DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		COMF	E SURVEY PLETED
		345133	B. WING			C / 15/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	000 COLLEGE STREET		
RIDGE VA	LLET CENTER FOR NOT	RSING AND REHABILITATION	v	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
F 550 SS=D	was conducted on 10 Additional information 10/13/21. A survey te on 10/14/21 through complaint allegations was changed to 10/19 33 of the 53 complain substantiated and cite Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, an access to persons an outside the facility, int this section. §483.10(a)(1) A facility with respect and dign resident in a manner promotes maintenand her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding tr provision of services residents regardless of	ed. cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clifty 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 of payment source.	F 550			11/15/21
	§483.10(b) Exercise of					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					11/11/2021

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.

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 08/15/202 /I APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345133	B. WING				_ 15/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		RSING AND REHABILITATION		1	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 SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 550		- 1	Í _				
F 550	Continued From page		- F :	550			
		right to exercise his or her					
	0	f the facility and as a citizen					
	or resident of the Uni	ieu Jiaies.					
	§483.10(b)(1) The fa	cility must ensure that the					
		his or her rights without					
		n, discrimination, or reprisal					
	from the facility.						
	\$483 10(b)(2) The re	sident has the right to be					
		coercion, discrimination, and					
		ity in exercising his or her					
	-	orted by the facility in the					
	exercise of his or her	rights as required under this					
	subpart.						
		Γ is not met as evidenced					
	by:						
		ons, record reviews, resident, views, the facility failed to			F550 Resident Rights 1. Resident #17 and #2 will continue to	a ha	
		gnified manner by not			monitored for and provided with	o ne	
		e care prior to a resident			incontinence care assistance per		
		ng through her brief onto her			residents' plan of care. Monitoring and	1	
		on, the facility failed to			care continues to be provided routinely		
	-	care to a resident (Resident			and as needed including before meals	s to	
		movement prior to dinner			maintain resident dignity.		
		nmate (Resident #1) ate			2. Residents' incontinence care needs		
	•	the bowel movement for 3			identified per ADL care plan and Karde	ex	
	UTO TESIGENIS LEVIEW	ed for dignity and respect.			will continue to be monitored for and provided by direct care staff routinely,	25	
	The findings included	1:			needed and before meals to maintain	45	
					resident dignity. ADL care plans and		
	1. Resident #17 was	admitted to the facility on			Kardex updated by MDS Coordinator	as	
	10/19/12 and readmi	-			appropriate for current facility resident		
	-	uded Alzheimer's disease,			11/10/2021.		
	dementia, seizure dis	order and anxiety disorder.			3. Education completed 10/18/21 –		
		A			11/12/21. The Director of Nursing		
		Area Assessment summary			provided education to current licensed	1	
		nnual Minimum Data Set			nurses, nurse aides and direct care		
	essessment d (פּּטוּאו) assessment d	ated 12/16/20 revealed she			agency staff on monitoring for and		

Facility ID: 923520

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					IO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			IE SURVEY MPLETED
		A. DOIEDING			С
	345133	B. WING		1	0/15/2021
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
			1000 COLLEGE STREET		
LLEY CENTER FOR NU	RSING AND REHABILITATION		WILKESBORO, NC 28697		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	e 2	F 55	0		
was incontinent of bo decreased mobility al Resident was at risk ulcer and urinary trach her incontinence. Reson nursing staff for in Resident #17's most Data Set assessmen she was severely imp making and required of 1 to 2 staff with all was totally dependent toileting. Resident #17's care p a plan of care for her bladder related to her mobility. The goal was remain free from infe incontinence and bried date of 11/20/21. The check for incontinence rinse and dry perineus incontinent episodes, during activities, use manufacturer's recon when soiled, encourse promote prompted voor resident has unobstrue (resident does not us voiding patterns, mor symptoms of UTI suc tinged urine, increase temperature, urinary	wel and bladder due to nd cognitive impairment. for developing pressure et infection (UTI) related to esident was totally dependent continence care. recent quarterly Minimum t dated 08/20/21 revealed baired for daily decision extensive to total assistance activities of daily living and at on 1 staff member for blan dated 09/15/21 revealed incontinence of bowel and r confusion and impaired as for Resident #17 to ction, skin breakdown due to ef use through the review e interventions included exe prn (as needed), wash, im, change clothing prn after , notify nursing if incontinent disposable briefs per mendation and change age fluids during the day to biding responses, ensure ucted path to the bathroom we bathroom), establish hitor/document for signs and ch as burning, pain, blood ed pulse, increased frequency, foul smelling		 providing incontinence caper residents' plan of cardignity. Newly hired licent nurse aides and direct cawill receive education up Direct care nursing staff and provide resident income as needed or requested a delivering meal trays. 4. The Director of Nursin and delegate to clinical nuccomplete an audit of income care and dignit provided. Monitoring will five (5) residents via rour observations at a frequent times weekly for four (4) weekly for eight (8) week necessary thereafter. The will report findings of the Interdisciplinary Team (III meetings monthly for threand will make changes to necessary to maintain corresidents right to dignity to the start of the start of	e to maintain sed nurses, are agency staff on hire. will determine ontinence needs and prior to g will oversee uursing to ontinent residents be completed for nding ncy of five (5) weeks, then as and as e Administrator monitoring to the DT) during QAPI ee (3) months o the plan as ompliance with with incontinence.	
	ROVIDER OR SUPPLIER LLEY CENTER FOR NU SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page was incontinent of bc decreased mobility a Resident was at risk ulcer and urinary trac- her incontinence. Re on nursing staff for in Resident #17's most Data Set assessmen she was severely imp making and required of 1 to 2 staff with all was totally dependent toileting. Resident #17's care p a plan of care for her bladder related to he mobility. The goal was remain free from infe incontinence and bried date of 11/20/21. The check for incontinence rinse and dry perineu- incontinent episodes during activities, use manufacturer's recom- when soiled, encourae promote prompted vor resident has unobstrue (resident does not us voiding patterns, mor symptoms of UTI suc- tinged urine, increase temperature, urinary urine, fever, chills, alt	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345133 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 was incontinent of bowel and bladder due to decreased mobility and cognitive impairment. Resident was at risk for developing pressure ulcer and urinary tract infection (UTI) related to her incontinence. Resident was totally dependent on nursing staff for incontinence care. Resident #17's most recent quarterly Minimum Data Set assessment dated 08/20/21 revealed she was severely impaired for daily decision making and required extensive to total assistance of 1 to 2 staff with all activities of daily living and was totally dependent on 1 staff member for toileting. Resident #17's care plan dated 09/15/21 revealed a plan of care for her incontinence of bowel and bladder related to her confusion and impaired mobility. The goal was for Resident #17 to remain free from infection, skin breakdown due to incontinence and brief use through the review date of 11/20/21. The interventions included check for incontinence prn (as needed), wash, rinse and dry perineum, change clothing prn after incontinent episodes, notify nursing if incontinent during activities, use disposable briefs per manufacturer's recommendation and change when soiled, enccurage fluids during the day to promote prompted voiding responses, ensure resident has unobstructed path to the bathroom (resident does not use bathroom), establish voiding patterns, monitor/document for signs and	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP A BUILDING 345133 B. WING ROVIDER OR SUPPLIER 345133 B. WING LLEY CENTER FOR NURSING AND REHABILITATION ID PREFIX ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 2 F 55 Was incontinent of bowel and bladder due to decreased mobility and cognitive impairment. Resident was at risk for developing pressure ulcer and urinary tract infection (UTI) related to her incontinence. Resident was totally dependent on nursing staff for incontinence care. Resident #17's most recent quarterly Minimum Data Set assessment dated 08/20/21 revealed she was severely impaired for daily decision making and required extensive to total assistance of 1 to 2 staff with all activities of daily living and was totally dependent on 1 staff member for toileting. Resident #17's care plan dated 09/15/21 revealed a plan of care for her incontinence of bowel and bladder related to her confusion and impaired mobility. The goal was for Resident #17 to remain free from infection, skin breakdown due to incontinence and brief use through the review date of 11/20/21. The interventions included check for incontinence prn (as needed), wash, rinse and dry perineum, change clothing prn after incontinent episodes, notify nursing if incontinent during activities, use disposable briefs per manufacturer's recommendation and change when soiled, encourage fluids during the day to promote prompted voiding responses, ensure resident has unobstru	DF DEFICIENCIES [X1] PROVIDERUSUPPLIERUCLIA (X2) MULTIPLE CONSTRUCTION ABUILDING	S FOR MEDICARE & MEDICAID SERVICES ONB N PF DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA LIDENTIFICATION NUMBER: (Z2) MULTPLE CONSTRUCTION A BUILDING (Z3) 346133 B. WING (2) ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLEY CENTER FOR NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFORMATION PREFX MEDICING STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFORMATION PREFX Main Continence Constructions PREFX Mass incontinent of bowel and bladder due to decreased mobility and cognitive impairment. Providing incontinence care to residents par residents' plan of care to maintain dignity. Newly hired licensed nurses, nurse aides and direct care agency staff will receive education upon hire. Data Set assessment dated 08/20/21 revealed she was soverely impaired for daily decision taking and required extensions included d plan of care for her incontinence of bowel and bladder related to her continuison and impaired mobility. The goal was for Resident #17 to remain free for her incontinence of bowel and bladder related to her continuison and impaired mobility. The goal was for Resident #17 to resident #17 s care plan dated 09/15/21 revealed a plan of care for her incontinence of bowel and bladder related to her continuison and impaired mobility. The goal was for Resident #17 to remain free for her incontinence of bowel and bladder related to her continuison and impaired mobility. The goal was for Resident #17

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345133	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	infection, constipation weaking of control mu capacity, diabetes, st effects, and obtain lal report abnormal to the Interview on 10/11/21 member of Resident a revealed she had just "smelled strong odor in the door." The fam spoken with the Nurs resident and NA #11 able to change the re 9:30 AM after breakfa Resident #17's room the resident and the f and came to find one incontinence care and resident was in." The stated when she com resident is soiled, she bathed her and cut ar because otherwise it this was nothing new some time. Interview on 10/11/21 revealed she was ass the 3:00 PM to 11:00 the resident as soon a supplies for her incom Observation on 10/11	h, loss of bladder tone, uscles, decreased bladder roke, and medication side os/tests as ordered and e MD. at 2:30 PM with family #17 in conference room gotten to the facility and of urine as soon as walked hilly member stated she had e Aide (NA) caring for the told her she had not been sident since around 9:00 or ast. NA #11 had been into around 2:20 PM to change amily member told her no of us so we could see her d "see the condition the e family member further es to the facility if the e usually changed her and nd cleaned her fingernails was not done. She indicated and had been going on for at 3:00 PM with NA #12 signed to Resident #17 for PM shift and would change as she was able to get	F	550			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/15/2023 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345133	B. WING				C / 15/2021
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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	was balled up in the c #17 had wet through sheet under her on th cleaned by NA #12 ar and clean draw sheet top of her sheet. An ir #12 revealed she did been checked or char to the amount of urine sheet under the reside Interview on 10/11/21 who had taken care of AM to 3:00 PM reveal to change the residen she had changed Res and went in to change PM and the family me wanted the surveyors #11 stated she had no the resident prior to 2 feedings, lifts, and eve today. NA #11 further week off orientation a with the workload whe the building." NA #11 "overwhelmed with th was assigned to care enough time to get eve indicated Resident #1 shower today but they showers and said she give her a bed bath d According to NA #11, for the NAs to have 20 for and there was no in 8 hours."	center of the brief. Resident her brief onto the draw e bed. Resident #17 was and new clean brief applied was placed under her on interview conducted with NA not think the resident had nged for several hours due e in the brief and the draw ent being wet. at 3:18 PM with NA #11 f Resident #17 on the 7:00 led she had only been able it once today. NA #11 stated sident #17 after breakfast e her around 2:00 to 2:30 ember told her no that she to see her changed. NA of been able to get back to :00 PM due to all the erything else she had to do stated this was her first nd she was "overwhelmed en there was only 3 NAs in indicated she was e number of residents she for" and said there was not rerything done. She further 7 was supposed to get a re was no one doing e had not even had time to	F	550			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345133	B. WING _				C 1 5/2021
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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Director of Nursing (E staffing challenges at there was only 1 full t shift and 1 full time er shift and the rest of the needed) or were ager stated they recently he salary to be more cor- had quite a few open indicated she expected and changed as need hours and would not of over 4 hours without 1 incontinence. 2. Resident #2 was an 11/25/16 and readmit diagnoses which inclu- dementia, osteoarthri among others. Resident #2's most ref (MDS) assessment da required extensive to staff with most activiti MDS further revealed assistance of 1 staff w Resident #2's care plat there was a plan of ca bowel and bladder du and was at risk of UT development. The go remain free from skin incontinence and bried date of 01/20/22. The barrier cream as order briefs according to ma	DON) revealed there were the facility. The DON stated ime employed nurse on day mployed nurse on evening he nurses were PRN (as ney nurses. She further had increased their base inpetitive with hiring but still positions. The DON ed residents to be checked hed or at least every 2-3 expect residents to go for being checked for dmitted to the facility on ted on 08/31/20 with uded Alzheimer's disease, tis, and anxiety disorder ecent Minimum Data Set ated 09/10/21 revealed she total assistance of 1 to 2 es of daily living (ADL). The she required extensive with toileting and wore briefs. an dated 10/12/21 revealed are for being incontinent of the to diagnosis of dementia I and pressure ulcer bal was for the resident to breakdown due to of use through the review e interventions included ered, use of disposable	F	550			

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		MEDICAID SERVICES					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ISTRUCTION	· · ·	TE SURVEY MPLETED
		345133	B. WING			С	
		343133				1	0/15/2021
NAME OF PF	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			COLLEGE STREET ESBORO, 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 550	Continued From pag	<u>.</u>		50			
1 000			F 5	50			
	•	peri-area when soiled and					
		with each incontinence					
		adequate fluid intake with with med pass, observe for					
		of UTI including pain,					
		d urine, cloudiness, no					
	0 · 0	ⁱ urine color, increased pulse,					
		re, urinary frequency, foul					
	•	, chills, altered mental status,					
		and change in eating habits,					
	-	ny possible causes of					
		r infection, constipation, loss					
		kening o control muscles,					
		apacity, diabetes, stroke and					
	medication side effect						
		1 at 4:00 PM with family					
	0	sident #2 revealed they were					
	•	resident's care. One of the					
	-	ner revealed they were					
		ident #1 as their family					
		because she looked out for					
		her family member described					
	-	n which Resident #2 had sat					
		over 4 hours because the NA					
		not come in and changed her					
		roommate, Resident #1. The					
	•	d Resident #1 had realized					
		that Resident #2 had a bowel					
		n she rang the call light they					
		nanged Resident #2 for over					
	•	member further stated there					
		lowing an elderly person who					
		rself to sit in poop for that					
		ndicated it was not good for					
		ng without being changed.					
	The family member in	-					
		rector of Nursing about the					

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		MEDICAID SERVICES		E CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
						С
		345133	B. WING		1	0/15/2021
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP COD	E	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET		
			I	WILKESBORO, NC 28697	PROTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 550	Continued From page	e 7	F 550			
		n." The family member				
	further indicated "that	t is not what you want to				
	•	oncerned about the care your				
	ioved one was receiv	ring in the nursing home."				
		1 at 4:30 PM with Resident				
		ate of Resident #2 revealed				
		1, at 4:00 PM she rang her				
	-	#2. Resident #1 stated				
		rang her light for a NA to				
	-	Resident #2. Resident #1				
	further stated NA #7 stated she had just c	answered the call light and				
	-	d she told NA #7 she had				
	had a bowel moveme	ent and she could smell it				
		n she had just changed the				
		1 further indicated it was 7 came in and changed				
		nt #1 explained that she and				
		at their dinner while smelling				
		Resident #1 further				
		formed Resident #2's family d complained about it and				
		emember by whom) that "it				
		." Resident #1 advised that				
	•	c times because she had				
		when she called out for ent #2 and looked at her				
		ey came in and changed her.				
	-	he wears her watch every				
	day.					
	Interview on 10/12/2	1 at 3:15 PM with NA #7				
		orking on 10/09/21 and was				
	assigned to Resident	t #1 and Resident #2. NA #7				
	stated there were goo staffing just like any o	od days and bad days with				
		sthor place very work and				

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SU COMPLE	
	CONTROLION		A. BUILDING		COMPLE	
		345133	B. WING		10/15	/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO		
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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 550	Continued From page	e 8	F 550			
		/s they were short staffed.				
	She stated lately the	e were more days than not				
	-	an adequate number of staff				
		#7 further stated it was ontinence rounds done every				
		e lucky to get 2 rounds done				
		A #7 indicated if she didn ' t				
		when Resident #1 rang the				
		bably because she was				
	-	dent and then supper trays d to pass trays and feed				
		be fed and then after all				
		bu can then start your second				
	round. NA #7 further					
		eone wet or messed up but				
		possible to get everything				
	best you can."	nd you just had to do the				
		1 at 4:45 PM with the interim				
		DON) revealed there were the facility. The DON stated				
		time employed nurse on day				
	shift and 1 full time e	mployed nurse on evening				
		ne nurses were PRN (as				
	, ,	ncy nurses. She further				
		nad increased their base mpetitive with hiring but still				
	had quite a few open					
	indicated she expected	ed residents to be checked				
	, i i i i i i i i i i i i i i i i i i i	ded or at least every 2-3				
		expect residents to go for				
	over 4 hours without incontinence.	Dening checked for				
F 561	Self-Determination		F 561		11	/15/21
SS=E	CFR(s): 483.10(f)(1)-	(3)(8)				
			1	1		

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/15/2023 1 APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345133	B. WING) 15/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10,		
RIDGE VA		RSING AND REHABILITATION			000 COLLEGE STREET			
				N	VILKESBORO, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 561	Continued From page	9	E E	561				
	The resident has the promote and facilitate through support of re	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)		001				
	activities, schedules (waking times), health							
		ident has a right to make s of his or her life in the cant to the resident.						
	with members of the	ident has a right to interact community and participate in both inside and outside the						
	religious, and commu interfere with the righ facility.	ident has a right to ctivities, including social, inity activities that do not ts of other residents in the ⁻ is not met as evidenced						
	by: Based on observatio family and staff interv honor the residents ' preferred number of s week for 3 of 3 reside	ns, record reviews, resident, iews, the facility failed to preferences regarding showers or bed baths per ents (Resident #1, Resident reviewed for choices.			F561 Self-Determination 1. On October 21st, the Administrator completed an updated bathing type an frequency preference assessment for Resident #1, #6 and #9. Unfortunately Resident #6 expired on 10/30/21. ADL care plans, POC tasks and Kardex's	,		
	The findings included	: dmitted to the facility on			right to self-determination. 2. On November 10th, the interdisciplin			

Facility ID: 923520

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		MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · ·	E SURVEY IPLETED
		345133	B. WING		1	C)/15/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 561	Continued From page	e 10	F 56	1		
	07/02/18 and readmit diagnoses which inclu- disease, diabetes me and chronic obstructi among others. Resident #1's Care A summary completed Minimum Data Set as able to make her nee for assistance, was b was incontinent of bo The CAA summary fu- was on dialysis Mono of each week. Resident #1's most re Data Set (MDS) asse revealed she was con decision making and of 1 staff member for Resident #1's care pl she had a care plan f assistance daily due goals were for the res activities of daily livin through the next revie have any significant of next review date of 1 included bathing/shor nursing staff, persona dependence of at lea efforts at self-care an non-ambulatory and	tted on 04/28/21 with uded end stage renal ellitus type II, hypertension, ve pulmonary disease area Assessment (CAA) 11/09/20 with her annual assessment revealed she was eds known, used the call bell wed to wheelchair bound and owel and bladder at times. arther revealed Resident #1 day, Wednesday, and Friday ecent quarterly Minimum essment dated 07/28/21 gnitively intact for daily required total dependence bathing. an dated 08/11/21 revealed for requiring physical to decreased mobility. The sident to participate in g (ADL) as she was able ew date of 11/18/21 and not decline in ADL through the 1/18/21. The interventions wering: dependent on 1-2 al hygiene: extensive ist 1 nursing staff, praise all ad resident was		 team (Administrator, Direct Activity Director, MDS coor care nurse, social worker, a Rehabilitation) completed a bathing preference assess current facility residents to preferences for bathing typ frequency are identified. Ca tasks, Kardex's and facility schedule updated accordin 3. Education completed 10, 11/12/21. The Director of N Social Services Director ed facility licensed nurses, nur direct care agency staff on residents right to self-deten bathing type and frequency Newly hired licensed nurse and direct care agency staff education upon hire. Resident preferences for ba frequency will be assessed admission and as needed to nurse and care provided by as reflected per the care pla Kardex and facility bathing 4. The Director of Nursing a designee will complete an a resident bathing preference proper care and self-detern Monitoring will be complete random residents for bathir at a frequency of five (5) tin four (4) weeks, then weekly weeks and as necessary th Administrator will report finde 	dinator, wound and Director of in updated ment for ensure e and are plans, POC bathing gly. /18/21 – ursing and/or ucated current se aides and honoring mination with preferences. s, nurse aides f will receive athing type and upon by the licensed of the nurse aide an, POC tasks, schedule. and/or nurse audit of es to ensure hination. of for five (5) ng preference nes weekly for of for eight (8) pereafter. The	
	nursing staff, among	others. e provided by the facility		(IDT) during QAPI meeting three (3) months and will m	s monthly for	

Facility ID: 923520

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ID HUMAN SERVICES MEDICAID SERVICES			FORM	08/15/2023 APPROVED 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SU COMPLE	JRVEY
345133	B. WING			5/2021
		STREET ADDRESS, CITY, STATE, ZIP CODE		,2021
		1000 COLLEGE STREET		
RSING AND REHABILITATION		WILKESBORO, NC 28697		
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	HOULD BE COMPL	
e 11 1 was scheduled for showers on Monday. There was no edule as to what shift the s to be provided. 1 at 4:30 PM with Resident om revealed she was not as scheduled as well as dent #1 stated there was a with Nurse Aides (NAs) ney called in the NA assigned d to work on the floor and s. She further stated she had ly without getting a shower eduled for showers was or due to another NA calling cated her last shower had urther indicated she was ower on 11/08/21 but there cility to do showers that day. pulled to work the floor. and Friday and stated she wer every other day but was nber by whom) that she ers per week." She sed to "showering every day" e facility and said she rer bed baths or partial baths iner. Resident #1 further o be clean because she went is 3 times a week and did not appear clean at the 1 at 11:27 AM with Nurse ed on day shift for at least 4 s had 20 to 25 residents and	F 561		ain	
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345133 RSING AND REHABILITATION ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ATEMENT OF DEFICIENCIES Y WITH NURSE AIDES (NAS) Net Sole further stated she had ly without getting a shower was over on 11/08/21 but there collicity to do showers that day. pulled to work the floor. At #1, she preferred her and Friday and stated she wer every other day but was neer by whom) that she ers per week." She sed to "showering every day" ATEMENT OF DEFICIENCE Sole to an because she went is 3 times a week and did not appear clean at the ATEMENT OF DEFICIENCE ATEMENT 	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 345133 B. WING RSING AND REHABILITATION D ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PREFIX TAG at 11 F 561 1 was scheduled for showers on Monday. There was no edule as to what shift the s to be provided. F 561 at 4:30 PM with Resident com revealed she was not as scheduled as well as dent #1 stated there was a with Nurse Aides (NAs) hey called in the NA assigned d to work on the floor and as. She further stated she had by without getting a shower eduled for showers was or due to another NA calling cated her last shower had urther indicated she was ower on 11/08/21 but there cillity to do showers that day. pulled to work the floor. It #1, she preferred her and Friday and stated she wer every other day but was nher by whom) that she ers per week." She ses to "showering every day" if facility and said she ter bed baths or partial baths iner. Resident #1 further b be clean because she went is 3 times a week and did not appear clean at the 1 at 11:27 AM with Nurse ed on day shift for at least 4 s had 20 to 25 residents and	MEDICAID SERVICES [x1] PROVIDERSUPPLENCLA IDENTIFICATION NUMBER: p2) MULTIPLE CONSTRUCTION A BUILDING 345133 B. WING RSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WLKESBORD, NC 28897 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SIG IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTVE ACTION SHOP (EACH CORRECTVE ACTION SHOP CROSS-REFERENCED TO THE PREFIX ON MORAY. There was no adule as to what shift the s to be provided. F 561 I at 4:30 PM with Resident om revealed she was not as scheduled as well as dent #1 stated there was a torn the floor and s. She further stated she had by without getting a shower duled for showers was or due to another NA calling bated her last shower had urther indicated she was ower on 11/08/21 but there sility to do showers that day. pulled to work the floor. It #1, she prefered her and Friday and stated she wer every other day but was her by whom) that she ars per week." She er bed batis or partial baths iner. Resident #1 further bace last shower had urther indicated she went is 3 times a week and did to dappear clean at the	UD HUMAN SERVICES FORM. MEDICAID SERVICES OMB NO. (1) PROVIDERSUPPLERCULA IDENTIFICATION NUMBER. (2) MULTIPLE CONSTRUCTION A. BUILDING (3) DATE SI COMPLE 345133 B. WING C 345133 B. WING C 1000 COLLEGE STREET WILKESBORO, NC 26697 ATEMENT OF DEFICIENCIES VILKESBORO, NC 26697 PROVIDER'S FLAN GC CORRECTION WILKESBORO, NC 26697 ATEMENT OF DEFICIENCIES VILLESCIDENTIFYING INFORMATION PREVENT ACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) a 11 If the plan as necessary to maintain compliance with residents right to self-determination with bathing. compliance date of 11/15/2021 If the plan as necessary to maintain compliance date of 11/15/2021 a 14 :30 PM with Resident om revealed She was not as scheduled as well as dent #1 stated there was a with Nurse Aides (NAS) hey called in the NA assigned do to work on the floor and a. She further stated she had ly without getting a shower rdule for showers mad or due to another NA calling a shower had with runs a shower had with runs a shower had with furth showers that day. pulled to work the floor. if 41, she prefered her and Friday and stated she wer every Other day but was hoer by whony that she ars per week." She sed to "showering every day" facility and said she er bed baths or partial baths er. Resident #1 further > be clean because she went is 3 times a week and did tot appear clean at the bat at 12.27 AM with Nurse

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345133	B. WING				C 15/2021
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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	and showers were off was not enough help Interview on 10/12/21 revealed she usually done. She stated rece she had been pulled to outs and showers we NA #1 further stated to to 16 showers schedu only 2 shower rooms. day she could probable done unless there we person lifts. On the da NA #1 said she could showers done in a da were done sometimes difficult to wash reside green tray for washing disappeared and had facility. Interview on 10/12/21 revealed there were of the facility. NA #7 ind ratio was sometimes able to complete all th stated on bad days th shower completed as they were not able to Interview on 10/12/21 revealed she and NA the 3:00 PM to 11:00 was usually only one since they were not a	er for. NA #14 stated bathing en not done because there to get showers done. at 12:07 PM with NA #1 did showers if showers were ently (the past 3-4 weeks) to the floor to fill in for call re not done as scheduled. here were usually about 10 uled per day and there were She indicated on a good ly get 10 to 12 showers re residents that required 2 ays there were a lot of lifts, only get about 8 to 10 y. NA #1 shared bed baths s on shower days, but it was ent 's hair because their g hair in the bed had not been replaced by the at 3:15 PM with NA#7 good days and bad days at icated the NA to resident crazy and the NAs were not ne assigned work. She ey were lucky to get 1 scheduled and sometimes	F	561			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 08/15/2023 MAPPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345133	B. WING				C 15/2021
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RIDGE VA	LLEY CENTER FOR NUP	RSING AND REHABILITATION			000 COLLEGE STREET VILKESBORO, NC 28697		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 561	Continued From page	9 13	F	561			
	Interview on 10/12/21	at 4:45 PM with the interim					
		ON) revealed there were the facility. The DON stated					
	there was only 1 full t	ime employed nurse on day					
		nployed nurse on evening le nurses were PRN (as					
	needed) or were ager	ncy nurses. She further					
		ad increased their base npetitive with hiring but still					
	had quite a few open	positions. The DON					
	explained that if the re showers on certain da	esidents wanted their ays then they should get					
	them, and it was her	expectation that the					
		r showers when they wanted ON also added that if the					
		cumented then they were not					
		dmitted to the facility on					
	01/06/21 with diagnos	ses that included heart					
	failure and renal insut	ficiency.					
	The quarterly Minimu						
		/17/21 revealed Resident #9 for daily decision making					
		ion assistance of one staff					
	A review of the Show						
	and Friday.	was scheduled for Monday					
		#9's Bathing record for					
		ough October 12, 2021 t received a shower on					
		and Monday October 11th.					
	A review of the Daily	Staffing record revealed					

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 08/15/2023 FORM APPROVED MB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		3) DATE SURVEY COMPLETED
		345133	B. WING				C 10/15/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUI	RSING AND REHABILITATION					
				V	WILKESBORO, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 561	Continued From page	e 14	F	561			
	there was no staff sch	neduled to give showers on Friday October 8th for the					
	10/12/21 at 11:00 AW explained he was sch week, but he was "luc shower a week. The l night (10/12/21) he ha 7 days and that was n his skin itched him all forward to his shower on some days the sta not as thorough as a preferred. The Reside when he does not rec tell him that they do n showers. During an interview w 10/11/21 at 2:58 PM for Resident #9 on 10 provided a partial bat there was not a perso showers that day.	to interview Nurse Aide #9 /21 evening shift but the					
	(DON) on 10/12/21 at Resident #9's Bathing 2021 and acknowled not received his two s for at least two weeks the residents wanted	cessful. vith the Director of Nursing t 4:30 PM she reviewed g record since October 1st, ged that the Resident had scheduled showers a week s. The DON explained that if their showers on certain d get them, and it was her					

Facility ID: 923520

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DEPARTMENT OF HE						FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345133	B. WING				C 15/2021
NAME OF PROVIDER OR SUP	PLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VALLEY CENTER	FOR NU	RSING AND REHABILITATION			000 COLLEGE STREET VILKESBORO, NC 28697		
PREFIX (EACH I	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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
 showers whe DON also ad documented An interview #2 on 10/13/ worked with shift. The NA received a sh not a staff per shift. An interview #3 on 10/13/ cared for Res The NA explain to give show pulled to the receive his si 3. Resident 10/07/21 with schizophrenii intellectual disuicidal ideal pulmonary dia atrioventricual Resident # 6 (MDS) assess resident was making and with 1-person assission assission assission assission assission assission assission assission assistication assisticat	hat the r en they w lded that then the was con 21 at 2:1 Resident erson sch was con 21 at 2:2 sident #2 ained the cheduled # 6 was n diagnos a, major isabilities tions, dia isease, c ar block, 's quarte sist for be sist for be sist for ba e care pl	esidents receive their vanted their showers. The if the showers were not y were not done. ducted with Nurse Aide (NA) 0 PM who confirmed she t #9 on 10/01/21 morning ed that the Resident did not at shift because there was heduled to give showers that ducted with Nurse Aide (NA) 0 PM who confirmed she 0 on 10/01/21 evening shift. Fre was no person scheduled day because they had to be refore, Resident #9 did not d shower. readmitted to the facility on ses that included paranoid depression, moderate s, anxiety disorder, epilepsy, abetes, chronic obstructive tongestive heart failure, and morbid obesity. rly Minimum Data Set ated 08/17/21 revealed the ely intact for daily decision nsive assistance with ed mobility, toilet use and d total dependence with	F	561			

Facility ID: 923520

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DEPARTMENT OF HEALT CENTERS FOR MEDICAR	_	-				FOR	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PRO	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345133	B. WING				C / 15/2021
NAME OF PROVIDER OR SUPPLIE	२		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VALLEY CENTER FOI	R NURSING AN	ID REHABILITATION			1000 COLLEGE STREET WILKESBORO, NC 28697		
PREFIX (EACH DEFI	CIENCY MUST BE	DF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
a goal to remain A review of the s Resident # 6 wa Monday and Thu A review of the E type: bathing so did not receive b June 2021 throu An interview with 12:23 PM reveal showers but only Resident # 6 furt bath today and h stated sometimes morning, someti sometimes woul An interview with 10/11/21 at 3:10 could in the amo further revealed but the shower p and they were do shift. An interview with AM stated the N residents to care time to get every stated showers a done because th An interview with (DON) on 10/12/	 self-perform at current lev hower schedu s to receive sl ursday. bocumentation hedule, indica ed baths daily gh October 10 n Resident # 6 ed he did not vanted a be her revealed ue never refus s he would ge mes in the aft d not get then n Nursing Ass PM revealed unt of time sh she occasion erson would one any time n NA #14 on 1 As sometimes for and there thing done. If and bed baths ere wasn't en t the Interim II 21 at 4:45 PM 	ule revealed howers every an Survey Report v2, ated Resident # 6 y for the months of 0, 2021. S on 10/11/21 at want to have d bath daily. he'd had no bed aed bed baths. He et them in the ernoon and n at all. sistant (NA) # 5 on she did what she he had. NA # 5 ally gave a bed bath give the bed baths throughout the first 10/12/21 at 11:27 s had 20-25 e wasn't enough NA # 14 further s often were not hough help.	F	561			

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	S FOR MEDICARE &				FORM APPROVE OMB NO. 0938-039		
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345133	B. WING		10/15/2021		
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, Z 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 PREFIZ TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED			
F 561	further revealed if the shower, they should I day. The Interim DO	e 17 them. The Interim DON e resident did not want a be getting a bed bath every N stated if the showers or locumented, they were not	F	561			
F 600 SS=G	§483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	om Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This hited to freedom from involuntary seclusion and hical restraint not required to edical symptoms.	F	600	11/15/21		
	physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on observation interviews, the facility incontinence care to with urine and resulted area on her buttocks residents reviewed for The resident stated th like it was on fire and	Γ is not met as evidenced on, record review and staff or neglected to provide a resident who was soiled ed in a small reddish open for 1 of 4 (Resident #23) or activities of daily living. that her bottom was burning wished she could care for ot have to sit in a soiled brief.		F 600-Free from Abuse 1. On October 11th, the provided incontinence of completed a thorough s for Resident #23, notified physician of skin conce treatment orders for red buttocks and updated s accordingly. Resident # home on 10/29/2021 wit concerns. 2. On October 18th, the	e nurse aide care and the nurse kin assessment ed the attending rn, obtained Idened area to kin care plan 23 discharged th no skin		

Event ID: JJ3711

Facility ID: 923520

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		MEDICAID SERVICES				DMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED	
		345133	B. WING			С	
		345133	B. WING		SS, CITY, STATE, ZIP CODE	10/15/202	1
NAME OF P	ROVIDER OR SUPPLIER						
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE WILKESBORG			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	F	PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPL	ETIO
F 600	Continued From page	e 18	F 6	0			
		mitted to the facility on			d skin assessments and		
		ses that included hemiplegia			nce care observations of currer	nt	
	-	accident affecting her left			y intact and cognitively impaire		
		ontractures, moisture			to ensure appropriate care	~	
		s, urinary incontinence, and			to prevent avoidable skin		
	anxiety.	,			and resident neglect. Resident	t	
					aire audits were completed by		
	Resident #23 has a s	kin care plan revised			Services Director for cognitive		
		ed she was at risk for skin			dents to further ensure all	, ,	
	breakdown.			residents	are free from neglect.		
					ion completed 10/18/21 to□		
	An incontinence care	plan revised 05/25/21			The Director of Nursing		
	indicated Resident #2	23 was incontinent of bowel		provided e	education to nurse aides,		
	and bladder with a go	oal of no skin breakdown due		licensed r	nurses, and direct care agency	,	
	to incontinence with i	nterventions that included		staff on th	e importance of providing time	ely	
	peri-care after each i	ncontinent episode and total		incontiner	nce care and prevention of skir	า	
	dependance from sta	ff for incontinence care.			n. The Director of Nursing, ator and Social Services Direc	tor	
	Resident #23 had a s	self-care deficit care plan			abuse and neglect in-service		
		inence revised on 07/01/21			or current direct and indirect ca	re	
	with a goal to remain	clean, dry and odor free and		-	d agency staff. Newly hired		
	-	de the need for assistance		-	nurses, nurse aides and direct		
	by staff for personal h	nygiene and grooming and		care ager	ncy staff will receive education		
	two personal physica	l assistance for bed mobility.		upon hire			
				Direct car	e nursing staff will monitor and	ł	
		Data Set (MDS) dated			continence care needs by		
		esident #23 to be require			g routine room rounds and as		
		for her bed mobility and			r requested. Newly identified		
		eds. The MDS further			erns will be communicated to		
		23 was always incontinent of			ed nurse for assessment then		
	bowel and bladder.				o the physician for treatment		
					indicated.		
		lental Status (BIMS) dated			ector of Nursing and/or nurse		
		esident #23 was cognitively			will complete an audit of		
	intact.				ncontinence care and skin		
	An abar and the				to ensure residents are free		
		nterview made on 10/11/21		-	ect. Monitoring will be complete	ed	
		Resident #23 laying on her) random residents at a		
	back in bed yelling fo	r assistance with		Trequency	of five (5) times weekly for fou	ur I	

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STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	PLETED
		0.45400					С
		345133	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10	/15/2021
NAME OF P	ROVIDER OR SUPPLIER		1000 COLLEGE STREET				
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			/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) COMPLETIO DATE
F 600	 F 600 Continued From page 19 incontinence care. Resident #23 was pulling at the blue incontinence brief she wore that was partially covered by a white sheet and she said, "please change me, my bottom it is on fire." There was a strong urine odor in the room during the observation. Resident #23's call light was not on during the observations; however, she was heard requesting assistance from outside of the door by the surveyor who entered. An observation and interview made on 10/11/21 at 1:00 PM revealed Resident #23 continue to lay in her bed still on her back yelling for assistance with incontinence care while staff walked by the room. Resident #23 stated "it is hurting worse; someone please get this off me before I have a hole in my butt. I wish I could just take care of myself, so I didn't need anyone to wipe my butt and sit wet." The surveyor told the resident she would make the nurse aware she needed assistance. The surveyor then told a nurse who was sitting behind the desk at the nurses' station 		F		(4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain resident freedom from abuse and neglect. Compliance date of 11/15/2021		
	(NA) to take care of it An observation and it at 3:45 PM revealed yelling for assistance care and when appro- saying her buttocks f was on fire and felt lift to sit on it any longer thought she had a ho verbalized staff did no The surveyor approa notified the oncoming was requesting assis	he would have an Nurse Aide t. Interview made on 10/11/21 Resident #23 was again requesting incontinence bached became tearful elt like it was burning like it ke she couldn't barely stand . Resident #23 indicated she ble on her butt. Resident #23 ot help when she called out. ched the nurses' station and g nurse that Resident #23 tance with incontinence care ation when it occurred.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345133	B. WING			D BE COMPLÉTION	
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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 600	 #12) and NA #19 reveload with a blue brief hring of liquid that reveload with a blue brief hring of liquid that reveload a separating and shedd. The bed pad under R with a yellow liquid su was discarded and visibuttocks revealed a q area to the left lower light area to the rectum. Resident #23's bottor to complain of burning the procedure. Once completed with a cleat NA #19 covered Resi and the Resident #23 An interview with NA at 3:53 PM stated the approximately an hour care to Resident #23 shift. They stated the provided incontinence before they left for the the state of which Resident #23 before an urse know. An interview with Wor 10:15 AM revealed shwounds in the facility; 	/11/21 at 3:47 PM of wided by Nurse Aide (NA ealed Resident #23 lying in heavily saturated with a dark ealed the interior cotton lining ling from the brief linings. esident #23 was visibly wet obstance present. The brief sualization of Resident #23's uarter sized red circular buttocks near Resident area was open and oximately 1 inch from the As NA #12 began to wipe n, Resident #23 continued g and stinging throughout the incontinence care was an brief and bed pad, then dent #23 up with the sheet stated she felt better. #12 and NA #19 on 10/11/21 y had only been on duty ir and had not yet provided since they arrived for their	F	600			

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If continuation sheet Page 21 of 67

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 08/15/2023 MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING					C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE,	ZIP CODE		
		RSING AND REHABILITATION		1	000 COLLEGE STREET			
KIDGE VA	LLET CENTER FOR NOT	SING AND REPABILITATION		V	WILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
TAG F 600	Continued From page being able to assess Nurse indicated she h Resident #23 was obs open area visible duri 10/11/21 but she wou An observation and in on 10/12/21 at 11:30 Nurse's observation of Wound nurse acknow open area to Residen Nurse was unable to area during the obser area and indicated sh for ointment from the An interview with NA revealed she had bee Resident #23 on 10/1 #11 indicated she felt assignment she was g only changed Resided morning. NA #11 indic feedings, and incontin	e 21 resident wounds. Wound had not been made aware served to have a reddened ing incontinence care on Id investigate this concern. Atterview with Wound Nurse AM revealed Wound of Resident #23's buttocks. Atterview with Wound Nurse AM revealed Wound of Resident #23's buttocks. Wound determine what caused the vation, stated it was a new ie would obtain a new order physician. #11 on 10/12/21 at 3:00 PM en assigned to care for 1/21 during day shift. NA overwhelmed with the given on 10/11/21 and had nt #23 before breakfast that cated with all the lifts, hence care it was more than		600	DEFIC		TE	DATE
	Resident #23 before I NA #11 stated she wa every two hours, but o twice when the NAs a residents on day shift noticing the red open #23's buttocks on 10/ her early that morning staff are aware that R	ot make it back in to change her shift ended on 10/11/21. ants to change residents often it may only be once or						
	often just wants some	d from the physician on						

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 10/15/2021
NAME OF PF	ROVIDER OR SUPPLIER	•		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETIO
F 600		e 22 for Zinc Oxide to Resident daily on day and evening	F 60	0	
F 677 SS=E	on 10/12/21 at 4:45 F residents to be change regardless of the faci shortages and increat indicated she Reside without being checke provided from before when second shift stat ADL Care Provided for	se workloads. The DON nt #23 should not have went d and incontinence rounds breakfast until 3:45 PM aff arrived on duty. or Dependent Residents	F 67	7	11/15/21
	out activities of daily l services to maintain g personal and oral hyg This REQUIREMENT by:	is not met as evidenced			
	family and staff interv provide incontinence (Resident #17) wettin draw sheet, failed to p a resident (Resident a movement, failed to p scheduled for 1 resid to provide nail care for and Resident #2) for			 F677-ADL Care Provided for Dep Residents 1. Resident #17 and #2 continues receive assistance with incontiner Resident #3 continues to receive assistance with bathing and Resid and #18 continue to receive assis with nail care per residents plan to maintain quality of care for dep residents. 2. On November 10th, MDS Coor and Director of Nursing completed 	a to nce care, dent #2 tance of care endent dinator
	The findings included 1. Resident #17 was			audit of resident⊡s dependent on assistance with incontinence, batl and/or nail care. Care needs prov	staff for hing

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				E CONSTRUCTION	(
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
						С
		345133	B. WING			10/15/2021
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	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PRC	OVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETI
F 677	Continued From page	e 23	F 67	7		
		uded Alzheimer ' s disease,		care plans, l	POC tasks and Kardex⊡s	
		order and anxiety disorder.			propriate by the MDS	
		-		Coordinator	and Director of Nursing.	
		Area Assessment summary			n completed 10/18/21	
		nnual Minimum Data Set			ne Director of Nursing	
	· · ·	ated 12/16/20 revealed she		·	ucation to current facility	
		wel and bladder due to nd cognitive impairment.			ses, nurse aides and agency staff on providing AE	
		for developing pressure			endent residents per reside	
		t infection (UTI) related to			OC tasks and Kardex.	
	-	esident was totally dependent			cludes the importance of	
	on nursing staff for in	• ·			tinence care and monitoring	3
					ine room rounds as needed	
		recent quarterly Minimum			roviding bathing assistance	
		t dated 08/20/21 revealed			preference and facility	
		paired for daily decision			nd providing nail care. Newl ed nurses, nurse aides and	У
		extensive to total assistance activities of daily living and			agency staff will receive	
		t on 1 staff member for		education up	•	
	toileting.				tor of Nursing and/or nurse	
	5				Il complete an audit of	
	Resident #17's care p	olan dated 09/15/21 revealed		dependent r	esidents for incontinence	
		incontinence of bowel and			g care and nail care to ensu	ire
		r confusion and impaired			dents requiring assistance	
		as for Resident #17 to			re being met. Monitoring wi	l
		ction, skin breakdown due to ef use through the review			d for five (5) random ADL care at a frequency o	f
		e interventions included			s weekly for (4) four weeks,	
		e prn (as needed), wash,			for eight (8) weeks and as	
		im, change clothing prn after		-	nereafter. The Administrator	r
		notify nursing if incontinent		will report fir	ndings of the monitoring to t	he
	during activities, use	disposable briefs per			nary team (IDT) during QAP	I
		nmendation and change			onthly for three (3) months	
		ige fluids during the day to			e changes to the plan as	
		biding responses, ensure			o maintain compliance with	
		ucted path to the bathroom			r dependent residents.	
		e bathroom), establish nitor/document for signs and		Compliance	date of 11/15/2021	
		h as burning, pain, blood				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · · ·	E SURVEY IPLETED
		345133	B. WING		1	C D/15/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	urine, fever, chills, alt in behavior or change monitor/document/rep medical causes of ind infection, constipation weaking of control mu capacity, diabetes, st effects, and obtain lal report abnormal to the Interview on 10/11/21 member of Resident a revealed she had just "smelled strong odor in the door." The fam spoken with the Nurs resident and NA #11 able to change the re 9:30 AM after breakfa Resident #17's room the resident and the f and came to find one incontinence care and resident is soiled, she bathed her and cut ar because otherwise it this was nothing new some time. Interview on 10/11/21 revealed she was ass	ed pulse, increased frequency, foul smelling ered mental status, change a in eating habits, port to MD prn possible continence, bladder n, loss of bladder tone, uscles, decreased bladder roke, and medication side ps/tests as ordered and e MD. at 2:30 PM with family #17 in conference room c gotten to the facility and of urine as soon as walked hily member stated she had e Aide (NA) caring for the told her she had not been sident since around 9:00 or ast. NA #11 had been into around 2:20 PM to change amily member told her no of us so we could see her d "see the condition the e family member further	F 677			

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						10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	FE SURVEY MPLETED
						С
		345133	B. WING		10/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
				1000 COLLEGE STREET		
	LLET 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 677	Continued From pag	e 25	F 67	7		
1 0//		1/21 at 3:06 PM of Resident	F 07			
		care revealed the resident				
		he way up her back, to all				
		astic border around the brief				
		n between the layer next to				
		ont and the plastic outer				
		n the center of the brief.				
		et through her brief onto the				
		r on the bed. Resident #17 12 and new clean brief				
	-	aw sheet was placed under				
		et. An interview conducted				
		she did not think the				
	resident had been ch	ecked or changed for				
		the amount of urine in the				
	brief and the draw sh wet.	eet under the resident being				
		1 at 3:18 PM with NA #11				
		of Resident #17 on the 7:00				
		aled she had only been able				
	-	nt once today. NA #11 stated				
	-	sident #17 after breakfast e her around 2:00 to 2:30				
		ember told her no that she				
	-	s to see her changed. NA				
	-	ot been able to get back to				
	the resident prior to 2	2:00 PM due to all the				
		verything else she had to do				
	-	r stated this was her first				
		and she was "overwhelmed				
	the building." NA #1	en there was only 3 NAs in 1 indicated she was				
	•	ne number of residents she				
		o for" and said there was not				
	-	verything done. She further				
		17 was supposed to get a				
	shower today but the	-				
		e had not even had time to				

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						IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		TE SURVEY MPLETED	
			A. BOILDIN	<u> </u>		С	
		345133	B. WING		1	0/15/2021	
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 26	F 6	77			
	give her a bed bath d According to NA #11, for the NAs to have 2						
E ss tt ss n ss h ir a h ss h ir 2 1 d d a F ((r r s N	Director of Nursing (I staffing challenges at there was only 1 full t shift and 1 full time e shift and the rest of th needed) or were age stated they recently h salary to be more con had quite a few open indicated she expects and changed as need hours and would not over 4 hours without incontinence.	ed residents to be checked ded or at least every 2-3 expect residents to go for being checked for					
	11/25/16 and readmit diagnoses which incl	s admitted to the facility on ted on 08/31/20 with uded Alzheimer ' s disease, itis, and anxiety disorder					
	(MDS) assessment d required extensive to staff with most activit MDS further revealed	ecent Minimum Data Set ated 09/10/21 revealed she total assistance of 1 to 2 ies of daily living (ADL). The d she required extensive with toileting and wore briefs.					
	there was a plan of c	an dated 10/12/21 revealed are for being incontinent of ue to diagnosis of dementia T and pressure ulcer					

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	OF DEFICIENCIES			CONSTRUCTION		10. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		345133	B. WING		1	0/15/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			10	000 COLLEGE STREET		
RIDGE VA	LLEY CENTER FOR NU	IRSING AND REHABILITATION	w	/ILKESBORO, NC 28697		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO DATE
F 677	Continued From pag	le 27	F 677			
		oal was for the resident to				
	remain free from ski					
	incontinence and bri	ef use through the review				
		ne interventions included				
		ered, use of disposable				
	briefs according to m					
		eck during care rounds when				
	- ·	n peri-area when soiled and				
		with each incontinence adequate fluid intake with				
		with med pass, observe for				
		of UTI including pain,				
		d urine, cloudiness, no				
		f urine color, increased pulse,				
		ire, urinary frequency, foul				
	-	, chills, altered mental status,				
	change in behavior a	and change in eating habits,				
		ny possible causes of				
		er infection, constipation, loss				
		kening of control muscles,				
		apacity, diabetes, stroke and				
	medication side effe	cts.				
	Interview on 10/11/2	1 at 4:00 PM with family				
	members visiting Re	sident #2 revealed they were				
		resident's care. One of the				
	-	ner revealed they were				
		ident #1 as their family				
		because she looked out for				
		her family member described				
		in which Resident #2 had sat over 4 hours because the NA				
		not come in and changed her				
		roommate, Resident #1. The				
		d Resident #1 had realized				
	-	that Resident #2 had a bowel				
		n she rang the call light they				
		nanged Resident #2 for over				
	I had not bonno and bi	langeu Resident #2 101 0vei				

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	S FOR MEDICARE &			PLE CONSTRUCTION		IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDIN	G		0
		345133	B. WING			С
		545155				0/15/2021
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	-	ATEMENT OF DEFICIENCIES	ID PREFIX		AN OF CORRECTION 'E ACTION SHOULD BE	(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCE	D TO THE APPROPRIATE	DATE
				DEFI	CIENCY)	
F 677	Continued From page		F 6	77		
	was no excuse for all	owing an elderly person who				
		rself to sit in poop for that				
	long at a time. She ir	ndicated it was not good for				
	her skin to go that lor	ng without being changed.				
	The family member ir	ndicated they had				
	complained to the Dir	rector of Nursing about the				
	care and were told "v	ve are short staffed and				
	doing the best we car	n." The family member				
	further indicated "that	t is not what you want to				
	-	oncerned about the care your				
	loved one was receiv	ing in the nursing home."				
	Intonviow on 10/11/21	at 4:30 PM with Resident				
		ate of Resident #2 revealed				
		1, at 4:00 PM she rang her				
	-	#2. Resident #1 stated				
		owel movement and she				
		rang her light for a NA to				
		Resident #2. Resident #1				
		answered the call light and				
	stated she had just cl	-				
		d she told NA #7 she had				
		ent and she could smell it				
	and NA #7 said agair	n she had just changed the				
	resident. Resident #	1 further indicated it was				
		7 came in and changed				
		nt #1 explained that she and				
		at their dinner while smelling				
		. Resident #1 further				
		formed Resident #2's family				
		d complained about it and				
		emember by whom) that "it				
		I." Resident #1 advised that				
	-	times because she had				
		vhen she called out for				
		ent #2 and looked at her				
		ey came in and changed her.				
	resident #1 stated st	he wears her watch every	1	1		

Facility ID: 923520

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	S FOR MEDICARE &			ONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		· · ·	E SURVEY IPLETED	
						С	
		345133	B. WING		10	/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	·	STR	10/10/2021			
		RSING AND REHABILITATION	1000 COLLEGE STREET				
RIDGE VA	LLET CENTER FOR NOT	KSING AND REHABILITATION	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 677	Continued From page	e 29	F 677				
	revealed she was wo assigned to Resident stated there were goo staffing just like any o said it was difficult to every resident on day She stated lately ther they worked without a for the workload. NA impossible to get inco 2 hours and they wer on every resident. Na change Resident #2 o bell for her it was pro cleaning another resi came out and she ha residents that need to trays are collected yo round. NA #7 further	Continued From page 29 Interview on 10/12/21 at 3:15 PM with NA #7 revealed she was working on 10/09/21 and was assigned to Resident #1 and Resident #2. NA #7 stated there were good days and bad days with staffing just like any other place you work and said it was difficult to get everything done for every resident on days they were short staffed. She stated lately there were more days than not they worked without an adequate number of staff for the workload. NA #7 further stated it was mpossible to get incontinence rounds done every 2 hours and they were lucky to get 2 rounds done on every resident. NA #7 indicated if she didn't change Resident #2 when Resident #1 rang the bell for her it was probably because she was cleaning another resident and then supper trays came out and she had to pass trays and feed residents that need to be fed and then after all trays are collected you can then start your second round. NA #7 further indicated they don ' t burposely leave someone wet or messed up but					
	Director of Nursing (E staffing challenges at there was only 1 full t shift and 1 full time er shift and the rest of th needed) or were age stated they recently h salary to be more cor had quite a few open	ed residents to be checked					

Facility ID: 923520

If continuation sheet Page 30 of 67

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 08/15/2023 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING	ING		C 10/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		SING AND REHABILITATION		1000 COLLEGE STREET			
	LLET CENTER FOR NUP	SING AND REPABILITATION		WILKESBORO, NC 2869	97		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	: 30	F 67	7			
	over 4 hours without t incontinence.						
	11/25/16 and readmitt diagnoses which inclu	admitted to the facility on ed on 08/31/20 with ided Alzheimer ' s disease, is, and anxiety disorder					
	(MDS) assessment da required extensive to staff with most activiti	cent Minimum Data Set ated 09/10/21 revealed she total assistance of 1 to 2 es of daily living (ADL). The she required extensive with personal hygiene.					
	PM with family memb revealed they were no care. One of the famil cleaning brown debris fingernails. The famil often came in and her dirty, so they cleaned waiting for the staff to member stated the ca expected and felt Res ignored because she herself. The family m were blessed to have member's roommate Resident #2 and kept care when she was in members indicated th Director of Nursing at "we are short staffed a	y member revealed they hands and fingernails were them for her instead of do it. The other family					
		at 11:10 AM with NA #10 / cared for Resident #2 and					

Facility ID: 923520

If continuation sheet Page 31 of 67

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	
		345133	B. WING				C 15/2021
NAME OF P	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 677	had taken care of her She stated Resident a staff for all activities of personal hygiene. N/ resident fingernails w she had not noticed F dirty because she had in a rush to complete she performed nail car resident was diabetic nurse know the reside trimmed. Interview on 10/11/21 revealed staff usually trimmed nails on show staff would perform nar requested by the resid further stated the NAs residents unless they were the nurses woul nails. Nurse #6 indica Resident #2's nails be med pass. Interview on 10/12/21 Director of Nursing (E staffing challenges at she expected fingernar filed any time they we resident or family requ 3. Resident #3 was an 02/20/20 with diagnos vascular accident and The quarterly Minimu	at 12:50 PM with Nurse #6 performed nail care and wer days. She stated the ail care at other times if dent or family. Nurse #6 performed nail care on were diabetic and if they d clean, trim, and file their at 4:45 PM with the interim DON) revealed there were the facility. The DON stated ails to be cleaned, cut, and ere long, dirty, or anytime the uested they be done. dimitted to the facility on ses that included cerebral d dementia. m Data Set (MDS) //03/21 revealed Resident	F	677			

Facility ID: 923520

If continuation sheet Page 32 of 67

		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	SURVEY LETED
		345133	B. WING				C 15/2021
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 SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 677	required extensive as bathing. The MDS als was incontinent and h of care. Resident #3's revised revealed the Residen performance deficit re dementia. The goals f remain at her current not decline in her acti through the next revie utilizing interventions assistance of one sta a sponge bath when a be provided. A review of the Show Resident #3 was sche Sunday and Thursday A review of Resident October 1, 2021 throu revealed the Residen during that time perio A review of Resident October 1, 2021 throu revealed no documer showers. An observation of Res 10:45 AM revealed the lying on her already n day clothes. The Res	 asistance of one staff for so indicated the Resident had no behaviors of rejection a care plan dated 08/16/21 thad a self-care elated to hemiplegia and that Resident #3 would level of function and would vities of daily living (ADL) aw would be attained by such as providing extensive ff for her ADL and providing a full bath or shower cannot er Schedule revealed eduled for showers on y. #3's Bathing record from ugh October 11, 2021 thad not received a shower d. #3's Progress Notes from ugh October 11, 2021 thad not refusal of sident #3 on 10/11/21 at he Resident was awake and hade bed fully dressed in her ident was neatly groomed incontinence. Resident #3 	F	677	7		

Facility ID: 923520

If continuation sheet Page 33 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345133 B. WING 10/15/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/15/2021 NAME OF PROVIDER FOR NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697 WILKESBORO, NC 28697 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 08/15/2023 DRM APPROVED NO. 0938-0391
345133 B WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MODE VALLEY CENTER FOR NURSING AND REHABILITATION Image: SumMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (CMPLET) TAG Continued From page 33 (EAch OERCIENCY) ID PREFIX TAG (EAch CORRECTIVE ACTION SHOULD BE (CMPLET) F 677 Continued From page 33 On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prome to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member who visited the Resident there was a family member who visited the Resident nearly every day and knew that she had not been given the 2 Image: State Sta	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /			(X3) D	ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION HEAPPROPRIATE DEFICIENCY) (X5) F 677 Continued From page 33 On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2 ID			345133	B. WING				-
RIDGE VALLEY CENTER FOR NURSING AND REHABILITATION WILKESBORO, NC 28697 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 677 Continued From page 33 On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2 F 677	NAME OF P	ROVIDER OR SUPPLIER	•		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
WILKESBORO, NC 28697 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X) COMPLET DATE F 677 Continued From page 33 On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2 F 677	RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000	COLLEGE STREET		
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLET TAGF 677Continued From page 33 On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2F 677					WIL	KESBORO, NC 28697		
On 10/11/21 at 1:10 PM an interview was conducted with family member who explained that Resident #3 was scheduled for showers on Sunday and Thursday and had not received a shower for at least 2 weeks. The family member stated the Resident was incontinent and was prone to yeast infection (rash) and needed to be showered when scheduled to help prevent the yeast infection from occurring. The family member added that there was a family member who visited the Resident nearly every day and knew that she had not been given the 2	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
During an interview on 10/11/21 at 4:05 PM with Nurse Aide (NA) #4 she confirmed she cared for Resident #3 on 10/03/21 evening shift. The NA explained that she was normally scheduled to give showers but was pulled to the hall to work that day due to call outs. The NA stated Resident #3 did not receive a shower that shift. The NA continued to explain that she was scheduled to care for Resident #3 on 10/07/21 evening shift as well but did not give the Resident her scheduled shower that shift. An interview was conducted with Nurse Aide (NA) #2 on 10/11/21 at 5:00 PM who confirmed she was scheduled for showers on 10/07/21 evening shift. The NA explained that she approached Resident #3 for her shower and the Resident refused (the refusal was not documented on the Bathing record). The NA stated she reported the refusal to the Nurse but could not remember who the Nurse was. An interview was conducted with the Director of Nursing (DON) on 10/12/21 at 4:30 PM. The DON	F 677	On 10/11/21 at 1:10 F conducted with family that Resident #3 was Sunday and Thursday shower for at least 2 stated the Resident w prone to yeast infection showered when sche yeast infection from of member added that the who visited the Reside knew that she had no scheduled showers a During an interview of Nurse Aide (NA) #4 s Resident #3 on 10/03 explained that she was give showers but was that day due to call of #3 did not receive a s continued to explain the care for Resident #3 well but did not give the shower that shift. An interview was con #2 on 10/11/21 at 5:0 was scheduled for sh shift. The NA explainer Resident #3 for her s refused (the refusal w Bathing record). The refusal to the Nurse the the Nurse was. An interview was con	PM an interview was y member who explained scheduled for showers on y and had not received a weeks. The family member vas incontinent and was on (rash) and needed to be duled to help prevent the occurring. The family here was a family member lent nearly every day and ot been given the 2 week. In 10/11/21 at 4:05 PM with the confirmed she cared for 8/21 evening shift. The NA as normally scheduled to s pulled to the hall to work uts. The NA stated Resident shower that shift. The NA that she was scheduled to on 10/07/21 evening shift as the Resident her scheduled iducted with Nurse Aide (NA) 10 PM who confirmed she rowers on 10/07/21 evening ed that she approached hower and the Resident vas not documented on the NA stated she reported the out could not remember who	F	677			

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		ND HUMAN SERVICES MEDICAID SERVICES					NTED: 08/15/2023 FORM APPROVED B NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUC) DATE SURVEY COMPLETED
		345133	B. WING				C 10/15/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDF	RESS, CITY, STATE, ZIP CC	DDE	10/10/2021
		RSING AND REHABILITATION		1000 COLLEG	GE STREET		
	LLET CENTER FOR NUI	RSING AND REHABILITATION		WILKESBO	RO, 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 C (EACH CORRECTIVE ACTION ROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	showers during the m DON acknowledged to reported that she knee a shower on 10/07/27 #10 because she obs Resident into the sho The DON added, reg given then the staff sl instead. The DON als showers to be given a showers to be given a showers were not do done. An interview was con #10 who confirmed sl evening shift but did scheduled shower. T not a person schedul shift. During an interview w 10/12/21 5:00 PM shi Resident #3 on 10/10	e 34 received her scheduled nonth of October 2021. The the Bathing record and we that Resident #3 received 1 given by Nurse Aide (NA) served the NA taking the over room and fixing her hair. ardless, if the showers were hould have given a bed bath so added she expected the as scheduled and if the cumented then they were not aducted with Nurse Aide (NA) he worked on 10/07/21 not give Resident #3 her he NA explained there was ed to give showers on that with Nurse Aide (NA) #7 on e confirmed she worked with 0/21 evening shift. The NA rson scheduled for showers	F 6	77			
		to work therefore, Resident					
	#6 on 10/13/21 at 1:4 she worked with Res morning shift and exp scheduled to give sho	ducted with Nurse Aide (NA) 0 PM. The NA confirmed ident #3 on 10/10/21 plained there was no staff owers that shift therefore, the her scheduled shower.					
	10/13/21 at 3:35 PM			Eacility ID: 0235			a shaat Daga 25 of 67

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/15/2023 MAPPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING		_		C 15/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, 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 CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	and did not give the F continued to explain the have a person schedule and the shower person to the hall to work. An interview was come #8 on 10/13/21 at 5:3 cared for Resident #3 The NA explained that person scheduled to g shift and she did not g scheduled shower. 4. Resident #18 was a 9/13/19 with diagnosis cerebrovascular accide diabetes, non-Alzhein and anxiety. Review of the quarter Data Set (MDS) dated Resident #18 was cog decision making and assistance of one stat daily living. Review of care plan do Resident #18 required activities of daily living mobility and cognitive for resident #18 wolf with current interventi extensive assist of on resident #18 with person	led for a shower that day Resident a shower. The NA hat they normally did not uled for showers on the ey were usually short staffed, on was almost always pulled ducted with Nurse Aide (NA) 0 PM who confirmed she on 10/07/21 morning shift. t there was not a staff give showers on the morning give Resident #3 her admitted to the facility on s that included dent (CVA), hypertension, ner dementia, hypertension, ly comprehensive Minimum d 09/21/21 revealed that gnitively impaired for daily required extensive ff member with activities of lated 10/12/21 revealed d physical assistance with g (ADLS) due to decreased impairment. The goal was d be clean, dry and odor free ons. Interventions included e person to physically assist	F 677				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 08/15/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING					C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUP	SING AND REHABILITATION			000 COLLEGE STREET VILKESBORO, NC 2869	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	All 10 of her fingernai quarter inch long and brown substance und An observation of Res 10/11/21 at 2:43 PM. bed. All 10 of his finge quarter inch long and brown substance und An interview was com 10/12/21 at 11:10 AM confirmed that she ro #18 and had taken ca 10/12/21. She stated #18 with getting dress She stated that Resid staff for all aspects of including nail care. Na checked nails wheney #10 stated that she po trimming unless they trimmed the nails. NA rushed during mornin the resident's finger n An interview was com 10/11/2021 at 12:50 F NA's usually performe nails on shower days. would perform nail care or resident was a diabet perform nail care and	. Resident #18 was r wheelchair in the hallway. Is were approximately a were noted to have dried er them. sident #18 was made on Resident #18 was resting in ernails were approximately a were noted to have dried er them. ducted with NA #10 on during first shift. NA #10 utinely cared for Resident re of her on 10/11/21 and that she assisted resident sed the morning of 10/11/21. ent #18 was dependent on activities of daily living A #10 stated she usually ver she provided care. NA erformed nail care and were diabetic then the nurse further stated that she was g care and had not noticed ails. ducted with Nurse #6 on PM. Nurse #6 stated that the ed nail care and trimmed She also stated the staff re if requested by a ther stated that the NAs n residents unless the ic, then the nurses would	F	677				

Facility ID: 923520

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			0.00		OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DOILDING		с
		345133	B. WING		10/15/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •
		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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 677	Continued From page	37	F 67		
1 0/1	-	4:05 PM. She stated that it is	F 07		
		ne NA to trim and clean			
	residents' nails, unles				
	diabetic then it was th	ne hall nurse's responsibility			
	to trim the nails.				
	An interview was con	ducted with the Director of			
		/12/21 at 4:14 PM. The DON			
		ted fingernails to be cleaned			
		e they were long or dirty.			
F 684	Quality of Care		F 68	4	11/15/21
SS=D	CFR(s): 483.25				
	§ 483.25 Quality of c	are			
		ndamental principle that			
	-	nt and care provided to			
	facility residents. Bas	ed on the comprehensive			
		dent, the facility must ensure			
		treatment and care in			
	!	essional standards of			
	care plan, and the res	nensive person-centered			
	, , , , , , , , , , , , , , , , , , ,	is not met as evidenced			
	by:				
	Based on observatio	n, record review, and staff		F684-Quality of Care	
		failed to prevent skin		1. On October 11th, the nurse aide	
		ontinence care was delayed		provided incontinence care and the	
	resulting in an open a	area of redness to the sident reviewed for neglect		for Resident #23, notified the attend	
	(Resident #23).	Sucht leviewed 101 Heyleot		physician of skin concern, obtained	"'Y
				treatment orders for reddened area	to
	Findings included:			buttocks and updated skin care plan	
	Resident #23 was ad	mitted to the facility on		accordingly. Resident #23 discharge home on 10/29/21 with no skin conc	
		ses that included hemiplegia		2. On October 18th, licensed nurses	
	-	ccident affecting her left		completed skin assessments and	
	non-dominate side, c	ontractures, moisture related		incontinence care observations of	
	dermatitis urinary ind	continence, and anxiety.		cognitively intact and cognitively imp	aired

Event ID: JJ3711

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 08/15/20 ORM APPROVE 3 NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		DATE SURVEY
		345133	B. WING				C 10/15/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUI	RSING AND REHABILITATION			00 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 684	Continued From page	e 38	F 68	84			
	indicated she had no identified skin breakd Resident #23 had a s related to total incont with a goal to remain interventions to inclue by staff for personal h two personal physica A quarterly Minimum 07/07/21 revealed Re extensive assistance personal hygiene nee A Brief Interview of M 10/05/21 indicated Re intact. A skin assessment da Resident #23's skin w A review of nurse pro 10/12/21 did not inclu breakdown nor an up completed. An observation and ir at 12:45 PM revealed back in bed yelling fo incontinence care. Re observed to be open was pulling at the blu wore that was partiall and she said, "please	self-care deficit care plan inence revised on 07/01/21 clean, dry and odor free and de the need for assistance nygiene and grooming and I assistance for bed mobility. Data Set (MDS) dated esident #23 required for her bed mobility and eds. lental Status (BIMS) dated esident #23 was cognitively ated 10/08/21 indicated was intact. gress notes for 10/8/21 to ide mention of any new skin dated skin assessment was hterview made on 10/11/21 I Resident #23 laying on her			residents to ensure appropriate care provided to prevent avoidable skin concerns and resident neglect. Res questionnaire audits were complete the Social Services Director for cog intact residents to further ensure all residents receive care in accordance professional standards of practice. 3. Education completed 10/18/21 11/12/21. The Director of Nursing provided education to nurse aides, licensed nurses and direct care age staff on providing timely incontinent and prevention of skin breakdown in accordance with professional stand practice. Newly hired licensed nurse nurse aides and direct care agency will receive education upon hire. Direct care nursing staff will monitor provide incontinence care needs by performing routine room rounds and needed or requested. Newly identifi skin concerns will be communicated the licensed nurse for assessment to reported to the physician for treatme orders as indicated. 4. The Director of Nursing and/or nu designee will complete an audit of resident incontinence care and skin condition to ensure residents receive in accordance with professional stat practice. Monitoring will be complete five (5) random residents at a freque of five (5) times weekly for four (4) w then weekly for eight (8) weeks and necessary thereafter. The Administi will report findings of the monitoring Interdisciplinary Team (IDT) during	ident d by nitively e with ency e care ards of es, staff d as ed d to hen ent urse e care nds of ed for ency weeks, as rator to the	

Facility ID: 923520

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		MEDICAID SERVICES			OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 10/15/2021
NAME OF P	ROVIDER OR SUPPLIER	I	s	STREET ADDRESS, CITY, STATE, ZIP CODE	
RIDGE VA	LLEY CENTER FOR NUI	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE
F 684	Continued From page	e 39	F 684		
	at 1:00 PM revealed I lay in her bed yelling incontinence care wh Resident #23 stated ' please get this off me butt. I wish I could jus didn't need anyone to During an observation provided by NA #12 a 3:47 PM, a quarter si left lower buttocks ne was seen when her h removed. The area w inch from the center of began to wipe Reside #23 continued to com throughout the procee #12 ran her fingers and did not blanch in colo An interview with NA at 3:53 PM stated the observed was new to cared for Resident #2 would let the nurse ki An interview with Wo 10:15 AM revealed si wounds in the facility; been working as a flo being able to assess Wound Nurse indicate aware Resident #23	ile staff walked by the room. 'it is hurting worse; someone a before I have a hole in my st take care of myself, so I o wipe my butt and sit wet." In of incontinence care and NA #19 on 10/11/21 at zed red circular area to the ar Resident #23's peri-area leavily soiled brief was ras open approximately 1 of her rectum. As NA #12 ent #23's bottom, Resident aplain of burning and stinging dure. After identification, NA cross the area and the area r. #12 and NA #19 on 10/11/21 ey felt the open area their knowledge as they had 23 before and stated they now. und Nurse on 10/12/21 at ne was responsible for ; however, she had recently for nurse more often than resident wounds. The ed she had not been made was observed to have a visible during incontinence		and will make changes to the plan necessary to ensure resident care maintained in accordance with professional standards of practice Compliance date of 11/15/2021	is

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM AP OMB NO. 09	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURV COMPLETE	
		345133	B. WING		C 10/15/2	021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		RSING AND REHABILITATION	1	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5) MPLETIO DATE
F 684	Continued From page	e 40	F 684			
	Nurse on 10/12/21 at Wound Nurse's obset buttocks. The Wound reddened open area During the observation she was uncertain wh and stated it was a new would obtain a new of physician. An interview with NA did not recall noticing Resident #23's buttoo changed her early that Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu provided to residents consistent with profess the comprehensive pr and the residents' goa	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,	F 697		11/*	15/21
	physician interviews, administer pain media physician to a hospica pain for 1 of 1 resider management (Resider Resident #15 reporter	cations as prescribed by the e resident to treat chronic nt reviewed for pain ent #15). As a result, d her pain level was 7 to 9 across all three shifts during		 F697-Pain Management 1. Resident #15 discharged from the facility on 08/30/21. 2. The Director of Nursing and MDS Coordinator interviewed all residents the ensure pain levels were managed and pain management was provided to residents who require such services, consistent with professional standards practice, the comprehensive 	t	
		•		consistent with professional standards	s of	

Event ID: JJ3711

Facility ID: 923520

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 08/15/2023 RM APPROVED O. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345133	B. WING _			10	C 0/15/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		RSING AND REHABILITATION		10	00 COLLEGE STREET		
RIDGE VA	LLET CENTER FOR NO	KSING 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 PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Continued From page	e 41	F6	697			
	Resident #15's hospii included the following 08/27/21: •Morphine Sulfate Im milligram (mg) tabs g hours for 15 days for MSIR is controlled su category used to treat Resident #15 was ad 08/27/21 under hospi hospitalization for nat and chronic obstructif (COPD) and she had accident (MVA) that r knee amputation. Review of Resident # Medication Administra- revealed an order dat inaccurately by the D include: •Morphine Sulfate Im milligram (mg) tabs g hours as needed for p A review of the Augus Resident #15 was ad occasions. •Resident #15 receive after her admission to •Resident #15 was ad the following time: 8:2	tal discharge summary g order with a fill date of mediate Release (MSIR) 15 tive 3 to equal 45mg every 4 pain. Ibstance in the opiate at moderate to severe pain. Imitted to the facility on tice services following a rcotic medication withdrawal ve pulmonary disease a history of a motor vehicle resulted in a left above the 415's August 2021 ation Record (MAR) ted 08/27/21 transcribed irrector of Nursing (DON). to mediate Release (MSIR) 15 tive 3 to equal 45mg every 4 pain for 15 days st 2021 MAR also revealed iministered MSIR on 7 ed no MSIR on 08/27/21			residents' goal and preferences. 3. Education completed 10/18/21 – 11/12/21. The Director of Nursing provided education to all licensed nur- staff were educated on documentation resident's pain levels, every shift pain observation and notification of MD wh pain is not managed. All nurse aides medication aides were educated on notifying licensed nursing staff when residents report pain or display pain indicators. 4. The Director of Nursing and/or nurse designee will complete a pain management audit tool to ensure pain management is provided. Monitoring be completed for five (5) random residents at a frequency of five (5) tim weekly for four (4) weeks, then weekle eight (8) weeks and as necessary thereafter. The Administrator will repor- findings of the monitoring to the Interdisciplinary Team (IDT) during Q. meetings monthly for three (3) month and will make changes to the plan as necessary to maintain ADL care for dependent residents. Compliance date of 11/15/2021	n of ien and se will nes y for vrt API	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		345133	B. WING				C 15/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUF	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	an 8. Based on the or Resident #15 missed ·Resident #15 missed at the following times: was documented to b unidentified pain level at 11:48 PM with pain Resident #15 missed ·Resident #15 missed ·Resident #15 was ac the following times: 4: documented to be a 7 levels documented at The discharge Minimu 08/30/21 assessed Re cognition and noted s antianxiety medication MDS assessment per indicated under a sec Resident #15 verbaliz on the pain scale ove A review of the nursin 08/27/21 through 08/3 documentation related management to inclue notification of the prov A facility social worke revealed a telephone SW and Resident #15 Resident #15's desire believing she will rece hospice services at he	th pain levels documented at riginal order prescribed 4 doses. Aministered MSIR on 08/29 : 4:58 AM when her pain be a 7, 10:57 AM with an I (NA was listed), and again I level documented to be a 8. 3 doses on 08/29/21. Aministered MSIR on 8/30 at :23 AM when pain was 7 and 8:58 AM with pain : a 3. UM Data Set (MDS) dated esident #15 with intact the received opiates and ns on 3 of 7 days during the riod. The MDS further tion titled pain assessment tring a pain level of a 9 of 10 r the last 5 days. Mg progress notes dated 30/21 revealed no d to Resident #15's pain de location of pain or vider. r (SW) note dated 08/30/21 conversation between the 5's family member about e for discharge due to eive better care under	F	697			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 08/15/2023 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	COMF	E SURVEY PLETED
		345133	B. WING				C / 15/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	IREET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Continued From page	e 43	F	697			
	by Hospice Nurse #1 expressed being very the facility due to not as prescribed and ha she requested them b administered. An interview with Med at 3:20 PM revealed a Resident #15 and had administering her me the evening shift. MA medicating Resident substances to include Resident #15 had app occasion although sh time inquiring why he being administered ro ask and wait to receiv wanted them. MA #1 Resident #15 the med needed and she woul receive them. MA #1 frequently complained pain although she wa pain level and she ma she was unable to red An interview with Nur 10/13/21 at 3:25 PM worked with Resident being in the room who family member who re complaining of being medications as presc overheard Resident #	d Aide (MA) #1 on 10/13/21 she was familiar with d been responsible for dications on 10/29/21 during #1 stated she recalled #15 with controlled e an opiate. MA #1 explained proached her on one e was unable to recall the r medications were not outinely and why she had to ve them every time she elaborated that she told dications were ordered as ld have to ask for them to indicated Resident #15 d of experiencing debilitating is unable to give an exact ade a nurse aware although call which nurse she notified.					

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 08/15/2023 FORM APPROVED B NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345133	B. WING				C 10/15/2021
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NU	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 PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 697	Continued From page	e 44 d going home where she	F	697			
	could get better care. Resident #15's nurse had overheard; howe	NA #13 indicated she told that day about what she ver, she was unable to recall igned to Resident #15 on					
	revealed she worked the facility and recalle complaining of pain ir generalized pain. At t her pain was excrucia Nurse #4 aware, but #15 received pain me	#3 on 10/13/21 at 3:29 PM with Resident #15 while in ed her constantly in her back and overall times, Resident #15 stated ating and NA #3 would make she was unsure if Resident edications to treat her pain or lminister the medications					
	revealed she was the and had been respon Resident #15 on the 08/30/21. MA #2 state administering controll however, Resident #7 pain in her back and Nurse #4 aware. MA names of the medicar day; however, she did	date of her discharge of					
		se #4 (an agency nurse) times without success.					
	(HSW) on 10/14/21 a had visited Resident :	Hospice Social Worker t 11:00 AM revealed she #15 in the facility and was t #15's concerns regarding					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/1 FORM APPR OMB NO. 0938	OVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	(
		345133	B. WING		C 10/15/202	1
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
				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	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION (X VE ACTION SHOULD BE COMPL ED TO THE APPROPRIATE DA FICIENCY)	ETION
F 697	made the medicating (although she could r believed it was the da Resident #15's concer receiving medications prolonged delays res and severe anxiety a negative effects on R not recall the staff me An interview with Hos at 11:13 AM revealed Resident #15 and ha for the last year prior Hospice Nurse #1 individent for indicated Resident # 75mcg/hr. patches, M and Lorazepam 1mg Nurse #1 stated she hospital with Resider discharged to the face facility shortly after he	nt. The HSW stated she had staff on the cart on that day not recall the exact date, she ay after admission) aware of erns with pain and her not s as requested without ulted in unmanaged pain nd had previously had tesident #15 but she could	F 69	97		
	notified the nurse on Resident #15 receivin ordered and not miss her history of side eff are not taken as press what the nurses' nam date. Hospice Nurse Resident #15 at the f was planned to disch services. Resident #' did not believe her m administered as order	the cart of the importance of ing her medications as sing or delaying doses due to ects when the medications cribed but did not recall he she spoke with on that #1 also revealed she visited acility on 08/30/21 when she arge home under hospice 15 expressed to her that she				
	-	ons were administered urse #1 recalled Resident		Facility ID: 923520	If continuation sheet Page	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/15/2023 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345133	B. WING			10	C / 15/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		RSING AND REHABILITATION		10	00 COLLEGE STREET		
	LLET CENTER FOR NOT	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	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	saturations, anxiety, a discharge and felt he withdrawal symptoms An interview with Nur PM revealed she was the facility however s Resident #15. Nurse day during Resident # by a staff member (al recall the date or the approached her) abo medications. Nurse # busy attempting to pr number of admission planned to phone the #15's pain managem completing the other remember and theref Resident #15's medic mentioned new admis to be verified and clair meeting the following however, she did not process of verifying F orders and felt she m that date due to it bei An interview with the on 10/12/21 at 10:45 unaware Resident #1 managed while in the did not receive her pa prescribed on the dis acknowledged she w transcribed the medic	heart rate, decrease oxygen and pain on the date of r to be experiencing some s from her medications. rese #5 on 10/14/21 at 3:12 s no longer employed with he was familiar with #5 stated she recalled one #15's stay being approached though she was unable to staff member who ut Resident #15's 5 indicated she was very ocess an overwhelming s on that day, she had physician about Resident ent concerns, but after tasks that day, she did not fore she did not look into cation concerns. Nurse #5 ssion orders were supposed rified during a clinical morning after admission; recall being involved in the Resident #15's admission ay have been off duty on ng a weekend. Director of Nursing (DON) AM revealed she was 5's pain had not been e facility or that Resident #15 ain medications as charge summary. The DON	F	697			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		O. 0938-03 E SURVEY
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED C
		345133	B. WING		10	0/15/2021
AME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
NDGE 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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 697	Continued From page	e 47	F 697			
		ns. The DON explained that				
	• • • •	ocedure included herself				
		rative nurse (typically Nurse other administrative nurses				
	, 0	ew admission orders were				
		y on the morning following				
	•	she is unsure how these f these orders were reviewed				
	the following day.	I these orders were reviewed				
	An interview with the					
		revealed he was not aware nad not been managed				
		use it was limited in days and				
		nile in the facility. The MD				
	administered as orde	tions should have been red on the hospital				
		The MD elaborated that a				
		ate dependance who was				
		6 times a day routine and an the prescribed doses				
	may result in adverse	-				
	Sufficient Nursing Sta		F 725			11/15/21
SS=G	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				
		sident, as determined by s and individual plans of care				
	and considering the r					
	diagnoses of the facil	ity's resident population in				
	accordance with the f at §483.70(e).	facility assessment required				

Facility ID: 923520

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		ND HUMAN SERVICES MEDICAID SERVICES					M APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345133	B. WING			10)/15/2021
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	LI FY CENTER FOR NU	RSING AND REHABILITATION		10	000 COLLEGE STREET		
				N	VILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From page	e 48	F	725			
		cility must provide services	•	0			
		s of each of the following					
		n a 24-hour basis to provide					
		sidents in accordance with					
	resident care plans:						
		ed under paragraph (e) of					
	this section, licensed	sonnel, including but not					
	limited to nurse aides						
	§483.35(a)(2) Except						
		section, the facility must nurse to serve as a charge					
	nurse on each tour o	•					
		Γ is not met as evidenced					
	by:						
		ons, record reviews, resident,			F725 Sufficient Nursing Staff-		
		views, the facility failed to			1 Desidents #1 #2 #0 #17 and #1	0 oro	
		sing staff for the provision of a resident (Resident #23)			1. Residents #1, #2, #9, #17, and #10 continuing to receive care and treatm		
		ling that it was burning and			according to their plan of care. Resid		
		as a result ended up with a			#6 and #23 are no longer current		
		r skin, failed to provide			residents of the facility.		
		a resident (Resident #17)			2. On 10/17/2021, facility implemente		
	-	her brief and onto her draw			updated wage scale to recruit and re		
	resident (Resident #2	de incontinence care to a) who had a bowel			additional nursing staff. The Director Nursing and Administrator implement		
	movement, failed to p				additional measures to ensure state		
		ents (Resident #1, Resident			regulatory compliance of sufficient st	affing	
	,	and failed to provide nail			by contacting local staffing agencies		
		Resident #18 and Resident			offering bonuses for shifts, and		
	,	ts reviewed for sufficient			incentivizing attendance. Upon hire,	oto	
	nursing staff.				appropriate competencies and skill s are initiated to provide nursing and re		
	The findings included	1:			services to assure resident safety an		
					attain highest practicable physical, m		
	This tag is cross refe	rred to:			and psychosocial well-being of each resident.	•	
	E600: Basad on abs	ervation, record review and			3. The interdisciplinary team discuss	-d	

Facility ID: 923520

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
		345133	B. WING		C 10/15/2021	
NAME OF P	ROVIDER OR SUPPLIER			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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 725	 incontinence care to a with urine and resulted area on her buttocks residents reviewed for The resident stated the like it was on fire and herself, so she did not F684: Based on obsets staff interviews, the fabreakdown when incomesulting in an open a buttocks for 1 of 1 res (Resident #23). F 561: Based on obsets failed to honor the reserregarding number of a week for 3 of 3 resident #6, and Resident #9) F677: Based on obsets failed to provide incomesident (Resident #1) onto her draw sheet, incontinence care to a had a bowel movemes as scheduled for 1 refailed to provide nailed to provide na	acility neglected to provide a resident who was soiled ed in a small reddish open for 1 of 4 (Resident #23) or activities of daily living. That her bottom was burning wished she could care for thave to sit in a soiled brief. ervation, record review, and acility failed to prevent skin portinence care was delayed area of redness to the sident reviewed for neglect ervations, record reviews, staff interviews, the facility sidents' preferences showers or bed baths per ents (Resident #1, Resident reviewed for choices. ervations, record reviews, staff interviews, the facility numeric care prior to a 7) wetting through her brief failed to provide a resident (Resident #2) who ent, failed to provide showers sident (Resident #3), and care for 2 residents esident #2) for 4 of 4 or activities of daily living for	F 72	recruiting and retention efforts in 11/8/21 that are in place and re- changes for future recruiting an efforts. The Administrator, DON scheduling coordinator meet fiv weekly to discuss current staffir and changes that could be put i ensure that quality care is provi on the acuity of resident popula 4. The Director of Nursing, Adm and scheduling coordinator will nursing department schedules f times a week for 4 weeks then v 3 months to ensure adequate si all shifts. Staffing agencies will as needed ongoing until in-hous can sufficiently cover all nursing Staffing coordinator will notify D Nursing of open positions that ti unable to fill for further direction the positions. Staff call outs will reviewed for trends during IDT in Compliance date of 11/15/2021	viewed for d retention d, and e times ng ratios n place to ded based tion. ninistrator, review four (4) weekly for taffing for be utilized se staffing g positions. virector of hey are i n filling be	

Facility ID: 923520

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JUTIPLE CONSTRUCTION
G 10/15/2021 G STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697 D PROVIDER'S PLAN OF CORRECTION CEFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET DEFICIENCY) DEFICIENCY
STREET ADDRESS, CITY, STATE, ZIP CODE 1000 COLLEGE STREET WILKESBORO, NC 28697 D PROVIDER'S PLAN OF CORRECTION CEFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
1000 COLLEGE STREET WILKESBORO, NC 28697 D PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE
WILKESBORO, NC 28697 D PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE
D PROVIDER'S PLAN OF CORRECTION (X5) FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET AG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET AG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 725

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IATEMENT			0/0)			<u>D. 0938-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY PLETED	
						С	
		345133	B. WING		10/15/2021		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		1000 COLLEGE STREET			
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 725	Continued From pag	e 51	F 72	5			
	get showers done as	scheduled and were lucky if					
	•	one shower per shift. Nurse					
		nurses did not have time ssist the NAs with resident					
	care.						
		1 at 4:45 PM with the DON) revealed there were					
		t the facility. The DON further					
		d 2 full time nurses working					
		other nurses were either as					
	. , -	ncy nurses. She stated Ily increased the base salary					
		o be more competitive with					
		veral positions open on all					
		ed she was not sure how					
		still open, that would be a ional Director of Operations.					
	Interview on 10/12/2	1 at 5:30 PM with the					
	-	Operations (RDO)revealed					
		ed Practical Nurse (LPN) gistered Nurse (RN) open					
		positions, and 3 Certified					
	Medication Aide (CM	A) open positions. She					
		the past 5 weeks they had					
		s and 1 RN. The RDO stated vages to allow for better					
		pen positions and were					
		y were hired. She further					
	•	and were not planning to stop					
F 760	taking admissions to Residents are Free c	the facility. of Significant Med Errors	F 76	0		11/15/21	
1 / 00	CFR(s): 483.45(f)(2)	-		Ŭ		11,10/21	
SS=G							
SS=G	The facility must ens	ure that its-					

Facility ID: 923520

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 08/15/20 1 APPROVE). 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		345133	B. WING			C 15/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
				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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETIO DATE
F 760	Continued From page	a 52	F 7			
1 700				50		
	by:	Γ is not met as evidenced				
	-	iew, staff, hospice, and		F760-Residents are Fr	ee of Significant	
	physician interviews,	the facility failed to prevent		Med Errors	Ū	
	significant medicatior	n errors by not accurately		1. Resident #15 discha	rged from the	
		inistering medication as		facility on 8/30/21.		
		pital discharge summary		2. The Director of Nurs	÷ .	
		ronic pain, shortness of		audit on November 10t		
	-	or a hospice resident for 1 of		admitted to the facility f		
	1 resident reviewed f			10/16/21-10/31/21 for a		
	(Resident #15). As a			transcription and admir		
		el was 7 to 9 on a scale of 1		medications as ordered	-	
	resident in the facility	shifts during her 4 days as		discharge summary. No was identified.		
				3. Education completed	10/18/21 -	
	Findings included:			11/12/21. The Director		
	i mango moladoa.			provided education to c	•	
	A review of the hospi	tal records dated		licensed nurses and ag	-	
		dicated in part Resident #15		proper transcription and		
		cotic pain medications		medication orders upor		
		symptoms. Resident #15's		Education includes the		
	-	evealed she had been		procedure for verifying,	-	
		ility with the following orders		administering medication	-	
	with fill dates of 08/27	7/21:		Medication Manageme		
				residents are free from	-	
	- Morphine Sulfate In			medication errors. New	•	
	, _, _	ive 3 to equal 45mg every 4		nurses and agency stat	tt will receive	
	hours for 15 days for	pain or shortness of breath.		education upon hire.		
	Lorozonen Amerikal	a avenu 4 hours for order		4. The Director of Nurs		
	- Lorazepam Tmg tat	os every 4 hours for anxiety.		designee will complete		
	A conv of the original	hard script for controlled		new admission orders a Medication Manageme	•	
		hard script for controlled by the hospital written by the		Monitoring will be comp		
		n's assistant indicated:		random newly admitted		
		is assistant indicated.		frequency of five (5) tim		
	- Morphine Sulfate Im	mediate Release 15		(4) weeks, then weekly	-	
		ive 3 to equal 45mg every 4		and as necessary there		
	, _, _	rt 08/27/21. Dispense 270		Administrator will repor		
	tablets.			monitoring to the Interd	•	

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/15/2023 MAPPROVED D. 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345133	B. WING _				C 10/15/2021	
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
RIDGE VA		RSING AND REHABILITATION		10	000 COLLEGE STREET			
				W	/ILKESBORO, NC 28697			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 760	Continued From page	e 53	F7	760				
	start 08/27/21. Disper Resident #15 was add 08/27/21 under hospi hospitalization for nar and chronic obstructiv (COPD) and she had accident (MVA) that re- knee amputation and dependance. She wa home on continued he A review of the contro- by pharmacy with the indicated in part contro by pharmacy with the indicated in part contro tablets by mouth ever was filled for 252 tabl remaining to be disper pharmacy and indicat administered. - Lorazepam 1mg table every 4 hours for 15 of tablets with 7 doses a	mitted to the facility on ce services following a rootic medication withdrawal ve pulmonary disease a history of a motor vehicle esulted in a left above the long-term opiate s subsequently discharged ospice services on 08/30/21. I substance sheets provided narcotic medications rolled substances were ing tablets (MSIR) three ry 4 hours for 15 days and ets with a quantity of 18 ensed later by Polaris ted 9 doses had been			(IDT) during QAPI meetings monthly three (3) months and will make chang to the plan as necessary to maintain <i>i</i> care for dependent residents. Compliance date of 11/15/2021	jes		
	orders were transcrib - Morphine Sulfate Im	imediate Release (MSIR) 15 ive 3 to equal 45mg every 4						
	- Lorazepam 1mg tab	s every 4 hours as needed						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		345133	B. WING				C 15/2021
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGE VA	LLEY CENTER FOR NUF	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 PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	for anxiety. A review of the MAR of revealed Resident #1 on 7 occasions: - Resident #15 receiv while in the facility. Resident #15 was add at the following time: documented to be a # with pain levels docur the original order press 4 doses which is over for 08/28/21. Resident #15 was add 08/29/21 at the follow her pain was docume with an unidentified pa again at 11:48 PM with be a #8. Resident #15 08/29/21. Resident #15 was add at the following times: documented to be a # levels documented at Resident #15 missed of doses of pain medi secondary to the facil determine the exact to facility.	dated August 2021 also 5 was administered: MSIR ed no MSIR on 08/27/21 ministered MSIR on 8/28/21 8:40 AM when her pain was 49 and again at 10:15 PM mented at an #8. Based on scribed Resident #15 missed thalf of her doses ordered ministered MSIR on ing times: 4:58 AM when nted to be a #7, 10:57 AM ain level- NA was listed, and th pain level documented to 5 missed 3 doses on ministered MSIR on 8/30/21 : 4:23 AM when pain was 47 and 8:58 AM with pain a #3. I an undetermined number cation on 08/30/21 ity being unable to ime of discharge from the	F	760			
	It further revealed Lor on 6 occasions:	azepam was administered					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345133	B. WING				C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RIDGE VA	LLEY CENTER FOR NUE	RSING AND REHABILITATION		1000 COLLEGE STREET			
				V	WILKESBORO, NC 28697		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE	
F 700							
F 760			F	760			
	Resident #15 was not administered any Lorazepam on 08/27/21 following her admission time of 5:20 PM.						
	Once on 8/28 at 3:52	PM. Based on the original					
		esident #15 missed 5 doses					
		at 4:57 AM, 10:57 AM, and loses of Lorazepam on					
	Twice on 8/30 at 4:23	AM and 8:56 AM.					
	08/30/21 assessed R cognition and noted s antianxiety medication MDS assessment per indicated Resident #1	um Data Set (MDS) dated esident #15 with intact the received opiates and ns on 3 of 7 days during the riod. The MDS further 15 had experienced pain on of 10 on the pain scale over					
	by Hospice Nurse #1 expressed being very the facility due to not prescribed and having	note dated 08/30/21 written indicated Resident #15 had displeased with her stay at receiving medications as g to wait 1-2 hours after she re they were administered.					
	with Resident #15 and administering her mer the evening shift. MA medicating Resident substances to include medication. MA #1 ex	revealed she was familiar d had been responsible for dications on 08/29/21 during #1 stated she recalled					

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		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED	
						с	
		345133	B. WING		1	0/15/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 760	Continued From page	e 56	F 76	50			
	was unable to recall t medications were no	the time inquiring why her t being administered					
	routinely and why she	e had to ask and wait to me she wanted them. MA #1					
	elaborated that she to						
		dered as needed and she r them to receive them.					
		d Aide #2 on 10/13/21 at 4:11 s the familiar with Resident					
		sponsible for medicating					
		date of her discharge of					
	08/30/21. MA #2 stat						
		led substances for pain and SIR and Lorazepam. MA #2					
	-	of thought to ensure the					
		c medical record matched					
		e log and card in which the					
		g dispensed, she only e dosage was equal to the					
	ordered dosage.	e uosage was equal to the					
		spice Nurse #1 on 10/14/21					
		l she was familiar with d overseen her hospice care					
		to admission to the facility.					
	Hospice Nurse #1 inc	dicated her records indicated					
		utinely ordered Fentanyl					
	. .	ISIR 45mg every 4 hours, every 4 hours. Hospice					
		had been present at the					
		nt #15 on the day she was					
		ility and saw her in the					
		er time of admission to the					
	-	Hospice Nurse #1 also her on the date Resident #15					
		e under hospice services on					
	-	Resident #15 expressing to					
		pelieve her medications had					

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/15/2023 RM APPROVED NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		345133	B. WING			C 0/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP			
RIDGE VA	LLEY CENTER FOR NUF	SING AND REHABILITATION					
				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	(X5) COMPLETION DATE	
F 760	did not have access to verify if the medication correctly. Hospice Nu #15 having increase h saturations, anxiety, a discharge and felt her withdrawal from her m An interview with Nur PM revealed she vag being in the facility alt any controlled substa medication should be ordered medication an is stored match both i and frequency before medication and she for when administering th #15. An interview with the (DON) on 10/12/21 at was the nurse who tra-	ordered, Hospice Nurse #1 o the physician's orders to ns were administered rse #1 recalled Resident heart rate, decrease oxygen and pain on the date of to be experiencing some hedications. se #3 on 10/14/21 at 2:18 uely recalled Resident #15 though verified that when nce is ordered the checked to verify the nd the card the medication n name, strength, route,	F 760				
	#15 on the date of ad medications should ha based on the dosage the MSIR and Loraze instead of scheduled	mission and felt the ave been as needed (PRN) and therefore transcribed pam as PRN medications medications. The DON					
	were not verified the f she could not provide happen.	verified in a clinical					

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/15/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 10/15/2021
NAME OF P	ROVIDER OR SUPPLIER	L	STR	EET ADDRESS, CITY, STATE, ZIP CO	
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION		O COLLEGE STREET KESBORO, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 760 F 880 SS=E	10/12/21 at 3:39 PM i Resident #15's medic incorrectly as her stay did not see her while indicated if Resident ; on long term use of o medication there was to experience withdra medications were not MD stated he expecte transcribed, verified, a possible following add classified these errors Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	revealed he was not aware eations were transcribed y was limited in days and he in the facility. The MD #15 was a patient who was piates and antianxiety a possibility for her to begin wal symptoms if her given as prescribed. The ed all orders to be and clarified as quickly as mission to the facility and s to be significant. & Control (2)(4)(e)(f) htrol blish and maintain an and control program a safe, sanitary and hent and to help prevent the hismission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following	F 760		11/15/21

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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	SURVEY LETED		
		345133	B. WING				C 15/2021		
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 880	Continued From page	5 9	F	880					
	procedures for the probut are not limited to: (i) A system of surveil possible communicabi infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how isco- resident; including bu (A) The type and dura- depending upon the in involved, and (B) A requirement that least restrictive possilic circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in din §483.80(a)(4) A system identified under the fat corrective actions take §483.80(e) Linens. Personnel must hand	lance designed to identify ole diseases or can spread to other in possible incidents of se or infections should be asmission-based precautions tent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ole for the resident under the s under which the facility ees with a communicable kin lesions from direct is or their food, if direct ine disease; and procedures to be followed rect resident contact.							

Facility ID: 923520

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/15/202 RM APPROVE NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345133	B. WING		1	C 0/15/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
				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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 880	§483.80(f) Annual re The facility will condu IPCP and update the	view. ıct an annual review of its ir program, as necessary.	F 88	30		
	by: Based on record rev interviews and the hig COVID-19 in the cou implement their infect Centers for Disease ((CDC) guidelines for Protective Equipmen members (Nurse #1 wear eye protection of resident (Resident #2 droplet contact preca members (Medication Medication Aide #2, I #7) failed to wear eye care to 7 of 7 residen #20, Resident #7, Re Resident #6 and Res halls. These practice reviewed for infection occurred during a CO	t (PPE) when 2 of 3 staff and Nurse Aide #1) failed to while providing care to 1 of 1 24) who was on enhanced nutions and when 5 of 8 staff in Aide #3, Nurse Aide #11, Nurse Aide #18 and Nurse e protection while providing its (Resident #19, Resident esident #22, Resident #21, ident #3) in the general es affected 8 of 8 residents in control. These failures DVID-19 pandemic.		 F880 Infection Prevention at 1. Residents #3, #7, #19, # and #24 are receiving care a that are adequate and appro- related to infection control pr during COVID-19 pandemic. is no longer a resident at the 2. On November 8th, the D Nursing and nurse designee infection control facility round standard and transmission-b precautions were being follow facility staff. Daily rounds are completed to ensure complia designee, Director of Nursing heads, and/or Administrator. 3. Education completed 10 11/12/21. The Director of Nur provided education to all faci ensure infection prevention a program practices were in completed to complete to an an	#20, #21, #22, ind services priate as actices Residents #6 facility. Director of performed ds to ensure ased wed by all being ance by nurse g, department D/18/21 – rsing lity staff to and control pmpliance	
	Prevention (CDC) CC 10/11/21 indicated th facility was located h transmission for COV The CDC guidance e	ers for Disease Control and DVID-19 Data Tracker on at the county where the ad a high level of community		with updated CDC and state 4. The Director of Nursing designee will complete an au the facility is maintaining an i prevention and control progra to provide a safe, sanitary ar comfortable environment and prevent the development and transmission of communicab and infections during a COV	and/or nurse udit to ensure infection am designed nd d to help d le diseases	
		I During the Coronavirus		pandemic. Monitoring will be		
		D-19) Pandemic," updated		for five (5) random staff at a		
	on 9/10/21 indicated	the following information		five (5) times weekly for four	(4) Weeks,	

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		MEDICAID SERVICES	(V2) MILLI 715	PLE CONSTRUCTION		O. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	· · ·	COMPLETED		
			-			С
		345133	B. WING		10)/15/2021
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
- 000						
F 880	Personal Protective E (Healthcare Personne *If SARS-CoV-2 infec patient presenting for and exposure history located in counties w transmission should a Protective Equipment including: Eye protect shield that covers the should be worn durin encounters. A review of the facility Coronavirus Preventi on 9/15/21 indicated: f. Implement standard precautions. Wear g shields, and a NIOSE	aplement Universal Use of Equipment for HCP el): totion is not suspected in a care (based on symptom), HCP working in facilities ith substantial or high also use PPE (Personal t) as described below totion (i.e., goggles or a face e front and sides of the face) g all patient care y policy entitled, "Novel on and Response," revised d, contact, and droplet loves, gowns, goggles/face 1-approved N95 or evel respirator upon entering	F 88	 then weekly for eight (8) weeks necessary thereafter. The Admi will report findings of the monito Interdisciplinary Team (IDT) dur meetings monthly for three (3) n and will make changes to the pl necessary to maintain complian residents right to self-determina bathing. Compliance date of 11/15/2021 	nistrator ring to the ng QAPI nonths an as ce with	
	10/11/21 from 10:05 / quarantine hallway for unvaccinated resident for rehab services. 1. a. At 10:12 AM Nu into Resident #24's ro medications. Resident admitted to the facility readmitted on 10/06/2 respirator, isolation g	its and residents admitted rse #1 was observed going bom with her morning nt #24 was unvaccinated and y on 10/04/19 and 21. Nurse #1 donned an N95 own, clean gloves and lent #24's room who was on ntact isolation with no				

Facility ID: 923520

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE COMF	SURVEY PLETED	
345133		345133	B. WING			C 10/15/202		
NAME OF PROVIDER OR SUPPLIER			•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 880	revealed she was an facility. Nurse #1 state eye protection into Re was on enhanced dro She stated she knew goggles on because i them on due to them Nurse #1 further state glasses to be able to difficult. b. At 10:25 AM NA #1 Resident #24's room #24 was unvaccinated on 10/04/19 and read donned an N95 mask prior to entering the re on top of her head bu face prior to going inte #1 doffed her gown at mask prior to coming and her goggles were Interview on 10/11/21 revealed she knew she eye protection while p on enhanced droplet stated she was in a h help the resident and goggles down on her resident's room. NA #	at 10:14 AM with Nurse #1 agency nurse working at the ed she should have worn esident #24's room since she oplet contact precautions. better but forgot to put her t was difficult to see with fogging up over her glasses. ed she had to wear her see and the goggles made it I was observed going into to provide care. Resident d and admitted to the facility mitted on 10/06/21. NA #1 , isolation gown and gloves bom. NA #1 had her goggles t never placed them on her o Resident #24's room e still on the top of her head. at 10:35 AM with NA #1 ne was supposed to wear providing care to residents contact precautions. NA #1 urry to get in the room to simply forgot to pull her face prior to going into the 1 further stated she knew ve placed the goggles on her	F	880				
	Interview on 10/12/21 Regional Director of 0	at 5:47 PM with the Clinical Services (RDCS)						

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/15/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345133	B. WING		C 10/15/2021
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CO	•
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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE
F 880	using eye protection of a resident or when The RDCS stated this residents in the facilit on enhanced droplet COVID status was un stated she was not su guideline from CDC h staff members in the on the quarantine hal PPE and to wear PPE 2. a. During an obser administration on Res 9:50 AM, Medication wearing a surgical ma eyeglasses which she head while she admin medications. MA #3 gear on. MA #3 used hands prior to leaving On 10/11/21 at 9:55 A observed walking bac the hallway and prepa medications. On 10/ entered Resident #20 medications to her wi and no eye protective An interview with MA revealed she had plat pocket and forgot to p while she was admini Resident #19 and Re she had difficulty see prescription eyeglass remove to put her go	policy for PPE use included when coming within six feet providing care to a resident. s policy applied to all y and especially residents contact precautions whose aknown. The RDCS further are whether this new had been presented to all the facility but expected all staff I to wear the appropriate E as indicated. vation of medication sident #19 on 10/11/21 at Aide (MA) #3 was observed ask and prescription e pulled over the top of her histered Resident #19's did not have eye protective I hand sanitizer to both g Resident #19's room. AM, MA #3 was further ck to the medication cart in aring Resident #20's 11/21 at 10:05 AM, MA #3 O's room and administered hile wearing a surgical mask	F 88		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345133	B. WING				/15/2021
NAME OF P	ROVIDER OR SUPPLIER	l		S	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	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	 eyeglasses but did no shield instead of gogg b. An observation w 10:10 AM of Nurse Ai Resident #7 inside he wearing a surgical ma gear on while talking six-feet distance. An interview with NA revealed she had not protective gear on wh within six feet of any later obtained a face one of the housekeep 	ot think about wearing a face gles as protective eye gear. as made on 10/11/21 at ide (NA) #11 talking to er room. NA #11 was ask with no eye protective to Resident #7 within #11 on 10/11/21 at 3:01 PM been instructed to wear eye henever she was going to be resident. NA #11 stated she shield after she was told by pers that all staff members ar eye protection whenever	F	880			
	made of Medication A preparing medication cart in the hallway. M mask with no eye pro 10/11/21 at 11:05 AM observed entering Re her medications. MA mask with no eye pro An interview with MA revealed she did not she started her shift b her vehicle and forgo MA #2 stated she retr she realized that she protection about halfw	 , MA #2 was further esident #22's room carrying #2 was wearing a surgical tective gear on. #2 on 10/11/21 at 10:55 AM have her face shield when because she had kept it in to bring it into the facility. rieved her face shield when was not wearing eye way through her medication 2 further stated they had 					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345133	B. WING _			C 10/15/2021	
NAME OF PROVIDER OR SUPPLIER			•		REET ADDRESS, CITY, STATE, ZIP CODE	-	
RIDGE VA	LLEY CENTER FOR NUP	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	 whenever there were facility, but she was a changed their guidelin which should be worm they were going to be residents. d. An observation wa 10:55 AM of Nurse Ai Resident #21's room and a bag of dirty line surgical mask with no #18 placed the bag of placed the bag of dirty linen room. NA #18 e and used hand sanitiz Further observation of 11:00 AM revealed her room and answering a continued to have the with no eye protection. An interview with NA PM revealed she coul earlier when her shift to provide care to reside eye protection. e. During an observation and an surgical protection. An interview with NA PM revealed she coul earlier when her shift to provide care to reside eye protection. and used na eye and the surgical protective gear on. An interview with NA #19 with was wearing a surgical protective gear on. 	no COVID-19 cases in the ware that the CDC had here regarding eye protection a all the time especially when a within six feet of the as made on 10/11/21 at de (NA) #18 coming out of while carrying a bag of trash ens. NA #18 was wearing a o eye protective gear on. NA f trash into the trash bin and y linens inside the soiled exited the soiled linen room zer to both hands. f NA #18 on 10/11/21 at er entering Resident #6's his call light. NA #18 e same surgical mask on n. #18 on 10/11/21 at 12:40 Id not find a face shield started, so she proceeded idents in their rooms without ation of incontinence care on /21 at 4:05 PM, Nurse #7 the procedure. Nurse #7 al mask with no eye se #7 on 10/11/21 at 4:10	F 8	880			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 08/15/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345133	B. WING _					C 15/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	TE, ZIP CODE	10/	10/2021
RIDGE VA	LLEY CENTER FOR NU	RSING AND REHABILITATION			00 COLLEGE STREET			
	· · · · · · · · · · · · · · · · · ·			W	ILKESBORO, NC 2869	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	not have to wear a fa	e 66 had been told that she did ce shield or goggles when s who were not on enhanced	F 8	380				
	An interview with the Services (RDCS) on revealed the facility's using eye protection of a resident or when The RDCS stated this residents in the facilit the resident was on p RDCS further stated	policy for PPE use included when coming within six feet providing care to a resident. s policy applied to all y and did not matter whether precautions or not. The she was not sure whether m CDC had been presented						

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