	-	ID HUMAN SERVICES			FORM	APPROVED
						0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMP	LETED
						c
		345133	B. WING			20/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
			1	000 COLLEGE STREET		
	LLET CENTER FOR NUP	RSING AND REHABILITATION	v	VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	The following intakes NC00198305, NC001 NC00197051, NC001 NC00196620, NC001 NC00195664, NC001 NC00198162, NC001	20/23. Event ID #HUV111.				
	of J. CFR 483. 45 at tag F of J.	was identified at: i80 at a scope and severity 760 at a scope and severity ied Substandard Quality of				
F 550 SS=G	care. Immediate Jeopardy removed on 2/17/23. was conducted.	began on 12/17/22 and was A partial extended survey cise of Rights	F 550			3/13/23
	§483.10(a) Resident The resident has a rig self-determination, an access to persons an outside the facility, ind this section.	Rights. ght to a dignified existence, nd communication with and d services inside and cluding those specified in ty must treat each resident				
		-				
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					03/13/2023

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

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 03/14/2023 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUC		(X3) DA	TE SURVEY MPLETED
		345133	B. WING			0	C 2/20/2023
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDR	RESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEC	GE STREET RO, NC 28697		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	WIERESDO	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE
F 550	Continued From page	<u>م</u> 1	F 5	50			
		and in an environment that	1.5	50			
		ce or enhancement of his or					
		ognizing each resident's					
	individuality. The faci promote the rights of						
	5492.10(a)(2) The factor	allity must provide aqual					
		cility must provide equal e regardless of diagnosis,					
		or payment source. A facility					
		aintain identical policies and					
		ansfer, discharge, and the under the State plan for all					
	residents regardless	-					
	§483.10(b) Exercise						
		right to exercise his or her f the facility and as a citizen					
	or resident of the Uni	-					
		cility must ensure that the					
		his or her rights without n, discrimination, or reprisal					
	from the facility.	· · · · · · · · · · · · · · · · · · ·					
		sident has the right to be					
		coercion, discrimination, and					
	-	ity in exercising his or her orted by the facility in the					
		rights as required under this					
	subpart.	-					
		「 is not met as evidenced					
	by: Based on record rev	iews, observations and		E550 R	Resident Rights		
		erviews, the facility failed to			nt #7 and Resident #6 w	vere bathed	
	treat residents in a di	gnified manner when staff		accordir	ng to their preferences.		
		luled bed baths requested.			dents have the potential		
	-	ed feelings of being dirty, Inclean. This affected 2 of 3			d. The resident shower a le per point of care task	-	
	residents reviewed for				e to be monitored and p		

Facility ID: 923520

TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) [	NO. 0938-039 DATE SURVEY COMPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			C
		345133	B. WING			02/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 550	Continued From page	e 2	F 55	D		
	(Resident #7 and Res	sident #6).		direct care staff. ADL	care plans and CNA	
	The findings included	: :		task list are updated Nursing or designee.	-	
	1.Resident #7 was a	dmitted to the facility on		and bathing complete	<b>U</b>	
	11/11/22 with diagnos	ses of hypertension and		The Director of Nursi	ing provided	
	muscle weakness.			education to current	•	
	A review of the admis	ssion Minimum Data Set		nurse aides, and dire on monitoring and pr		
		2 indicated Resident #7 was		bathing to residents		
		e MDS revealed Resident #7		of care to maintain c		
	-	and required two staff assist S also indicated it was very		agency staff will rece	aides, and direct care	
		dent #6 to choose between a		hire. Direct care nurs		
	tub bath, shower, or l	bed bath.		determine and provid and bathing as need	de resident shower ed or requested.	
		ervation with Resident #7 on		The Director of Nursi		
		revealed she had not howers as scheduled since		will complete an aud schedule completion	•	
		#7 further revealed she		completed for 5 resid		
		and had to ask nursing staff		observations at a fre		
		ive one. Resident #7 stated her hair felt dirty and had		weekly for four week week for four weeks,		
	expressed this to stat			weeks until interdisci		
	Observation revealed	Resident #7 to have greasy		determines continua	nce of audits is	
		have facial expressions of		unnecessary. The ac		
	being unhappy.			interdisciplinary team to the plan as necess	•	
	An interview with Nur	se Aide (NA) #1 on 02/15/23		resident regarding sh		
		she worked on the shower		Date of Compliance	03/13/2023	
		ut was often pulled to the IAs due to short staffing . NA				
		esident #7 had missed				
	-	multiple days and had				
	complained of feeling					
		d complained showers and given as scheduled as				
	preferred.	g. s. as conocaida do				

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345133	B. WING _				20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			000 COLLEGE STREET /ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	An interview with NA revealed assisted NA and Resident #7 had the facility sometimes so staff assisting with the floor. NA #5 state expressed she had fe receiving a scheduled An interview with Unit 02/15/23 at 12:05 PW Resident #7 had refus before. UM #1 further showers and baths ha assist other NAs due UM #1 indicated she missed multiple bed to expressed feelings of An interview with the on 02/15/23 at 12:30 preferred a bad bath had missed several s complained of feeling revealed she expecter residents to receive th scheduled days and to comfortable. 2. Resident #6 was a 11/11/22 with diagnos arthritis. A review of the admiss (MDS) dated 11/18/22 cognitively intact. The Resident #6 was tota two staff assist for ba	<ul> <li>#5 on 02/15/23 at 2:15 PM</li> <li>#1 with showers and baths not refused. NA #5 indicated a did not have enough NAs showers would get pulled to d Resident #7 had eff dirty at time due to not d bed bath.</li> <li>t Manager (UM) #1 on I revealed she did not recall sed preferred bed baths revealed NA's completing ad been pulled to the floor to to staff who had called out.</li> <li>was not aware #7 had baths as scheduled and being unclean.</li> <li>Director of Nursing (DON) PM revealed Resident #7 and was not aware that she cheduled days and dirty. The DON further eff for Resident #7 and other heir shower or bath on to feel clean and</li> <li>dmitted to the facility on ses of hypertension, and</li> <li>esion Minimum Data Set 2 indicated Resident #6 was e MDS further revealed I dependent and required</li> </ul>	F	550			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345133	B. WING				C 20/2023
NAME OF F	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	ALLEY CENTER FOR NUP	RSING AND REHABILITATION			1000 COLLEGE STREET NILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	to choose between a bath. An interview and obse 2/14/23 at 1:00 PM re- consistent showers at admission. Resident a preferred bed baths a had not received pref #6 stated he felt dirty bed baths as schedul to nursing staff. Obse #6 to have an odor. An interview with NA revealed she worked consistently for the fa the floor to assist othe NA #1 further reveale preferred bath baths is complained of feeling residents had compla were not being given An interview with NA revealed assisted NA and Resident #6 had the facility sometimes so staff assisting with the floor. NA #5 state residents had compla showers or baths as s An interview with Unit 02/15/23 at 12:05 PM Resident #6 had refus had expressed he had	tub bath, shower, or bed ervation with resident #6 on evealed he had not received s scheduled since #6 further revealed he and had told nursing staff he erred bed baths. Resident and itchy and wanted his ed and had expressed this rvation revealed Resident #1 on 02/15/23 at 2:05 PM on the shower team cility but was often pulled to er NAs due to short staffing. d Resident #6 had missed multiple days and had dirty. NA #1 stated multiple ined showers and baths as scheduled as preferred. #5 on 02/15/23 at 2:15 PM #1 with showers and baths not refused. NA #6 indicated a did not have enough NAs showers would get pulled to d Resident #6 and other ined they had not received scheduled.	F	550			

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	OF DEFICIENCIES		(X2) MULTIPLE CO		OMB NO. 0938-03	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
		345133	B. WING		02/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION	1000 WIL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIO	
F 550	Continued From page	e 5	F 550			
		out. UM #1 indicated she d missed multiple bed baths				
	on 02/15/23 at 12:30 preferred a bad bath had missed several s complained of feeling revealed she expected	dirty. The DON further d for Resident #6 and other heir shower or bath on				
F 580 SS=J		jury/Decline/Room, etc.) )(i)-(iv)(15)	F 580		3/13/23	
	consult with the resid consistent with his or representative(s) whe (A) An accident invol- results in injury and h physician intervention (B) A significant chan	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical,				
	status in either life-th clinical complications (C) A need to alter tre a need to discontinue	n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of				
	commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii).	sfer or discharge the				

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	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPF OMB NO. 0938	8-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345133	B. WING		C 02/20/202	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMP	X5) PLETION ATE
F 580	all pertinent informati is available and provi physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must fu update the address (f phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on interview, Director, Telemedicin Medical Director, and the facility failed to no Provider that was ma intravenous (IV) antit to treat a right subdur pus between the laye Cerebritis (inflammat	on specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, a or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph a. record and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations T is not met as evidenced record review, staff, Medical the Physician, Regional d Infectious Disease provider obtify the Infectious Disease unaging Resident #1's plotic which was being used ral empyema (collection of ers of the brain) and ion of cerebrum of the brain) ripherally inserted central	F 58	F580 Notification of Changes Resident #1 discharged from facili 12/25/2022. All residents receiving IV antibiotic the potential to be affected. Theref audit was completed by the Directo Nursing on 02/15/2023 to ensure medication administration complia notification to provider for any miss administrations. On 02/15/23, the Director of Nursin	s have fore, an or of nce and sed	

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 MAPPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345133	B. WING			02	C 2/20/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	000 COLLEGE STREET		
RIDGE VA	LLEY CENTER FOR NUM	RSING AND REHABILITATION		W	/ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	of 1 resident reviewed errors. There was the regrowth, resistance is to hospital due to the Immediate jeopardy is facility failed to notify Provider Resident #1 dislodged, and the IV administered as orde was removed on 02/1 provided an acceptab immediate jeopardy r remain out of complia severity of D (no actu more than minimal ha jeopardy) to ensure n place and the comple The findings included Resident #1 was adm 12/17/22 with diagnos metastasis (cancer th chronic subdural hem The physician order of Oxacillin (antibiotic) 1 Use 12 gm IV one tim encephalitis/sepsis fo over a 24-hour period	dministered as ordered for 1 d for significant medication e high likelihood for bacterial to antibiotic, sepsis, or return missed medications. Degan on 12/22/22 when the the Infectious Disease 's PICC line became antibiotics were not being red. Immediate jeopardy 17/23 when the facility ole credible allegation of emoval. The facility will ance at a lower scope and tal harm with potential for arm that is not immediate nonitoring systems are in stion of employee education.	F	580	requirements to notify the MD when medication cannot be administered a ordered. The Director of Nursing will ensure no licensed nurses will work without receiving this education. Any hires including direct care agency wil receive education prior to the beginn their first shift. Education was comple on 02/16/2023 by Director of Nursing Unit Manager. The Chief Nursing Officer educated t Administrator and Director of Nursing 02/15/23 regarding the clinical mornin meeting process to include reviewing notification. The Director of Nursing and/or design will complete an audit of the MD notification on 03/07/2023 to include residents receiving IV antibiotics at a frequency of five times weekly for four weeks, then three times a week for for weeks, then weekly for four weeks un interdisciplinary team determines continuance of audits is unnecessary administrator and interdisciplinary teat will make changes to the plan as necessary to ensure MD is notified of missed administrations. Date of Compliance 03/13/2023	new I ing of eted or he on ng MD nee five five ur ntil	
	dated 12/2022 reveal responsible for admin						

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345133	B. WING				C / <b>20/2023</b>
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			000 COLLEGE STREET		
				v	VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	responsible for admir Oxacillin on 12/25/22 A nurse's note dated by Nurse #1 read, ma PICC line was out an Writer noted PICC lin floor and asked reside resident he got caugh have pulled it out. On for replacement. Nurse #1 was intervie at 3:55 PM who confi on 12/22/22. She stat Resident #1 and anot could not recall notifie PICC line was out. No Resident #1's room a on the floor at the foo Nurse #1 stated she in 45 centimeters and p gave to Nurse #2 and MD to get the IV line confirmed that she has Infectious Disease Pr the PICC line with Nu notify the MD to get the Review of a physician	and 12/24/22. Nurse #4 was histering Resident #1's 12/22/23 at 7:34 AM written ade aware that resident's d at the foot of the bed. e of 45 centimeters on the ent what happened. Per at up turning in bed and must coming nurse made aware ewed via phone on 02/14/23 rmed that she was working ted she was responsible for ther staff member who she ed her that Resident #1's urse #1 stated she went to nd found his PICC line lying it of Resident #1's bed. measured the PICC line to laced the line in a bag and d instructed her to call the replaced. Nurse #1 ad not called the MD or the rovider, she stated she left urse #2 and instructed her to he IV line replaced. m order dated 12/23/22 read,	F	580			
		due to antibiotic use. The Illy signed by Nurse #3 and (MD).					
	at 4:56 PM. Nurse #3 Resident #1 as he wa	ewed via phone on 02/15/23 stated that she recalled as on IV antibiotics that ran at a time. She stated she					

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	OF DEFICIENCIES	MEDICAID SERVICES			(X3) DATE	0.0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	. ,	LETED
			AL BOILDIN			C
		345133	B. WING	······		20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				1000 COLLEGE STREET		
RIDGE VA	LLET CENTER FOR NUI	RSING AND REHABILITATION		WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	<del>-</del> 9	F 5	80		
		his PICC line got pulled out	1.5			
		f the IV line got reinserted or				
		not recall why or how she				
		ated 12/23/22 to obtain a				
		antibiotic use for Resident				
		at she had not notified the				
		Disease Provider that				
	orders.	vas out or to obtain any new				
	The MD was interviev	wed on 02/15/23 at 10:03				
		had been the MD at the				
	facility since June 20	22 and was at the facility				
	once a week. The MI	D stated that he was not at				
	all familiar with Resid					
		ne was in the facility. He				
	who evaluates a resid	emed Physician (a physician				
		d evaluated Resident #1 and				
		wer questions regarding				
	•	stated that if he had a				
	resident who was rec	eiving IV antibiotic via a				
		eing followed by Infectious				
		efer to consult with them				
	PICC line.	with the IV antibiotic or				
	A follow up interview	via phone was conducted				
		5/23 at 8:42 PM. The MD				
		d getting a call from a nurse				
		ould not recall which nurse				
		1's PICC line coming out. ed his judgement to just				
		. The MD indicated he				
		rders that night and he				
	-	it was a better option to just				
	observe him and if he	e deteriorated then we would				
		The MD stated, "looking				
	back I should have de					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345133	B. WING				20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			000 COLLEGE STREET NILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	further confirmed that staff to the Infection I previously stated he we stated he thought it we Resident #1. The Regional Medica on 02/15/23 at 11:50 was not familiar with I resident was on IV and reason and would be missed doses of the I stated that he had rewo medical record and it provider was made and PICC line was out. The Telemed Physicia phone on 02/15/23 at Physician stated she Resident #1. She state the facility and was not PICC line came out. Sishe was not the provi- antibiotic therapy, she that would need to go ordered the medication Infectious Disease Pr had someone called I staff contact the Infect then try to figure out I next dose of schedule possible. Nurse #4 was intervie- at 2:43 PM. Nurse #4 Resident #1 and reca- antibiotics. Nurse #4	the did not refer the nursing Disease provider as he would do. The MD again as best to just observe I Director was interviewed AM via phone who stated he Resident #1 but stated if a tibiotic it was for good important if the resident V antibiotic. He further viewed Resident #1's did not appear that any ware that Resident #1's an was interviewed via 11:18 AM. The Telemed really could not recall ted she did not take call for ot notified Resident #1's She stated that generally if	F	580			

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		MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED
					С	
		345133	B. WING		0	2/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				1000 COLLEGE STREET		
RIDGE VA	LLET CENTER FOR NU	RSING AND REHABILITATION		WILKESBORO, NC 28697		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	o 11	F 58	30		
1 000	line out and they wer		F 50			
		tated he could not confirm				
		replaced and stated he had				
	not contacted the MD	or the Infectious Disease				
	Provider for any addi	tional orders.				
	Nume #2 uses intervi	$\sim$				
		ewed via phone on 02/16/23 2 stated she vaguely recalled				
		pulling his PICC line out.				
		not called the MD to get any				
		or antibiotics as she was not				
		ntibiotics Resident #1 was				
	-	or the duration of his				
		ntibiotics. Nurse #2 stated if out on her shift she would				
	assess the resident a					
		ine came out on the shift				
	before hers and she	assumed that had all been				
		e #2 confirmed that she had				
		ication with the Infectious				
		all. She stated "if I called the				
		n sure that I texted the MD to had pulled the PICC line				
		it replaced" but could not				
		Nurse #2 again stated that				
		ine came out on Nurse #1's				
		e been her responsibility to				
	-	e line came out and obtain				
	any new orders.					
	The Director of Nursi	ng (DON) was interviewed				
		PM who stated she vaguely				
		. She stated he was on IV				
		CC line that was used for				
		se IV antibiotics got pulled				
		that when PICC's line				
	became dislodged th notified but she did n	e provider was immediately				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/14/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345133	B. WING			( 02/2	, 20/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		000 COLLEGE STREET VILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	hold the antibiotic unt but they could also ge antibiotic via a differe until the IV line could not aware of any addi obtained regarding th The Infectious Diseas via phone on 02/15/2: was very familiar with followed him several hospital before comin indicated that Resider a specific organism th culture that was obtai Provider stated that h Resident #1's nurse a 10:04 AM to confirm t correct order for the I' duration for the antibio orders for the required was needed. At no tim or other time was her Resident #1's PICC li receiving his IV Oxac Provider also explained day 19 (4 at the facilith his entire six-week co he was not just startir he had not reached th therapy. The Infectiou that if she would have would have immediat Resident #1 back to t his IV access replace	y got a hold order to just il the IV line can be replaced et an order to give another int route like intramuscularly be replaced. The DON was itional orders that were e IV Oxacillin. The DON was interviewed 3 at 1:50 PM who stated she Resident #1 as she had days while he was in the g to the facility. She int #1 was on IV Oxacillin for nat was detected on a ned. The Infectious Disease er office had contacted at the facility on 12/22/22 at that the facility had the V antibiotic, the correct otics, and that they had d weekly blood work that ne during that conversation office made aware that ne was out, and he was not illin. The Infectious Disease ed that Resident #1 was on ry and 15 at the hospital) of purse of antibiotic indicating ng his course of therapy, but	F 580				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345133	B. WING				20/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2020
					1000 COLLEGE STREET		
	LLEY CENTER FOR NUP	RSING AND REHABILITATION			WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page The Administrator wa jeopardy on 02/15/23 The facility provided t F580: Identify those r or likely to suffer, a se result of the noncomp Resident #1 did not re 12/22/22, 12/23/23, 1 secondary to IV access infectious disease pro access was dislodged not received. On 02/15/23, the Direc resident's medications compliance and notifin missed administration identified during this a 02/16/23. Specify the action the process or system fail	e 13 s notified of the immediate at 5:20 PM. he following IJ removal plan: esidents who have suffered, erious adverse outcome as a bliance: eceive IV antibiotics on 2/24/23, and 12/25/23 ss becoming dislodged. The ovider was not notified the d and the antibiotics were ector of Nursing reviewed s for administration cation to the provider for any ns. Any opportunities audit will be addressed by e entity will take to alter the lure to prevent a serious		580	DEFICIENCY)		
		n occurring or recurring, and					
	licensed nurses on re when medication can ordered. Education w notifying the provider becomes dislodged. T phone at the time me Director of Nursing wi will work without rece	ector of Nursing educated quirements to notify the MD not be administered as vas also completed on in the event the IV access The MD will be notified by dication is not given. The ill ensure no licensed nurses iving this education. Any gency will receive education					

Facility ID: 923520

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345133	B. WING			C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	SING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580 F 600 SS=D	will be completed on ( Nursing or Unit Mana, The Chief Nursing Off Administrator and Dir regarding the clinical include reviewing MD medications and dislo Effective 02/15/2023, responsible to ensure removal plan for this a The alleged date of IJ A credible allegation v conducted in the facili education provided to facility including Nurse and Nurse #4 was rev revealed that the licer trained on the process immediately reporting when medications cou they were ordered. Th cause analysis to help reviewed without cond immediate jeopardy rev was validated. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the in neglect, misappropria	of their first shift. Education 02/16/2023 by Director of ger. ficer educated the ector of Nursing on 02/15/23 morning meeting process to notification of missed dged IV access. the Administrator will be implementation of this IJ alleged non-compliance. removal is 02/17/2023. validation of notification was ty on 02/20/23. The the licensed nurses in the e #1, Nurse #2, Nurse #3, viewed. The interviews nsed nurses had been s of notification and to the medical provider uld not be given in the way he facility conducted a root o identify issues and was cern. The facility's emoval date of 02/17/23	F 58			3/13/23

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	-	ND HUMAN SERVICES			PRINTED: 03/14/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 02/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	·
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		000 COLLEGE STREET	
	1		I ¥	VILKESBORO, NC 28697	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 600	Continued From page	e 15	F 600		
	includes but is not lin		1 000		
		, involuntary seclusion and			
		nical restraint not required to			
	treat the resident's m				
	§483.12(a) The facili	ty must-			
	§483.12(a)(1) Not us physical abuse, corp	e verbal, mental, sexual, or oral punishment, or			
	involuntary seclusion				
	-	Γ is not met as evidenced			
		iew and staff interview the		F600 Free of Abuse and Negleo	t
	facility neglected to re			Resident #1 discharged from fac	
		piotic when his IV access		12/25/2022. Resident #6 and Re	esident #7
		1 resident (Resident #1)		were bathed according to their	
	reviewed and they al			preferences.	
		as requested. The residents		All residents have the potential t	
		f being dirty, unhappy, itchy, 3 residents reviewed for		affected. To ensure shower and schedule is completed per reside	
	neglect (Resident #7			preference, the Director of Nursi	
				monitor plan of care bathing tasl	-
	The findings included	1:		Director of Nursing reviewed all receiving IV antibiotics for misse	residents
	Resident #1 was adn	nitted to the facility on		administrations.	,u
		ses that included: brain		Education completed on 03/10/2	2023 on
		nat has spread to the brain),		abuse and neglect. The Director	
	chronic subdural hen	natoma, and sepsis.		Nursing or designee provided ec	ducation to
	Dovious of a physicia	n order dated 12/19/22 read		current licensed nurses, nurse a	
		n order dated 12/18/22 read, 10 grams (gm) reconstituted.		direct care agency staff. Newly h nurses, nurse aides, and direct of	
	Use 12 gm IV one tin			agency staff will receive education	
		or 27 days. Infuse 12 gm		hire.	
	over a 24-hour period			The Director of Nursing and/or d will complete an audit of residen	-
	Review of the Medica	ation Administration Record		schedule completion and IV med	-
		2 indicated that Oxacillin was		administration. Monitoring will be	
	given as ordered on			completed for 5 residents at a fro	
		22. The MAR indicated that		of five times weekly for four wee	

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPI	
					0	;
		345133	B. WING			20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	<u>e</u> 16	F 60			
	Oxacillin was not adn 12/23/22, 12/24/22, a	ninistered on 12/22/22,		three times a week for four we weekly for four weeks until interdisciplinary team determi continuance of audits is unne	nes	
	AM written by Nurse a resident's PICC line w bed. Per resident he and must have pulled	#1 read, made aware that vas out and at the foot of the got caught up turning in bed it out. On coming nurse		administrator and interdiscipli will make changes to the plan necessary to ensure that resid free from abuse and neglect. Date of Compliance 03/13/20	nary team as dents are	
	made aware for replacement. Review of a nurse's note dated 12/22/23 at 9:56 AM written by Nurse #2 read, IV company called, stated a central line (type of IV line) would be appropriate and a nurse would call shortly to establish when it could be done.					
	12/24/22 at 11:31 AM	ninistration note dated and written by Nurse #2 access, IV replacement to				
	company indicated th they arrived at the fac access in Resident #	ation from an external IV at on 12/24/22 at 3:48 PM cility and inserted an IV 1's right hand. The line was and Resident #1 tolerated				
		ninistration note dated and written by Nurse #4 g for IV insertion.				
	at 3:55 PM who confi on 12/22/22. She stat Resident #1 and anot could not recall notifie PICC line was out. No	ewed via phone on 02/14/23 rmed that she was working ted she was responsible for ther staff member who she ed her that Resident #1's urse #1 stated she placed nd gave it to Nurse #2 and				

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		ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 03/14/2023 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		345133	B. WING			C 02/20/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZI		
RIDGE VA	LLEY CENTER FOR NUF	SING AND REHABILITATION		000 COLLEGE STREET VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 600	get the IV line replace Nurse #2 was intervie at 2:39 PM. Nurse #2 Resident #1 and him She stated if she doc have it replaced then could not recall if she line or not nor could s company came to rep stated that the extern someone know that th IV line. Nurse #2 conf Oxacillin was not adm 12/24/22 because his out. Nurse #4 was intervie at 2:43 PM. Nurse #4 Resident #1 and reca antibiotics. Nurse #4 few days and when he report on 12/25/22 tha his PICC line out and replaced. Nurse #4 st that the IV was ever r confirmed that Reside pulled out on his shift line was never replace Oxacillin was not give The Director of Nursir on 02/20/23 at 12:50 12/22/22 Resident #1 and Nurse #2 had cal stated that they learned	he Medical Director (MD) to ed. weed via phone on 02/16/23 stated she vaguely recalled pulling his PICC line out. umented that she called to she had done so. Nurse #2 attempted to reinsert the IV he recall if the external IV blace the IV line. Nurse #2 al IV company usually let ney were there to replace an firmed that Resident #1's ninistered on 12/22/22 or on PICC line had been pulled weed via phone on 02/15/23 stated that he recalled lled that he was on IV stated that he was off for a e came back, he was told in at Resident #1 had pulled we were waiting for it to be ated he could not confirm eplaced. Nurse #4 ent #1's IV had not been and to his knowledge the ed and that was why his IV	F 600			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT C	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY PLETED
		345133	B. WING			-		C 20/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUF	RSING AND REHABILITATION			000 COLLEGE STREET VILKESBORO, NC 2869	17		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	"she was at loss at wi and 12/25/22" about v receive his IV antibiot getting a lot of informa The Infectious Diseas via phone on 02/15/23 was very familiar with followed him several of hospital before comin indicated that Resider a specific organism the culture that was obtai that Oxacillin's affects which was why in the very frequently but in was infused over a tw Infectious Disease pro Resident #1's IV acce Oxacillin should have as ordered. 2. Resident #7 was ac 11/11/22 with diagnos muscle weakness. A review of the admiss (MDS) dated 11/18/22 cognitively intact. The was total dependent a for bathing. The MDS important to for Resid tub bath, shower, or b An interview and obse 2/14/23 at 10:15 AM r	started. The DON stated hat happened on 12/24/22 why Resident #1 did not tic and stated she was "not ation about that." Se Provider was interviewed 3 at 1:50 PM who stated she a Resident #1 as she had days while he was in the log to the facility. She int #1 was on IV Oxacillin for nat was detected on a ined. She further explained is peaked at thirty minutes hospital setting it was given the skilled nursing facility it venty-four-hour period. The ovider stated that once eas had been restored his IV immediately been restarted dmitted to the facility on ses of hypertension and scion Minimum Data Set 2 indicated Resident #7 and required two staff assist also indicated it was very lent #6 to choose between a bed bath. ervation with Resident #7 on revealed she had not howers as scheduled since #7 further revealed she	F	600				
		and had to ask nursing staff						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING					C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZI	P CODE	-	
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			1000 COLLEGE STREET WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD B		(X5) COMPLETION DATE
F 600	she felt unclean, and expressed this to staf Observation revealed and tangled hair and being unhappy. An interview with Nur- at 2:05 PM revealed st team for the facility but floor to assist other N #1 further revealed Re preferred bath baths in complained of feeling multiple residents had baths were not being preferred. An interview with NA revealed assisted NA and Resident #7 had the facility sometimes so staff assisting with the floor. NA #5 states expressed she had fe receiving a scheduled An interview with Unit 02/15/23 at 12:05 PM Resident #7 had refus before. UM #1 further showers and baths ha assist other NAs due UM #1 indicated she missed multiple bed be	ve one. Resident #7 stated her hair felt dirty and had f multiple times. Resident #7 to have greasy have facial expressions of se Aide (NA) #1 on 02/15/23 she worked on the shower ut was often pulled to the As due to short staffing. NA esident #7 had missed multiple days and had nasty. NA #1 stated d complained showers and given as scheduled as #5 on 02/15/23 at 2:15 PM #1 with showers and baths not refused. NA #5 indicated o did not have enough NAs showers would get pulled to d Resident #7 had It dirty at time due to not bed bath. : Manager (UM) #1 on revealed she did not recall sed preferred bed baths revealed NA's completing ad been pulled to the floor to to staff who had called out. was not aware #7 had baths as scheduled and	F	600				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345133	B. WING				20/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			1000 COLLEGE STREET WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	had missed several s complained of feeling revealed she expecte residents to receive th scheduled days and t comfortable. 3. Resident #6 was an 11/11/22 with diagnos arthritis. A review of the admis (MDS) dated 11/18/22 cognitively intact. The Resident #6 was total two staff assist for ba- indicated it was very it to choose between a bath. An interview and obse 2/14/23 at 1:00 PM re- consistent showers as admission. Resident a preferred bed baths a had not received pref #6 stated he felt dirty bed baths as schedul to nursing staff. Obse #6 to have an odor. An interview with NA revealed she worked consistently for the fa the floor to assist othe NA #1 further reveale preferred bath baths of	and was not aware that she cheduled days and dirty. The DON further d for Resident #7 and other heir shower or bath on o feel clean and dmitted to the facility on ses of hypertension, and sion Minimum Data Set 2 indicated Resident #6 was a MDS further revealed d dependent and required thing. The MDS also mportant to for Resident #6 tub bath, shower, or bed ervation with resident #6 on evealed he had not received as scheduled since #6 further revealed he and had told nursing staff he erred bed baths. Resident and itchy and wanted his ed and had expressed this rvation revealed Resident #1 on 02/15/23 at 2:05 PM on the shower team cility but was often pulled to er NAs due to short staffing. d Resident #6 had missed	F	600			

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	VENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 10. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345133	B. WING		0	C 2/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1000 COLLEGE STREET		
	LLET CENTER FOR NUI	RSING AND REHABILITATION		WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 21	F 600			
		ained showers and baths	1 000			
	•	as scheduled as preferred.				
		#5 on 02/15/23 at 2:15 PM				
	and Resident #6 had	#1 with showers and baths not refused. NA #6 indicated				
		s did not have enough NAs				
	0	showers would get pulled to describe to describe the description of th				
		ained they had not received				
	showers or baths as	-				
	02/15/23 at 12:05 PM Resident #6 had refut had expressed he ha revealed NAs complet been pulled to the floo staff who had called of	t Manager (UM) #1 on I revealed she did not recall sed preferred bed baths and d felt dirty. UM #1 further eting showers and baths had or to assist other NA's due to but. UM #1 indicated she d missed multiple bed baths				
	on 02/15/23 at 12:30 preferred a bad bath had missed several s complained of feeling revealed she expected	dirty. The DON further d for Resident #6 and other heir shower or bath on				
F 655	Baseline Care Plan		F 655			3/13/23
SS=D	CFR(s): 483.21(a)(1)	-(3)				
	§483.21 Comprehens Planning §483.21(a) Baseline §483.21(a)(1) The fac					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING					C 20/2023
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				10	000 COLLEGE STREET			
RIDGE VA	LLET GENTER FOR NUP	SING AND REHABILITATION		W	VILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	that includes the instrueffective and person-of that meet professional The baseline care pla (i) Be developed withi admission. (ii) Include the minimu- necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomme §483.21(a)(2) The fact comprehensive care p care plan if the compre- (i) Is developed within admission. (ii) Meets the requirem (b) of this section (exc this section). §483.21(a)(3) The fac- resident and their repu- of the baseline care p limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fac on behalf of the facility (iv) Any updated infor	care plan for each resident uctions needed to provide centered care of the resident I standards of quality care. In must- In 48 hours of a resident's Im healthcare information care for a resident ed to- on admission orders. endation, if applicable. ility may develop a blan in place of the baseline ehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not the resident. resident. residents to be acility and personnel acting	F	355				
	(iv) Any updated infor	mation based on the details						

Facility ID: 923520

If continuation sheet Page 23 of 56

	-	ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/14/202 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED C
		345133	B. WING	·····	02	2/20/2023
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET		
	I			WILKESBORO, NC 28697		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	Continued From pag	e 23	F 65	5		
1 000	- 13	F is not met as evidenced	F 00	5		
	by:	i is not met as evidenced				
	-	view and staff interview the		F655 Baseline Care Plans		
		op a baseline care plan that		On 12/17/2023, the Baseline		
		lly inserted central catheter		was completed for Resident		
		dminister IV medications) ibiotic for 1 of 1 residents		line and IV antibiotic were no the special services/ instructi		
	reviewed (Resident #			Baseline Care Plan assessm		
				resident was discharged fron		
	The findings included	1:		December 25th, 2022.	<b>,</b>	
				All current residents on 02/16		
		nitted to the facility on		PICC lines or IV antibiotics w		
		ses of that included: brain nat has spread to the brain),		to ensure proper documentat Baseline Care Plan.	tion on the	
	chronic subdural hen			On 3/9/2023, the Regional D	irector of	
				MDS educated the Director of		
	-	order dated 12/17/22 read IV		Assistant Director of Nursing		
	PICC line monitor ev			Manager on adding IV antibio		
	symptoms of infection	n or infiltration.		access lines to the special se instructions section of the ba		
	Review of a Physicia	n order dated 12/18/22 read,		plan. On 03/10/2023, the Dire		
		10 grams (gm) reconstituted.		Nursing educated licensed n		
	Use 12 gm IV one tin			adding IV antibiotics and IV a		
	encephalitis/sepsis for	or 27 days. Infuse 12 gm		to the special services/ instru		
	over a 24-hour period	d.		section of the baseline care p		
	Poviow of Posident +	t1's baseling care plan dated		The Director of Nursing and/		
		#1's baseline care plan dated o information regarding		will complete an audit of base plans for residents who recei		
		dication or his PICC line. The		antibiotics or have an IV acce		
		ment had a box that read,		03/07/2023 to include five res		
		tructions: none. The baseline		frequency of five times week	•	
		eted by Nurse #3 and signed		weeks, then three times a we		
	by the Director of Nu	rsing (DON).		weeks, then weekly for four w interdisciplinary team determ		
	Nurse #3 was intervi	ewed on 02/17/23 at 12:39		continuance of audits is unne		
		#3 confirmed that she had		administrator and interdiscipl	•	
	-	ne care plan for Resident #1.		will make changes to the plan	-	
		aseline care plan was		necessary to ensure accurac		
	basically an assessm	nent that she checked the		care plans with residents rec	eiving IVs.	

Facility ID: 923520

If continuation sheet Page 24 of 56

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 02/20/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		000 COLLEGE STREET VILKESBORO, NC 28697	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 655	stated that the baseli a section regarding IV and she did not belie add that information. the information regar- line could be added to assessment.	e 24 able to the resident. She ne care plan did not contain / medications or PICC lines ve that there was a place to Nurse #3 further stated that ding IV medication and PICC hrough the daily nursing ewed on 02/20/23 at 12:50	F 655	Date of Compliance 03/13/2023	
F 677 SS=E	started by the admiss the supervisors would baseline care plan. T baseline care plan did for IV medication or F information should be services/instructions document. She stated required to care for th included the other se should be added at th the section titled "spe ADL Care Provided for	e added to the special box at the end of the d that anything that was ne resident that was not ctions of the document ne end of the document in ccial services/instruction." or Dependent Residents	F 677		3/13/23
	out activities of daily services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio Resident interviews to dependent residents	is not met as evidenced ns, record reviews, staff and he facility failed to provide with showers for 3 of 6 2, Resident #6, Resident		F677 ADL Care for Dependent Reside Resident #2, Resident #6, and Reside #7 were bathed according to their preferences. All residents have the potential to be affected. The resident shower and bat	nt

Event ID: HUV111

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				FOF	ED: 03/14/2023 RM APPROVED IO. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DA	TE SURVEY MPLETED
	345133	B. WING		0	C 2/20/2023
PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	E	
			1000 COLLEGE STREET		
			WILKESBORO, NC 28697		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
Continued From page	e 25	F 67	7		
The finding included: 1. Resident #2 was a 09/03/22 with diagnos artery disease and ini sustained in a motor of The annual Minimum assessment dated 11 was cognitively intact assistance with bathing the Resident was free bladder and bowel ar rejection of care. The care plan dated 0 #2 had a self-care de pain with the goal to in functioning by utilizing encouraging the resident Review of the shower Resident #2 was scher Tuesday and Friday of shift. Review of the shower shower Resident #2 massing the resident Review of the shower shower Resident #2 massing the resident Review of the shower the shower resident #2 massing the	dmitted to the facility on ses that included coronary tervertebral disc disorder vehicle accident. Data Set (MDS) /11/22 revealed Resident #2 and required total ng. The MDS also indicated quently incontinent of nd had no behaviors of 05/31/22 revealed Resident ficit related to chronic back improve current level of g interventions such as dent to wash her face. r schedule revealed eduled for showers on during the 7 AM to 7 PM		schedule per point of care task continue to be monitored and direct care staff. ADL care pla task list are updated by the Di Nursing or designee. Education on ADL care regard and bathing completed on 03/ The Director of Nursing provid education to current licensed nurse aides, and direct care a on monitoring and providing si bathing to residents per reside of care to maintain compliance hired nurses, nurse aides, and agency staff will receive educa hire. Direct care nursing staff determine and provide resider and bathing as needed or requ The Director of Nursing and/o will complete an audit of resid schedule completion. Monitori completed for 5 residents via 1 observations at a frequency of weekly for four weeks, then the weeks until interdisciplinary te determines continuance of au unnecessary. The administrat	provided by ns and CNA rector of ling showers (10/2023. ded nurses, gency staff hower and ent⊡s plan e. Newly d direct care ation upon will nt shower uested. r designee ent bathing ing will be rounding f five times ree times a ekly for four am dits is or and	
Review of Resident # (ADL) revealed the R shower, as assigned Tuesday 02/14/23. On 02/14/23 at 10:30 and interview with Re lying in bed with no o	AM during an observation esident #2 revealed she was dors and her hair appeared		to the plan as necessary to ma resident regarding showers.	aintain	
	RS FOR MEDICARE &         OF DEFICIENCIES         F CORRECTION         PROVIDER OR SUPPLIER         ALLEY CENTER FOR NULL         SUMMARY ST (EACH DEFICIENC REGULATORY OR)         Continued From page The finding included:         1. Resident #2 was a 09/03/22 with diagno: artery disease and in sustained in a motor         The annual Minimum assessment dated 11 was cognitively intact assistance with bathii the Resident was free bladder and bowel ar rejection of care.         The care plan dated 0 #2 had a self-care de pain with the goal to if functioning by utilizing encouraging the resident Review of the shower Resident #2 was schu Tuesday and Friday of shift.         Review of the shower shower Resident #2 in January 24th, 2023.         Review of Resident #2 Non 02/14/23 at 10:30 and interview with Resident #2 Non 02/14/23 at 10:30 and interview with Resident #2	F CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345133         PROVIDER OR SUPPLIER         ALLEY CENTER FOR NURSING AND REHABILITATION         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 25 The finding included:         1. Resident #2 was admitted to the facility on 09/03/22 with diagnoses that included coronary artery disease and intervertebral disc disorder sustained in a motor vehicle accident.         The annual Minimum Data Set (MDS) assessment dated 11/11/22 revealed Resident #2 was cognitively intact and required total assistance with bathing. The MDS also indicated the Resident was frequently incontinent of bladder and bowel and had no behaviors of rejection of care.         The care plan dated 05/31/22 revealed Resident #2 had a self-care deficit related to chronic back pain with the goal to improve current level of functioning by utilizing interventions such as encouraging the resident to wash her face.         Review of the shower schedule revealed Resident #2 was scheduled for showers on Tuesday and Friday during the 7 AM to 7 PM shift.         Review of the shower notebook revealed the last shower Resident #2 received on a Tuesday was January 24th, 2023.         Review of Resident #2 received on a Tuesday was January 24th, 2023.         Review of Resident #2 's Activity of Daily Record (ADL) revealed the Resident did not receive a shower, as assigned o	RS FOR MEDICARE & MEDICAID SERVICES       (22) MULTIP         OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIP         A BUILDING       345133       B. WING         PROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX         Continued From page 25 The finding included:       ID PREFIX       PREFIX         1. Resident #2 was admitted to the facility on 09/03/22 with diagnoses that included coronary artery disease and intervertebral disc disorder sustained in a motor vehicle accident.       F 67         The annual Minimum Data Set (MDS) assessment dated 11/11/22 revealed Resident #2 was cognitively intact and required total assistance with bathing. The MDS also indicated the Resident was frequently incontinent of bladder and bowel and had no behaviors of rejection of care.       The care plan dated 05/31/22 revealed Resident #2 had a self-care deficit related to chronic back pain with the goal to improve current level of functioning by utilizing interventions such as encouraging the resident to wash her face.         Review of the shower schedule revealed Resident #2 was scheduled for showers on Tuesday and Friday during the 7 AM to 7 PM shift.         Review of Resident #2's Activity of Daily Record (ADL) revealed the Resident did not receive a shower, as assigned on Tuesday 02/07/23 and Tuesday 02/14/23.         On 02/14/23 at 10:30 AM during an observation and interview with Resident #2 revealed she was lying in bed with no odors and her hair appeared	ES FOR MEDICARE & MEDICAID SERVICES           OF DEFICIENCIES         (x1) PROVIDERSUPPLERVILIA DENTIFICATION NUMBER         (x2) MULTIPLE CONSTRUCTION A BUILDING           ACTION         345133         STREET ADDRESS, CITY, STATE, ZIP COD 1000 COLLEGE STREET WILKESDRON, NC 28697           ALLEY CENTER FOR NURSING AND REHABILITATION         STREET ADDRESS, CITY, STATE, ZIP COD 1000 COLLEGE STREET WILKESDRON, NC 28697           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PRECINCES (EACH DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 25 The finding included:         F 677         Schedule per point of care tas continue to be monitored and direct care staff. ADL care play task list are updated by the DI Nursing or designee.           Education on ADL care regard and bathing compileted on 03/ The Director of Nursing provi- was cognitively intact and nequired total assistance with bathing. The MDS also indicated the Resident was frequently incontinent of bladder and bowel and ha ob heaviors of rejection of care.         F 677           The care plan dated 05/31/22 revealed Resident #2 had a self-care deficit related to chronic back pain with the goal to improve current level of functioning by utilizing interventions such as encouraging the resident for S mesident suita schedule completion. Monitor compileted for 5 residents via doservations at a frequency or weekky for four weeks, then tw weeks until interdisciplinary team www.eess.utm Will maker or the Director of Nursing and/o will compilete an audit of reside schedule completion. Monitor compileted for 5 residents via doservations at	SS FOR MEDICARE & MEDICAID SERVICES     OMB h       OF DERICENORS     (x1) PROVIDER/MEPUER/CLIAN UDENTIFICATION NUMBER     (x2) MULTIPLE CONSTRUCTION A BUILDING     (x3) (x3) MAIN       346133     a WING     (x3) (x4) MAIN     (x4) MAIN       PROVIDER OR SUPPLIER     346133     (x4) MAIN       ALLEY CENTER FOR NURSING AND REHABILITATION     STREET ADDRESS, CITY, STATE, ZIP CODE tiono COLLEGE STREET       SUMMARY STRUEMENT OF DEFICIENCIES     (x6) MAIN       Continued From page 25     F 677       The finding included:     (x6) MAIN       1. Resident #2 was admitted to the facility on 09/03/322 with diagnoses that included coronary artery disease and intervertebral disc disorder sustained in a motor vehicle accident.       The annual Minimum Data Set (MDS) assessment dated 11/11/22 revealed Resident #2 was cognitively intact and required total assistance with bathing. The MDS also indicated the Resident was frequently incontinent of bladder and bowel and had no behaviors of rejection of care.       The care plan dated 05/31/22 revealed Resident #2 was day and Friday during the 7 AM to 7 PM shit.       Review of the shower schedule revealed shower, Resident #2's Activity of Daily Record (ADL) revealed the Resident did no receive a shit.       Review of Resident #2's Activity of Daily Record (ADL) revealed the Resident did no receive a shit.       Review of the shower notebook revealed shower, Resident #2's Activity of Daily Record (ADL) revealed the Resident did not receive a shit.       Review of the shower notebook revealed shower, Resident #2's NetWith Departed    <

Facility ID: 923520

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	S FOR MEDICARE &				OMB NO. 0938-
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			The Bollebille		с
		345133	B. WING		02/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, STATE, ZIP CC	
		RSING AND REHABILITATION		1000 COLLEGE STREET	
				WILKESBORO, NC 28697	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLE IE APPROPRIATE DAT
F 677	Continued From pag	e 26	F 67		
1 0/7		she was going to get her	F 07	, i i i i i i i i i i i i i i i i i i i	
		esday). The Resident			
		as supposed to get two			
		esday and Friday) but lately			
		etting one shower a week			
	which was on Friday	s. She explained that when			
		bout her showers on			
		old by the "girls" that there			
		ff to give all the showers. The			
	Resident continued t	-			
		as hard to get people to work			
		taking two or three showers			
		would like to continue taking a week at the facility			
		spilled food on herself when			
		ad accidents in her briefs.			
		he enjoyed her showers and			
	never refused them.				
		) AM an interview was			
	conducted with Nurs				
		cility scheduled a shower			
		consisted of two nurse aides			
		rom 7:00 AM to 7:00 PM and			
		be up to 30 residents on the that she and NA #2 were			
		wers on Tuesday (02/07/23)			
		ed until 3:00 PM that day and			
	-	he residents on the list to			
		erefore, she could not get to			
	-	The NA explained that the			
	•	ve up to 30 residents a day			
		rs and that did not include			
		re left over from the day			
		howers that management			
		e so it was impossible to			
	complete all the show	wers that were due. The NA			
		ever refused her showers			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345133	B. WING				C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION	1000 COLLEGE STREET WILKESBORO, NC 28697				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 677	Continued From page	27	F	677			
	02/15/23 at 2:55 PM t was assigned to give she was the facility w work until 3:00 PM. N scheduled to give sho Tuesday, 02/07/23, b to work till 3:00 PM. T she was scheduled to showers that she was her showers. An interview was con #3 on 02/15/23 at 2:4 give showers on Tues unable to give Reside her partner which was floor to work, and she showers that were lef #2 enjoyed taking her them. Attempts were made but were unsuccessful	ut she was only scheduled The NA explained that when give Resident #2 her always agreeable to taking ducted with Nurse Aide (NA) 5 PM who was assigned to aday, 02/14/23 but she was ent #2 her shower because as NA #4 was pulled to the could not give all the t. The NA stated Resident showers and never refused to interview Nurse Aide #4					
	presence of the Direct at 4:45 PM, the Admin residents should be a showers as they want looking at different wat workload. 2. Resident #7 was at 11/11/22 with diagnost muscle weakness.	tor of Nursing on 02/15/23 nistrator explained that the ble to receive as many ted and that they were ays to simplify the shower dmitted to the facility on ses of hypertension and					
		sion Minimum Data Set 2 indicated Resident #7 was					

Facility ID: 923520

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						IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY
						С
		345133	B. WING			2/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From pag	e 28	F 67	7		
		e MDS revealed Resident #7				
	was total dependent	and required two staff assist				
		S also indicated it was very				
	important for Resider tub bath, shower, or	nt #6 to choose between a bed bath				
	-	shower log documented				
		eduled to receive showers				
		Sundays. The shower log Resident #6 had only				
		on 01/01/23, 01/04/23,				
		01/29/23, and 02/12/23. The				
		eviewed from 01/01/23				
	through 02/13/23.					
	An interview and obs	ervation with Resident #7 on				
	2/14/23 at 10:15 AM	revealed she had not				
		showers as scheduled since				
		#7 further revealed she				
	· ·	and had to ask nursing staff ive one. Resident #7 stated				
	she felt unclean, and					
		d Resident #7 to have greasy				
	and tangled hair.					
	An interview with Nu	rse Aide (NA) #1 on 02/15/23				
		she worked on the shower				
		ut was often pulled to the				
		NAs due to short staffing . NA Resident #7 had missed				
		multiple days and had				
		g nasty. NA #1 stated				
		d complained showers and				
	baths were not being preferred.	given as scheduled as				
	prototiou.					
		#5 on 02/15/23 at 2:15 PM				
		sted with showers and baths				
	and Resident #7 had	not refused. NA #5 indicated	1			

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/14/2023 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345133	B. WING			_		C 20/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUF	RSING AND REHABILITATION			000 COLLEGE STREET WILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	so staff assisting with the floor. NA #5 stated residents had compla showers or baths as a An interview with Unit 02/15/23 at 12:05 PM Resident #7 had refus before. UM #1 further showers and baths ha assist other NAs due UM #1 indicated she with had missed multiple b An interview with the on 02/15/23 at 12:30 preferred a bad bath a had missed several so further revealed she e and other residents to bath on scheduled da 3. Resident #6 was ad 11/11/22 with diagnos arthritis. A review of the admiss (MDS) dated 11/18/22 cognitively intact. The Resident #6 was total two staff assist for bat indicated it was very i to choose between a bath. Review of the facility s	a did not have enough NA ' s showers would get pulled to d Resident #6 and other ined they had not received scheduled. t Manager (UM) #1 on I revealed she did not recall sed preferred bed baths revealed NAs completing ad been pulled to the floor to to staff who had called out. was not aware Resident #7 bed baths as scheduled. Director of Nursing (DON) PM revealed Resident #7 and was not aware that she cheduled days. The DON expected for Resident #7 o receive their shower or tys. dmitted to the facility on ses of hypertension, and scion Minimum Data Set 2 indicated Resident #6 was a MDS further revealed I dependent and required thing. The MDS also important to for Resident #6 tub bath, shower, or bed	F	677				
		eduled to receive showers aturdays. The shower log						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 03/14/2023 MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		NSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING _					C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD	E		
		RSING AND REHABILITATION		1000	COLLEGE STREET			
				WIL	KESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 677	01/21/23, 01/25/23, a documentation was re through 02/13/23. An interview and obs 2/14/23 at 1:00 PM re consistent showers a admission. Resident is preferred bed baths a had not received pref #6 stated he felt dirty bed baths as schedul Resident #6 to have a An interview with NA revealed she worked consistently for the fa the floor to assist othe NA #1 further revealed preferred bath baths complained of feeling residents had compla were not being given An interview with NA revealed assisted NA and Resident #6 had the facility sometimes so staff assisting with the floor. NA #5 state	Resident #6 had only on 01/14/23, 01/18/23, and 02/04/23. The eviewed from 01/01/23 ervation with resident #6 on evealed he had not received s scheduled since #6 further revealed he and had told nursing staff he ferred bed baths. Resident and itchy and wanted his led. Observation revealed an odor. #1 on 02/15/23 at 2:05 PM on the shower team ucility but was often pulled to er NAs due to short staffing. ed Resident #6 had missed multiple days and had d dirty. NA #1 stated multiple ained showers and baths as scheduled as preferred. #5 on 02/15/23 at 2:15 PM a #1 with showers and baths not refused. NA #5 indicated a did not have enough NAs a showers would get pulled to d Resident #6 and other ained they had not received	F 6	577				
	02/15/23 at 12:05 PN Resident #6 had refu	t Manager (UM) #1 on 1 revealed she did not recall sed preferred bed baths r revealed NAs completing						

Facility ID: 923520

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE \$	<u>. 0938-039</u> SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED
		0.45400			C	
		345133	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	02/2	20/2023
NAME OF PI	ROVIDER OR SUPPLIER			O COLLEGE STREET		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		LKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 31	F 677			
		ad been pulled to the floor to				
	assist other NAs due to staff who had called out.					
		was not aware #6 had				
	missed multiple bed b	Jains as scheduled.				
		Director of Nursing (DON)				
		PM revealed Resident #6				
	•	and was not aware that she cheduled days. The DON				
		expected for Resident #6				
		receive their shower or				
	bath on scheduled da	-				
F 725 SS=E	0		F 725			3/13/23
33-E	CFR(s): 483.35(a)(1)	(2)				
	§483.35(a) Sufficient	Staff.				
		e sufficient nursing staff with				
		etencies and skills sets to elated services to assure				
		ttain or maintain the highest				
		mental, and psychosocial				
	0	sident, as determined by				
	and considering the r	s and individual plans of care				
		ity's resident population in				
	accordance with the f	acility assessment required				
	at §483.70(e).					
	§483.35(a)(1) The fac	cility must provide services				
	by sufficient numbers	of each of the following				
		a 24-hour basis to provide				
	nursing care to all res	sidents in accordance with				
	-	ed under paragraph (e) of				
	this section, licensed	nurses; and				
		sonnel, including but not				
	limited to nurse aides					

Facility ID: 923520

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STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		345133	B. WING				C 02/20/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	000 COLLEGE STREET		
RIDGE VA	LLET CENTER FOR NU	RSING AND REHABILITATION		v	VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Continued From page	e 32	F	725			
1 1 20			1	125			
	§483.35(a)(2) Except	section, the facility must					
		nurse to serve as a charge					
	nurse on each tour of	•					
		「 is not met as evidenced					
	by:						
		ons, record reviews, staff,			F725 Sufficient Nursing Staff		
		ws the facility failed to			Resident #2, Resident #6, and Resi	dent	
	provide sufficient nur				#7 were bathed according to their		
	-	reated in a dignified manner for 3 of 6 sampled residents			preferences. All residents have the potential to be		
	(Resident #2, #6 and	•			affected. The Director of Nursing,	-	
					Administrator, and Scheduling		
	The findings include:				Coordinator will review the schedule		
					during clinical meeting to ensure sur	ficient	
	This tag is crossed re	eferenced to F 550:			staffing regarding all bathing is com per schedule.	oleted	
		ews, observations and			The Director of Nursing provided		
		erviews, the facility failed to			education to current licensed nurses		
		gnified manner when staff			nurse aides, and direct care agency	staff	
	•	duled bed baths requested. ed feelings of being dirty,			on completion of showers when designated shower nurse aides are		
		unclean. This affected 2 of 3			unavailable. Newly hired nurses, nu	<b>19</b>	
	residents reviewed for				aides, and direct care agency staff v		
	(Resident #7 and Re				receive education upon hire. Direct		
					nursing staff will determine and prov		
	This tag is crossed re	eferenced to F 677:			resident shower and bathing as nee	ded or	
					requested.		
		ns, record reviews, staff and			The Director of Nursing, Administrat		
		the facility failed to provide			and scheduling coordinator will revie		
		with showers for 3 of 6 \$2, Resident #6, Resident			nursing department schedules to en adequate staffing for all shifts at a	Suie	
	#7) reviewed for activ				frequency of five times weekly for fo	ur	
		······································			weeks, then three times a week for		
	On 02/15/23 at 2:45 l	PM during an interview with			weeks, then weekly for four weeks u		
	Nurse Aide (NA) #3 s	she explained that the facility			interdisciplinary team determines		
	-	team which consisted of 2			continuance of audits is unnecessar	-	
		howers or bed baths every			administrator and interdisciplinary te	am	
	∣ day from 7 AM to 7 P	M. The NA continued to			will make changes to the plan as		

Facility ID: 923520

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
						С
		345133	B. WING		02	2/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
RIDGE VA	LLEY CENTER FOR NUI	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 725	Continued From page	e 33	F 7	25		
F 725	showers unless there aides to cover the har and no shows then in aides assigned to giv to the hall and the har for providing the sche whichever the case. It than not the showers provided because of residents and in that added to the shower explained that the shower could contain up to 30 include the added res The NA stated it was nurse aides assigned to the hall to work. Sh factors that prevented scheduled showers we required two people st timeframe of up to tw which also took up a team could not showed of the residents eating An interview was con 02/20/23 at 10:39 AW "staffing is horrible". enough help, but the shifts especially on the impossible to get ever	normally assigned to provide e were not enough nurse lls due to call outs or no calls a that case one or both nurse e showers would be pulled ll staff would be responsible eduled showers or bed baths The NA indicated more times were not able to be the workload on the hall with case the residents would be list for the next day. The NA ower list for any given day 0 residents and that did not sidents from the day prior. frequent that one or both I to give showers were pulled ne also explained that other d them from providing were several residents shower assist and required a to hours to give showers lot of time and the shower er during mealtimes because	F 72	25 necessary to ensure the far sufficient nursing staff. Date of Compliance 03/13/.	-	
	(MA) #1 on 02/20/23 that staffing was grea	ot enough staff. ducted with Medication Aide at 10:43 AM who explained at when the agency staff but they had a lot of agency				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/14/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345133	B. WING		02/20/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 725	staff that did not show and that made getting difficult. The MA cont were fully staffed the complete the shower were pulled to the flog get done. An interview was con Administrator on 02/2 Administrator explain staff because of issue higher wages and the rural area. The facility staffing agencies but or no shows happen difficult to find covera continued to explain the rehab nurse aides size shower team seven of nurse aides were pull the shower team was case scenario the Ad be, the department he facility and take care Residents are Free of CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Residen medication errors. This REQUIREMENT by: Based on record rev Director, Medical Dire Provider interviews th	v up or they would call out g resident care done very inued to explain when they shower team was able to s but when the shower team or then the showers did not ducted with the 20/23 at 1:45 PM. The ed the facility was difficult to es like nearby plants offering e facility being located in a y utilized nine different when call outs and no calls especially at night it was ge. The Administrator that the facility utilized two a days a week along with the lays a week and the rehab led to the hall to work before a pulled to the hall. Worst ministrator stated, if need eads could come to the of the residents. f Significant Med Errors	F 725	F760 Residents are Free from Significa Med Errors Resident #1 discharged from facility on 12/25/2022.	ant	

Event ID: HUV111

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		345133	B. WING		02/20/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIO
F 760	Continued From page	2 35	F 76	n	
	12/22/22 and 12/23/2 Central Catheter (PIC used to administer IV replaced with a different 12/24/22 and the staff antibiotic on 12/24/22 resident (Resident #1 medication errors. The for bacterial regrowth sepsis, or return to he medications. Immediate jeopardy to staff failed to administ IV antibiotics. Immediate acceptable credible a jeopardy removal. The compliance at a lower (no actual harm with p minimal harm that is ne ensure monitoring syst completion of employ The findings included Resident #1 was administ 12/17/22 with diagnost metastasis (cancer the chronic subdural hem The physician order of Oxacillin (antibiotic) 1 Use 12 gm IV one tim	<ul> <li>2. The Peripherally Inserted C) (intravenous (IV) line antibiotics) line was ent type of IV access on if failed to administer the IV and 12/25/22 for 1 of 1) reviewed for significant ere was the high likelihood, resistance to antibiotic, ospital due to the missed</li> <li>began on 12/22/22 when ter 4 doses of Resident #1's liate jeopardy was removed a facility provided an llegation of immediate e facility will remain out of r scope and severity of D potential for more than not immediate jeopardy) to stems are in place and the ee education.</li> <li>initted to the facility on set that included: brain lat has spread to the brain), hatoma, and sepsis.</li> <li>dated 12/18/22 read, 0 grams (gm) reconstituted. The a day for r 27 days. Infuse 12 gm</li> </ul>		affected. Therefore, an audit wa completed by the Director of Nur 02/15/2023 to ensure medication administration compliance regar missed doses of IV antibiotics. On 02/15/23, the Director of Nur educated licensed nurses on requirements to notify the MD w medication cannot be administer ordered. The Director of Nursing ensure no licensed nurses will w without receiving this education. hires including direct care agend receive education prior to the be their first shift. Education was co on 02/16/2023 by Director of Nur Unit Manager. The Chief Nursing Officer educa Administrator and Director of Nu 02/15/23 regarding the clinical m meeting process to include revier notification. The Director of Nursing and/or d will complete an audit of the sigr medication errors on 03/07/2023 include five residents at a freque five times weekly for four weeks three times a week for four week weekly for four weeks until interdisciplinary team determine continuance of audits is unneces Date of Compliance 03/13/2023	rsing on h ding rsing hen red as g will vork Any new cy will rginning of ompleted rsing or tted the trising on horning ewing MD lesignee hificant b to ency of , then ss ssary.

Facility ID: 923520

If continuation sheet Page 36 of 56

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345133	B. WING				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			000 COLLEGE STREET VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	as ordered on 12/18/2 12/21/22. The MAR ir not administered on 1 12/24/22, and 12/25/2 The nurse's note date written by Nurse #1 re resident's PICC (IV lin antibiotics) line was o Writer noted PICC lin floor and asked reside resident he got caugh have pulled it out. On for replacement. Nurse #1 was intervie at 3:55 PM who confii on 12/22/22. She stat Resident #1 and anot could not recall notified line was out. Nurse # her shift and was read to Resident #1's room lying on the floor at th Resident #1 was unal #1 and could not reca #1 stated she measur centimeters and place to Nurse #2 and instru Director (MD) to get the added Resident #1's a did not require any ac she left the facility be A nurse's note dated by Nurse #2 read, IV central line (type of IV	22, 12/19/22, 12/20/22, and ndicated that Oxacillin was 2/22/22, 12/23/22, 22. ed 12/22/22 at 7:34 AM	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				(X3) DATE COMF	SURVEY LETED
		345133	B. WING			_		C 20/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				1	000 COLLEGE STREET			
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		W	VILKESBORO, NC 286	97		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	х		CTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG				TE	DATE
						DEFICIENCY)		
F 760	Continued From page	27		700				
F 700	Continued From page	307	F	760				
	Nurse #2 was intervie	ewed via phone on 02/16/23						
		stated she vaguely recalled						
	Resident #1 and him	pulling his PICC line out.						
		umented that she called to						
		she had done so but had						
		get any alternate medication						
		as not familiar with which						
		<sup>t</sup> 1 was on, why he was on it,						
	or the duration of his							
		stated if the PICC line came ould assess the resident						
		t Resident #1's PICC line						
	came out on the shift							
		been taken care of. Nurse						
		she attempted to reinsert the						
		#2 confirmed that Resident						
		t administered on 12/22/22						
	because his PICC line	e had been pulled out.						
		ion note dated 12/23/22 at						
		by Nurse #3 read, Oxacillin,						
	•	time due to resident pulling						
	and place peripheral	iting on IV access to come						
	and place peripheral	inte.						
	Nurse #3 was intervie	ewed via phone on 02/15/23						
		stated that she recalled						
		as on IV antibiotic that ran for						
		a time. She stated she was						
	-	PICC line got pulled out and						
		IV line got reinserted or not.						
		hat on 12/23/22 she did not						
		#1's Oxacillin because his						
		oulled out and he did not						
	-	e #3 stated that she knew						
	that someone had cal	lled for the IV line to be						
	replaced could not re	call if she had attempted to						
		She also confirmed she had						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/14/2023 APPROVED . 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPI	LETED
		345133	B. WING			02/2	, 20/2023
NAME OF PF	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 2869	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 760	orders regarding the of The MAR administration 11:31 AM and written no iv access, IV replate A document from an e- indicated that on 12/2 at the facility and inse- Resident #1's right has and flushed, and Res- well. The MAR administration 9:59 AM and written to waiting for IV insertion Nurse #4 was intervie at 2:43 PM. Nurse #4 Resident #1 and reca antibiotics. Nurse #4 few days and when have report on 12/25/22 that his PICC line out and replaced. Nurse #4 st that the IV was ever mot contacted the MD already done that, not reinsert the IV becaus IV company to come #4 also stated that Re- IV out during his shift not administer the Ox he did not have an IV he was told in report.	wider for any additional Dxacillin. ion note dated 12/24/22 at by Nurse #2 read, Oxacillin, cement to be done today. external IV company 4/22 at 3:48 PM they arrived erted an IV access in and. The line was secured ident #1 tolerated procedure ion note dated 12/25/22 at by Nurse #4 read, Oxacillin, n. ewed via phone on 02/15/23 stated that he recalled lled that he was on IV stated that he was off for a e came back, he was told in at Resident #1 had pulled they were waiting for it to be ated he could not confirm eplaced and stated he had because someone had	F 760				

Facility ID: 923520

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/14/2023 APPROVED 0: 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE : COMPI	SURVEY LETED	
		345133	B. WING		_	02/2	C 20/2023
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUF	RSING AND REHABILITATION		000 COLLEGE STREET VILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Resident #1's death or cause of death to be of term for any brain disc function mostly comm The MD was interview AM and stated he had since June 2022 and week. The MD stated with Resident #1 as h he was in the facility. Telemed Physician (a resident via computer evaluated Resident # answer questions reg stated that if he had a IV antibiotic via a PIC followed by Infectious consult with them reg. IV antibiotic or PICC I A follow up interview w with the MD on 02/15 stated that he recalled on 12/22/22 but he cor regarding Resident #1. provided no further or "thought at that point observe him and if he get some lab work." T back I should have do further confirmed that staff to the Infection D previously stated he w	certificate indicated his encephalopathy (a broad ease that alters brain nonly caused by infection). wed on 02/15/23 at 10:03 d been the MD at the facility was at the facility once a he was not at all familiar ne never evaluated him while He indicated that the physician who evaluates a r or electronic device) had 1 and maybe she could harding Resident #1. The MD a resident who was receiving C line and was being b Disease he would prefer to arding any issues with the	F 760				

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						10.0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
					С		
		345133	B. WING		0	2/20/2023	
NAME OF PR	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP COD	E		
		RSING AND REHABILITATION		1000 COLLEGE STREET			
RIDGE VA	LLET CENTER FOR NO	KSING AND REHABILITATION		WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 760	Continued From page	e 40	F 76	n			
1 100		al Director was interviewed	170	с 			
	U U	AM via phone who stated he					
		Resident #1 but stated if a					
		ntibiotic it was for good					
		important if the resident					
	missed doses of the	IV antibiotic.					
	The Director of Nursi	ng (DON) was interviewed					
		PM who stated she vaguely					
		. She stated that he was on					
	IV antibiotics and his	PICC line that was used for					
		se IV antibiotics got pulled					
		it was replaced in the facility					
	the process for when	npany. The DON stated that					
	-	ovider was immediately					
		es we get a hold order to					
	just hold the antibiotio	c until the IV line can be					
		d also get an order to give					
	another antibiotic via						
		the IV line could be replaced.					
		as important to get the IV line as possible, so the resident					
	did not miss schedule	•					
	medications.						
		se Provider was interviewed					
		3 at 1:50 PM who stated she					
		n Resident #1 as she had days while he was in the					
	hospital before comir	-					
		ent #1 was on IV Oxacillin for					
	a specific organism tl	hat was detected on a					
		ined. She further explained					
		s peaked at thirty minutes					
		hospital setting it was given					
		the skilled nursing facility it venty-four-hour period. The					
	พลอ แแนออน บงอเ ส เง		1	1		1	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345133	B. WING				_ 20/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 760	15 at the hospital) of l antibiotic indicating he course of therapy but halfway point in his th Disease Provider stat disease standpoint it medication error when doses of the IV Oxaci would have intervene his PICC line had bec with getting IV access different antibiotic that administered intramus could be obtained. The Administrator wa jeopardy on 02/15/23 The facility provided t F760: Identify those r or likely to suffer, a se result of the noncomp Resident #1 was iden medication error. Res access line was dislow was not administered as ordered on 12/22/2 12/25/22. Resident #1 was adm 12/17/22 with diagnos to viral encephalitis, r subdural hemorrhage	lay 19 (4 at the facility and his entire six week course of e was not just starting his he had not reached the erapy. The Infectious ed that from an infectious was a very significant in Resident #1 missed four llin. She further stated she d if she had been aware that come dislodged by assisting a reinserted and using a t could have been scularly until IV access as notified of the immediate at 5:20 PM. he following IJ removal plan: esidents who have suffered, erious adverse outcome as a bliance: tified as having a ident #1's intravenous dged on 12/22/22 and he his IV antibiotics (Oxacillin) 22, 12/23/22. 12/24/22, and witted to the facility on ses included but not limited	F	760				

If continuation sheet Page 42 of 56

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/14/2023 RM APPROVED O. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		345133	B. WING _			C 02/20/2023		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			00 COLLEGE STREET			
				W	ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 760	resident medications compliance. Any opport this audit will be addr 2/15/23, the Director residents with intrave opportunities identifie corrected by the Director Specify the action the process or system fail adverse outcome from when the action will b On 02/15/23, the Director licensed nurses on m the documentation to medication administra- included requirement for any missed admin IV, access becomes of will be notified by pho- not given. The Director licensed nurses will w education. Any new h receive education pro- next shift. Education of 02/16/2023 by Director Manager. The Chief Nursing Of Administrator and Dir regarding the clinical include medication action validation of documer education was provid is notified in the even	ector of Nursing reviewed for administration ortunities identified during essed by 02/16/23. On of Nursing reviewed nous access. Any d during this audit will be ctor of Nursing by 02/15/23. e entity will take to alter the lure to prevent a serious m occurring or recurring, and e complete: ector of Nursing educated all edication administration and indicate completion of ation. Education also s for notification to the MD distrations and in the event dislodged/removed. The MD one at the time medication is or of Nursing will ensure no vork without receiving this nires including agency will or to the beginning of their will be completed on or of Nursing or Unit ficer educated the ector of Nursing on 02/15/23 morning meeting process to dministration and the nation. Furthermore, ed on ensuring the provider t the IV access is dislodged.	F	760				
	Effective 02/15/2023,	the Administrator will be						

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM OMB NO.	APPROVE	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPLI		
		345133	B. WING		C 02/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		000 COLLEGE STREET /ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIO DATE	
F 760	responsible to ensure removal plan for this	e 43 e implementation of this IJ alleged non-compliance. J removal is 02/17/2023.	F 760				
	medication errors war 02/20/23. The educat nurses in the facility i #2, Nurse #3, and Nu interviews revealed th been trained on the p significant medication reporting to the medic requesting a hold ord other medication that conducted a root cau issues and was revie facility immediate jeo 02/17/23 was validate	n errors by immediately cal providing and either er or additional orders for could be used. The facility se analysis to help identify wed without concern. The pardy removal date of ed.					
F 804 SS=D	CFR(s): 483.60(d)(1) §483.60(d) Food and Each resident receive §483.60(d)(1) Food p conserve nutritive val §483.60(d)(2) Food a	drink es and the facility provides- prepared by methods that ue, flavor, and appearance; and drink that is palatable,	F 804		3	8/13/23	
	by: Based on observatio interviews, the facility food that was appetiz	afe and appetizing is not met as evidenced ins and staff and resident failed to provide palatable ting in temperature for 2 of 3 or food concerns. (Resident		F804 Nutritive Value/ Appearance, Palatable/ Preferred Temp Resident #7 discharged from facility 03/03/2023. Resident #11⊡s meal tra			

Event ID: HUV111

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345133	B. WING			C 02/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NUI	RSING AND REHABILITATION			000 COLLEGE STREET /ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 804	Continued From page	e 44	F	804				
	#7 and Resident #11)	).			be monitored for proper palatability an temperature.	nd		
	The findings included	l: Idmitted to the facility on			All residents have the potential to be affected. Therefore, an audit was completed on 03/9/2023 by the Food			
	11/11/22.	·			Service Director and Director of Nursi to ensure that meal trays are distribut	•		
	Data Set assessment	#7's admission Minimum t dated 11/22/22 revealed gnitively intact and needed ng.			proper temperature. The Director of Nursing provided education to all current facility staff regarding timely distribution of meal to with proper temperature on 03/10/202			
	at 1:08 PM, she repo and she had eaten at	vith Resident #7 on 02/15/23 rted her meal tray was cold pout 50% of it. Resident #7			Newly hired facility staff will receive education upon hire. The Director of Nursing, Food Service	e		
	brought to her room a was because it came	ypically cold when it was and she did not know if it from the kitchen cold or if it staff took too long to pass			Director, and Administrator will audit t ensure food is distributed at proper temperature at a frequency of five tim weekly for four weeks, then three time week for four weeks, then weekly for	es es a		
	B. Resident #11 adm 04/27/22.	itted to the facility on			weeks until interdisciplinary team determines continuance of audits is unnecessary. The administrator and interdisciplinary team will make chang	185		
	Minimum Data Set as revealed Resident #1	#11's most recent quarterly ssessment dated 11/04/22 1 to be cognitively impaired king. Resident #11 was ing.			to the plan as necessary to ensure th facility maintains compliance. Date of Compliance 03/13/2023			
	family member, who at 12:52 PM, reported daily around lunch tin	erview with Resident #11's visited routinely, on 02/15/23 d she came to the facility ne. She stated she had ent #11's meal tray off the						
	meal cart when it arrishe waited for Reside	ved on the hall because if ent #11's meal tray to be his food would be ice cold						

Facility ID: 923520

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 03/14/2023 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		345133	B. WING			C 02/2	; 20/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, 2	ZIP CODE	-	
RIDGE VA	LLEY CENTER FOR NUR	SING AND REHABILITATION		000 COLLEGE STREET			
			V	VILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 804	Continued From page	45	F 804				
	was requested. The te tomato soup and a gri plated at 12:28 PM ar tray arrived on the hal at 12:32 PM. Staff beg 12:44 PM with the las PM. Once the final tra observation of the tes the Dietary Manager. there was no steam ri cheese in the grilled of melted. The soup was sandwich had no heat cheese was no longer The Dietary Manager lukewarm and needed cheese sandwich was reported she felt the te better if served timelie stated over the past of as though food temper increased. She report because she felt the ke problem even temping food to ensure the tem consistent. She report urgency by hall staff to cooling and being color residents. During an interview w 02/15/23 at 1:40 PM, resident meal trays to	2 12:00 PM and a test tray est tray which included illed cheese sandwich was and left the kitchen. The test Il with the other meal trays gan passing meal trays at t tray being served at 1:35 mys were served an t tray was completed with When the lid was removed sing from the soup and the cheese sandwich was not is barely warm, and the t to it, was soggy, and the melted. Stated the soup was d to be hotter and the grilled is cold and "not fresh". She est tray would have been er. The Dietary Manager ouple of weeks, it had felt erature complaints had ed it was frustrating stichen had tried to fix the g the leftover, non-plated inperatures had remained ted she felt the lack of o pass trays had led to food					

If continuation sheet Page 46 of 56

						NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		ATE SURVEY OMPLETED	
		345133	B. WING			C 02/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NUI	RSING AND REHABILITATION		1000 COLLEGE STREET WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	Continued From page	e 46	F 867				
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(c)(d)		F 867			3/13/23	
	monitoring. A facility must establi policies and procedur collections systems, a adverse event monito procedures must inclu following:	feedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the					
	systems to obtain and from direct care staff, resident representativ information will be us	d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that lume, or problem-prone, and					
	systems to identify, c information from all d not limited to the facil §483.70(e) and include	r maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance					
	and evaluation of per	ology and frequency for such					
	including the method systematically identify	adverse event monitoring, s by which the facility will y, report, track, investigate, a and information relating to a facility, including how the					

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345133	B. WING _				C 20/2023
NAME OF P	ROVIDER OR SUPPLIER		- <b>·</b> [	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			000 COLLEGE STREET /ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	prevent adverse even §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance improvements are rea §483.75(d)(2) The fac implement policies ac (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance im ensure that improven §483.75(e)(1) The fac performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform	ta to develop activities to tas. systematic analysis and cility must take actions a improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and ldressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to nents are sustained. activities. cility must set priorities for its ment activities that focus on a, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. mance improvement nedical errors and adverse	F	367			

Facility ID: 923520

If continuation sheet Page 48 of 56

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/14/202 MAPPROVEI D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345133		(X1) PROVIDER/SUPPLIER/CLIA	ARED		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING _				C 1 <b>20/2023</b>	
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		10	00 COLLEGE STREET		
				W	ILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 867	Continued From page	e 48	F 8	67			
		e actions and mechanisms					
	· · ·	and learning throughout the					
	8483 75(a)(3) As par	t of their performance					
		es, the facility must conduct					
		improvement projects. The					
		cy of improvement projects					
		ility must reflect the scope facility's services and					
		as reflected in the facility					
	assessment required						
		s must include at least					
		at focuses on high risk or identified through the data					
	-	is described in paragraphs					
	(c) and (d) of this sec						
	§483.75(g) Quality as	ssessment and assurance.					
		ality assessment and					
		e reports to the facility's					
	governing body, or de	esignated person(s) erning body regarding its					
		nplementation of the QAPI					
		der paragraphs (a) through					
	(e) of this section. Th	e committee must:					
		ement appropriate plans of					
		tified quality deficiencies;					
		and analyze data, including the QAPI program and data					
		egimen reviews, and act on					
	available data to mak						
		is not met as evidenced					
	by:						
		ns, record reviews, and staff v Quality Assessment and			F867 QAPI/ QAA Improvement Activit No residents were identified in the 256		
		mmittee failed to maintain			All residents have the potential to be	<i>.</i>	

Facility ID: 923520

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	NG	COMPLETED	
		B. WING		C 02/20/2023	
			STREET ADDRESS, CITY, STATE, ZIP		
RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION				1000 COLLEGE STREET WILKESBORO, NC 28697	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 867	conducted on 03/11/2 complaint investigation 05/07/21, 10/15/21, 0 failure was for 08 defit cited in the areas of F F580) Abuse, Neglec (F600), Comprehensi plan (F655), Quality of Services (F725), Pha Dietary Services (F80 recited on the current survey of 02/20/23. T during seven federal pattern of the facility's effective QA program The findings included This tag is cross refer F550: Based on recon resident and staff inte treat residents in a dig did not provide sched The resident express unhappy, itchy, and u resident #7 and Res	rres and monitor mittee put into place pation and complaint survey 20 and 05/26/22 and for the on conducted on 03/05/21, 9/01/22, and 12/22/21. This ciencies that were originally Resident Rights (F550 and t, and Misappropriation ve Resident Centered Care of Life (F677), Nursing rmacy Services (F760), and 04) there were subsequently complaint investigation he repeat deficiencies surveys of record showed a a inability to sustain an	F 8	affected, therefore the Adr Social Services Director, a Services Director reviewed improvement initiatives an with resident council on 03 The Administrator and/or of provided education to all s completion of QAPI/ QAA regulatory compliance. Ne staff will receive education The Administrator will hold at a frequency of once a n months. Administrator will Assurance and Performan Improvement meetings an ensuring that any areas of non-compliance are addred deficient practices and/or citations related to Notifica (F580), Baseline Care Pla care (F677), and Significa Error (F760). Date of Compliance 03/13	and Food d QAPI/ QAA d opportunities 3/02/2023. designee staff on the purpose and ewly hired facility n upon hire. d QAPI meetings month for six lead Quality nee d focus on essed to prevent repeated ation of Changes ns (F655), ADL nt Medication
	10/15/21 the facility fa dignified manner by n care prior to a resider onto her draw sheet. to provide incontinent	investigation conducted on ailed to treat residents in a not providing incontinence nt wetting through her brief In addition, the facility failed ce care to a resident who nt prior to dinner and she			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/14/2023 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE COM	(X3) DATE SURVEY COMPLETED		
345133			B. WING			C 02/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RIDGE VA	LLEY CENTER FOR NUF	SING AND REHABILITATION			000 COLLEGE STREET WILKESBORO, NC 28697		
				v			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 867	Continued From page	50	F	867			
	and her roommate ate	e dinner while smelling the 3 of 6 residents reviewed for					
	Medical Director, Tele Regional Medical Dire Disease Provider the Infectious Disease Pro- Resident #1's intraver was being used to tre empyema (collection the brain) and Cerebr cerebrum of the brain peripherally inserted of IV used to administer dislodged and his ant administered as order reviewed for significant was the high likelihoo resistance to antibiotic hospital due to the mi	ector, and Infectious facility failed to notify the povider that was managing nous (IV) antibiotic which at a right subdural of pus between the layers of itis (inflammation of ) that Resident #1's central catheter (PICC) (an medications) had become biotics were not red for 1 of 1 resident nt medication errors. There d for bacterial regrowth, c, sepsis, or return to ssed medications.					
	facility failed to notify change in status imm burn sustained by a re involved in an accider wearing oxygen for 1 notification of the med During the Focused In complaint investigatio	nt involving smoking while of 1 resident reviewed for lical provider. nfection Control and n of 09/01/22 the facility					
	medications. F600: Based on recor	visician of medication 3 residents reviewed for d review and staff interview o resume Resident #1's					

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345133	B. WING _			C 02/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION					000 COLLEGE STREET /ILKESBORO, NC 28697			
(X4) ID PREFIX TAG				×	E ATE	(X5) COMPLETION DATE		
F 867	was restored for 1 of During the complaint facility neglected to pur resident who was soil a small reddish open 4 residents reviewed The resident stated the like it was on fire and herself, so she did no F655: Based on record the facility failed to det that included a periphe catheter (PICC) (IV us medications) and the resident reviewed (Ref During the recertificate failed to complete a be hours of admission for for pressure ulcers. During the complaint facility failed to develop the area of dialysis for for dialysis and failed plan for a resident where residents reviewed with During the complaint facility failed to develop the area of dialysis for for dialysis and failed plan for a resident where residents reviewed with During the complaint facility failed to develop care plan that address of daily living for 1 of activities of daily living During the recertificate	iotic when his IV access 1 resident reviewed. investigation of 10/15/21 the rovide incontinence care to a led with urine and resulted in area on her buttocks for 1 of for activities of daily living. hat her bottom was burning wished she could care for it have to sit in a soiled brief. rd review and staff interview evelop a baseline care plan herally inserted central sed to administer IV use of IV antibiotic for 1 of 1 esident #1). tion of 03/11/20 the facility haseline care plan within 48 or 2 of 4 residents reviewed investigation of 05/07/21 the op a baseline care plan in r 1 of 2 residents reviewed to develop a baseline care no required oxygen for 1 of 2 ith oxygen. investigation of 12/22/21 the op and implement a baseline sed the resident's activities 8 residents reviewed for g.	F	367				
		ion and complaint /22 the facility failed to						

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY LETED
345133		B. WING					C 20/2023	
NAME OF PROVIDER OR SUPPLIER			•		REET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	RSING AND REHABILITATION			00 COLLEGE STREET ILKESBORO, NC 28697				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BI		(X5) COMPLETION DATE
F 867	was fed through a Ga was to have nothing b reviewed with a GT. F677: Based on obse staff and Residents' ir provide dependent re 6 residents (Resident #7) reviewed for activ	re plan for a resident who istrostomy tube (GT) and by mouth for 1 of 2 residents ervations, record reviews, nterviews the facility failed to sidents with showers for 3 of #2, Resident #6, Resident	F 86	67				
	facility failed to provid a resident wetting through sheet, failed to provid resident who had a bo provide showers as so failed to provide nail of	le incontinence care prior to ough her brief onto her draw le incontinence care to a owel movement, failed to cheduled for 1 resident and care for 2 residents for 4 of 4 r activities of daily living for						
		9/01/22 the facility failed to are for 1 of 3 residents						
	staff, and Resident in provide sufficient nurs residents not being tre	eated in a dignified manner for 3 of 6 sampled residents						
	facility failed to provid the provision of incom who was wet and yell hurting her skin and a	investigation of 10/15/21 the le sufficient nursing staff for tinence care to a resident ing that it was burning and as a result ended up with a r skin, failed to provide						

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/14/2023 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED		
345133			B. WING		_	( 02/:	20/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION				000 COLLEGE STREET VILKESBORO, NC 286	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	through her brief and to provide incontinent had a bowel moveme as scheduled for 3 res nail care for 2 residen reviewed for sufficient F760: Based on interv Medical Director, Tele Regional Medical Dire Disease Provider the Infectious Disease Pr Resident #1's intraver was being used to tre empyema (collection the brain) and Cerebr cerebrum of the brain peripherally inserted of IV used to administer dislodged and his ant administered as order reviewed for significant was the high likelihoo resistance to antibiotii hospital due to the mi During the complaint facility failed to preven errors by not accurate administering medica hospital discharge su chronic pain, shortnes a hospice resident for medication errors As reported her pain leve	a resident who was wet onto her draw sheet, failed be care to a resident who int, failed to provide showers sidents and failed to provide its for 7 of 7 residents t nursing staff. view, record review, staff, emedicine Physician, ector, and Infectious facility failed to notify the ovider that was managing nous (IV) antibiotic which at a right subdural of pus between the layers of itis (inflammation of ) that Resident #1's central catheter (PICC) (an medications) had become ibiotics were not red for 1 of 1 resident int medication errors. There d for bacterial regrowth, c, sepsis, or return to ssed medications. investigation of 10/15/21 the int significant medication ely transcribing and tion as ordered from the mmary prescribed to treat as of breath, and anxiety for 1 of 1 resident reviewed for a result, the resident el was 7 to 9 on a scale of 1 shifts during her 4 days as	F 867				

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/14/2023 MAPPROVED ). 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED		
	345133		B. WING			_		C 20/2023		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE				
				1	000 COLLEGE STREET					
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION		v	VILKESBORO, NC 286	97				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S	PLAN OF CORRECTION		(X5)		
PREFIX	-	Y MUST BE PRECEDED BY FULL	PREF	IX		CTIVE ACTION SHOULD B	E	COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	6			TE	DATE		
						DEFICIENCY)				
F 867	Continued From page	9 54	F	867						
	During the Focused Ir	nfection Control and								
	Complaint investigation	on of 09/01/22 the facility								
	failed to prevent signi	ficant medication errors								
	when medications we	re not obtained and								
	administered per the	physician orders for 3 of 3								
	residents reviewed fo	r medications.								
	F804: Based on obse									
		ne facility failed to provide								
	•	as appetizing in temperature								
		viewed for food concerns.								
	(Resident #7 and Res	ident #11).								
	During the recentificat	ion over 102/11/20 the								
		ion survey of 03/11/20 the food and coffee at lunch								
	-									
		it were palatable and at an re for 1 of 2 resident meals								
	sampled for palatabili									
		ty.								
	The Administrator wa	s interviewed on 02/20/23 at								
	1:32 PM who stated t									
		mittee met monthly and								
		tment heads, the Medical								
	-	ant Pharmacist. They each								
		enings from the previous								
		, wounds, pharmacy reports,								
		plans, and safety issues.								
		d about and brainstormed								
		etter going forward to ensure								
		e. The Administrator stated								
		key routine systems that								
		ded "fine tuning" and that								
	would keep them on t	-								
	-	ninistrator stated going								
	-	g to track the happenings in								
	-	g an excel spreadsheet for								
		ey discussed to ensure they								
	-	the information but really								
		issues and discussing								

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		ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION		0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
							C	
	345133	B. WING	_		02/	20/2023		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			000 COLLEGE STREET /ILKESBORO, NC 28697			
	1			v				
(X4) ID PREFIX	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE	
					,			
F 867	Continued From page	<del>2</del> 55	F	867				
	-	tor stated she believed that		007				
	would help the facility							
	sustaining compliance	e long term.						

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