>A review of Resident #6's Minimum Data Set (MDS) assessments revealed there was no assessment for a significant change.<br><br>On 04/26/23 at 9:45 AM an interview was conducted with the former MDS Nurse who confirmed that the significant change MDS should be completed within 14 days of the determination of Hospice Services. The Nurse explained that she was aware that the assessment was not completed because at the time she was far behind on all the MDS assessments and was not able to get them caught up before she left her employment with the facility.<br><br>During an interview with Director of Nursing (DON) #1 on 04/26/23 at 10:25 AM she acknowledged that the facility was behind on the MDS process because she used to help with the process before she became the DON. The DON #1 explained that they had obtained assistance with the MDS process from sister facilities to help them get caught up.<br><br>An interview was conducted with Administrator #2 | F 637 | potential to be affected by the deficient practice. The Minimum Data Set coordinator or designee will complete a 100% audit of Minimum Data Set assessments for residents receiving hospice services to ensure significant change assessment was opened. This audit was completed 5/20/23.<br>Education will be completed with IDT on significant change assessments related to hospice. This education will be completed by 5/19/23. New members of IDT will be educated upon hire.<br>Audits of all residents admitted on hospice will occur weekly x4 weeks and then monthly x2 months to ensure timely opening of the significant change assessment.<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br><br>Date of Compliance: 5/21/23 | |

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|---|---|---|---|---|
| F 637 | Continued From page 5<br>on 04/26/23 at 3:05 PM who confirmed that she was aware that the MDS process was behind and informed that the facility had hired a new MDS Nurse who would be starting soon. | F 637 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interview the facility failed to accurately code cognition in section C of the Minimum Data Set (MDS) for 5 of 5 residents reviewed (Resident #1, Resident #7, Resident #10, Resident #11, and Resident #12). The facility also failed to accurately code the MDS in the area of indwelling catheters for 1 of 2 resident reviewed with indwelling catheters (Resident #7).<br><br>The finding included:<br><br>1. Resident #1 was admitted to the facility on 09/27/22 and expired in the facility on 02/07/23.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 01/04/23 indicated that Resident #1's cognition was not assessed. The staff assessment of resident cognition was also not completed. The MDS was completed by the traveling MDS nurse.<br><br>Attempts to speak to the traveling MDS nurse were made on 04/19/23 at 5:51 PM and were unsuccessful. | F 641 | Resident #1 no longer resides in the facility. Resident #11 cognition was assessed on 5/19/23 and section C will be updated in line with ARD schedule and with significant changes.Resident #12 cognition was assessed on 5/19/23 and section C will be updated in line with ARD schedule and with significant changes.Resident #10 cognition was assessed on 2/19/23 per the ARD schedule.Resident discharged prior to date of compliance. Cognition will be assessed upon return to facility section C will be updated in line with ARD schedule and with significant changes. Resident #7 cognition was assessed on 5/19/23 and Quarterly MDS completed 12/18/22 noting foley was corrected. Quarterly MDS completed 3/20/23 accurately assessed no foley. Section C and H will be accurately updated in line with ARD schedule and with significant changes. All residents have the potential to have cognition and indwelling catheters coded incorrectly on their Minimum Data Set assessment. All residents with | 5/21/23 |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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| F 641 | Continued From page 6<br>The Social Worker (SW) was interviewed on 04/20/23 at 12:07 PM. The SW stated that he began working at the facility on 09/19/22 and was responsible for completing the cognition section of the MDS. The SW stated that in November 2022 the facility's number of admissions and discharges greatly increased and he could not keep up with the influx of responsibilities that the admission/discharge process brought to him. He stated, "I just did not have time to complete them" and he assumed if he did not complete the cognition section of the MDS that no one else did either. He further stated, "I chose to ensure the residents had safe discharge," over completing the MDS.<br><br>The former MDS nurse was interviewed via phone on 04/26/23 at 9:34 AM. She stated that she completed MDS at the facility for about a year. She stated that late last fall the facility had an influx of admissions and discharges and the SW did not have time to complete the cognition section of the MDS so when she would complete the MDS she would select not assessed. She stated she had discussed it with the administration at the time, but no assistance was offered in attempt to get the information caught up.<br><br>Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM. The DON #1 stated she was hired at the facility on 12/05/22 as a second MDS Nurse and remained in that role until 04/07/23 at which time she became the Interim DON. The DON #1 stated that the SW got behind with completing the cognition section or Section C of the MDS because of the other duties that he was assigned. She explained that he was the only SW the facility had, and he just did not have time | F 641 | assessment dates in the part 30 days will be audited for BIMS completion. The social worker or designee will complete outstanding assessments by 5/19.<br>Education will be provided to the IDT in timely and accurate completion of interview items and proper assessment of the presence of a foley catheter. New members of IDT will be educated upon hire.<br>All obra assessments will be audited to ensure completion of section C and accurate coding of foley catheters. Audits will be conducted weekly x 4 weeks then monthly x2 months.<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br><br>Date of Compliance: 5/21/23 | |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 641 | Continued From page 7 | F 641 | | |

to get everything completed on time. The DON #1 stated when she would complete an MDS, and the SW had not completed the cognition section she would check not assessed.

Administrator #2 was interviewed on 04/26/23 at 3:02 PM. Administrator #2 stated that the previous MDS nurse had gotten behind with the MDS assessments and has since resigned. She stated they have hired a new MDS coordinator who will start in May 2023, she further stated that she had approved to hire an assistance for the SW to help him get caught up with his assigned duties including completion of Section C of the MDS.

2. Resident #11 was admitted to the facility on 01/23/23.

Review of the significant change Minimum Data Set (MDS) dated 01/28/23 revealed that Resident #11's cognition was not assessed and Section C of the MDS was not completed. The staff assessment of cognition was also not completed. The MDS was completed by the former MDS Nurse.

The Social Worker (SW) was interviewed on 04/20/23 at 12:07 PM. The SW stated that he began working at the facility on 09/19/22 and was responsible for completing the cognition section of the MDS. The SW stated that in November 2022 the facility's number of admissions and discharges greatly increased and he could not keep up with the influx of responsibilities that the admission/discharge process brought to him. He stated, "I just did not have time to complete them" and he assumed if he did not complete the cognition section of the MDS that no one else did

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|---|---|---|---|---|
| F 641 | Continued From page 8 | F 641 | | |

either. He further stated, "I chose to ensure the residents had safe discharge," over completing the MDS.

The former MDS nurse was interviewed via phone on 04/26/23 at 9:34 AM. She stated that she completed MDS assessments at the facility for about a year. She stated that late last fall the facility had an influx of admissions and discharges and the SW did not have time to complete the cognition section or Section C of the MDS so when she would complete the MDS she would select not assessed. She stated she had discussed it with the administration at the time, but no assistance was offered in attempt to get the information caught up.

Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM. The DON #1 stated she was hired at the facility on 12/05/22 as a second MDS Nurse and remained in that role until 04/07/23 at which time she became the Interim DON. The DON #1 stated that the SW got behind with completing the cognition section or Section C of the MDS because of the other duties that he was assigned. She explained that he was the only SW the facility had, and he just did not have time to get everything completed on time. The DON #1 stated when she would complete an MDS, and the SW had not completed the cognition section she would check not assessed.

Administrator #2 was interviewed on 04/26/23 at 3:02 PM. Administrator #2 stated that the previous MDS nurse had gotten behind with the MDS assessments and had since resigned. She stated that they have hired a new MDS coordinator who will start in May 2023, she further stated that she had approved to hire an

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|---|---|---|---|
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|---|---|---|---|---|
| F 641 | Continued From page 9 | F 641 | | |

assistance for the SW to help him get caught up with his assigned duties including the completion of Section C of the MDS.

3. Resident #12 was admitted to the facility 08/03/20.

Review of the quarterly Minimum Data Set (MDS) dated 02/24/23 revealed that the Cognition Patterns section or Section C of the MDS was not completed. The staff assessment of cognition was also not completed. The MDS was completed by the former MDS Nurse.

The Social Worker (SW) was interviewed on 04/20/23 at 12:07 PM. The SW stated that he began working at the facility on 09/19/22 and was responsible for completing the cognition section of the MDS. The SW stated that in November 2022 the facility's number of admissions and discharges greatly increased and he could not keep up with the influx of responsibilities that the admission/discharge process brought to him. He stated, "I just did not have time to complete them" and he assumed if he did not complete the cognition section of the MDS that no one else did either. He further stated, "I chose to ensure the residents had safe discharge," over completing the MDS.

The former MDS nurse was interviewed via phone on 04/26/23 at 9:34 AM. She stated that she completed MDS at the facility for about a year. She stated that late last fall the facility had an influx of admissions and discharges and the SW did not have time to complete the cognition section or Section C of the MDS so when she would complete the MDS she would select not assessed. She stated she had discussed it with

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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|---|---|---|---|---|
| F 641 | Continued From page 10 | F 641 | | |

the administration at the time, but no assistance was offered in attempt to get the information caught up.

Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM. The DON #1 stated she was hired at the facility on 12/05/22 as a second MDS Nurse and remained in that role until 04/07/23 at which time she became the Interim DON. The DON #1 stated that the SW got behind with completing the cognition section or Section C of the MDS because of the other duties that he was assigned. She explained that he was the only SW the facility had, and he just did not have time to get everything completed on time. The DON #1 stated when she would complete an MDS, and the SW had not completed the cognition section she would check not assessed.

Administrator #2 was interviewed on 04/26/23 at 3:02 PM. Administrator #2 stated that the previous MDS nurse had gotten behind with the MDS assessments and had since resigned. She stated that they have hired a new MDS coordinator who will start in May 2023, she further stated that she had approved to hire an assistance for the SW to help him get caught up with his assigned duties including the completion of Section C of the MDS.

4. Resident #10 was admitted to the facility on 02/24/22.

a. A review of Resident #10's quarterly Minimum Data Set (MDS) assessment dated 11/04/22 revealed Resident #10 had the ability to understand others and made herself understood but Cognitive Patterns or Section C was left blank.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 641 | Continued From page 11 | F 641 | | |

A review of Resident #10's quarterly MDS assessment dated 02/04/23 revealed Resident #10 had the ability to understand others and made herself understood. Cognitive Patterns or Section C was marked as yes, the Brief Interview for Mental Status should be conducted with the Resident, but the areas were left blank.

An interview was conducted with the Social Worker (SW) on 04/20/23 at 12:09 PM who stated he started his employment at the facility on 09/19/22 and was responsible for completing the Cognitive Patterns section on the MDS. The SW indicated due to his multiple duties he did not have time to complete all the MDS.

During an interview with Director of Nursing (DON) #1 on 04/26/23 at 10:25 AM she explained that the SW had other duties that caused him to get behind on his part of the MDS and they have been behind for months. She explained that they had obtained help from their sister facilities to get caught up on the MDS process, but they remained behind.

An interview was conducted with Administrator #2 on 04/24/23 at 3:05 PM. She indicated she was aware that the MDS process was behind and lacking in the facility including the Cognition Sections. She stated that after investigation in the matter she had given her approval for a SW assistant to be hired.

5. a. Resident #7 was admitted to the facility on 04/02/22.

Review of the quarterly Minimum Data Set (MDS) dated 12/18/22 indicated that Resident #7's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (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 12 | F 641 | | |

cognition was not assessed. The staff assessment of resident cognition was also not completed.

The Social Worker (SW) was interviewed on 04/20/23 at 12:07 PM. The SW stated that he began working at the facility on 09/19/22 and was responsible for completing the cognition section of the MDS. The SW stated that in November 2022 the facility's number of admissions and discharges greatly increased and he could not keep up with the influx of responsibilities that the admission/discharge process brought to him. He stated, "I just did not have time to complete them" and he assumed if he did not complete the cognition section of the MDS that no one else did either. He further stated, "I chose to ensure the residents had safe discharge over completing the MDS".

Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM. The DON #1 stated she was hired at the facility on 12/05/22 as a second MDS Nurse and remained in that role until 04/07/23 at which time she became the Interim DON. The DON #1 stated that the SW got behind with completing the cognition section of the MDS because of the other duties that he was assigned. She explained that he was the only SW the facility had, and he just did not have time to get everything completed on time. The DON #1 stated when she would complete an MDS, and the SW had not completed the cognition section she would check not assessed.

Administrator #2 was interviewed on 04/26/23 at 3:02 PM. Administrator #2 stated that the previous MDS nurse had gotten behind with the MDS assessments and had since resigned. She

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 641 | Continued From page 13<br>stated that they have hired a new MDS coordinator and also had approved to hire an assistant for the SW to help him get caught up with his assigned duties including the completion of the cognition section of the MDS.<br><br>b. Review of the quarterly MDS dated 12/18/22 indicated that Resident #7 had an indwelling urinary catheter.<br><br>Facility documentation indicated his indwelling urinary catheter was discontinued 12/09/22.<br><br>An observation of Resident #7 on 4/18/23 at 10:00 AM revealed he did not have a urinary catheter in place.<br><br>In an interview with Resident #7 on 04/19/23 at 8:30 AM, he stated they took out his catheter several months ago.<br><br>In an interview with DON #1 and Administrator #2 on 4/27/23 at 1:40 PM, the DON #1 stated not having a dedicated MDS nurse, things had been missed on the MDS assessments such as a catheter being coded in error. The DON stated this issue will be fixed when the new MDS nurse starts working. The DON #1 stated it was her expectation that MDS assessments were coded accurately. | F 641 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced | F 677 | | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 677 | Continued From page 14<br>by:<br>Based on observation, record review, and staff interviews the facility failed to trim a dependent resident's fingernails for 1 of 3 residents reviewed for activity of daily living (Resident #11).<br><br>The findings included:<br><br>Resident #11 was admitted to the facility on 01/23/23 with diagnoses that included: acute respiratory failure with hypoxia and others.<br><br>Review of the significant change Minimum Data Set (MDS) assessment dated 01/28/23 revealed that Resident #11's cognition was not assessed nor was the staff assessment of his cognition. The MDS further revealed that Resident #11 required extensive assistance with personal hygiene and had limitation of range of motion to bilateral upper and lower extremities. No rejection of care was noted on the MDS.<br><br>Review of a care plan revised on 02/01/23 read in part; Resident #11 had an activity of daily living (ADL) performance deficit related to trauma from multiple injuries sustained in a motor vehicle accident. The interventions included: Resident #11 is totally dependent on one staff member for personal hygiene and oral care. There was no care plan for rejection of care.<br><br>An observation of Resident #11 was made on 04/18/23 at 10:09 AM. Resident #11 was resting in bed and was alert and verbal. His bilateral hands were contracted, and Resident #11 was asked if he could open his right hand. He was able to open his right hand a small bit, enough to visualize his fingernails. The fingernails on his right hand were approximately three fourth inch | F 677 | Residents #11 was provided nail care on 4/25/23 All residents have the potential to be affected by the same deficient practice. An audit was completed by the Director of Nursing and Administrator on all residents checking to ensure that no other resident had concerns with nails. Audit was completed on 5/2/23.<br>The Director of Nursing will provide education to nursing staff on Nail Care. Nursing staff not receiving the education by 5/19/23 will not be able to work until the education is completed. Newly hired staff will complete education in orientation.<br>Observations will be made by the Administrator or designee for 10 residents a week for 4 weeks, then 5 residents a week for 4 weeks, and then 2 residents a week for 4 weeks. Observations will include nail care for length and cleanliness.<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of Compliance: 5/21/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 677 | Continued From page 15 | F 677 | | |

long extending past the end of his finger and there was an indentation in the palm of his hand where the nails had been resting but the skin was intact. Resident #11 was asked if he could open his left hand, he was able to do so a small bit but stated "that it hurt". The thumb and two middle fingers were visualized, and the fingernails were approximately three fourth inch long extending past the end of his finger and there was an indentation in the palm of his hand where the nails had been resting but the skin was intact.

Nurse Aide (NA) #10 was interviewed on 04/18/23 at 1:48 PM. She stated that she generally worked as one member of the shower team in the facility. NA #10 stated that Resident #11 preferred bed bath so she had given him a complete bed bath "a couple of weeks ago" but could not recall the exact date and could not locate the shower sheet from that day. NA #10 stated that she could not recall the status of Resident #11's fingernails and she could not recall if she trimmed them or not. She stated it was generally her practice to clean fingernails so she believed she would have cleaned them but could not say for sure if she trimmed them or not.

NA #7 was interviewed on 04/19/23 at 12:14 PM. NA #7 confirmed that she had given Resident #11 a complete bed bath on 04/14/23 and had cleaned his nails. She stated Resident #11's fingernails were long on 04/14/23 but could not explain why she had not trimmed them. NA #7 stated that she assisted Resident #11 on 04/19/23 before he was transferred to the hospital and again noticed his fingernails were long but there was not time to trim them before he left the facility earlier on the shift.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 677 | Continued From page 16<br>Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM. The DON #1 explained that the facility generally had two staff members in the shower room completing showers on a daily basis. Anytime the resident received a bath or shower she would expect the staff to perform nail care. If Resident #11 received a complete bed bath on 04/14/23 and the staff noted his nail to be long the staff should have trimmed them at that time. | F 677 | | |
| F 678 SS=K | Cardio-Pulmonary Resuscitation (CPR)<br>CFR(s): 483.24(a)(3)<br><br>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff, Nurse Practitioner and Medical Director interviews the facility failed to have basic lifesaving equipment readily available for use to immediately begin cardiopulmonary resuscitation (CPR) when Resident #3 experienced sudden cardiac arrest on 08/14/22 and staff were unable to immediately begin CPR that included chest compressions and rescue breathing because the first crash cart (cart of emergency supplies) that was brought to the bed side did not have a ambu bag or manual resuscitator (device to administer rescue breathing) on it, staff began chest compressions and it took the staff approximately three minutes to get the second crash cart that did have a ambu bag to begin rescue breathing. Resident #1 experienced sudden cardiac arrest on 02/07/23 | F 678 | Resident #1, #2 and # 3 have expired. All current residents that have a full code status have the potential to be affected by current practice deficiency. On 4/20/2023, the Regional Nurse Consultant completed record review of residents that expired in a medical facility, expired in the facility, and/or discharged to another hospital for the following dates, 1/1/2023 □ 4/20/2023 to ensure procedures for CPR were followed with no issues.<br>On 4/19/2023, the Regional Director of Nursing educated the Administrator, Director of Nursing, and the Unit Manager CPR procedure, what basic lifesaving equipment needs to be on the two crash carts and in central supply. The | 5/21/23 |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 678 | Continued From page 17<br>and staff were unable to immediately begin CPR that included chest compressions and rescue breathing because the staff could not locate an ambu bag or manual resuscitator to begin rescue breaths and could not locate a backboard (hard surface to do chest compressions on while in bed). It took the staff approximately five minutes to locate the needed items to begin CPR. On 03/07/23 Resident #2 experienced sudden cardiac arrest and staff were unable to immediately begin CPR that included chest compressions and rescue breathing because they could not locate an ambu bag or manual resuscitator and had to borrow one from another resident's room. The staff also could not locate the paddles for the Automatic External Defibrillator (AED) (device used to deliver a shock to the heart). It took staff "several minutes" to locate the ambu bag and paddles for the AED to begin CPR. This affected 3 of 4 residents reviewed who experienced sudden cardiac arrest. Resident #1, #2, and #3 expired in the facility or in the hospital.<br><br>Immediate Jeopardy began on 08/14/22 when Resident #3 experienced sudden cardiac arrest and staff were unable to immediately begin CPR that included chest compressions and rescue breathing because they could not locate an ambu bag to begin rescue breathing. Immediate jeopardy was removed on 04/21/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity E (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education. | F 678 | equipment will include an Ambu bag, non-rebreather mask, suctioning kit, oxygen tank, IV kit, normal saline, yankauer □ oral suctioning tool used to remove secretions by effective coughing, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board.<br>On 4/19/2023, the Director of Nursing and the Unit Manager educated current staff on CPR procedure and location and items of the basic lifesaving equipment. The equipment includes an Ambu bag, non-rebreather mask, suctioning kit, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board. The basic lifesaving equipment is in the two crash carts with back boards that are located at each nurse□s station. In addition to the two crash carts, basic lifesaving equipment is in the central supply office. The basic lifesaving equipment is located on the right side of the room on the racks. Education completed 4/20/2023. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. Education will continue in orientation for newly hired staff, to include agency staff.<br>On 4/19/2023, the Director of Nursing and the Unit Manager reviewed the two crash carts located at each nurse□s station to ensure that all basic lifesaving equipment is readily available for use while performing Cardiopulmonary | |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 18<br>The finding included:<br><br>Review of the facility's policy titled "CPR Procedures", last revised on 03/22 read in part: "1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing a. Verify or direct a staff member to verify the DNR (Do Not Resuscitate) or code status of an individual b. Instruct a staff member to activate the emergency response system (code) and call 911 c. Instruct a staff member to retrieve the crash cart d. Initiate the basic life support (BLS) sequence of events.<br><br>1. Resident #3 was admitted to the facility on 11/10/20 with diagnoses that included acute and chronic respiratory failure with hypoxia and congestive heart failure.<br><br>Review of a physician order dated 04/07/21 indicated Resident #3 was a full code.<br><br>Review of a care plan dated 07/29/22 read; Resident #3 has an established advanced directive; Full Code. The goal read: Resident #3 wishes as expressed in Advanced Directive will be followed.<br><br>Review of Resident #3's progress notes revealed a note by Nurse #13 dated 08/14/22 at 7:28 AM that read in part: Resident reported on floor at 6:15 AM by Med Aide #3 (MA) following ambulation by resident from smoking area. Resident assessed for pulse and respiration. Resident #3 was placed in a supine position and chest compressions were initiated immediately. EMS (Emergency Medical Services) notified by staff while this Nurse #13 and additional Nurse #7 performed CPR in (cardiopulmonary | F 678 | Resuscitation. The equipment will include an Ambu bag, non-rebreather mask, suctioning kit, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board. Any opportunities identified during this audit will be corrected by the Director of Nursing and the Unit Manager by 4/19/2023.<br>On 4/19/2023, the Regional Director of Nursing educated the central supply coordinator on ensuring basic lifesaving equipment is always readily available and easily accessible to current staff on the crash carts and in the central supply office. The equipment will include an Ambu bag, non-rebreather mask, suctioning kit, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board.<br>The Administrator and/or designee will audit the crash cart for checklist completeness and equipment readily available five times a week for four weeks, three times a week for four weeks and two times a week for four weeks. In addition the Administrator or designee will complete an audit of the central supply room twice a week for 3 months to ensure back up supplies are available.<br>The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 678 | Continued From page 19 | F 678 | | |

resuscitation] in residents' room. EMS arrived at 6:25 AM and began working with resident. Resident pronounced expired by EMS at 6:46 AM.

An interview with Nurse #13 (agency nurse) was conducted on 04/19/23 at 3:44 PM via telephone and revealed he was an agency nurse and the first nurse to respond to calls for help from MA #3 on 08/14/22 when Resident #3 was found unresponsive but still warm. He reported he requested the crash cart and assistance from Nurse #7. He stated he immediately began chest compressions until Nurse #7 arrived at the room and began assisting with rescue breaths via an ambu bag. He reported he did not know if a second crash cart had to be retrieved as his main concern was trying to save Resident #3's life.

Review of the facility's staffing schedule from 08/14/22, the morning Resident #3 passed away, revealed Nurse Aide (NA) #11, NA #12, Nurse #7, Nurse #12, Nurse #13, and Medication Aide (MA) #3 were working.

An interview with MA #3 on 04/19/23 at 3:14 PM revealed when she found Resident #3 in the floor of his room unresponsive around 5:30 AM on 08/14/22 she immediately called for help and Nurse #13 arrived at the room. She reported she was told by Nurse #13 to go gather the necessary paperwork for transport, so she left the room. She did not know if there were issues with items not being on the crash carts.

An interview with NA #13 (agency) was conducted on 04/19/23 via telephone, at 2:42 PM and revealed she was working in the facility on 8/14/22 as a nurse aide the morning Resident #3

make additional interventions and recommendations based on the audits to ensure continued compliance.
Date of Compliance- 5/21/23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 20 | F 678 | | |

had passed away. She stated around 5:30 AM, MA #3 entered Resident #3's room and found him unresponsive. She reported the first crash cart was brought to the room and she ran to get Nurse #7 who was working on the other unit. She stated when she returned from notifying Nurse #7, she found out the crash cart did not have an ambu bag on it and she ran back down the hall to get the other crash cart. She reported there was an approximate 5-minute delay in getting the supplies gathered to begin CPR.

During an interview with NA #11 on 04/19/23 at 12:05 PM she reported she and NA #12 were assigned to Resident #3 on 8/14/23, the morning he passed away. She reported he had gone out to smoke around 4:00 AM and seemed his normal self. She reported when MA #3 went into his room around 5:00 AM, she found him on the floor and screamed for help. NA #11, NA #12, NA #13 and Nurse #13, responded to Resident #3's room. She reported NA #13 ran to get the crash cart while Nurse #13 began Cardiopulmonary Resuscitation (CPR). She reported she remembered the second crash cart had to be retrieved because the first crash cart did not have an ambu bag.

An interview with NA #12 was conducted on 04/19/23 at 12:35 PM and revealed she was working on 8/14/22 the morning Resident #3 died. She reported that when the staff were made aware Resident #3 was in cardiac arrest, Nurse #13 sent NA #13 to go get the crash cart while she started CPR. NA #12 reported when NA #13 returned with the crash cart she had to go get a second crash cart because the first one did not have a backboard or an ambu bag. She reported it took 2-3 minutes before all the supplies were at

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 21 | F 678 | | |

Resident #3's room to begin CPR.

An interview was attempted with Nurse #7 and was unsuccessful.

A joint interview with Unit Manager (UM) #1 and UM #2 on 04/18/23 at 1:15 PM revealed they were responsible for ensuring crash carts were stocked and that the crash carts were checked daily and completed a log of inventory that was kept on the crash carts. They reported they checked the crash carts to ensure they contained ambu bags, oxygen, a suction machine, and other needed materials in the event of a cardiac arrest event. They also reported the logs from August 2022 had been long removed and were unable to locate them. UM #1 and UM #2 insisted both of the facility's crash carts had an ambu bag and that backboards were kept next to the crash carts.

A telephone interview with the Medical Director on 04/19/23 at 5:13 PM revealed he expected the facility to have the supplies they needed on the crash carts to immediately start CPR in the case of a sudden onset of cardiac arrest.

An observation of the facility's crash carts was made on 04/18/23 at 1:09 PM. Both crash carts were observed to have ambu bags on the bottom of the cart and a backboard was next to each crash cart. The crash carts were also stocked with a suction machine, tubing, nasal cannulas, stethoscope, blood pressure cuff, and other supplies that may be needed during a cardiac arrest emergency.

An interview was attempted with the Director of Nursing #3 and was unsuccessful.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 22 | F 678 | | |

An interview was attempted with Administrator #3 and was unsuccessful.

2. Resident #1 was admitted to the facility on 09/27/22 with diagnoses that included diabetes, hypertension, peripheral vascular disease, atrial fibrillation, and others.

Review of a physician order dated 09/27/22 read: Full Code.

Review of a care plan dated 09/29/22 read; Resident #1 will have Full Code Advance Directives. The goal read: Resident #1 will have his Advance Directives followed.

Review of a nurses note written on 02/07/23 as a late entry by Nurse #1 read, "Resident was found to be unresponsive by the NA who was in the process of making rounds. CPR was started immediately. EMS was called and they arrived in 10 minutes. EMS took over CPR compressions and proceeded to continue to perform full code on resident. Resident continue to be none responsive. The ER doctor on call pronounced resident deceased at 2:26 AM".

Resident #1 expired on 02/07/23.

Nurse #1 (agency nurse) was interviewed via phone on 04/18/23 at 12:14 PM who confirmed she was working third shift on 02/06/23. She stated she was passing medications and had passed Resident #1's room and he was in bed and was his usual self. Nurse #1 stated that a short time later one of the NAs who she did not know came to her and stated that Resident #1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 23 | F 678 | | |

was not breathing. Nurse #1 stated that she was not aware how to page overhead, so she began yelling loudly to alert other staff that she needed some help. She stated that she sent the NAs to get the crash cart while she began chest compressions. Nurse #1 stated "I was getting mad because they could not find anything" that was needed, it took them over five minutes to find what we needed (backboard and ambu bag) and she was not aware of where they located the items. Nurse #1 stated she was the only nurse in the room and had to "teach the nurse aides how to use the ambu bag really quick." Nurse #1 stated that she worked at the facility through an agency, and she did not get any orientation to the facility regarding emergency procedures or protocols. She stated she knew where the crash carts were from just observing during her times in the facility, she stated, "I was very upset, I felt like that when you have crash carts it should be supplied even with the basics" and that night it did not have an ambu bag and the back board could not be located. Nurse #1 confirmed that when the NA told her that Resident #1 was not breathing, she had gone to the electronic medical record and verified his code status as Full Code and when she began chest compression Resident #1's body was still warm to touch, and she confirmed that she checked all his pulse points and could not find one so chest compression were initiated while she waited for the appropriate equipment.

NA #1 (agency NA) was interviewed via phone on 04/18/23 at 11:06 AM who confirmed that she worked at the facility through an agency and was working third shift on 02/06/23 when Resident #1 went into cardiac arrest. NA #1 stated that she was very familiar with Resident #1 and each night

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 24 | F 678 | | |

that she worked she would always go and check on him, she stated he particularly loved milk and shortly after the start of her shift on 02/06/23 she had gone and got Resident #1 a carton of milk to drink. She stated she had passed by his room several times during the shift and Resident #1 was in his bed in his usual state. She stated then she heard the staff verbally hollering that they had Code Blue (code for sudden cardiac arrest), and she went running towards Resident #1's room. NA #1 stated that someone had grabbed the crash cart but there was no ambu bag on it and no backboard was available. She stated that Nurse #1 began chest compressions, but he was on the soft bed not on a hard surface. NA #1 stated she suggested to Nurse #1 that they lower him to the floor to begin compressions, but she continued to do compressions while the staff frantically tried to locate an ambu bag to do rescue breathing. NA #1 stated that it took a few minutes for someone to find an ambu bag, but she could not recall who found it and she did not know where they found it. NA #1 stated that she believed the crash carts were to be checked daily to ensure all the supplies were available but stated that when they needed to do CPR on Resident #1 the crash cart did not have an ambu bag and no back board was available. She added that the crash cart they used stayed in disarray for about three weeks after the event until someone returned it to the correct place and restocked it.

NA #2 was interviewed via phone on 04/18/23 at 11:23 AM and confirmed that she worked third shift on 02/06/23 and was responsible for Resident #1. NA #2 stated that she had answered a call light for another room and had walked past Resident #1's room on her way to the nurse's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 25 | F 678 | | |

station to tell the nurse what that resident needed. She stated that as she passed by Resident #1's room he was in bed and was kicking the covers off of him, she proceeded to the nurse's station and as she walked back by Resident #1's room she noticed that his color was "gone", and he was very pale. She stated that Resident #1 was warm to touch but was not breathing so she yelled Code Blue to the other staff on the unit. NA #2 stated she did not know how to overhead page, so she ran to the other side to alert the staff and on her way back grabbed the crash cart. She stated that there was no ambu bag on the crash cart and she could not find a backboard. NA #2 stated that she "rushed around trying to find all the stuff that was needed for him." NA #2 recalled that eventually they found the backboard but finding the ambu bag was little more difficult because she was not sure what she was looking for. NA #2 stated that eventually another staff member who she did not know returned to the room with an ambu bag and they began rescue breathing around the same time that EMS arrived on scene. NA #2 stated that it took approximately five minutes to gather all the needed supplies to do CPR on Resident #1.

Medication Aide (MA) #1 (facility staff) was interviewed via phone on 04/18/23 at 12:33 PM who confirmed that she was working third shift on 02/06/23. She stated that she recalled hearing the Code Blue for Resident #1 and she went to assist as needed. She stated that Nurse #1 was a agency Nurse and really did not know what to do so she was telling her the procedure. She stated that Nurse #1 began CPR, but she could not recall anything regarding the supplies. MA #1 stated it had been a while since the event and she really could only recall that Resident #1 had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 26 | F 678 | | |

passed away.

NA #3 was interviewed via phone on 04/18/23 at 4:41 PM who confirmed that she was working third shift on 02/06/23. She stated what she recalled about that evening was that Resident #1 coded and the crash cart was not fully stocked because it did not have an ambu bag and they could not find the backboard. She could not recall if they ever found the ambu bag but stated EMS was there quickly and they began working on Resident #1, but he passed away. NA #3 stated she was aware of where the crash cart was located but stated that when the staff brought it to the room it did not have what they needed.

Unit Manager (UM) #1 and #2 were interviewed together on 04/18/23 at 1:15 PM. UM #2 stated that she was aware that Resident #1 had coded during the night when she was not in the building and had passed away. UM #1 stated that she and UM #2 were responsible for checking and stocking the crash carts daily and they logged those checks in a binder kept on the crash cart. UM #1 and UM #2 stated that they were not aware that the staff could not locate an ambu bag or backboard when Resident #1 went into cardiac arrest. Both stated that they checked the crash carts daily and both had an ambu bag and the backboard was always kept next to the crash cart. Both UM confirmed that they checked and restocked the crash carts daily on the days that they were working in the facility.

Director of Nursing (DON) #2 was interviewed via phone on 04/18/23 at 11:18 AM. DON #2 stated that there were two crash carts in the building, one on each unit and the UMs were responsible for checking them and stocking them daily and as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 27 | F 678 | | |

needed. DON #2 stated she recalled during one emergency the staff could not locate an ambu bag, but they found one and then she had the UMs check and restock the crash carts. She stated she could not recall if that emergency was with Resident #1 or not. DON #2 stated she believed that during the emergency the staff eventually found an ambu bag to use. Following the emergency when the ambu bag could not be immediately located they discussed the issue in morning meeting, and she had stressed the importance of checking the crash carts daily and ensuring that it contained all the supplies that would be needed during an emergency.

Administrator #1 was interviewed on 04/18/23 at 5:03 PM who stated that she was not aware of issues with Resident #1 and could not say for sure how or when he passed away. Administrator #1 stated that she does not recall any staff member expressing concerns that the crash carts were not stocked appropriately and that they did not have the supplies they needed during an emergency.

The Medical Director (MD) was interviewed via phone on 04/19/23 at 5:13 PM. The MD explained that Resident #1's diagnoses placed him at high risk for sudden cardiac arrest. The immediate start of CPR had a high likelihood of changing Resident #1's outcome and the MD stated he fully expected the facility to have the supplies they needed to immediately start CPR in the case of sudden cardiac arrest.

An observation of the facility's crash carts was made on 04/18/23 at 1:09 PM. Both crash carts were observed to have ambu bags on the bottom of the cart and a back board was next to each

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 28 | F 678 | | |

crash cart. The crash carts were also stocked with a suction machine and tubing, nasal cannulas, stethoscope, blood pressure cuff and other supplies that may be needed during an emergency.

3. Resident #2 was admitted to the facility on 01/05/23 with diagnoses that included history heart attack, diabetes, atrioventricular heart block, chronic kidney disease, and others.

Review of a physician order dated 01/27/23 read: Full Code.

Review of a nurse's note dated 03/07/23 written by Nurse #2 read; "Resident seen upon morning care in dire straits, resident seen in bed foaming at the mouth; this nurse checked resident for responsiveness. When patient did not respond this nurse called a code-initiated others to get a crash cart and call 911. CPR was initiated after patient was placed on back board. Necessary staff was present, and EMS arrived shortly after."

Resident #2 was transferred to the local hospital where he died on 03/07/23.

Attempts to speak to Nurse #2 (agency nurse) were unsuccessful.

Nurse #3 (agency nurse) was interviewed on 04/18/23 at 3:09 PM who confirmed that she was working on 03/07/23 when Resident #2 went into cardiac arrest. She stated that the staff brought the crash cart to the room and there was no ambu bag on it. She stated the staff were doing chest compressions, and someone went and got a non-rebreather mask (mask used to deliver oxygen with a bag on end), and we began

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 29 | F 678 | | |

pushing oxygen through the mask. Nurse #3 stated that initially Nurse #2 was doing chest compressions and when the crash cart arrived at the room with no ambu bag she took over chest compressions and Nurse #2 went to find an ambu bag. Nurse #3 stated that when she began chest compressions Resident #2 was still warm and it took the staff "several minutes" to find the ambu bag and she believed that they went to another resident's room in the facility that had a tracheostomy and got the one in his room. The ambu bag was found as Emergency Medical Services (EMS) was coming on scene and they took over and transported Resident #2 to the hospital, but he passed away shortly thereafter.

Nurse #4 (agency nurse) was interviewed on 04/18/23 at 3:25 PM who confirmed that she was working on 03/07/23 when Resident #2 went into cardiac arrest. She stated when she heard the Code Blue called, she immediately responded to the room. Nurse #2 was in the room, and she was beginning to do compressions without a backboard. She stated she hollered at the staff to get the backboard and once it was found and brought to the room chest compressions were started again. Nurse #4 stated she instructed Nurse #3 to turn the oxygen all the way up and then realized that there was no ambu bag on the crash cart. When the staff finally found the ambu bag and brought it to the room she began administering rescue breaths. At some point during the time, they could not find an ambu bag, Nurse #4 instructed the staff to go into another resident's room that had an ambu bag and get it so they could start rescue breaths on Resident #2. Nurse #4 stated that prior to Resident #2's cardiac arrest she had informed Unit Manager (UM) #2 that the crash cart needed an ambu bag

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 30 | F 678 | | |

because she had worked a night shift back in January 2023 and while doing a routine check of the crash cart, she discovered it did not have an ambu bag, so she reported to UM #2 that it needed one. Nurse #4 stated that she followed up and asked UM #2 about the ambu bag a of couple days later and she stated that she had told the former Director of Nursing #2 (DON) about the need for the ambu bag.

Nurse Aide (NA) #4 was interviewed on 04/19/23 at 10:02 AM who confirmed that he was working when Resident #2 coded and went into cardiac arrest. He stated that when he arrived at Resident #2's room it was "very disorganized", and staff were running around trying to locate equipment that was not on the crash cart. NA #4 stated he was on standby to do compressions if needed so he did not leave the room and was not sure where they located the ambu bag or backboard. He added that they located all the equipment around the same time EMS arrived and they took over CPR until Resident #2 was transferred to the local hospital.

NA #5 was interviewed on 04/19/23 at 12:11 PM who confirmed that she was working on 03/07/23 when Resident #2 coded. NA #5 stated that when she got to Resident #2's room they did not have a backboard and the first crash cart was in the room and did not have an ambu bag on it. She stated that she recalled seeing a backboard in the break room, so she left to go and get it. NA #5 stated that as she was returning to Resident #2's room with the backboard she saw NA #6 coming down the hallway with the other crash cart, but it did not have an ambu bag either. When she got to Resident #2's room with the backboard another staff member had yelled to go and get the ambu

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 31 | F 678 | | |

bag from another resident's room and someone ran to get it, but she could not recall who that was. Once they had the supplies to do CPR, they staff began performing CPR until EMS came and took over and Resident #2 was transferred to the hospital.

NA #7 was interviewed on 04/19/23 at 12:14 PM and confirmed that she was working on 03/07/23 when Resident #2 coded. She stated when she heard the Code Blue, she grabbed the other crash cart. NA #6 had grabbed the one from the other side of the building. NA #7 stated when the crash carts arrived in Resident #2's room there was no ambu bag on either crash art. NA #7 stated she ran to the resident's room in the facility that had an ambu bag in his room and grabbed it and ran to the supply closet and got a suction canister and tubing so that the Nurse Practitioner could suction Resident #2 because the crash cart did not have the right equipment to suction him.

NA #6 was interviewed on 04/19/23 at 3:00 PM who confirmed she was working on 03/07/23 when Resident #2 coded. She stated that when she heard the page for Code Blue, she grabbed the crash cart and ran to Resident #2's room. NA #6 stated that once she arrived in the room, she broke the seal on the crash cart but could not find the ambu bag. She stated she looked over the crash cart several times and there was no ambu bag, she stated she heard that they found one in another's resident room. NA #6 stated both crash carts were supposed to have an ambu bag on them, but she could not say whether the other crash cart had one or not.

Nurse Practitioner (NP) #1 was interviewed via phone on 04/18/23 at 3:52 PM who confirmed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 32 | F 678 | | |

she was in her office charting on 03/07/23 when she heard the Code Blue page. She stated she when she got to the room the staff were doing chest compressions on the bed with no backboard, "I instructed the staff to go and get the backboard." Then the NP said, "where is the ambu bag so we can do rescue breaths? "The crash cart was in the room with no ambu bag on it, so she again instructed the staff to go and find an ambu bag. The NP stated Resident #2 had fluids running out of his mouth and he needed to be suctioned but there was no suction machine on the crash cart, so instructed staff to go and find a suction machine. The NP stated she was aware that the facility had an Automatic External Defibrillator (AED) she questioned that staff where the AED was. She stated that another staff member ran to get the AED and when they brought it to the room there was no paddles to use it. The NP stated, "we did the best we could with what we had until EMS arrived." She stated that she questioned UM #1 about why the crash cart was not stocked but the check list indicated that everything was there. The NP stated UM #1 stated that she had checked the crash cart, and everything was there. The situation was "awful and should not have happened that way," the NP added that she expected the crash carts to be stocked to run codes and perform CPR when needed. The NP also stated she had met with Administrator #1 and Director of Nursing (DON) #2 and expressed her dissatisfaction with the situation but really did not get any answers as to why it had happened the way it did.

Unit Manager (UM) #1 and #2 were interviewed together on 04/18/23 at 1:15 PM. UM #1 stated that she and UM #2 were responsible for checking and stocking the crash carts daily and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 33 | F 678 | | |

they logged those checks in a binder kept on the crash cart. UM #1 and UM #2 stated that they were not aware that the staff could not locate an ambu bag, backboard, and other equipment when Resident #2 went into cardiac arrest. Both stated that they checked the crash carts daily and both had an ambu bag and the back board was always kept next to the crash cart. Both UM confirmed that they checked and restocked the crash carts daily on the days that they were working in the facility.

DON #2 was interviewed via phone on 04/19/23 at 11:18 AM. DON #2 stated that there were two crash carts in the building one on each unit and the UMs were responsible for checking them and stocking them daily and as needed. DON #2 stated she recalled during one emergency the staff could not locate an ambu bag, but they found one and then she had the UMs check and restock the crash carts. She stated she could not recall if that emergency was with Resident #2 or not. DON #2 stated she believed that during the emergency the staff eventually found an ambu bag to use. Following the emergency when the ambu bag could not be immediately located they discussed the issue in morning meeting, and she had stressed the importance of checking the crash carts daily and ensuring that it contained all the supplies that would be needed during an emergency.

Administrator #1 was interviewed on 04/18/23 at 5:03 PM who stated that she was not aware of issues with Resident #2 and could not say for sure how or when he passed away. The Administrator stated that she did not recall any staff member expressing concerns that the crash carts were not stocked appropriately and that they

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 678 | Continued From page 34 | F 678 | | |

did not have the supplies they needed during an emergency.

The Medical Director (MD) was interviewed via phone on 04/19/23 at 5:13 PM. The MD explained that Resident #2's diagnoses placed him at high risk for sudden cardiac arrest. The immediate start of CPR had a high likelihood of changing Resident #2's outcome and the MD stated he fully expected the facility to have the supplies they needed to immediately start CPR in the case of sudden cardiac arrest.

An observation of the facility's crash carts was made on 04/18/23 at 1:09 PM. Both crash carts were observed to have ambu bags on the bottom of the cart and a back board was next to each crash cart. The crash carts were also stocked with a suction machine and tubing, nasal cannulas, stethoscope, blood pressure cuff and other supplies that may be needed during an emergency.

Administrator #1 and the DON #1 were notified of the Immediate Jeopardy on 04/19/23 11:03 AM.

The facility provide the following IJ removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 02/07/23 at approximately 1:00 AM Resident #1 experienced sudden cardiac arrest. The staff were unable to locate an Ambu bag or manual resuscitator used to deliver ventilation to residents not breathing. The staff were also unable to locate a back board (hard surface) to correctly deliver chest compressions to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 678 | Continued From page 35 | F 678 | | |

correct depth for delivery of CPR. It took the staff approximately 5 minutes of time to locate the required items to deliver CPR when Resident #1 was pulseless. Resident #1 expired on 02/07/23 in the facility.

On 03/07/23 at approximately 10:30 AM Resident #2 experienced sudden cardiac arrest. The staff were unable to locate an Ambu bag or manual resuscitator used to deliver ventilation to residents not breathing. The staff were also unable to locate a back board (hard surface) to correctly deliver chest compressions to the correct depth for delivery of CPR. The Nurse Practitioner (NP) responded to the code and requested the basic lifesaving equipment and indicated that it took "several minutes" before a manual resuscitator was taken from another residents' rooms to use, the NP requested the facilities Automatic External Defibrillator (AED) and when staff retrieved the AED failed to have the paddles used to deliver the shock readily available for use by the NP. The NP also requested a suction machine that was not readily available for use. Resident #2 was transported to the Emergency Room (ER) and expired in the hospital.

On 08/14/22 Resident #3 who had an extensive history of drug and opioid abuse was found on the floor with a white powdery substance on his bedside table. Resident #3 was warm to touch but was pulseless and was in cardiac arrest. Staff responded with the crash cart and there was no ambu bag on the crash cart. Another staff member had to obtain the other crash cart to get an ambu bag. It took approximately two to three minutes to obtain the other crash cart with the ambu bag and begin rescue breathing and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 36 | F 678 | | |

compressions.

Resident #1 expired on 02/07/2023 at 2:26 AM in the facility.
Resident #2 expired on 03/07/2023 in the hospital.
Resident #3 expired in the facility on 08/14/22.

All current residents that have a Full Code status have the potential to be affected by current practice deficiency.

On 04/20/2023, the Regional Nurse Consultant completed record review of residents that expired in a medical facility, expired in the facility, and/or discharged to another hospital for the following dates, 01/01/2023 - 04/20/2023 to ensure procedures for CPR were followed with no issues. Staff interviews completed with nurse involved. This was completed on 04/20/2023.

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

On 04/19/2023, the Regional Director of Nursing removed the Automatic External Defibrillator from the facility. The facility CPR procedure does not include usage of AED.

On 04/19/2023, the Regional Director of Nursing educated the Administrator, Director of Nursing, and the Unit Manager CPR procedure, what basic lifesaving equipment needs to be on the two crash carts and in central supply. The equipment will include an Ambu bag, non-rebreather mask, suctioning kit, suctioning machine, oxygen tank, IV kit, normal saline, yankauer - oral suctioning

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 37 | F 678 | | |

tool used to remove secretions by effective coughing, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board.

On 04/19/2023, the Director of Nursing and the Unit Manager educated current staff on CPR procedure and location and items of the basic lifesaving equipment. The equipment includes an Ambu bag, non-rebreather mask, suctioning kit, suctioning machine, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board. The basic lifesaving equipment is in the two crash carts with back boards that are located at each nurse's station. The education included use of back board under resident that is receiving compression while in bed. In addition to the two crash carts, basic lifesaving equipment is in the central supply office located at the back of the building beside room 145. The central supply office is always accessible to staff via keypad. Education included keypad code. The basic lifesaving equipment is located on the right side of the room on the racks. Education completed 4/20/2023. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. Education will continue in orientation for newly hired staff, to include agency staff. The Director of Nursing and/or designee will maintain list of employees who have received education. The Scheduler will cross reference schedules to ensure all employees scheduled have received education. If employees wish to be scheduled and are not on the employee list, scheduler will coordinate training prior to next scheduled shift with Director of Nursing. Director of Nursing was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 38 | F 678 | | |

notified to include education in new hire orientation.

On 04/19/2023, the Director of Nursing and the Unit Manager reviewed the two crash carts located at each nurse's station to ensure that all basic lifesaving equipment is readily available for use while performing Cardiopulmonary Resuscitation. The equipment will include an Ambu bag, non-rebreather mask, suctioning kit, suctioning machine, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board. Any opportunities identified during this audit will be corrected by the Director of Nursing and the Unit Manager by 04/19/2023.

On 04/19/2023, the Regional Director of Nursing educated the central supply coordinator on ensuring basic lifesaving equipment is always readily available and easily accessible to current staff on the crash carts and in the central supply office. The equipment will include an Ambu bag, non-rebreather mask, suctioning kit, suctioning machine, oxygen tank, IV kit, normal saline, yankauer, masks, gloves, disposable gowns, flashlight, alcohol wipes, blood pressure cuff, stethoscope, and back board.

Effective 04/19/2023, the Central Supply Coordinator will check the two crash carts Monday through Friday in the morning to ensure basic lifesaving equipment is readily available to perform CPR. The administrator and/or designee will check the two crash carts Monday through Friday in the evening to ensure basic lifesaving equipment is readily available to perform CPR. Effective 04/19/2023 the manager on duty will

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 39 | F 678 | | |

check the two crash carts during weekends to ensure basic lifesaving equipment is readily available to perform CPR. The crash carts will be checked by using the emergency crash cart checklist located on the crash cart. The Central Supply Coordinator, Administrator, Nurse Mangers, and/or designees will be responsible for stocking the crash carts as needed with the stock located in the central supply office. Managers on weekend duty were notified of this responsibility on 04/20/23

Effective 04/19/2023, the Administrator will ensure the emergency crash cart checklist is completed.

Facility policy dictates licensed nurses must have current/active CPR certification and reflects the licensed nurses will perform CPR on residents that are currently a full code. CPR certified staff will be available at all times to perform CPR. Current staff educated on the facility CPR policy and Procedure and their role, emergency crash cart checklist, location of crash carts in facility, location of additional BLS equipment, Education included the following:
Procedure
1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR:
Verify or instruct a staff member to verify the DNR or code status of the individual.
Instruct a staff member to activate the emergency response system (code) and call 911.
Instruct a staff member to retrieve the crash cart.
Initiate the basic life support (BLS) sequence of events.
The BLS sequence of events is referred to as "C-A-B" (chest compressions, airway, breathing).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 40 | F 678 | | |

Chest compressions:
a. Following initial assessment, begin CPR with chest compressions. Position flat hand over left chest and using heal of hand.
b. Push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute.
Allow full chest recoil after each compression; and
Minimize interruptions in chest compressions.
Airway: Tilt head back and lift chin to clear airway.
Breathing: After 30 chest compressions provide 2 breaths via resuscitator or manually (with CPR shield).
All rescuers should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2.
Continue with CPR/BLS until emergency medical personnel arrive.
2. Emergency Crash Cart Checklist
3. Location of crash carts
4. Location of backup BLS supplies

Education completed 04/20/23. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education.

Effective 04/20/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 04/21/2022

On 04/26/23 and 04/27/23 the facility's credible allegation of immediate jeopary removal was validated. Both of the facility crash carts were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 678 | Continued From page 41<br>observed to be fully stocked including ambu bags, backboard, and suction machine. The audit log for each crash cart was also observed to be completed daily from 04/21/23. The central supply closet was observed to have a back up supply of emergency items that included ambu bags, suction machine and canisters, and other frequently used items. Staff interviews across all disciplines in the facility revealed that they had received the education on how to respond to a sudden cardiac event. They were able to articulate the facility's procedure for overhead paging a Code Blue (code for cardiac arrest), where the crash carts/backboard was located, where to find resident code status information, and who should be initiating CPR. The facility had conducted "mock" or trial run of a CPR situation to allow staff to practice in a non-emergent time. The facility's immediate jeopardy removal date of 04/21/23 was validated. | F 678 | | |
| F 689 SS=K | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and interviews with resident, Nurse Practitioner, and staff, the facility failed to implement measures to mitigate the risk of an accidental drug overdose for a resident who had a known history of | F 689 | Resident #3 expired in the facility on 8/14/23. Resident #4 no longer resides in the facility.<br>Current residents that have a history of drug abuse have the potential to be | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 689 | Continued From page 42<br>substance abuse that included crushing and snorting pills/medications. On 8/14/22 Resident #3 was found unresponsive in his room as a result of sudden onset cardiac arrest and he was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in his room. The facility also failed to provide the necessary supervision to prevent accidents for a cognitively impaired resident (Resident #4) who was assessed as a high fall risk due to a history of multiple falls and tendency to overestimate or forget his limits. On the morning of 3/17/23, Resident #4 was left unsupervised in his room in his wheelchair after a therapy session. He was found by staff that afternoon after suffering an unwitnessed fall that resulted in right 9th through 11th rib fractures, facial fractures, right frontal bone fracture extending into the superior orbit roof and lateral orbit wall (fracture that extended to the top and to the side of right eye socket), right hemothorax (blood collecting between chest wall and lungs which can collapse the lung), and intraparenchymal hemorrhage of the brain (bleeding in the tissue of the brain). He was transferred from the Emergency Room to the local trauma center for a higher level of care. This deficient practice was for 2 of 3 residents (Residents #3 and #4) reviewed for supervision to prevent accidents.<br><br>Immediate jeopardy began for example #1 on 07/20/22 when Nurse Practitioner #2 was informed by staff that Resident #3 was seen "cutting" a white powdery substance on his tray table, she ordered Narcan (a reversal agent used in case of an overdose) to treat an accidental overdose, but no measures were implemented by the facility to mitigate the risk of an overdose. | F 689 | affected. A list was made of the residents who have a known history of polysubstance abuse. The list is located at each nurse□s station and in the narcotics book. The Director of Nursing reviewed and is responsible for updating the list with new admissions. Current residents that were identified as High fall risk using the Morse fall scale have the potential to fall and obtain injury. The review and collaboration was conducted by the Regional Nurse Consultant on 4/25/23. A list of resident who are at high risk for falls is located at each nurse station. The Director of Nursing is responsible for updating the list with new residents that are high fall risk.<br>On 04/25/23, the Director of Nursing and Chief Nursing Officer educated staff on where to locate the list of residents with a history of polysubstance abuse. The Director of Nursing and Chief Nursing Officer educated staff on understanding of roles and responsibilities in identifying, reporting, and responding to residents who exhibit behaviors of seeking, acquiring and self-medicating with illegal drugs or medications not prescribed by the attending physician at the nursing home. Education included the following: dangers of self-medicating including serious adverse side effects and death, observing for medications/illegal substances in resident□s room or in resident possession that are not prescribed by the nursing home MD/NP and responding by remaining with resident, calling out for nursing assistance for assessment and safe collection of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 43<br>Immediate jeopardy began for example #2 on 03/17/23 when the facility failed to provide the necessary supervision to prevent an accident for Resident #4. Immediate jeopardy was removed on 04/26/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.<br><br>The findings included:<br><br>Resident #3 was admitted to the facility on 11/10/20 with diagnoses that included cocaine dependence, congestive heart failure, and chronic respiratory failure.<br><br>A physician's order for Resident #3 dated 06/16/22 indicated Oxycodone HCl (narcotic pain medication) tablet 20 milligrams (mg) every 6 hours as needed for pain. The order indicated to crush the tablet and for the resident to take the medication in front of the nurse.<br><br>Resident #3's quarterly Minimum Data Set assessment dated 06/17/22 revealed he was cognitively intact with no psychosis, behaviors, or rejection of care. Resident #3 was coded with having frequent pain and he received opioids on 7 of 7 days during the lookback period. The MDS revealed Resident #3 was born in 1960 indicating he was 62 years old.<br><br>A physician's order for Resident #3 dated 07/20/22 indicated Narcan liquid 4 mg/0.1 milliliter (ml), provide 4 mg in nostril every 6 hours as | F 689 | substances and follow-up reporting by the licensed nurse to the MD/NP and to the Administrator or DON, intervening and asking to search resident with suspicious activity, ensuring resident safety by remaining with resident and calling for licensed nurse assistance, licensed nurse assessing resident for safety and s/s of potential self-medication such as changes in vital signs or altered mental status, visual observation of consumption, response in the event of resident self-medication to include; immediate removal of substance from resident to stop ingestion if possible, then providing emergency medical care as necessary and remaining with resident, calling MD/NP for new orders and calling 911 if indicated, then removing, counting and securing under double lock and key any medications/illegal substances with a second licensed nurse witness, then notification to the DON and Administrator for further investigation and follow-up, revising resident care plan to reduce risk of reoccurrence, education of the facility abuse and neglect policy and reporting immediately to the charge nurse if they hear or suspect a staff member is self-medicating or has an illegal substance in the facility. In the event illicit drug use is suspected the local police department will be contacted and a report made. The Director of Nursing will ensure no licensed nurses or medication aides will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 44<br>needed for overdose.<br><br>Resident #3's care plan last updated on 07/29/22 revealed the following information:<br>- Resident #3 exhibits or has the potential to exhibit verbal/physical behaviors related to opioid dependence and anxiety; history of snorting pills/medications, misuse of oxygen. Interventions included monitoring medication administration to ensure medications are taken and swallowed prior to leaving resident.<br><br>- Resident #3 does complain of pain at times due to impaired mobility. Resident #3 has a diagnosis of chronic pain and opioid dependence. Resident has pain medication in place and is followed by pain clinic." Interventions included "Per MD order Narcan 1 milliliter by nasal route as needed for opioid overdose. Repeat every 2 minutes until emergency medical services arrive."<br><br>A progress note written by Nurse Practitioner (NP) #2 dated 08/03/22 for Resident #3 indicated the following: "Behavioral concerns - this NP recommends that the patient be discharged from this facility for numerous documented reports from the staff of overdose, abuse, and noncompliance. I believe that the patient puts the facility at risk for liability if he were to overdose. I have added Narcan 4mg nasal every 6 hours as needed for overdose. I have expressed my concerns with the [Former] Director of Nursing, Administration, and Medical Director."<br><br>During an interview via telephone on 04/20/23 at 9:01 AM with Nurse Practitioner (NP) #2 she stated she was no longer working at the facility. She reported Resident #3 had a history of taking his narcotic pain medication and then turning his | F 689 | On 4/25/2023, the Director of Nursing and Chief Nursing Officer educated current staff members on fall protocol. Education to include the following: Identifying high fall risk residents upon admission using the Morse fall scale and putting interventions using the Strategies for Reducing the Risk of Falls. Once residents are identified as high fall risk nurse management will update list and place at areas noted to staff. High risk fall residents will be communicated in the morning meeting with department heads and then to the floor staff. During meal tray pass, Department Heads, weekend Manager on Duty, and Night Supervisor is present on the floors in order to provide increased supervision of residents at high risk for falls. Care plans will be updated by Minimum Data Set Coordinator or designee with appropriate interventions. Nurse management will in-service staff on the appropriate interventions.<br>The Director of Nursing will ensure staff will not work without receiving education. Any new hires including agency will receive education prior to the beginning of their next shift. Education will be completed on 4/25/23 by the Director of Nursing and Chief Nursing Officer.<br><br>The Director of Nursing or designee will audit the list in the narcotic book of residents with a known history of polysubstance abuse to ensure it is current five times a week for four weeks, three times a week for four weeks and two times a week for four weeks.<br>The Director of Nursing or designee will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 45 | F 689 | | |

oxygen up on his portable tanks and concentrator until he passed out. She stated she was concerned about Resident #3 abusing his narcotics because she heard from staff (unable to recall their names) that he pocketed the medications and then crushed and snorted them. She reported several months before August of 2022 she refused to prescribe him narcotic pain medications and referred him to a pain clinic for monitoring. The pain clinic ordered the oxycodone. She reported Resident #3's narcotic pain medication was to be crushed and Resident #3 observed until it was fully taken in applesauce or another medium. She revealed she received information from an NA (unable to recall the NA's name) who informed her a picture was turned into facility administration that showed Resident #3 cutting a white powdery substance on his tray table in the facility. She explained this was when she prescribed Resident #3 Narcan (7/20/22) to be given in the event of an accidental overdose.

During a follow up interview with the NP #2 via phone on 04/20/23 at 4:00 PM she revealed she prescribed Narcan on 7/20/22 to be administered "not if but when" Resident #3 overdosed.

The Medication Administration Record (MAR) for August 2022 revealed oxycodone was administered to Resident #3 on 08/14/22 at 2:16 AM by Medication Aide (MA) #3.

During an interview with NA #7 on 04/19/23 at 3:28 PM she reported she believed Resident #3 died from an overdose due to her experience of seeing him snort an unidentified powdery substance on more than one occasion. NA #7 stated each time she observed Resident #3 snorting a white substance, she stopped him and

audit the list at the nurses station of residents identified as high fall risk to ensure it is current five times a week for four weeks, three times a week for four weeks and two times a week for four weeks. Administrator or designee will round during meal service 5 times per week for four weeks to ensure identified residents are supervised.
Date of Compliance- 5/21/23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 46 | F 689 | | |

got the nurse on the hall. She reported by the time she and the nurse returned to the room, the white, powdery substance was gone, and Resident #3 stated it was baby powder and denied snorting it. She reported she also wrote two separate statements regarding what she observed and slid them under Administrator #3's door. NA #7 stated she could not remember the dates she completed the reports but was certain she slid them underneath Administrator #3's door. She reported to her knowledge, nothing was done to prevent Resident #3 from snorting a white, powdery substance.

Administrator #1 was asked on 04/19/23 at 4:30 PM to provide the written statements from NA #7 regarding Resident #3's observed behaviors of crushing and snorting his medications. Administrator #1 reported on 04/20/23 at 10:00 AM she was unable to locate them.

An interview with Resident #3's former roommate, Resident #13, was conducted via telephone on 04/21/23 at 1:16 PM. He revealed he had reported Resident #3's drug abuse to facility staff multiple times including to the Wound Nurse and to Former Social Worker #1. He stated he even sent pictures and a video he had taken on his cell phone to them on their cell phones. Resident #3's former roommate reported he felt that someone from the facility was bringing in either cocaine or opioids and providing them to Resident #3. He stated he watched Resident #3 numerous times pull out pills, chop them up on his tray table, and snort them.

On 04/21/23 at 12:18 PM the photograph and video recorded by Resident #13 was observed. They showed Resident #3 sitting in his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 47 | F 689 | | |

wheelchair, in his room, next to his bed with his back to the door. Resident #3 had a bank debit card in his hand pressing the edge down onto a white, powdery substance that was on his tray table beside his bed.

An interview with the Wound Nurse on 04/21/23 at 12:01 PM via telephone revealed it was very well known that Resident #3 had a substance abuse problem and crushed his opioid medications and snorted them. She also reported she had received a photograph and a short video, unable to recall the date, from Resident #3's roommate, Resident #13, that showed Resident #3 using a credit card to "cut" a white, powdery substance on his tray table in his room at the facility. She reported she immediately sent them to Director of Nursing #3 at the time and also provided them to a Corporate Staff member who was a female. She was unable to remember the Corporate Staff member's name or her title. She stated she also wrote a statement, unable to recall the date, and provided it to the Corporate Staff member. The Wound Nurse reported she heard nothing back from Director of Nursing #3 or the Corporate Staff member about the situation. The Wound Nurse reported she felt that the situation was ignored.

An interview with Social Worker #1 via telephone on 04/21/23 at 3:15 PM revealed she remembered Resident #3 and that he had a history of abusing his medications by crushing and snorting them. She reported Resident #3's former roommate, Resident #13, had approached her in her office some time, unable to recall the date, and told her Resident #3 was storing medications under his tongue then crushing and snorting them. She stated she brought it up to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 48 | F 689 | | |

Director of Nursing #3 and Administrator #3 immediately after being informed, but it was "blown off". She stated, "everyone knew about it, and no one did anything". She reported there were no additional interventions put into place to increase supervision and despite his behaviors being discussed "weekly" at morning meeting it "was always not taken seriously".

A nurse progress note completed by Nurse #13 dated 08/14/22 at 7:28 AM read, in part, "Resident #3 reported on floor at 6:15 AM by NA following ambulation by resident from smoking area ...emergency medical services [EMS] notified by staff while this nurse and additional nurse performed cardiopulmonary resuscitation in resident room. EMS arrived at 6:25 AM ...Resident #3 pronounced expired by EMS at 6:46 AM."

An interview with Medication Aide #3 (MA) on 04/20/23 at 3:14 PM revealed she was assigned on the medication cart and was responsible for providing Resident #3 with his medication from 7:00 PM on 08/13/22 until 7:00 AM on 08/14/22. She stated she last gave him his narcotic pain medication at 2:16 AM on 08/14/22 and found him unresponsive around 5:30 AM. She could not recall with certainty if she crushed his oxycodone when she last administered the medication. She went onto say that she would have administered them as it was ordered on the MAR. MA #3 stated she had worked with Resident #3 a few times previously and she remembered reading in his chart that he had some drug seeking behaviors. She revealed when she worked with him, he came up to her medication cart before he was due to receive his narcotic pain medication and waited there until it

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 49 | F 689 | | |

was time for it to be administered.

Interview with NA #12 (agency) on 04/20/23 at 12:35 PM revealed she worked the night shift (7:00 PM to 7:00 AM) that ended on 8/14/22 on the date Resident #3 expired. She indicated she ran to the room when MA #3 called for help after finding him unresponsive. She stated Resident #3 was well known in the facility as a substance abuser and had a history of crushing and snorting his medications and she believed there was a crush order for his opioid medications that he was prescribed. She stated when she arrived at the room, she noticed a white, powdery substance on his tray table, and she immediately believed that he had crushed and snorted his medication due to her understanding of his history. NA #12 also reported that at some point during the emergency, Housekeeper #1 entered the room and wiped down Resident #3's tray table.

During an interview with NA #17 (agency) on 04/20/23 at 2:42 PM via telephone, she reported she was present on 8/14/22 working as an NA at the time Resident #3 was found unresponsive in his room. She stated it was well known that Resident #3 had a history of substance abuse and had a history of crushing his opioid medications and snorting them. She reported around 6:20 AM to 6:30 AM on 8/14/22, while EMS was working on Resident #3, she noted Housekeeper #1 entered the room and wiped down Resident #3's tray table.

An interview with Housekeeper #1 on 04/20/23 at 3:33 PM via telephone, revealed she went into Resident #3's room on 8/14/22 and wiped off a white, powdery substance from his tray table. She reported she did not know Resident #3's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 50 | F 689 | | |

medical history or if he had a history of substance abuse. She reported she only wiped off the tray table after EMS requested her to do so. She could not provide any information on why EMS asked her to wipe off Resident #3's tray table.

During an interview via telephone on 04/20/23 at 9:01 AM with NP #2 she verified she was the NP at the time Resident #3 expired. She indicated the death certificate indicated he died of natural causes. She revealed when she was asked to sign the death certificate, she refused because based on the information she received from the staff (unable to recall specific staff members) that were present at the time he went into cardiac arrest, she believed Resident #3 had died of an accidental overdose and not due to natural causes as was listed on the death certificate.

During a follow-up interview with NP #2 via telephone on 04/21/22 at 4:00 PM she reported she felt an autopsy and toxicology report needed to be completed before signing off on the death certificate. She explained Resident #3 was one of the youngest residents at the facility and he was in relatively good health. She further explained that because of his history of drug abuse and the sudden onset of cardiac arrest she felt an autopsy and toxicology report had to be completed to confirm the cause of death. She reported the medical examiner was to conduct the autopsy and complete the toxicology testing, but the resident had already been embalmed prior to the medical examiner having access to the resident. She explained that due to the embalming the toxicology report was unable to determine any narcotic drug levels in Resident #3's system at the time of his death. She reported after she reviewed the autopsy and was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 51 | F 689 | | |

told he had already been embalmed prior to getting a completed toxicology report, she signed off on the death certificate. The NP revealed it was her professional opinion, based on the circumstances of his death and what was observed by staff at the time of the sudden cardiac arrest, that Resident #3 had suffered cardiac arrest due to an overdose of some type of narcotic. She stated she believed that the administration did not take her concerns seriously leading to a lack of supervision by the floor staff which ultimately resulted in Resident #3's cardiac event. She stated the administration knew her concerns and did nothing to prevent the accidental overdose.

An interview attempt with Director of Nursing #3 was unsuccessful.

An interview attempt with Administrator #3 was unsuccessful.

An interview with DON #1 was conducted on 04/26/23 at 10:26 AM revealed she was not working at the facility at the time Resident #3 was admitted. She also reported for a resident who had a history of pocketing medications, crushing, and snorting them, the facility should have had a crush order and provide them to the resident in applesauce or some other median and observed until the medication is fully given and swallowed. She also reported there should have been increased supervision of Resident #3 to curtail attempts to abuse medications or use illicit drugs at the facility.

2. Resident #4 was initially admitted to the facility on 02/28/23 with diagnoses that included repeated falls, weakness, and a Thoracic-12

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 52 | F 689 | | |

fracture (T-12 - lower back fracture), Alzheimer's, and Non-Alzheimer's dementia.

Review of a fall risk assessment dated 02/28/23 revealed that Resident #4 was at high risk for falls due to his history of multiple falls and tendency to over-estimate or forget his limits.

Resident #4 had a care plan initiated on 03/03/23 that read in part, The resident is at high risk for falls related to confusion. The interventions included: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, ensure that the resident is wearing appropriate footwear, non-skid socks when mobilizing in wheelchair.

Review of Resident #4's medical record revealed a note written by Nurse #15 on 03/05/23 at 7:10 AM that read, "this nurse and Nurse Aide (NA) were in front of resident's doorway and witnessed resident's fall. He rolled out of bed and fell. This nurse-initiated head to toe skin check and found no injuries related to this incident. Resident had no complaints of pain. Resident was placed back in his bed and on-call physician notified."

Resident #4's care plan was updated on 03/06/23 to continue interventions on the at-risk plan and ensure bed is in lowest position prior to exiting resident's room.

Review of the admission Minimum Data Set (MDS) dated 03/06/23 revealed that Resident #4 was moderately cognitively impaired and required extensive assistance of 1-2 staff members with activities of daily living (ADL). A fall within one

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 53 | F 689 | | |

month, prior to admission with a fracture was reported, and an additional fall since admission, with no injury, was reported on the MDS. Resident #4 was always incontinent of bowel and bladder, his balance was not steady and only able to stabilize with staff assistance, and ambulation with 1-2-person assistance only occurred 1-2 times in the look back period.

On 03/12/23 at 7:30 AM a progress note made by Nurse #16 read, Medication Aide (MA) called to writer and stated Resident #4 was on the floor of his own room. Writer entered room and observed Resident #4 on his hands and knees on floor and observed blood on floor. Writer assessed Resident, and a laceration to the right eyebrow was noted. Writer and medication aids assisted Resident off floor and onto bed at this time. Resident alert at this time and stated that area to eyebrow hurt. Writer applied pressure to eyebrow. Vital signs obtained and within normal limits. Physician notified and order received to send resident to Emergency Room (ER). Writer called for Emergency Medical Services (EMS) transportation.

Resident #4's care plan was revised on 03/13/23 to add floor mats for injury prevention.

On 03/17/23 at 11:07 AM an Occupational Therapy encounter note written by the Occupational Therapy Assistant (OTA) read in part, "Patient was found up in the wheelchair and was seen to address self-feeding. The patient was returned to his room via wheelchair and left up seated to visit his Family Member (FM) #1."

In a phone interview on 4/21/23 at 12:30 PM with the OTA, she stated she worked at the facility as

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 54 | F 689 | | |

needed (PRN). She recalled Resident #4 as a small frail man who tried to stand-up on his own sometimes from his wheelchair, but he was too weak to support himself. The OTA stated she writes her notes after therapy was finished. The OTA confirmed Family Member (FM) #1 was not in the room when she left Resident #4 alone in his room in a wheelchair. She stated she must have assumed FM #1 was in the building or on her way to visit. The OTA stated she likely told someone at the nurses' desk that Resident #4 was back in his room but could not recall. She stated Resident #4's room was right across from nursing station or at least very close. The OTA stated with Resident #4's history of falls and high risk for falls, she would not have left him alone in his room without notifying a staff member.

A phone interview was conducted with MA #6 on 4/20/23 at 4:40 PM and MA #6 confirmed she was working on the unit where Resident #4 resided on 03/17/23. MA #6 stated she recalled Resident #4 was in therapy that morning. She recalled FM #1 was usually with Resident #4 and cared for him all day through supper, but on 03/17/23 she was not present. MA #6 stated she was passing medications around lunchtime when an NA (can't remember the name) came to her and said Resident #4 was on the floor. MA #6 stated she went into Resident #4's room and found him on his face on the floor bleeding from a facial cut. She stated she told the NA to find a nurse. MA #6 stated UM #2 came into the room, and they kept Resident #4 on the floor to avoid additional injuries. She stated he had a cut above one of his eyes that was open. MA #6 stated Resident #4 was conscious but never said anything. The MA was unsure if Resident #4 was a fall risk and added she usually observed him in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 689 | Continued From page 55 | F 689 | | |

bed but had observed when the resident was in his wheelchair, he tended to lean forward.

An interview was conducted with NA #14 on 04/19/23 at 4:39 PM and she stated she assumed care for Resident #4 on 3/17/23 at 11:00 AM from NA #15. The NA stated while she knew Resident #4 was high risk for falls, she was a restorative aide and only works on the floor when there are a lot of call-outs such as on 03-17-23. She stated she was not very familiar with Resident #4's plan of care or fall interventions. NA #14 explained on 03/17/23 at 10:30 AM she saw therapy bring Resident #4 back to his room but was not the resident's nurse aide at that time. NA #14 further explained around 1:00 PM she saw Resident #4 sitting in a wheelchair alone in his room waiting for his lunch tray. She added she left him there sitting up in his wheelchair because therapy told her he ate better sitting up. NA #14 stated she left the hall to pass meal trays and as she was coming back to Resident #14's hall she saw Emergency Medical Services (EMS) entering Resident #4's room to take him to the Emergency Room (ER). She stated when she entered the room behind EMS, Unit Manager (UM) #1 and Unit Manager (UM) #2 were both attending Resident #4. She stated Resident #4 had fallen out of his wheelchair. NA #4 confirmed that Resident #4 was alone in his room, in his wheelchair, for approximately 3 hours and had not received his lunch tray prior to his fall.

An interview with NA #15 was conducted on 4/20/23 at 3:16 PM she stated she was assigned to Resident #4 from 8:00 AM - 11:00 AM. She stated during this time, the resident was already dressed and out of his room with therapy. NA #15 explained at 11:00 AM NA #14 picked him up

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 56 | F 689 | | |

on her assignment. NA #15 did not recall the OTA or anyone telling her Resident #4 was back from therapy. She stated the first time she saw Resident #4 was when EMS was taking him out of his room on a stretcher.

On 4/21/23 at 12:07 PM the Director of Therapy was interviewed and stated Resident #4 was admitted due to falls and high risk for falls. She stated she would have told someone Resident #4 was back or put him in the doorway, so he was visible.

On 03/17/23 at 1:30 PM a progress note written by Unit Manager (UM) #2 read, "Resident fell out of wheelchair to floor. Laceration noted above right eyebrow. Resident unable to answer questions due to Alzheimer's disease. Physician notified; EMS called for transport to the Emergency Department (ED) for evaluation."

On 4/20/23 at 12:32 PM an interview was conducted with UM #2, and she shared Resident #4 was admitted to the facility due to falls at home. She stated when he was admitted he had several fractures in his neck and back, and stitches on the side of his head from falls he experienced at home. She stated she recalled on 03/17/23 she was working on the floor. She stated she knew OTA took Resident #4 to the therapy room at breakfast time because MA # 6 asked her where he was, so she called OTA to see if that had taken him to therapy and they confirmed they had picked him up for his therapy. She stated it was common practice for therapy to come get residents and bring them back without letting anyone know. She stated she did not know Resident #4 was back from therapy until she heard a loud thump that came from his room

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 57 | F 689 | | |

around 1:30 PM. She stated when she got to his room, she observed Resident #4 on his face on the floor. She added MA #6 was present in the room when she arrived.

Review of the Emergency Medication Services (EMS) report dated 03/17/23 revealed the 911 call was received at 1:31 PM, EMS reached Resident #4 at 1:43 PM and Resident #4 was transported to the local hospital at 2:08 PM.

The ER physician at the local hospital documented an admission note dated 03/17/23 that read, in part, Review of a computed tomography scan (CT scan) of the head and abdomen confirmed Resident #4 sustained right 9th through 11th rib fractures, and a sub-acute T-12 fracture (fracture in the spine that has already been present). Additionally Resident #4 sustained facial fractures, right frontal bone fracture extending into the superior orbit roof and lateral orbit wall (fracture that extended to the top and to the side of right eye socket), right hemothorax (blood collecting between chest wall and lungs which can collapse the lung), and intraparenchymal hemorrhage of the brain (bleeding in the tissue of the brain).

A review of an ER physician notes from the local ER dated 03/17/23 at 6:42 PM, revealed Resident #4 was to be transferred to the local trauma center for definitive care (higher level of care). The noted further documented they had stabilized Resident #4 to the best of their ability.

Review of a Trauma Center ED note dated 03/17/23, read in part, The patient presentation is most consistent with acute presentation with potential threat to life or bodily function. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 58 | F 689 | | |

trauma team managed Resident #4's care in the ED. Neurosurgery, Ophthalmology, Ear/Nose and Throat (ENT) consults ordered for evaluation of facial injuries. No surgical intervention was required.

A trauma hospital physician discharge note dated 3/22/23, read in part, Palliative Care consulted for Goals of Care (GOC) due to patient injuries and history. After GOC meeting on 03/21/23 Resident #4 was transitioned to a Do No Resuscitate (DNR)/Comfort Care (CC) status. They will transfer Resident #4 back to a different skilled nursing facility (SNF) and will be followed by Hospice for end-of-life care.

An interview was conducted on 4/21/23 at 12:00 PM with Director of Nursing (DON) #1 and Administrator #1. Administrator #1 stated it's their goal to keep all their residents safe. Residents who are at high risk for falls needed extra supervision and the staff were knowledgeable about preventing falls. The staff often kept residents at risk for falls visible in the hallway, by the desk, or even by the medication cart with the nurse for extra supervision. With Resident #4's fall history, he should have been monitored closely. She stated it sounded like miscommunication among departments and nursing staff. She stated he should not have been left alone in his room for 3 hours.

Administrator #2 was notified of immediate jeopardy on 04/24/23 at 12:00 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

F689: Identify those residents who have suffered,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 59 | F 689 | | |

or likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #3 had a known history of substance abuse. Resident #3 was not supervised for illicit drug use. Resident #3 had an order for oxycodone to be crushed and the nurse to watch the resident take. On 8/14/22 the nurse failed to supervise Resident #3 after medication administration. On 8/14/22 Resident #3 was found unconscious. Resident #3 expired on 8/14/22 at the facility.

All current residents that have a history of drug abuse have the potential to be affected. A list was made of the residents who had a history of polysubstance abuse. The list is located at each nurse's station. The Director of Nursing reviewed and is responsible for updating the list.

Resident #4 who was a high fall risk was left alone and unattended in his room for approximately three hours after therapy session. Resident #4 was found on his floor and was sent to the local Emergency Room and then transferred to local trauma center for treatment of his injuries. Resident #4 sustained right 9 through 11 rib fractures, right frontal bone fracture extending into the superior orbit roof and lateral orbit wall.

Current residents that were identified at High fall risk using the Morse fall scale have the potential to fall and obtained injuries. The review and collaboration was conducted by the Regional Nurse Consultant on 4/25/23. The Director of Nursing is responsible for updating the list with new residents that are high fall risk.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 60<br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:<br><br>On 04/25/23, the Director of Nursing and Chief Nursing Officer educated staff on where to locate the list of residents with a history of polysubstance abuse. The Director of Nursing and Chief Nursing Officer educated staff on understanding of roles and responsibilities in identifying, reporting, and responding to residents who exhibit behaviors of seeking, acquiring and self-medicating with illegal drugs or medications not prescribed by the attending physician at the nursing home. Education included the following: dangers of self-medicating including serious adverse side effects and death, observing for medications/illegal substances in resident's room or in resident possession that are not prescribed by the nursing home MD/NP and responding by remaining with resident, calling out for nursing assistance for assessment and safe collection of substances and follow-up reporting by the licensed nurse to the MD/NP and to the Administrator or DON, intervening and asking to search resident with suspicious activity, ensuring resident safety by remaining with resident and calling for licensed nurse assistance, licensed nurse assessing resident for safety and s/s of potential self-medication such as changes in vital signs or altered mental status, visual observation of consumption, response in the event of resident self-medication to include; immediate removal of substance from resident to stop ingestion if possible, then providing emergency medical care as necessary and remaining with resident, calling MD/NP for new orders and calling 911 if indicated, then removing, counting and securing | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 61 | F 689 | | |

under double lock and key any medications/illegal substances with a second licensed nurse witness, then notification to the DON and Administrator for further investigation and follow-up, revising resident care plan to reduce risk of reoccurrence, education of the facility abuse and neglect policy and reporting immediately to the charge nurse if they hear or suspect a staff member is self-medicating or has an illegal substance in the facility. In the event illicit drug use is suspected the local police department will be contacted and a report made. The Director of Nursing will ensure no licensed nurses or medication aides will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift.

On 4/25/2023, the Director of Nursing and Chief Nursing Officer educated current staff members on fall protocol. Education to include the following: Identifying high fall risk residents upon admission using the Morse fall scale and putting interventions using the Strategies for Reducing the Risk of Falls. Once residents are identified as high fall risk nurse management will update list and place at areas noted to staff. High risk fall residents will be communicated in the morning meeting with department heads and then to the floor staff. During meal tray pass, Department Heads, weekend Manager on Duty, and Night Supervisor is present on the floors in order to provide increased supervision of residents at high risk for falls. Care plans will be updated by Minimum Data Set Coordinator or designee with appropriate interventions. Nurse management will in-service staff on the appropriate interventions.

The Director of Nursing will ensure staff will not work without receiving education. Any new hires including agency will receive education prior to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 689 | Continued From page 62<br>the beginning of their next shift. Education will be completed on 4/25/23 by the Director of Nursing and Chief Nursing Officer.<br><br>Effective 04/25/2023, Administrator #2 will be responsible for ensuring implementation of this IJ removal plan for this alleged non-compliance.<br><br>The alleged date of IJ removal is 04/26/23.<br><br>On 04/27/23, the credible allegation of Immediate Jeopardy removal was validated by onsite verification through facility staff interviews. The interviewed staff across all disciplines including nursing, front office, and therapy, revealed they had all received in-service training regarding supervision of residents who had a history of drug abuse and those who were at high risk for falls. The facility had implemented lists of residents at high risk for falls and residents who had a history of substance abuse located at each nurses' stations and on each medication cart. Observations completed on-site revealed increased supervision of residents at high fall risk and those with substance abuse. The interviewed staff were able to articulate the newly implemented practices for increased supervision of residents with substance abuse histories and those who were at high risk of falling. The facility alleged completion of training on 04/26/23 with immediate jeopardy removed effective 04/26/23 was validated. | F 689 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who | F 695 | | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews the facility failed to keep emergency tracheostomy (surgically created airway in the front of neck) supplies needed for an unplanned extubation (removal of airway tube) or emergency supplies for mechanical ventilation (ambu bag) at bedside and easily accessible for immediate use in an emergency (Resident #11). The facility also failed to change oxygen tubing as ordered and clean oxygen filters (Resident #10). This affected 2 of 3 residents reviewed for respiratory services.<br><br>The findings included:<br><br>1. Resident #11 was readmitted to the facility on 01/23/23 with diagnoses that included: attention to tracheostomy, acute respiratory failure with hypoxia, disorder of diaphragm, and others.<br><br>Review of a physician order dated 01/23/23 read: Tracheostomy size 8 cuffless<br><br>The significant change Minimum Data Set (MDS) dated 01/28/23 revealed that Resident #11's cognition was not assessed. He was noted to have a tracheostomy during the assessment reference period.<br><br>An observation of Resident #11's room was made on 04/18/23 at 10:09 AM. Resident #11 was resting in bed with his eyes open and was | F 695 | Emergency tracheostomy supplies were placed in room for Resident #11 on 4/24/23. Oxygen tubing was changed as ordered and the filter cleaned for Resident #10 on 4/27/23.<br>Residents on oxygen and/or with a tracheostomy have the potential to be affected by the same alleged deficient practice. An audit of residents on oxygen was completed by the Director of Nursing or Designee on 4/27/23 to ensure tubing was changed as ordered and filters were clean with no concerns identified.<br>Residents with tracheostomies were audited by the Director of Nursing or Designee for proper emergency supplies at their bedside for unplanned extubation or mechanical ventilation. Audits were completed by 5/19/23<br>The Director of Nursing educated nursing staff on Oxygen use to include changing tubing and monitoring the filter for cleanliness. The Director of Nursing educated the nurses on having emergency tracheostomy supplies at bedside for residents with tracheostomies. Newly hired staff will receive this education in orientation. Any staff that has not received an education by 5/19/23 will be required to do so prior to the next scheduled shift. The Director of Nursing | |

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| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 695 | Continued From page 64<br>observed to have a tracheostomy in place with oxygen at four liters being delivered via tracheostomy collar. There was no ambu bag noted at Resident #11's bedside or in his nightstand that was next to his bed. Upon closer inspection of Resident #11's nightstand it was noted that there were several spare tracheostomies for size 6 tracheostomy, size 7 tracheostomy, and 8.5 size tracheostomy. There was no spare tracheostomy size 8 noted in Resident #11's room.<br><br>Nurse #10 was interviewed on 04/19/23 at 2:30 PM who confirmed that she was working at the facility through an agency and was taking care of Resident #11. Nurse #10 was unaware of what size tracheostomy Resident #11 had and was not sure of what emergency supplies were kept at bedside, she stated she worked at the facility through an agency and was not there that frequently enough to know that information.<br><br>An observation of Resident #11's room was made on 04/19/23 at 2:53 PM along with Nurse Aide (NA) #5. In Resident #11's nightstand there was tracheostomy replacements for size 6, 7, and 8.5 but no size 8 tracheostomies were found. There were multiple inner cannulas found for size 6 and 7. There was also no ambu bag noted in Resident #11's room.<br><br>Director of Nursing (DON) #2 was interviewed via phone on 04/19/23 at 11:18 AM who confirmed that all residents that had a tracheostomy should have an ambu bag and replacement tracheostomy of the correct size in their room and easily accessible to staff in case of emergency.<br><br>DON #1 was interviewed on 04/26/23 at 10:16 | F 695 | educated nursing staff on completing scheduled rounds to monitor oxygen filters.<br>The Administrator or designees will audit residents on oxygen during room rounds 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks to ensure tubing is changed as ordered and filters are clean. The Director of Nursing or designee will audit 3 residents with tracheostomies for emergency supplies at the bedside weekly for three months.<br>The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of compliance: 5/21/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 695 | Continued From page 65 | F 695 | | |

AM who confirmed that all residents who had a tracheostomy should have a suction machine, an ambu bag, and a spare tracheostomy of the correct size at bedside and easily accessible by staff in case of an emergency.

2. Resident #10 was readmitted to the facility on 02/24/22 with diagnoses that included chronic obstructive pulmonary disease.

Resident #10's quarterly Minimum Data Set (MDS) assessment dated 02/04/23 revealed the Resident was cognitively intact and received oxygen.

A review of Resident #10's physician orders dated revealed:

*An order dated 06/22/22 to change oxygen tubing and set up weekly on Wednesday.
*An order dated 07/03/22 for oxygen at 2 liters per minute via nasal cannula.

A review Resident #10's Medication Administration Record (MAR) for 04/2023 revealed the oxygen tubing and set up was changed on Wednesday 04/12/23.

On 04/18/23 at 10:00 AM an observation and interview were made of Resident #10 who was lying in bed with oxygen being delivered via nasal cannula by the bedside concentrator at a setting of 2 liters per minute. The oxygen tubing was dated 04/09/23 with no initials and the black filters on the oxygen concentrator were gray with dust accumulation. Resident #10 explained that she did not know when the last time the oxygen tubing was changed or when the filters were cleaned.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (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 66 | F 695 | | |

On 04/19/23 at 12:15 PM an observation was made of Resident #10's oxygen concentrator revealed the filters remained in the same condition. Resident #10 was not in the room but at dialysis.

An interview was conducted with Nurse #5 on 04/19/23 at 2:33 PM who was scheduled to work on Wednesday night 04/12/23. The Nurse stated she did not remember changing Resident #10's oxygen tubing or cleaning the oxygen filters.

An observation was made of Resident #10 at 04/19/23 at 5:00 PM. The Resident wore the oxygen tubing dated 04/09/23 and the oxygen filters remained with the dirty gray filters.

On 04/19/22 at 5:15 PM during an interview with Nurse #6 who was working with Resident #10 that day explained that Resident #10 required oxygen at 2 liters per minute via nasal cannula. She continued to explain that the correct oxygen setting should be checked once a shift and the oxygen tubing and set up was changed once a week on Wednesday by the night shift. The Nurse stated the oxygen filters should be cleaned when the tubing was changed as well. The Nurse referred to Resident 10's 04/2023 MAR and stated the oxygen tubing and set up was changed on Wednesday 04/12/23. The Nurse went to Resident #10's room and observed that the oxygen tubing was dated 04/09/23 and the filters on the oxygen concentrator were dusty gray. Nurse #6 stated the filters should be black not gray and indicated the filters looked as if the filters had not been changed in a while.

At 5:30 PM on 04/19/23 an interview was conducted with Unit Manager (UM) #2 who

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 695 | Continued From page 67<br>explained oxygen concentrators should be washed and cleaned at the same time as the tubing change.<br><br>On 04/19/23 at 5:45 PM during an interview with Medication Aide (MA) #2 he explained that he was only filling in for the Scheduler who also functioned as the Medical Supply Clerk while she was on her vacation. The MA stated changing the oxygen tubing and set up was a duty of the Medical Supply Clerk, but he had not done it in about 1.5 weeks because he had been too busy with other duties. The MA stated he remembered changing Resident #10's oxygen set up about 2 weeks ago but did not clean the oxygen filters.<br><br>An interview was conducted with Director of Nursing (DON) #1 on 04/26/23 at 10:25 AM who stated it should be the responsibility of the nurse on the hall once a week on Wednesday to change out the oxygen tubing and clean the oxygen filters.<br><br>On 04/26/23 at 3:05 PM an interview was conducted with Administrator #2 who indicated that she understood that there was a problem with the facility's current system on maintaining oxygen compliance and the current system needed to change. | F 695 | | |
| F 745 SS=D | Provision of Medically Related Social Service CFR(s): 483.40(d)<br><br>§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: | F 745 | | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 745 | Continued From page 68<br>Based on record review, staff, Hospice, and family interviews the facility failed to arrange transportation to a follow up medical appointment (hematologist) for 1 of 3 residents (Resident #6) reviewed for medically related social services.<br><br>The finding included:<br><br>Resident #6 was readmitted to the facility on 01/15/23 with diagnoses that included thrombocytopenia (a low platelet level) and thoracic aortic aneurism.<br><br>A review of Resident #6's Progress Notes from a Hematology/Oncology office visit dated 01/26/23 provided by the facility revealed: 1. Thrombocytopenia, 2. Low Fibrinogen and 3. Follow up in one month.<br><br>A review of Resident #6's After Visit Summary from the Hematology/Oncology office visit dated 01/26/23 provided by the family member revealed: Next appointment February 27th at 3:00 PM for lab work and patient visit.<br><br>A review of Resident #6's physician orders revealed an order dated 02/14/23 for Hospice Services. There was no order for Resident #6 to discontinue outside medical appointments.<br><br>On 04/18/23 at 11:40 AM an interview was conducted with the Transportation Aide (TA) who also arranged transportation to medical appointments for the residents. The TA explained that she transported residents to their appointments as well as using an outside transportation service if the residents' appointments were double booked. The TA continued to explain that the outside | F 745 | Resident #6 appointment expired in the facility 3/3/23.<br>All residents have the potential to be affected by the same deficient practice regarding appointment confirmation and transportation. The Social Worker and Transportation Director completed an audit looking back 30 days to ensure medically necessary appointments were attended as scheduled. This audit was completed by 5/19/23.<br>The Administrator provided education to the Transportation Director on scheduling and ensuring resident appointment needs are met. Education was completed by 5/19/23.New transportation driver will be educated upon hire.<br>The Administrator or designee will audit 7 residents a week for 4 weeks, then 5 residents a week for 4 weeks, and then 2 residents a week for 4 weeks to confirm appointments are confirmed and transportation provided.<br>The Administrator or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of Compliance: 5/21/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 745 | Continued From page 69 | F 745 | | |

transportation service took Resident #6 to her 01/26/23 medical appointment and there was a follow up appointment scheduled for 02/27/23 at 3:00 PM. The TA stated someone must have notified her of the appointment or the doctor's office called her to confirm the appointment because when they did, she remembered that Resident #6 had recently changed to Hospice Services and knew that when the residents went Hospice, they normally stopped all their doctor's appointments and lab work. The TA explained that she asked the former Director of Nursing #2 about the situation, and she was told not to take Resident #6 to the scheduled appointment because the Resident was under Hospice Services. The TA stated she did not cancel the scheduled medical appointment for February 27th because she was on the road all day transporting residents a lot and must have forgot.

An interview was conducted with the family member of Resident #6 on 04/18/23 at 7:35 PM who was the Resident #6's Power of Attorney (POA). The POA explained that she was unaware that the Resident did not go to the scheduled hematology appointment until she received a letter in the mail from the doctor's office notifying her of the missed appointment and she confirmed the appointment was missed through another family member. The POA continued to explain that Resident #6 began Hospice Services on 02/14/23 related to a diagnosis of a thoracic aorta aneurism but also had a diagnosis of thrombocytopenia and required close monitoring by the hematologist/oncologist. The POA stated there was never a decision made to discontinue outside medical appointments for Resident #6.

An interview was conducted with the Hospice

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| (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 70 | F 745 | | |

Nurse on 04/20/23 11:20 AM who explained that Resident #6 began Hospice Services on 02/14/23 for a thoracic aortic aneurism. She continued to explain that cancelling further medical appointments was a decision made by the Resident's family and in reference to Resident #6 there was no decision made to cancel outside medical appointments. The Hospice Nurse stated she was not aware that Resident #6 did not go to her scheduled medical appointment until after the fact and it was brought to her attention by the Resident's family member.

On 04/20/23 at 1:05 PM an interview was conducted with Unit Manager (UM) #2 who explained that the TA was responsible for arranging transportation for medical appointments for the residents by either transporting the residents herself with the facility van or by an outside transportation company. The UM stated she did not recall that Resident #6 had a follow up appointment made for February 27th.

During an interview with Director of Nursing (DON) #2 on 04/21/23 at 3:05 PM she explained that normally when a resident went under Hospice Services, they discontinued all lab work and medical appointments outside the facility. The DON continued to explain that she remembered the TA had asked her about Resident #6's medical appointment and remembered that the Resident recently went under Hospice Services, and she told the TA that she would speak with Hospice about the situation, but the DON never got around to doing it so Resident #6 missed the medical appointment.

On 04/26/23 at 10:25 AM an interview was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 71<br>conducted with Director of Nursing (DON) #1 who explained that the facility had problems receiving paperwork from the residents' medical appointments and it needed to be the responsibility of the hall nurse, unit manager or transportation to obtain the progress notes from their medical appointments and follow up with scheduling appointments according to the order. The DON continued to explain that there should have been a discussion with Hospice and the family about whether Resident #6's outside medical appointments should be continued and a physician's order should have been written so that everyone understood the situation. The DON indicated what should not have happened was Resident #6 not being taken to her medical appointment. | F 745 | | |
| F 760 SS=J | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and interviews with staff and the Nurse Practitioner the facility failed to prevent a significant medication error when Narcan (reversal agent used in case of overdose) was not administered as prescribed for a resident who had a known history of substance abuse that included crushing and snorting pills/medications. The Nurse Practitioner ordered Narcan as needed for overdose on 7/20/22 for Resident #3. Resident #3 was found unresponsive in his room on 8/14/22, Cardiopulmonary Resuscitation (CPR) was initiated but Narcan was not administered as ordered and the resident was | F 760 | Resident #3 has expired.<br>All current residents that have a history of drug abuse have the potential to be affected. A list was made by the Chief Nursing Officer of the residents who had a history of polysubstance abuse. The list was placed on the nurse carts and placed in the narc book. The Director of Nursing will be responsible for updating the list with new admissions that have a history of polysubstance abuse.<br>On 04/22/23, the Director of Nursing and Chief Nursing Officer educated licensed | 5/21/23 |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 72<br>unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in Resident #3's room. The facility also failed to notify Emergency Medical Services (EMS) that responded to Resident #3's cardiac arrest on 08/14/22 that he had a history of drug abuse nor that there was a white powdery substance found next to him. This affected 1 of 4 residents reviewed with sudden cardiac arrest (Resident #3) Resident #3 expired in the facility on 08/14/22.<br><br>Immediate Jeopardy began on 08/14/22 when Resident #3 was found unresponsive in his room with a white powdery substance on his bedside table and the facility staff failed to administer an ordered dose of Narcan for a suspected drug overdose. Immediate jeopardy was removed on 04/23/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.<br><br>The findings included:<br><br>Resident #3 was admitted to the facility on 11/10/20 with diagnoses that included cocaine dependence, congestive heart failure, and chronic respiratory failure.<br><br>Resident #3's quarterly Minimum Data Set (MDS) assessment dated 06/17/22 revealed he was cognitively intact with no psychosis, behaviors, or rejection of care. Resident #33 was coded with | F 760 | nurses and medication aides on the administration of NARCAN in the event a resident with known history of polysubstance abuse should be found unconscious and that residents with history of polysubstance abuse had physician order for NARCAN. Education also included signs and symptoms of overdose and nursing communication shift to shift on residents with history of polysubstance abuse and presence of list of residents with history of polysubstance abuse being located in the narc book on the cart for ease of access. Furthermore, education included notifying EMS upon their arrival of the substance abuse history and the administration of Narcan. The Director of Nursing will ensure no licensed nurses or medication aides will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift.<br>The Director of Nursing or designee will audit the list in the narcotic book of residents with a known history of polysubstance abuse to ensure it is current five times a week for four weeks, three times a week for four weeks and two times a week for four weeks.<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 760 | Continued From page 73 | F 760 | Date of Compliance: 5/21/23 | |

having frequent pain and he received opioids 7 of 7 days during the lookback period. The MDS revealed Resident #3 was born in 1960 indicating he was 62 years old.

Review of Resident #3's physician orders revealed the following physician orders: - Oxycodone (opioid pain medication) HCl Tablet 20 milligrams (mg) - Give one table by mouth every 6 hours as needed for pain. Crush oxycodone and the patient is to take the medication in front of the nurse. The order's start date was 06/16/22 - Narcan [reversal agent used in case of overdose] liquid 4mg/0.1 milliliter (ml) - 4 mg in nostril every 6 hours as needed for overdose. The order's start date was 07/20/22.

Resident #3's care plan last updated on 07/29/22 revealed the following information: - Resident #3 exhibits or has the potential to exhibit verbal/physical behaviors related to opioid dependence and anxiety; history of snorting pills/medications, misuse of oxygen. Interventions included monitoring medication administration to ensure medications are taken and swallowed prior to leaving resident.

- Resident #3 does complain of pain at times due to impaired mobility. Resident #3 has a diagnosis of chronic pain and opioid dependence. Resident has pain medication in place and is followed by pain clinic." Interventions included "Per MD order Narcan 1 milliliter by nasal route as needed for opioid overdose. Repeat every 2 minutes until emergency medical services arrive."

An interview with the Pharmacist on 04/21/23 at 12:12 PM revealed they received the physician order for Narcan on 07/20/22 and that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 760 | Continued From page 74 | F 760 | | |

prescription was filled and delivered on 07/21/22. She reported the Narcan they sent would have had Resident #3's name on it along with the dosing schedule.

A review of Resident #3's medication administration record from August 2022 revealed the order for Narcan to be administered in the event of an overdose. No dose of Narcan was signed off on as having been given on 08/14/22.

A review of Resident #3's physician progress notes revealed a note from 08/03/22 that included the following: "Behavioral concerns - this NP [Nurse Practitioner] recommends that the patient be discharged from this facility for numerous documented reports from the staff of overdose, abuse, and noncompliance. I believe that the patient puts the facility at risk for liability if he were to overdose. I have added Narcan 4mg [Milligrams] nasal every 6 hours as needed for overdose. I have expressed by concerns with the [Former] Director of Nursing, Administration, and Medical Director." The note was electronically signed by NP #2.

During an interview via telephone on 04/20/23 at 9:01 AM with Nurse Practitioner (NP) #2 reported she was no longer working at the facility. She reported Resident #3 had a history of taking his narcotic pain medication and then turning his oxygen up on his portable tanks and concentrator until he would pass out. She stated she was concerned about Resident #3 abusing his narcotics because she heard from unknown staff members that he pocketed the medications and then crushed and snorted them. She reported several months before August of 2022 she refused to prescribe him narcotic pain

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 75 | F 760 | | |

medications and referred him to a pain clinic for monitoring. The pain clinic ordered oxycodone. She reported Resident #3's narcotic pain medication was to be crushed and Resident #3 observed until it was fully taken in applesauce or another medium. She reported she received information from a staff member whom she could no longer remember, who informed her there was a picture of Resident #3 cutting a white powdery substance on his tray table in the facility that was turned into administration. She explained this was when she prescribed Resident #3 Narcan (7/20/22) to be given in the event of an accidental overdose.

The Medication Administration Record (MAR) for August 2022 revealed oxycodone was administered to Resident #33 on 08/14/22 at 2:16 AM by Medication Aide (MA) #3.

An interview with Medication Aide #3 (MA) on 04/20/23 at 3:14 PM revealed she was assigned on the medication cart and was responsible for providing Resident #3 with his medication from 7:00 PM on 08/13/22 until 7:00 AM on 08/14/22. She stated she last gave him his narcotic pain medication at 2:16 AM on 08/14/22 and found him unresponsive around 5:30 AM. She could not recall with certainty if she crushed his oxycodone when she last administered the medication. She went onto say that she would have administered them as it was ordered on the MAR. MA #3 stated she had worked with Resident #3 a few times previously and she remembered reading in his chart that he had some drug seeking behaviors. She revealed when she worked with him, he came up to her medication cart before he was due to receive his narcotic pain medication and waited there until it was time for it to be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 76 | F 760 | | |

administered. She further stated Resident #3 did not have a physician order for Narcan because she would have made a note to herself. She also reported she did not have Narcan on her cart and that it would have been out of the ordinary for a resident to have a physician order for Narcan. She reported during the entirety of time she assisted with Resident #3's emergency, she never saw anyone administer Narcan or tell EMS personnel when they arrived that Resident #3 had a history of drug abuse. Med Aide #3 indicated she had not received any formal education on how to administer Narcan nor any education on how to identify a resident who had an overdose.

A nurse progress note completed by Nurse #13 dated 08/14/22 at 7:28 AM read in part, "Resident #3 reported on floor at 6:15 AM by [Med Aide #3] following ambulation by resident from smoking area ...emergency medical services [EMS] notified by staff while this nurse and additional nurse performed cardiopulmonary resuscitation in resident room. EMS arrived at 6:25 AM ...Resident #3 pronounced expired by EMS at 6:46 AM."

During an interview with Nurse #13 via phone on 04/20/23 at 3:44 PM, he reported he responded to calls for help from MA #3. He stated he went to Resident #3's room and found him on the floor, still warm but with no pulse or respiration. He stated he immediately called a code blue and began chest compressions. Nurse #13 stated Resident #3 was not on his assignment, and he did not know anything about Resident #3's medical history including past drug abuse or overdoses. He stated he had no reason to suspect a drug overdose and stated that Narcan was not administered by him. He reported he was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| (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 760 | Continued From page 77 | F 760 | | |

assigned to oversee the Medication Aide #3 on that hall but stated he had no knowledge of Resident #3's medical history or care needs.

A review of the EMS run report from 08/14/22 at 6:25 AM revealed they arrived at the facility and began CPR on an unresponsive resident. Per the report, the responding EMS personnel were not informed of a potential overdose situation when they arrived or at any time while they provided emergency assistance to Resident #3.

An interview with NA #11 (agency) on 04/20/23 at 12:05 PM via telephone, she reported she was assigned to Resident #3 on 8/14/22 on 3rd shift. She stated MA #3 went into Resident #3's room to give him his medications around 5:00 AM and found him unresponsive. She reported MA #3 screamed for assistance and she and NA #12 went running. She stated when she got to the room, she noticed a white, powdery substance on Resident #3's tray table.

Interview with NA #12 (agency NA) on 04/20/23 at 12:35 PM revealed she worked the night of 8/14/22 Resident #3 and had run to the room when MA #3 called for help after finding him unresponsive. She stated when she arrived at the room, she noticed a white, powdery substance on his side table.

An interview with Housekeeper #1 on 04/20/23 at 3:33 PM via telephone, revealed she went into Resident #3's room on 8/14/23 and wiped off a white, powdery substance from his tray table. She reported she did not know Resident #3's medical history or if he had a history of substance abuse. She reported she only wiped off the tray table after EMS requested her to do so. She could not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 78 | F 760 | | |

provide any information on why EMS asked her to wipe off Resident #3's tray table.

During an interview with NA #7 on 04/19/23 at 3:28 PM she reported she believed Resident #3 died due to an overdose due to her experience of seeing him snort an unidentified powdery substance on more than one occasion. NA #7 stated each time she observed Resident #3 snorting a white substance, she stopped him and got the nurse on the hall. She reported by the time she and the nurse returned to the room, the white, powdery substance was gone, and Resident #3 stated it was baby powder and denied snorting it. She reported she also wrote two separate reports regarding what she observed and slid them under Administrator #3's door. NA #7 stated she could not remember the dates she completed the reports but was certain she slid them underneath Administrator #3's door. She reported to her knowledge, nothing was done to prevent Resident #3 from snorting a white, powdery substance.

Administrator #1 was asked on 04/19/23 at 4:30 PM to locate the written statements from NA #7 regarding Resident #3's observed behaviors of crushing and snorting his medications but she reported on 04/20/23 at 10:00 AM she was unable to locate them.

An interview with Resident #3's former roommate, Resident 13, was conducted via telephone on 04/21/23 at 1:16 PM revealed he had reported Resident #3's drug abuse to facility staff multiple times including to the Wound Nurse and to former Social Worker #1. He stated he even sent pictures and video he had taken on his cell phone to them on their personal cell phones. Resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 760 | Continued From page 79 | F 760 | | |

#3's former roommate reported he felt that someone from the facility was bringing in either cocaine or opioids and providing them to Resident #3. He stated he watched Resident #3 numerous times pull out pills, chop them up on his tray table, and snort them.

On 04/21/23 at 12:18 PM the photograph and video recorded by Resident #13 was reviewed. They showed Resident #3 sitting in his wheelchair, in his room, next to his bed with his back to the door. Resident #3 was wearing a lime green t-shirt and had a bank debit card in his hand pressing the edge down onto a white, powdery substance that was on his tray table beside his bed.

An interview with the Wound Nurse on 04/21/23 at 12:01 PM via telephone revealed it was very well known that Resident #3 had a substance abuse problem and crushed his opioid medications and snorted them. She also reported she had received a photograph and a short video, unable to recall the date, from Resident #3's roommate, Resident #13, that showed Resident #3 using a credit card to "cut" a white, powdery substance on his tray table in his room at the facility. She reported she immediately sent them to Director of Nursing #3 and provided them to a Corporate Staff member who was a female. She was unable to remember her name or her position. She stated she also wrote a statement, unable to recall the date, and provided it to the Corporate Staff member. The Wound Nurse reported she heard nothing back from Director of Nursing #3 or the Corporate Staff member about the situation. The Wound Nurse reported she felt that the situation was ignored.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 80 | F 760 | | |

Interview with the former Social Worker #1 via telephone on 04/21/23 at 3:15 PM revealed she remembered Resident #3 and that he had a history of abusing his medications by crushing and snorting them. She reported Resident #3's former roommate, Resident #13, had approached her in her office some time, unable to recall the date, and told her Resident #3 was storing medications under his tongue then crushing and snorting them. She stated she brought it up to Director of Nursing #3 and Administrator #3 immediately after being informed, but it was "blown off". She stated, "everyone knew about it, and no one did anything". She reported there were no additional interventions put into place to increase supervision and despite his behaviors being discussed "weekly" at morning meeting; it "was always not taken seriously".

An interview was attempted with Director of Nursing #3 and was unsuccessful.

An interview was attempted with Administrator #3 by telephone and was unsuccessful.

An interview with Director of Nursing (DON) #1 on 04/26/23 at 10:26 AM, revealed although she was not working in the facility at the time of the incident, if there was a suspected overdose situation with a resident with a known substance abuse issue, who had a physician order for Narcan, she expected her staff to administer the Narcan as ordered. She also reported she expected the medication aides and the hall nurses to know which residents were at risk for overdose and administer Narcan as ordered. She reported she also expected her medication aides and hall nurses to be educated on how to administer Narcan and to notify responding EMS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 760 | Continued From page 81 | F 760 | | |

personnel on the drug abuse history of the resident in distress immediately upon their arrival.

During a follow up interview with Nurse Practitioner (NP) #2 via phone on 04/20/23 at 4:00 PM, she stated due to Resident #3's history of drug abuse, along "with continued observed abuses of his opioid medications while admitted to the facility she prescribed Narcan to be administered "not if but when" Resident #3 overdosed." She reported the Narcan was on the medication cart and should have been dedicated to Resident #3. She stated the failure of the facility to administer the ordered Narcan was a significant medication error and reported if it had been given, more than likely, could have saved Resident #3's life. She reported giving Resident #3 a dose of Narcan if he was having a genuine cardiac arrest of respiratory failure situation would have had no significant adverse effect. She reported when Narcan was ordered, it should have shown up directly under Resident #3's opioid prescription because that was the medication, she was worried he would overdose using.

Administrator #2 was notified of the immediate jeopardy on 07/21/22 at 4:33 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #3 was identified as having a significant medication error. Resident #3 was found unconscious on 8/14/22 with a white, powdery

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 82 | F 760 | | |

substance noted on the bedside and NARCAN was not administered. Resident #3 had a history of substance abuse. Resident #3 expired on 8/14/22 at the facility.

All current residents that have a history of drug abuse have the potential to be affected. A list was made by the Chief Nursing Officer of the residents who had a history of polysubstance abuse. The list was placed on the nurse carts and placed in the narc book. The Director of Nursing will be responsible for updating the list with new admissions that have a history of polysubstance abuse.

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

On 04/22/23, the Director of Nursing and Chief Nursing Officer educated licensed nurses and medication aides on the administration of NARCAN in the event a resident with known drug use history should be found unconscious and that residents with history of polysubstance abuse had physician order for NARCAN. Education also included signs and symptoms of overdose and nursing communication shift to shift on residents with history of polysubstance abuse and presence of list of residents with history of polysubstance abuse being located in the narc book on the cart for ease of access. Furthermore, education included notifying EMS upon their arrival of the substance abuse history and the administration of Narcan. The Director of Nursing will ensure no licensed nurses or medication aides will work without receiving this education. Any new hires including agency will receive education prior to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 760 | Continued From page 83<br>the beginning of their next shift. Education will be completed on 04/22/2023 by the Director of Nursing or Chief Nursing Officer.<br><br>Effective 04/22/2023, Administrator #2 will be responsible to ensure implementation of this IJ removal plan for this alleged non-compliance.<br><br>The alleged date of IJ removal is 04/23/23.<br><br>On 04/26/23 and 04/27/23 the credible allegation of immediate jeopardy was validated. A full list of residents with histories of drug abuse was observed at the nurses' stations and on the medication carts. The interviewed medication aides and nurses were aware of the individuals identified by the facility as having histories of drug abuse and were also able to articulate what they needed to do in a suspected overdose situation and how to administer doses of Narcan. The facility's immediate jeopardy removal date of 04/23/23 was validated. | F 760 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper | F 761 | | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 84<br>temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§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 quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview the facility to secure 1 of 4 medications carts (Cart D) observed during medication pass.<br><br>The findings included:<br><br>A continuous observation of Nurse #5 was made on 04/20/23 at 5:21 AM to 5:38 AM. Nurse #5 was at medication cart D and was preparing medications. The medication cart was parked near one end of the hall. Once Nurse #5 had the medications prepared, she would walk from the medication cart to rooms at various locations on the hallway leaving the medication cart unlocked and unsecured. During the continuous observation a male resident in a wheelchair rolled up to the unlocked and unsecured medication cart and observed it for several minutes before continuing down the hallway.<br><br>An observation of Nurse #5 was made on 04/20/23 at 6:10 AM to 6:14 AM. Nurse #5 was again at medication cart D and was continuing to prepare medications. The medication cart remained parked at one end of the hall. Nurse #5 | F 761 | Identified staff member (Nurse #5) was not scheduled again.<br>Nurses and medication aides have the potential to have the same deficient practice.<br>Education was completed by the Director of Nursing to nurses and medication aides regarding the need to secure medications in the locked medication cart when not in direct supervision. Education completed by 5/19/23. Any nurses or medication aides that have not completed the education will not be able to work until education is completed. New hires will receive education during orientation.<br>The Director of Nursing or designee will complete 10 observations weekly for secured medication carts for a total of three months.<br>The Director of Nursing or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 761 | Continued From page 85<br>continued to prepare medications and walk them to various rooms on the hallway leaving the medication cart unlocked and unsecured.<br><br>Nurse #5 was interviewed on 04/20/23 at 6:15 AM who stated, "I know what is going on with my cart and if I am going to be gone away from it for a bit I will lock it." Nurse #5 confirmed that her medication cart should be locked and secured anytime she walked away from the cart.<br><br>Director of Nursing (DON) #1 was interviewed on 04/20/23 at 10:16 AM who stated that medication carts should locked and secured anytime the staff walked away from the cart and was administering medications in a resident room. | F 761 | make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of Compliance: 5/21/23 | |
| F 835 SS=K | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, Nurse Practitioner, and Medical Director interviews the facility's Administration failed to provide leadership and oversight to ensure the facility had supplies that were readily available and easily accessible to immediately start Cardiopulmonary Resuscitation (CPR) when 3 of 4 residents experienced sudden cardiac arrest (Resident #1, Resident #2, and Resident #3). This practice had the high likelihood of affecting other residents. | F 835 | On 4/19/23 Administrator was educated by Regional Director of Nursing on CPR process and role of those involved, location of crash carts, equipment required on crash carts, emergency crash cart checklist and location of basic life equipment supplies.<br>On 4/21/23 an Administrator change was made, and Administrator #2 was educated on the CPR process and role of those involved, location of crash carts, | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 835 | Continued From page 86<br>Immediate Jeopardy began on 08/14/22 when Resident #3 experienced cardiac arrest and the facility did not have an ambu bag (used to deliver rescue breaths during CPR) readily available for use and it took the staff approximately three minute to locate the ambu bag and start rescue breathing. Immediate jeopardy was removed on 04/21/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity E (no actual harm with potential for more than minimal harm that is no immediate jeopardy) to ensure monitoring system are in place and the completion of employee education.<br><br>The findings included:<br><br>This tag is cross referenced to F678:<br><br>F678: Based on record review, staff, Nurse Practitioner and Medical Director interviews the facility failed to have basic lifesaving equipment readily available for use to immediately begin cardiopulmonary resuscitation (CPR) when Resident #3 experienced sudden cardiac arrest on 08/14/22 and staff were unable to immediately begin CPR because the first crash cart (cart of emergency supplies) that was brough to the bed side did not have a ambu bag or manual resuscitator (device to administer rescue breathing) on it, staff began chest compressions and it took the staff approximately three minutes to get the second crash cart that did have a ambu bag to begin rescue breathing. Resident #1 experienced sudden cardiac arrest on 02/07/23 and staff were unable to immediately begin CPR because the staff could not locate an ambu bag or manual resuscitator to begin rescue breaths | F 835 | equipment required on crash carts, emergency crash cart checklist and location of basic life equipment supplies. Newly hired administrator will be educated upon hire.<br>The Regional Director of Operations or designee will monitor the Administrator once weekly for three months to ensure crash cart checklist are complete, adequate BLS equipment is present on cart and in the supply room and review cardiac events since prior visit.<br>The Regional Director of Operations or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.<br>Date of Compliance 5/21/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 87 | F 835 | | |

and could not locate a backboard (hard surface to do chest compressions on while in bed). It took the staff approximately five minutes to locate the needed items to begin CPR. On 03/07/23 Resident #2 experienced sudden cardiac arrest and staff were unable to immediately begin CPR because they could not locate an ambu bag or manual resuscitator and had to borrow one from another resident's room. The staff also could not locate the paddles for the Automatic External Defibrillator (AED) (device used to deliver a shock to the heart). It took staff "several minutes" to locate the ambu bag to begin CPR and paddles for the AED. This affected 3 of 4 residents reviewed who experienced sudden cardiac arrest.

Director of Nursing (DON) #1 was interviewed on 04/26/23 at 10:16 AM who explained that she began working in the facility as the Minimum Data Set (MDS) nurse at the beginning of December 2022 and had become the interim DON at the beginning of April 2023. The DON stated she had no knowledge of Resident #1 as he was expired months prior to her arrival at the facility. She also stated she was not familiar at all with Resident #2 or any issues that arose during his sudden cardiac arrest and code situation. The DON further stated that she recalled hearing during the clinical morning meeting that when Resident #3 went into cardiac arrest and was coded by the staff that the facility did not have the appropriate equipment to immediately begin Cardiopulmonary Resuscitation (CPR). She added that she distinctly remembered the former Nurse Practitioner (NP) who was directly involved in the code situation voicing her dissatisfaction with how the code was handled and the lack of equipment that was available. The DON stated she recalled the former NP going around to the nurses talking

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 835 | Continued From page 88 | F 835 | | |

to them about the situation and how it should have gone differently. The DON stated that she also recalled Administrator #1 asking the Unit Managers (UM) why the crash carts were not stocked, and they continued to insist that they had checked them, and they were stocked and believed that someone was taking the ambu bags off the crash carts. From what the DON could recall there was no resolution to that issue but stated after the event another staff member had gone to the hospital and borrowed a box of ambu bags.

Administrator #2 was interviewed on 04/26/23 at 3:02 PM who confirmed that from 12/01/22 to 04/21/23 she was the Regional Vice President of Operations and provided oversight to the facility under the direction of Administrator #1. Administrator #2 stated that she had no knowledge of the situations that had occurred with Resident #1, Resident #2, and Resident #3, she stated that nothing had been communicated to her that there were issues that had arisen during the code situations that all three residents experienced. She contributed the failures of the facility on lack of effective leadership.

Administrator #1 and DON #1 were notified of the Immediate Jeopardy on 04/19/23 at 11:03 AM.

The facility provided the following IJ removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility's administration did not ensure that the crash carts (used in emergency situations) were stocked with the needed equipment that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 89 | F 835 | | |

included Ambu bag or manual resuscitator, back board, suction machine, and automatic external defibrillator (AED) which are all required to perform CPR in the event of cardiac arrest.

On 02/07/23 at approximately 1:00 AM Resident #1 experienced sudden cardiac arrest. The staff were unable to locate an Ambu bag or manual resuscitator used to deliver ventilation to residents not breathing. The staff were also unable to locate a back board (hard surface) to correctly deliver chest compressions to the correct depth for delivery of CPR. It took the staff approximately 5 minutes of time to locate the required items to deliver CPR when Resident #1 was pulseless. Resident #1 expired on 02/07/23 in the facility.

On 03/07/23 at approximately 10:30 AM Resident #2 experienced sudden cardiac arrest. The staff were unable to locate an Ambu bag or manual resuscitator used to deliver ventilation to residents not breathing. The staff were also unable to locate a back board (hard surface) to correctly deliver chest compressions to the correct depth for delivery of CPR. The Nurse Practitioner (NP) responded to the code and requested the basic lifesaving equipment and indicated that it took "several minutes" before a manual resuscitator was taken from another residents' rooms to use, the NP requested the facilities Automatic External Defibrillator (AED) and when staff retrieved the AED failed to have the paddles used to deliver the shock readily available for use by the NP. The NP also requested a suction machine that was not readily available for use. Resident #2 was transported to the Emergency Room (ER) and expired in the hospital.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 90<br><br>On 08/14/22 Resident #3 who had an extensive history of drug and opioid abuse was found on the floor with a white powdery substance on his bedside table. Resident #3 was warm to touch but was pulseless and was in cardiac arrest. Staff responded with the crash cart and there was no ambu bag on the crash cart. Another staff member had to obtain the other crash cart to get an ambu bag. It took approximately two to three minutes to obtain the other crash cart with the ambu bag and begin rescue breathing and compressions.<br><br>Resident #1 expired on 2/7/2023 at 2:26 AM in the facility.<br>Resident #2 expired on 3/7/2023 in the hospital.<br>Resident #3 expired in the facility on 08/14/22.<br><br>All current residents that have a full code status have the potential to be affected by current practice deficiency. On 4/20/2023, the Regional Nurse Consultant completed record review of residents that expired in a medical facility, expired in the facility, and/or discharged to another hospital for the following dates, 1/1/2023 - 4/20/2023 to ensure procedures for CPR were followed with no issues. Staff interviews completed with nurse involved. This was completed on 4/20/2023.<br><br>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:<br><br>On 4/19/23 Regional Director of Nursing educated Administrator on the facility CPR policy and procedure and their role, emergency crash | F 835 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 91 | F 835 | | |

cart checklist, location of crash carts in facility, and location of additional BLS equipment.
Education included the following:
Procedure
1. If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR:
Verify or instruct a staff member to verify the DNR or code status of the individual.
Instruct a staff member to activate the emergency response system (code) and call 911.
Instruct a staff member to retrieve the crash cart.
Initiate the basic life support (BLS) sequence of events.
The BLS sequence of events is referred to as "C-A-B" (chest compressions, airway, breathing).
Chest compressions:
a. Following initial assessment, begin CPR with chest compressions. Position flat hand over left chest and using heal of hand.
b. Push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute;
Allow full chest recoil after each compression; and
Minimize interruptions in chest compressions.
Airway: Tilt head back and lift chin to clear airway.
Breathing: After 30 chest compressions provide 2 breaths via resuscitator or manually (with CPR shield).
All rescuers should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2.
Continue with CPR/BLS until emergency medical personnel arrive.
2. Emergency Crash Cart Checklist
3. Location of crash carts
4. Location of backup BLS supplies

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 92<br><br>On 4/20/23, Administrator was educated by Regional Director of Operations on Administrator's responsibility to thoroughly investigate cardiac events. Administrator must be notified by Director of Nursing or Designee of any cardiac events and must review code response to ensure CPR procedure was followed. Staff participating in cardiac event response must be interviewed by a member of nurse management team proceeding the incident and findings of cardiac event investigation must be shared with the Administrator for confirmation that CPR procedure was followed, basic life support supplies were readily available. If variation from CPR procedure is identified Administrator should immediately consult Regional Director of Nursing, initiate Ad Hoc QAPI meeting to include IDT and Medical Director, and modify plan of correction in order to achieve compliance.<br><br>On 4/20/2023, the Regional Nurse Consultant educated the nurse management team on interviewing the staff that participated in the CPR proceeding the incident to ensure CPR procedures were followed and basic lifesaving equipment was readily available.<br>Effective 4/20/23, Administrator will receive on site visit from Regional Director of Operations or designated outside Administrator no less than once per week. Visit will include audit of the following:<br><br>" crash carts to ensure location, supply, and emergency crash cart checklist completed and accurate<br>" ensure adequate supply of BLS equipment is present on the crash cart and supply room and is housed in designated location | F 835 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 93<br>" review of cardiac event investigations since previous visit to ensure CPR procedure was followed<br>" interview staff to confirm knowledge of CPR procedure and role in cardiac event response.<br>" Review any new hires since last visit to ensure CPR procedure education was completed.<br><br>Effective 4/20/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.<br><br>Alleged Date of IJ Removal: 4/21/2023<br><br>On 04/26/23 and 04/27/23 the facility's credible allegation of immediate jeopardy removal was validated. Interviews with the DON and Administrator #2 revealed that they had been educated by the Regional Director of Nursing on the CPR policy and procedures, emergency crash cart check list, location of crash carts, and location of back up supplies. Administrator #2 is also the Regional Director of Operations (RDO) and was aware of her responsibility as the Administrator to thoroughly investigate cardiac events to ensure the facility's policy and procedures were followed. The investigation should include interviews with staff directly involved with the incident and should be reviewed by Administrator #2/RDO. Interviews with the management team confirmed that they had been educated on the importance of conducting thorough investigation after any cardiac event to ensure facility staff followed the proper procedures and that basic life saving equipment was readily available for use by the direct care staff. Administrator #2/RDO verbalized understanding of her responsibility to check crash | F 835 | | |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 835 | Continued From page 94<br>carts and availability of supplies, review any cardiac events and review new hire orientation to ensure newly hired staff received the education during the orientation process. The facility's immediate jeopardy remove date of 04/21/23 was validated. | F 835 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. | F 867 | | 5/21/23 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 867 | Continued From page 95<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health | F 867 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 867 | Continued From page 96 | F 867 | | |

outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 867 | Continued From page 97<br>resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigations that occurred on 03/05/21, 05/07/21, 10/15/21, 09/01/22, and 02/20/23 and the recertification and complaint investigation that occurred on 05/26/22. This failure was for eight deficiencies that were originally cited in the areas of Resident Assessment (F637 and F641), Quality of Life (F677), Quality of Care (F689 & F695), Pharmacy Services (F760 & F761), and Administration (F835) and were subsequently recited on the current complaint investigation of 04/27/23. The repeat deficiencies during multiple surveys of record showed a pattern of the facility's inability to sustain an effective QA program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F637: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set assessment within 14 days of the determination of Hospice services for 1 of 1 resident (Resident #6) for Hospice.<br><br>During the recertification and complaint investigation conducted on 5/26/22 the facility failed to complete a significant change Minimum Data Set Assessment for a resident who admitted | F 867 | The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigations that occurred on 03/05/21, 05/07/21, 10/15/21, 09/01/22, and 02/20/23 and the recertification and complaint investigation that occurred on 05/26/22. This failure was for eight deficiencies that were originally cited in the areas of Resident Assessment (F637 and F641), Quality of Life (F677), Quality of Care (F689 & F695), Pharmacy Services (F760 & F761), and Administration (F835) and were subsequently recited on the current complaint investigation of 04/27/23.<br>Plan of correction was put in to place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued.<br>The Administrator initiated in-service to all administrative staff on 5/17/23 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, | |

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|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 867 | Continued From page 98<br>to hospice care for 1 of 2 residents (Resident #16) reviewed for hospice.<br><br>F641: Based on record review and staff interview, the facility failed to accurately code cognition or section C of the Minimum Data Set (MDS) for 5 of 5 residents reviewed (Resident #1, Resident #7, Resident #10, Resident #11, and Resident #12). The facility also failed to accurately code the MDS in the area of indwelling catheters for 1 of 2 residents reviewed with indwelling catheters.<br><br>During the complaint investigation conducted on 05/07/21 the facility failed to accurately code the Minimum Data Set assessments to reflect residents received dialysis therapy, this was evident for 2 of 2 residents reviewed for dialysis.<br><br>F677: Based on observation, record review, and staff interviews, the facility failed to trim a dependent resident's fingernails for 1 of 3 residents reviewed for activities of daily living (Resident #1).<br><br>During the complaint investigation conducted on 10/15/21, the facility failed to provide incontinence care prior to a resident wetting through her brief onto her draw sheet, failed to provide incontinence care to a resident who had a bowel movement, failed to provide showers as scheduled for 1 resident, and failed to provide nail care for 2 residents for 4 of 4 residents reviewed for activities of daily living for dependent residents.<br><br>During the complaint investigation completed on 09/01/22, the facility failed to provide incontinence care for 1 of 3 residents reviewed for pressure ulcers. | F 867 | developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education.<br>The Quality Assurance Performance Improvement Committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance.<br>The Administrator will be responsible for the plan of correction.<br>Date of Compliance: 5/21/23 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

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|---|---|---|---|---|
| F 867 | Continued From page 99 | F 867 | | |

During the complaint investigation completed on 02/20/23, the facility failed to provide dependent residents with showers for 3 of 6 residents reviewed for activities of daily living.

F689: Based on record review, observation, and interviews with resident, Nurse Practitioner, and staff, the facility failed to implement measures to mitigate the risk of an accidental drug overdose for a resident who had a known history substance abuse that included crushing and snorting pills/medications. On 8/14/22 Resident #3 was found unresponsive in his room as a result of sudden onset cardiac arrest and he was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in his room. Additionally, the facility failed to provide supervision to a cognitively impaired resident (Resident #4) who was a high fall risk and was left alone and unattended in his room after a therapy session, and was later found on the floor, and was sent to the local Emergency Room (ER) then transferred to a local trauma center for treatment of his injuries that included right ninth through eleven rib fractures, right frontal bone fracture extending into the superior orbit roof and lateral orbit wall. (Resident #3 & Resident #4) This deficient practice was for 2 of 3 residents reviewed for supervision to prevent accidents.

During the complaint investigation completed on 03/05/21, the facility failed to provide a safe smoking environment for two smokers when staff failed to properly store oxygen at a safe distance from open flame and prevent a resident who utilized oxygen from smoking while his oxygen was in use for 2 of 2 residents reviewed for safe

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345133 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION | 1000 COLLEGE STREET WILKESBORO, NC 28697 |

| (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 |
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| F 867 | Continued From page 100 | F 867 | | |

smoking. A resident lit a cigarette with his nasal cannula in his nares and his oxygen tank on while out in the designated smoking area which resulted in burns to the resident's face and high likelihood of injury to the other resident who was in the smoking area.

F695: Based on observations, record review, and staff interviews, the facility failed to keep emergency tracheostomy (surgically created airway in the front of the neck) supplies needed for an unplanned extubation (removal of airway tube) or emergency supplies for mechanical ventilation (ambu bag) at bedside and easily accessible for immediate use in an emergency (Resident #11). The facility also failed to change oxygen tubing as ordered and clean oxygen filters (Resident #10). This affected 2 of 3 residents reviewed for respiratory services.

During the recertification and complaint investigation survey completed on 05/26/22, the facility failed to ensure oxygen therapy was delivered at the prescribed rate ordered for 3 of 5 residents reviewed for oxygen and failed to provide routine maintenance to oxygen concentrators to ensure the air filters were free from dust and debris for 4 of 5 residents reviewed for oxygen therapy.

F760: Based on record review, and interviews with staff and the Nurse Practitioner the facility failed to prevent a significant medication error when Narcan (reversal agent used in case of overdose) was not administered as prescribed for a resident who had a known history of substance abuse that included crushing and snorting pills/medications. The Nurse Practitioner ordered Narcan as needed for overdose on 7/20/22 for

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|---|---|---|---|---|
| F 867 | Continued From page 101 | F 867 | | |

Resident #3. Resident #3 was found unresponsive in his room on 8/14/22, CPR was initiated but Narcan was not administered as ordered and the resident was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in Resident #3's room. The facility also failed to notify Emergency Medical Services (EMS) that responded to Resident #3's cardiac arrest on 08/14/22 that he had a history of drug abuse nor that there was a white powdery substance found next to him. This affected 1 of 4 residents reviewed with sudden cardiac arrest (Resident #3) Resident #3 expired in the facility on 08/14/22.

During the complaint investigation completed on 10/15/21, the facility failed to prevent significant medication errors by not accurately transcribing and administering medication as ordered from the hospital discharge summary prescribed to treat chronic pain, shortness of breath, and anxiety for a hospice resident for 1 of 1 resident reviewed for medication errors. As a result, the resident reported her pain level was a 7 to 9 on a scale of 1 to 10 across all three shifts during her 4 days as a resident in the facility.

During the complaint investigation completed on 09/01/22, the facility failed to prevent significant medication errors when medications were not obtained and administered per the physician orders for 3 of 3 residents reviewed for medications.

During the complaint investigation completed on 2/20/23 the facility failed to prevent a significant medication error when staff failed to administer ordered doses of an IV antibiotic on 12/22/22 and

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| F 867 | Continued From page 102 | F 867 | | |

12/23/22. The Peripherally Inserted Central Catheter (PICC) (intravenous (IV) line used to administer IV antibiotics) line was replaced with a different type of IV access on 12/24/22 and the staff failed to administer the IV antibiotic on 12/24/22 and 12/25/22 for 1 of 1 resident (Resident #1) reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications.

F761: Based on observation, record review, and staff interview, the facility failed to secure 1 of 4 medications carts (Cart D) observed during medication pass.

During the complaint investigation completed on 05/26/22, the facility failed to ensure controlled substances were stored and secured using a double lock feature for 1 of 2 medication storage refrigerators. Additionally, the facility also failed to remove a local anesthetic patch placed at bedside for 1 of 1 resident.

F835: Based on record review, staff, Nurse Practitioner, and Medical Director interviews, the facility's Administration failed to provide leadership and oversight to ensure the facility had supplies that were readily available and easily accessible to immediately start Cardiopulmonary Resuscitation (CPR) when 3 of 4 residents experienced sudden cardiac arrest (Resident #1, Resident #2, and Resident #3). This practice had a high likelihood of affecting other residents.

During the complaint investigation completed on 09/01/22, the facility failed to provide effective oversight to ensure nurses obtained and administered medications as ordered for newly

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| F 867 | Continued From page 103<br>admitted residents. This practice resulted in missed doses of medications for 3 residents.<br><br>During an interview with Administrator #2 on 04/26/23 at 3:02 PM, she reported her quality assurance (QA) team met monthly and included the medical director, unit managers, administrative staff, and even some direct care staff. She reported she had not been involved in the QA process yet before taking over as the Administrator but planned to run the meeting and set her expectations clearly. She reported she felt there was a lack of effective leadership in the facility prior to her arrival and stated all the repeat deficiencies would be entered into the facility's QA program and monitored extensively to ensure compliance is met moving forward. | F 867 | | |