STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/26/2026

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

(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
F0000	INITIAL COMMENTS An unannounced complaint investigation was completed from 05/20/26 through 05/21/26. Additional information was gathered offsite through 5/26/26 therefore, the exit date was changed to 5/26/26. There was one complaint intake investigated 3004033. 1 of 1 allegation resulted in a deficiency.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, family, police department and Medical Director interviews, the facility failed to protect a resident's right to be free from physical abuse when Resident #1 became combative during incontinence care and Nurse Aide (NA) #1 forcibly continued to provide care and "grabbed [the resident] by the lower thigh and back and then gave him a hard push" in an attempt to finish care. This resulted in the resident suffering a broken femur (thighbone) in the resident requiring traction (the application of a slow, steady pulling force to a part of the body) and 200 micrograms (mcg) of Fentanyl (an opioid medication given for	F0600		

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

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

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F0600 SS = G	Continued from page 1 pain) while in transit to the emergency room. The resident was administered Dilaudid (another opioid medication) while in the emergency room for pain, and required surgical intervention. This was for 1 of 3 residents reviewed for prevent employee-to-resident abuse. (Resident #1). The findings included: Resident #1 was an 80 year old resident who admitted to the facility 06/25/25 with diagnoses that included Parkinson's disease, depression, muscle weakness, hypertension, dementia, and disorientation. Review of Resident #1's quarterly Minimum Data Set assessment dated 04/03/26 revealed the resident was moderately cognitively impaired with no delusions, behaviors, rejection of care, or instances of wandering. Resident #1 was coded with no impairments to his upper extremities but with impairments to both sides of his lower extremities. Resident #1 was coded as requiring limited assistance with oral hygiene and rolling left and right in bed. He required extensive assistance with toileting hygiene, bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. Resident #1 was dependent on others for going from sitting to lying, lying to sitting, sitting to standing, and all transfers. Resident #1 was coded as always incontinent of bowel and bladder and taking antidepressant, antibiotic, and antiplatelet medications. Review of Resident #1's care plan, last updated on 04/14/26, revealed the following care area: "[Resident #1] is resistive to care, i.e. yells/screams/pushes staff." Interventions included to allow Resident #1 to make self-determination and have freedom of choice; give a clear explanation of all care activities prior to and as they occur during each contact; if [Resident #1] resists with activities of daily living (ADLs), reassure him, leave, and return in 5-10 minutes later and try again; and praise [Resident #1] when behavior is appropriate. Review of the facility's reportable incidents revealed a report filed with the state survey agency dated 5/02/26 in which it was reported the facility was made aware on 5/02/26 at 5:20 PM that Resident #1 was reporting that a nurse aide (NA #1) had injured his leg while providing care. Per the initial notification to the state survey agency, Resident #1 was discharged to the hospital for evaluation and NA #1 was suspended pending a complete	F0600		

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F0600 SS = G	Continued from page 2 investigation. The initial report was dated 5/02/26 at 6:25 PM. Review of the facility's investigation dated 05/07/26 revealed they interviewed Resident #1, NA #1, and Nurse #1 since they were the staff and resident involved. The facility's final investigation report indicated that after completing the investigation, they were unable to substantiate the allegation of physical abuse by NA #1. The report alleged there was no evidence of caregiver misconduct and due to the resident's acute pain outside of his baseline, the facility provider was notified and provided orders to send Resident #1 to the emergency room for further evaluation. The facility's investigation also indicated that the police department responded to the facility in response to a call about a possible injury during care. Review of Resident #1's hospital records dated 5/02/26 revealed Resident #1 arrived at the emergency room with a concern of a left leg injury and was in traction and provided 200 micrograms of Fentanyl in route. Per the hospital records, Resident #1 appeared alert, calm and could answer simple questions with Parkinson's and significant dementia. Resident #1 was treated for a left closed femur fracture and treated with Dilaudid (an opioid medication) for pain and surgical intervention for the femur fracture. Review of Resident #1's x-ray diagnostics revealed a minimally comminuted (crushed or splintered) oblique fracture of the mid femoral diaphysis with anterior and lateral angulation (a break in the middle of the thigh bone with an angled fracture line with minor fragmentation, and the broken segments are shifted and tilted outward and forward). Multiple attempts to reach Resident #1 via telephone call on 5/21/26 and 5/22/26 were unsuccessful. (He was residing at another skilled nursing facility.) Review of Resident #1's undated written statement in the facility's investigation revealed the following: "When asking [Resident #1] what happened, he replied with 'that son of a b…'." A telephone interview on 5/20/26 at 9:19 AM with Resident #1's Family Member revealed she was aware of the incident that occurred on 5/02/26 and that Resident #1 had told her that there was a guy who came into his room to change him and fell on him. Resident #1's Family Member reported Resident #1's femur was broken completely in two and he had to have surgery to repair it. She continued,	F0600		

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F0600 SS = G	Continued from page 3 stating that she did not ask a lot of questions about what happened. An interview with NA #1 on 5/21/26 at 1:48 PM revealed he remembered the interaction with Resident #1 that occurred on 5/02/26. NA #1 reported he was working at the time as an agency nurse aide on an as needed basis and 5/02/26 was his 2nd shift he had worked at the facility. He reported when he arrived at the facility for the start of his shift, he observed several residents that needed to be changed including Resident #1. He stated when he went into Resident #1's room, he found Resident #1 in bed and described him as being "soaked" with urine and feces and he also noted Resident #1 had what appeared to be blood on his brief and bedsheet. NA #1 reported when he observed the blood on Resident #1's brief and bed sheet, he left the room and notified Nurse #1 who walked into Resident #1's room, looked at Resident #1, and then stated to NA #1 that she would report the condition of Resident #1 to the supervisor. NA #1 stated he did not know who the supervisor was that evening. NA #1 stated that Nurse #1 then left the room and he left to retrieve a new bed sheet. NA #1 reported he returned to Resident #1's room, spoke to Resident #1 and explained what care he was there to provide. NA #1 stated Resident #1 did not respond to him and NA #1 began the process of changing Resident #1. NA #1 stated as he began to provide care to Resident #1, Resident #1 became aggressive and attempted to elbow and punch at him but did not strike him. NA #1 stated when Resident #1 became aggressive, he stopped providing care and stepped back from Resident #1. He stated Resident #1 then settled back down moments after he stepped back, so he reapproached Resident #1 and continued providing care. NA #1 stated as he rolled Resident #1 onto his right side, Resident #1 became aggressive and agitated again attempting to knee NA #1. NA #1 reported deflecting the attempted strikes and grabbed Resident #1 on his left leg right near his knee and continued to roll Resident #1 over onto his right side. He stated while doing this, he felt a "popping" sensation and stopped providing care, released his hands from Resident #1 and went and reported the situation to Nurse #1. NA #1 stated although it was his 2nd shift working in the facility, no one had informed him that Resident #1 had a history of refusing care and aggressive behaviors towards staff. He stated he had been a nurse aide for 7 years and had briefly received training on resistive and combative residents. He reported with residents who were resistive or combative during care, he would typically stop care and go and get another nurse aide to assist in providing the care.	F0600		

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F0600 SS = G	Continued from page 4 NA #1 also reported he had access to Resident #1's electronic health record but indicated that he had not reviewed Resident #1's care plan and did not know if he even had access to review it, stating he "did not have time for it". Review of NA #1's written statement that was provided to the facility when he was questioned by the police department on 5/02/26 read as follows: "I went to change [Resident #1]. [Resident #1] was covered in feces and there was blood in his brief. I went to get the nurse [Nurse #1] to report the witnessing of blood in his brief. His drawsheet also had blood, urine, and feces on it. [Nurse #1] witnessed the blood and stated "I don't know what that's from. I'll have to report it to supervision". I then went to get a drawsheet and reentered the room, told [Resident #1] what I was going to do, stating "hey buddy, I've got to change your brief". I started to roll him and he became resistant. He started pushing back so I gave him an extra push. [Resident #1] then tried to elbow me. I dodged it. Then he attempted to elbow me again then I let him roll back a little and then he tried to punch me twice and then tried to knee me, almost hitting me in the mouth. I grabbed him by the lower thigh and back and then gave him a hard push by both [thigh and back] to try and finish cleaning him. I felt a series of pops. I let go and reported it to the nurse." A review of NA #1's personnel file revealed he was 6'5 with no listed weight. An interview with Nurse #1 on 5/20/26 at 11:58 AM revealed she remembered the incident on 5/02/26. She stated she was initially informed that there was a little blood in Resident #1's brief. She indicated she observed the blood and believed it to be due to some rawness on Resident #1's bottom. She then stated shortly after, she was standing outside of Resident #1's room with Medication Aide (MA) #1 when NA #1 walked out of the room, threw his hands up in the air and stated, "his leg is broke". Nurse #1 reported NA #1 was shaking and appeared panicked or worried and did not appear angry or frustrated. She stated she went into the room and asked Resident #1 what happened and all Resident #1 said was "that son of a b….." She stated there was no bruising or redness to Resident #1's leg but that she could easily tell something was not right with his leg, stating, "it was kind of raised at the top." Nurse #1 stated she left the room and stayed with NA #1 while she called the on-call physician who provided her a verbal order to send Resident #1	F0600		

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F0600 SS = G	Continued from page 5 to the hospital. She stated she contacted emergency medical services and then the Director of Nursing to inform her of the incident. She stated while speaking with the Director of Nursing, she was told to send NA #1 home immediately to which she relayed to NA #1 who simply replied “ok” and left without incident. Review of Nurse #1’s written statement in the facility’s investigation read as follows: “I was standing on the 100 hall with [MA #1] when [NA #1] came out of [Resident #1’s] room with hands up screaming “his leg is broke”. I walked in the room and looked at his (Resident #1’s) leg. I asked [Resident #1] what happened and he responded with “that son of a b....” I asked [NA #1] what happened and he stated that the resident was trying to kick and [he] tried to block it and grabbed his leg. I notified Nurse Practitioner… and the Director of Nursing [DON]. Called EMS [emergency medical services] after.” An interview with MA #1 on 5/21/26 at 9:19 AM revealed she was standing in the hallway outside of Resident #1’s room with Nurse #1 when NA #1 came out of Resident #1’s room panicked and pale. She stated she had recently provided Resident #1 his evening medications and reported he was calm and pleasant during her interaction with him. She stated she did hear NA #1 introduce himself and tell Resident #1 he was there to “check him real quick.” MA #1 stated if she had to estimate, NA #1 was not in Resident #1’s room for more than a minute before he walked out of the room and stated that Resident #1 was being combative. An interview with Police Officer #1 on 5/20/26 at 11:28 AM revealed he was one of the responding officers to the facility on 5/02/26. He reported they were dispatched to the facility along with EMS regarding a possible injury that occurred during care. Police Officer #1 stated when he arrived, he found Resident #1 in his room. He stated Resident #1 was lethargic and complaining about pain in his knee and Resident #1 had a visible deformity in his femur. Police Officer #1 stated that he was able to question NA #1 at the time and that NA #1 had reported to him that he had gone into Resident #1’s room to provide care when he found Resident #1 covered in excrement (waste matter discharged from the body). He stated while NA #1 was being questioned, he became increasingly agitated and was very defensive. He stated NA #1 complained about a previous resident he had provided care to who had taken their brief off and “flung it at him”. NA #1 reported to him that while he was attempting	F0600		

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F0600 SS = G	Continued from page 6 to provide Resident #1 care, Resident #1 had become resistive and attempted to hit him multiple times. NA #1 also informed him that while he was pushing resident onto his side to continue with care, NA #1 heard an audible “pop”. The Police Officer reported that their investigation was still ongoing. An interview with the DON on 5/20/26 at 3:13 PM revealed she was not in the facility at the time of the incident related to NA #1 and Resident #1 on 5/02/26 and was informed via telephone call around 5:30 PM by Nurse #1 who told her that Resident #1 was going to the hospital because he was complaining of leg pain. The DON stated she was told that NA #1 reported to Nurse #1 that Resident #1 was being combative during care and NA #1 had exited Resident #1’s room saying something about Resident #1’s leg. The DON stated that EMS arrived to the building along with the police department before she arrived at the facility. The DON reported she informed Nurse #1 while speaking to her on the phone to go ahead and send NA #1 home due to her not fully understanding what happened during the care. She continued, stating when she arrived at the facility, NA #1 was not at the facility, and she contacted him via telephone, and he reported to her that he had gone into Resident #1’s room to provide incontinence care. NA #1 reported to her as he went to roll Resident #1 onto his side, Resident #1 attempted to either kick or knee him. NA #1 reported to the DON that he caught Resident #1’s leg to prevent him from being kicked and that’s when he heard a pop. The DON reported she believed that NA #1 had worked in the facility 3 times over several months. The DON reported ideally, she would want her staff to stop care immediately when a resident became combative or resistive, ensured the resident was safe, and then reapproach the resident later. The DON stated NA #1 did not meet that expectation by continuing to try and provide care to Resident #1 who had become combative. The DON stated NA #1 should have stopped care when Resident #1 became resistive or combative and walked out of the room. The DON verified that Resident #1 was care planned for resistive and combative behaviors but had not received any recent complaints of Resident #1 being combative or resistive during care. The DON stated she was unable to personally speak to Resident #1 because when she arrived at the facility, he had already been transported to the hospital but stated she was on the phone with Nurse #1 when she went into Resident #1’s room and inquired with him about what happened and she heard Resident #1 simply reply “that son of a b….”. The DON also reported that while there were cameras in the facility, the only ones that were currently in operation were ones that	F0600		

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F0600 SS = G	Continued from page 7 covered the exits of the facility. An interview with the Administrator on 5/20/26 at 4:07 PM revealed she was first notified of the incident related to NA #1 and Resident #1 from the DON via telephone call on 5/02/26. She stated it was explained to her that Resident #1 was being sent out to the hospital after becoming combative during care and while NA #1 was attempting to provide care, Resident #1 suffered, what could have been a broken leg. The Administrator stated the DON and herself spoke with NA #1 who stated he was trying to provide care when Resident #1 attempted to kick him and while NA #1 had his hands on Resident #1, he heard a pop. She stated NA #1 stated after he heard the pop, he left Resident #1's room and retrieved the nurse. The Administrator stated it was her understanding that Resident #1 was actively resisting care at the time the pop was heard. She also reported that it was her understanding that NA #1 did pause briefly providing care when Resident #1 became resistive but returned shortly to continue providing care. She stated she felt that NA #1 was "really focused on getting [Resident #1] changed." The Administrator stated when she arrived at the facility, Resident #1, NA #1, EMS, nor the police department were at the facility. She stated she expected her staff to immediately stop providing care to residents who become resistive or combative and reapproach them in 5-15 minutes with a different approach. She stated she would also like for her staff to report combative or resistive behaviors to the hall nurses. The Administrator indicated while the facility investigated an allegation of employee to resident abuse, it was ultimately unsubstantiated due to the belief that NA #1 did not intentionally mean to harm Resident #1. An interview with the Medical Director via telephone call on 5/20/26 at 2:14 PM revealed he was not at the facility at the time of the incident but was made aware of it via the administrative team. The Medical Director stated Resident #1 was an elderly man with cognitive impairments. He reported it was his understanding that Resident #1 was kicking at a nurse aide who was attempting to provide care and then was complaining about leg pain. He continued, stating he had contacted the hospital where Resident #1 was sent and was told that Resident #1 had suffered a femur fracture. He stated the femur was a "really hard bone to break" stating that it was usually something you would see in traumatic accidents. He reported he was shocked the Resident #1's femur had been fractured and stated he began investigating further and found that it appeared as though Resident #1 had some osteopenia (bone	F0600		

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F0600 SS = G	Continued from page 8 density degradation) and relayed that it could have developed from the use of some medications that Resident #1 had been taking. The Medical Director stated he determined that although the end result was a fracture of the femur, he believed there was some underlying softness to Resident #1's bones which may have caused Resident #1's femur to break more easily. He reported he was familiar with Resident #1 and stated there had been instances where Resident #1 was resistive or aggressive with he and his team. He also reported for a resident with cognitive deficits, it would be typical to attempt to redirect the resident or to stop care and reapproach the resident 10-15 minutes later. The Medical Director finished by reporting that it was quite possible that if Resident #1 kicked someone and made contact, the femur could have broken but he did not believe it would have broken simply by touching the area. The facility provided a corrective action plan that was not accepted by the state agency.	F0600		