PRINTED: 02/07/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
				_		(c
		345223	B. WING _			01/	17/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY H	IILL HEALTH & REHAB (CENTER			510 HEBRON ROAD ENDERSONVILLE, NC 28739		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
F 689 SS=J	conducted from 01/10 survey team entered conduct a complaint i exited on 01/12/24. The facility on 01/17/2 action plan. Therefore to 01/17/24. Event ID intake was investigated allegations resulted in NC00211745 resulted Past-noncompliance of CFR 483.25 at tag F6 CFR 483.25 at tag F6 CFR 483.25 at tag F7 The tags F689 and F7 Quality of Care. Non-noncompliance of facility came back in control of the facility came back in control of the facility must ensure \$483.25(d) (1) (1) (1) (2) (2) (3) (4) (2) (4) (2) (4) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	d in immediate jeopardy. was identified at: 889 at a scope and severity J 700 at a scope and severity J 700 constituted Substandard Degan on 11/19/23. The compliance effective rvey was conducted. ards/Supervision/Devices (2)	Fé	889	Past noncompliance: no plan of correction required.		
	This REQUIREMENT by:	is not met as evidenced					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed 01/29/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345223	B. WING		0,	C / /17/2024		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL 1510 HEBRON ROAD HENDERSONVILLE, NC 28739		111/2024		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 689	interviews with the E Technician, the Medi facility failed to safeg cognitive impairment when bilateral quarte conjunction with an a mattress. Resident # life on 11/19/23 after bed with bed rails in was observed with hi and his head laying f his chin and neck pre This occurred for 1 o accidents (Resident a Findings included: The hospital history a revealed Resident # generalized weaknes history and physical i completed by the Phy Occupational Therap provided a list of prol including decreased strength and range o risk. Resident #1 was adn 09/07/23 with diagno thrive and dementia.	ons, record review and mergency Medical cal Doctor, and staff the quard a resident with severe from an avoidable hazard or bed rails were utilized in alternating air pressure 1 was found with no signs of experiencing a fall from a the up position. The resident is buttocks on the ground face up on the mattress with essed against the bed rail. If 3 residents reviewed for #1). and physical dated 09/03/23 and severe dementia. The included assessment notes sysical Therapist (PT) and position, decreased af motion, and being a fall mitted to the facility on sees including adult failure to	F 6		<u>, </u>			
	09/07/23 signed by N medical needs consideralls was positioning	ail assessment dated lurse #1 indicated the dered for the use of the side and indicated Resident #1 ie use of side rails to aid in DT were listed on the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		345223	B. WING		_	C 01/17/2024	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, S 1510 HEBRON ROAD HENDERSONVILLE, NO	·	0111112024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		
F 689	failed to meet the ne the potential risks from checked including if the body would be caught of rails, or between the mattress. The type of not included as part of the fall risk evaluation. Resident #1 was a handle Resident #1 was a handle Resident #2 with periods of agitation incontinent of bowel mechanical lift for transistance with bed of the fall care plan initial Resident #1 was at rimmobility. Intervention	Iternatives attempted but eds of Resident #1. None of m the use of side rails were the resident or part of his not between rails, the opening he bed rails and the f bed rails being used was not the assessment. In dated 09/07/23 indicated high risk for falls. Is was oriented only to self ion and aggression. He was and bladder and required a insfers and 2-person mobility and toileting. It was one of the was and bladder and required a insfers and 2-person mobility and toileting.	F	689			
	implement preventat devices; maintain ca educate resident to coccupational, and sp treat as necessary promaintain resident's nother was no care pused bed rails for poor The admission Minin 09/12/23 assessed Fibeing severely impair assistance was need use. Assist with transextensive 2-person as	eech therapy to screen and er physician order; and eeded items within reach. lan to indicate Resident #1					

STATEMENT OF DEFICIENCIES (X*) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345223	B. WING			C 01/17/2024		
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739			11/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 689	Resident #1 was alwa	e 3 d occurred since admission. ays incontinent of bladder esment indicated bed rails as a physical restraint.	F	689				
	MDS dated 09/12/23 would be long term caws a fall risk due to limited mobility. Staff incontinence due to needed for reposition to being at risk for pre Resident #1 had dem	scribed as grabbing at bars						
	09/27/23 revealed a s	ocumented by the nurse on skin assessment identified w pressure ulcer wound on						
	completed by Nurse # were made to the ass Resident #1 would be rails to aid in position attempted that failed the potential risks froi checked including: Th body would be caugh of rails, or between th	were PT and OT. None of m the use of side rails were he resident or part of his t between rails, the opening he bed rails and the mattress s. The type of bed rails						
		y order revealed on 10/04/23 re mattress was placed on 1.						

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345223	B. WING_		C 01/17/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	01/11/2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 689	Continued From pag	ge 4	F 68	39			
		ail assessment completed for 0/04/23 through 11/19/23.					
	11/14/23 for the chie possible coffee grou	scharged to the hospital on of complaint emesis and and colored emesis. Resident back to the facility on					
	on 11/19/23 at 7:55 by Nurse Aide (NA) from the bed. Resid pulse present and E (EMS) was called. T	ess note written by Nurse #2 AM revealed she was alerted #1 Resident #1 partially fell ent #1 was assessed with no imergency Medical Services the on-call Nurse Practitioner for and Administration were					
	11/19/23 at 5:30 AM the bed. The lead E (EMT) documented was dispatched for scene was met by a room. While walking scene advised the pfound him lying half was stuck in the rail Resident #1 lying or (flat on one's back) apneic (without breawas pale and cool to the EMT was advised last seen at 3:15 AM initial position descriassessment of a call	incident report revealed on I Resident #1 had fallen from mergency Medical Technician narrative read in part, "EMS a fall and when arrived on the nd followed facility staff to the nd followed facility staff to the nd to the room staff on the natient was gone and they had way off the bed and his head ing." The EMT found in the floor in a supine position and described the resident as of the skin of touch. The note indicated and by staff Resident #1 was I and found at 5:30 AM in the libed. At 6:32 AM the EMS rediac monitoring device (without a heartbeat) heart					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345223	B. WING			1	C 17/2024	
NAME OF DE	ROVIDER OR SUPPLIER	0.10220		9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	17/2024	
NAME OF T	TOVIDEN ON OUT FIELD							
VALLEY H	ILL HEALTH & REHAB (CENTER			510 HEBRON ROAD HENDERSONVILLE, NC 28739			
(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 X (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 689	Continued From page	÷ 5	F	689				
	at 2:13 PM with the learnarative on the EMS Resident #1 was layir on one's back) position room. He stated the of they arrived at the fact unable to identify, was aid Resident #1 was Resuscitate. He though who told him Resident bed rail and confirmed During the assessment notice any bruising or the resident or see an Review of the facility's statement from NA#1 part, "Doing my 5:00 was on the floor in be notify the nurse. The at 3:00 AM. I changed down on his back." A #1's statement dated "At 3:00 AM I went in and Resident #1 was the rail and fighting as coming out of the bed right side to hold onto his brief. When I left to lowest position. At 5:1 #1's room and noticed in rail and his body was floor with his brief half some his blanket. I was was rising up and down and the control of the bed some his blanket. I was was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail and his body was rising up and down and noticed in rail	was conducted on 1/11/24 and EMT who wrote the report. The EMT confirmed ing on the floor in supine (flat on when they entered the stall came in as fall and when stility a staff member, he was liked him to the room and gone and was Do Not goth it was the same person at #1's head was stuck in the dothat was said to him. Int of Resident #1 he did not reimpression of a bed rail on mything that stood out to him. It is investigation revealed a dated 11/19/23 that read in AM rounds I noticed resident attween the bed rail. I went to last time I did a round was at resident and he was laying clarification was made to NA 11/19/23 and read in part, the room to change brief laying on his back holding as usual. His left leg was at I redirected his arms to the at the rail so I could change the room put the bed in the list AM I walked into Resident dothat he was laying with jaw line as on left side of bed on flowy off with the sheets and alked over to see if his chest we and noticed it wasn't. I						
	some his blanket. I was rising up and dow	alked over to see if his chest vn and noticed it wasn't. I to find nurse. She and I						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345223	B. WING _	WING			C 01/17/2024	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 017	1772024	
VALLEY H	IILL HEALTH & REHAB (CENTER		1510 HEBRON ROAD HENDERSONVILLE, NC 28739				
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page Resident #1 was decided with other NAs." included in the invest information related to Resident #1 after being passed and before himpassed and hot recommassed himpassed himpas	e 6 eased. I assist to get into the Other staff statements igation did not provide the position they saw ng made aware he had s body was moved. Iterview on 01/11/24 at 1:29 ed she had completed the for Resident #1. She t was cognitively impaired, as a high fall risk or did not ow they would use a bed rail mend rails and stated like that. Nurse #1 stated entia but most of the time e bed rails. She reported he fter developing a pressure		689				
	leaning and/or pressi between the rails. The bed and the bed was and the bed rail was in around the bed and p #1's chest to check for She left the room and got NA #2. NA #2 did	ng into the rail but not in e air mattress was on the always kept low to ground, n an up position. She went but her hand on Resident or breathing and he wasn't. I did not see the nurse and not enter the room but Resident #1 was dead and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345223	B. WING		C 01/17/2024
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	1 0111112024
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 689	nurse. NA #1 stated #1 around 3:30 AM around 5:15 AM and She was told by Nur #1 until the Adminis #1 stated it did not a in the bed rail or bet She stated Residen and was a 2-person mechanical lift for the Resident #1 would gid not follow cues thimself over onto his During a telephone PM Nurse #2 reveal nurse for Resident # morning of 11/9/23. not very familiar with assigned nurse a fe She described durin Resident #1 he did confused. During he 11/19/23 NA #1 said room and when she the bed to the side to t	ge 7 #2) both went to find the she last changed Resident and her next check was that's when she found him. It is a proper Resident that are to came to the facility. NA appear Resident #1 was stuck ween the rail and mattress. It #1 was combative with care assist and needed a prab onto the bed rails, but he to use the bed rail and pull is side for bed mobility. Interview on 01/10/24 at 5:48 and the facility of 11/18/23 to have was the assigned and the night of 11/18/23 to have #2 revealed she was an Resident #1 and been his witimes prior to the incident. In the morning of the needed to come to the entered, she walked around any window and found Resident por and halfway on the bed then #1 was sitting on his with his arms bedside him inst the side of the bed. His the mattress facing up and the property was the side of the bed rail. She	F 68	,	
	felt warm to touch b Nurse #3 if she wou stated Nurse #3 did told her to call the A	and described Resident #1 ut had no pulse. She asked ld check Resident #1 and not find a pulse. Nurse #3 dministrator then EMS and id. The Administrator told her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345223	B. WING _			01/) 17/2024
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	ZIP CODE	<u> </u>	17/2024
				1510 HEBRON ROAD			
VALLEY H	ILL HEALTH & REHAB (CENTER		HENDERSONVILLE, NC 287	739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	÷ 8	F 6	689			
F 689	not to move Resident spoke to EMS on the only recalled telling the breathing and was or arrived approximately over the situation and continued with her may pass. A telephone interview at 9:25 AM with NA # morning of 11/19/23 I slid out of bed and as stated when she got the top half of Reside and his buttocks was was against the side lowest position to floo walk in the room but sould tell he was decowere open. She state #1's head was at the could not say it was skept him from falling thard for her recall and time trying to picture revealed she had probefore the incident ar 3 persons because he care. When first admit going to the hospital Resident #1 followed bed rail and pull hims	#1. Nurse #2 revealed she phone to give a report and nem Resident #1 was not a the floor. The Administrator 7 minutes later and took I Nurse #2 stated she edication administration was conducted on 01/11/24 2. NA #2 stated on the NA #1 told her Resident #1 ked if she could help. NA #2 to the door, she could see not #1's body was on the bed on the floor with his back of the bed and bed was in or. NA #2 stated she did not saw Resident #1's face and eased because his eyes d the left part of Resident edge of the rail, but she stuck in the rail or the rail to the floor and stated it was d she was having a difficult what she saw. NA #2 vided care for Resident #1 and stated usually it took 2 to be was combative during tted (9/7/23) she stated cues and would grab the elf over during care but after	F	589			
	when the behaviors in more staff due to increstion follow cues.	e hospital (11/16/23) that's ncreased, and he needed eased behaviors and didn't					
	A relebitorie iliterylew	was conducted on 01/11/24				1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345223	B. WING			C 1/17/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1510 HEBRON ROAD HENDERSONVILLE, NC 28739		1/11/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Nurse #2 requested seriod Resident #1 on the masked what she need was obvious Resider had no respirations, a very pale. Nurse #3 serespirations and check Resident #1 had neit call the Administrator she saw when she end the top half of Resider mattress and his lower his legs out and facing stated Resident #1's braced into the bed reall and rail kept Resident #1 the floor. A telephone interview at 1:46 PM with Mediworked on the same on the night of 11/18, 11/19/23. MA #1 state #1 that night until NA MA #1 revealed the swhat happened and seriod Resident #1's head to bed rail and he was the bed. She stated in #1 was trapped in the kept him from falling staff had to anticipate	se #3. Nurse #3 stated she come and help assess forning of 11/19/23 and led to do. Nurse #3 stated it at #1 had expired because he and his skin coloring was stated she listened for sked for a pulse and her and advised Nurse #2 to . Nurse #3 described what hered the room and stated ent #1's body was on the er body was on the floor with g the window. Nurse #3 left shoulder and neck were ail, and it appeared he was rse #3 stated the bed was in the floor and it was g Resident #1 braced and it appeared to her the bed from sliding off the bed onto If was conducted on 01/10/24 cation Aide (MA) #1 who unit Resident #1 was located 23 through the morning of ed she did not see Resident #2 told her he passed away. Itaff on the unit went to see estated what she saw was etween the mattress and half in the bed and half out a pepeared to her Resident e bed rail, and the bed rail to the floor. MA #1 revealed e Resident #1's care needs e call light to request care	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRU IG		(X3) DATE SURVEY COMPLETED		
		345223	B. WING_			1	C / 17/2024	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739			17/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 689	not let go as a behavito reposition for mobile to reposition for mobile of the reposition of the repositi	would grab the bed rail and or, but he did not use them lity during care. In 01/10/24 at 4:06 PM the she did the investigation for rred on morning of 11/19/23 e reported she came to the ified by Nurse #2. The ed the position she saw ed his legs were on the floor is head was resting on the air was on the bed rail, but it in the rail. She stated ge bowel movement and alfway off and it was thought diac issues and having a finite had a vagal (vasovagal a reaction to something od pressure and heart rate diousness) response and erview on 01/11/24 at 1:06 fine Administrator stated ave a significant change in and used the bed rails to ontinent changes and as a old on to the bed rail. She ential risk with entrapment in 23, and reiterated Resident II but she did come to the Her investigation included	F	889				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED		
		345223	B. WING _					C 17/2024	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		1 017	11/2024	
					1510 HEBRON ROAD				
VALLEY H	ILL HEALTH & REHAB	CENTER		ı	HENDERSONVILLE, NC 28739				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BI		(X5) COMPLETION DATE	
F 689	Continued From page	e 11	F 6	689	9				
		#1 required extensive							
		for activities of daily living							
		mpaired and he questioned							
		1 could physically use the							
	•	ident had the cognitive							
		when using the bed rails.							
		de assessment would need							
	-	ded information related to							
		to move in bed and if not, he							
	would raise the ques								
	beneficial if the reside	ent could not turn himself							
	while in bed and was	dependent on staff for							
	assistance with bed r	nobility. The MD stated if							
	Resident #1 could us	e the bed rails and was able							
	to grab hold and follo	w cues with staff assistance							
	to roll over, then bed	rails would be beneficial but							
	based on the therapy	's information he would							
	question if Resident	#1 had the strength to move							
	himself and safely re	position. He stated if a							
	resident refused to pa	articipate in therapy, he							
	would expect a signif	icant decline in their ability to							
		laily living and at that point a							
		an would need to be done							
		le reviewing the need for bed							
		he would expect the bed rail							
		entify how a resident would							
		nefit themselves such as							
	could they grab hold								
		bed rail. The MD stated if a							
		e bed rail but was too weak							
	to physically use it to								
		I, he would question if bed							
		d would expect staff were							
		residents that could or could							
		e MD stated based on							
		e bed rail assessments it							
		re inconsistencies with							
		lity that he could use the bed							
	rail for mobility. For c	ognitively impaired residents							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345223	B. WING _	B. WING		C 01/17/2024	
	ROVIDER OR SUPPLIER	CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 HEBRON ROAD ENDERSONVILLE, NC 28739	1 011	11/2027
(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 689	Continued From page	e 12	F	689			
	the MD stated he woo	uld question if they were ng the bed rail and could free as a situation, they were					
	On 01/12/24 at 9:01 I notified of Immediate	PM the Administrator was Jeopardy.					
	The facility provided the following corrective action plan with the completion date of 11/20/23:						
	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:						
	Resident #1 expired of	on 11/19/23.					
	investigation for the a	y IDT team completed an illeged incident, the regional reviewed the investigation in					
	Address how the faci residents having the the same deficient pr	potential to be affected by					
	team, which included Nursing, Therapy and	nterdisciplinary Team (IDT) : Social Services (SSW), I Maintenance, completed a entified all residents that had esses.					
	reviewed/completed	ails assessments were on all residents. 10 residents d based on new bed rail					
		eviewed care plans related tes made to the care plan as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345223	B. WING_	B. WING		C 01/17/2024	
NAME OF PR	ROVIDER OR SUPPLIER	0.10220		STREET ADDRESS, CITY, STATE, ZIP CODE		/1//2024	
VALLEY H	ILL HEALTH & REHAB C	ENTER		1510 HEBRON ROAD HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	Continued From page	e 13	F 6	89			
		rsing staff and Certified re updated on changes to					
	On 11/19/2023 and w on any future change:	ill be updated immediately s to care plan.					
	mattress to ensure the based on recommend wound healing, comformanagement. Only or mattress that was rec for pain control relater and prevention of wor that resident at end of	ewed all residents with an air at they were appropriate lations from provider for ort, and/or pain ne other resident has an air ommended by the provider d to an unstageable wound resening of that wound for f life. This intervention was ropriate for this resident, this					
	explained the risks an	SW/Designee called and and benefits of the bed rails to and or responsible parties med consent.					
		Designee reviewed and decision trees for the side policy.					
	Rail Safety Inspection per company bed safe Food and Drug Admir Dimensional Limit rec negative findings.	completed the Bed and Bed n on all beds in the facility ety inspection policy and nistration (FDA) Bed commendations No					
		linimum Data Set (MDS) wed all care plans to ensure					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED		
	345223	B. WING		C 01/17/2024		
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	1 01111/2024		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
bed rails, and special planned appropriately On 11/19/2023, facilitinvestigation for the aclinical nursing team full. Address what measus systemic changes madeficient practice will Education 11/19/2023, the LAdministrator (LNHA supervisor on Bed Id Inspection Policy On 11/19/2023, the Ladministrator Policy on 11/19/2023,	ty IDT team completed an alleged incident, the regional reviewed the investigation in ares will be put into place or ade to ensure that the not recur: 3: i.i.censed Nursing Home) educated the maintenance entification and Safety NHA educated the DON on nd Restraint Policy NHA educated all staff on bed identification and safety NHA educated all staff on se, and neglect. NHA/Designee educated all for how to complete a bed arately as well as the restraint ment, this would guide ecision to add bed rails sessment. Licensed nursing bed rail assessment to ability and need for bed rail	F 68	39			
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page bed rails, and special planned appropriately On 11/19/2023, facility investigation for the actinical nursing team full. Address what measus systemic changes madeficient practice will Education 11/19/2023, the Laddinistrator (LNHA supervisor on Bed Id Inspection Policy On 11/19/2023, the Laddinistrator policy	CORRECTION 345223 COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 bed rails, and specialized air mattress was care planned appropriately. On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education 11/19/2023: On 11/19/2023, the Licensed Nursing Home Administrator (LNHA) educated the maintenance supervisor on Bed Identification and Safety Inspection Policy On 11/19/2023, the LNHA educated the DON on the Bed Rail Policy and Restraint Policy On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety	CORRECTION A BUILDIN 345223 B. WING COVIDER OR SUPPLIER ILL HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 bed rails, and specialized air mattress was care planned appropriately. On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education 11/19/2023, the Licensed Nursing Home Administrator (LNHA) educated the maintenance supervisor on Bed Identification and Safety Inspection Policy On 11/19/2023, the LNHA educated the DON on the Bed Rail Policy and Restraint Policy On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy. On 11/19/2023, the LNHA educated all staff on entrapment, restraints, and neglect. On 11/19/2023, the LNHA educated all staff on entrapment, restraints, and neglect. On 11/19/2023, the LNHA/Designee educated all in house nursing staff on how to complete a bed rail assessment accurately as well as the restraint decision tree assessment, this would guide nursing staff in the decision to add bed rails based the bed rail assessment to determine resident's ability and need for bed rail utilization, this assessment will be done on admission and periodically as needed, including	TOURIER OR SUPPLIER 1. SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 Bed rails, and specialized air mattress was care planned appropriately. On 11/19/2023, facility IDT team completed an investigation for the alleged incident, the regional clinical nursing team reviewed the investigation in full. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education 11/19/2023, the Licensed Nursing Home Administrator (LINHa) educated the maintenance supervisor on Bed Identification and Safety Inspection Policy On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and Restraint Policy On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy. On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy. On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy. On 11/19/2023, the LNHA educated all staff on Bed Rail Policy and bed identification and safety inspection policy. On 11/19/2023, the LNHA educated all staff on entrapment, restraints, and neglect. On 11/19/2023, the LNHA is such as the restraint decision tree assessment, this would guide nursing staff in the decision to add bed rails based the bed rail assessment to determine resident's ability and need for bed rail utilization, this assessment will be done on administion and periodically as needed, including		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		
		345223	B. WING			C 01/17/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 1510 HEBRON ROAD HENDERSONVILLE, NC		1 01/11/2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		D.**E	
F 689	Continued From page	e 15	F 6	89			
	orders, as well as en	ation on following physician suring that the resident is rails was completed with all					
	On 11/19/2023, educ on appropriate linen f	ation provided with all staff or air mattresses.					
	by phone and educat 11/19/2023. Ongoing	ducated either in person or ion was completed on geducation will be provided f as well as any agency staff.					
	Nursing team on noti	A educated the IDT and fication of new mattress and nance/designee is aware, ompleted.					
		ity plans to monitor its sure that solutions are					
	Ongoing Quality Assu Improvement:	urance and Performance					
	11/19/2023, DON/Deadmissions for bed raweeks, then monthly	nil assessments weekly x 4					
	frame, mattress chan rails to ensure that th	esignee will audit any bed ges, or any changes to bed e bed safety inspection has kly x 4 weeks, then monthly					
		ts of the audits to be ity Quality Assurance and ement (QAPI) committee for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345223	B. WING _	WING			C 01/17/2024	
	ROVIDER OR SUPPLIER	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	CODE	01/1	77202-4	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 689	and Medical Director to review the event place 11-20-2023. recommendation. Alleged date of commendation. Alleged date of commendation. Alleged date of commendation. The correction action of 11/20/24 and conclain plemented an acconcion of 11/20/23 once so and the corrective as implemented during 11/20/23. Interview staff, revealed the fron the facility's bed policy, entrapment, Licensed nursing staff, revealed the fronth of the mandal how to compone the facility are also able proper fit of the mandal ensure there were and who they inform identified. Observating the facility revealed the bed unless the assessment and sabefore installation of monitoring tools that completed weekly/recorrective action place.	recommendations. Ing held with the DON, LNHA For, RDCS, and the ID team on For and the QAPI plan put in No additional	F6					
F 700 SS=J	Bedrails		F 7	700				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345223	B. WING			01/	7/2024
	ROVIDER OR SUPPLIER	CENTER	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 HEBRON ROAD IENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 700	alternatives prior to in a bed or side rail is use correct installation, us rails, including but no elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the resi representative and obto installation. §483.25(n)(3) Ensure are appropriate for the search and maintaining bed. This REQUIREMENT by: Based on observation interviews with the Entrapment and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe cognitive imparent and the bilateral bed rails for severe	mpt to use appropriate istalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed it limited to the following the resident for risk of rails prior to installation. If the risks and benefits of dent or resident otain informed consent prior that the bed's dimensions are resident's size and weight. If the manufacturers' dispecifications for installing rails. It is not met as evidenced ins, record review and mergency Medical cal Doctor, and staff the rehensively assess the risk are use of quarter length are dependent resident with	F	700	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345223	B. WING		C 04/47/2024	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	01/17/2024	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPROPRIES OF T	JLD BE COMPLETION	
F 700	on the floor and partipressed against the bractice occurred for bed rails (Resident # Findings included: The hospital history arevealed Resident #1 generalized weaknes Physical Therapist (OT) notes decreased cognition, range of motion, as beto minimally assist us reposition but unable needed physical assiup in bed. Resident #1 was adm 09/07/23 with diagnothrive and dementia. The admission bed ra 09/07/23 indicated the for the use of the side Resident #1 would be rails to aid in position on the assessment a but failed to meet the of the potential risks were checked including 2. The resident or pacaught between rails between the bed rails	and observed to be partially ally on the bed with his head bed rail. This deficient 1 of 3 residents reviewed for 1). and physical dated 09/03/23 's diagnoses included is and severe dementia. The PT) and Occupational indicated Resident #1 had decreased strength and leing a fall risk; and was ableing bed rails to roll and to hold a position and istance by 2-person to scoot in the decreased strength and eating a fall risk; and was ableing bed rails to roll and to hold a position and istance by 2-person to scoot in the decreased strength and eating a fall risk; and was ableing bed rails to roll and to hold a position and istance by 2-person to scoot in the decreased strength and eating a fall risk; and was ableing bed rails was position and in the matter to see including adult failure to see including adult failure to eating. PT and OT were listed in the alternatives attempted in the alternatives attempted in the use of side rails ing: It of his body would be the opening of rails, or and the mattress. Such as muscle functioning	F 70			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345223	B. WING_			C 01/17/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1510 HEBRON ROAD HENDERSONVILLE, NC 28739		11/1//2024		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	using the bathroom, hydration, walking, a 11. Induces agitation The assessment (dainformation was press of Resident #1 and ir obtained prior to inst. 09/08/23. The bed rainclude the use of an entrapment or type of assessment was sign. Review of the admissive revealed Resident #2 with periods of agitat incontinent of bowel mechanical lift for train assistance with bed in A fall care plan initiat Resident #1 was at rimmobility. Intervention resident and family primplement preventated devices; maintain caleducate resident to use (ST) to screen and train physician order; and items within reach. Tindicate Resident #1 positioning.	eas of daily living such as continence, eating, and mobility. or anxiety. ted 09/07/23) indicated the ented to the representative aformed consent was calling the bed rail on ill assessment used did not air mattress as a risk for a f bed rails used. The ned by Nurse #1. Sion note dated 09/08/23 I was oriented only to self ion and aggression. He was and bladder and required a ansfers and 2-person mobility and toileting. ed on 09/08/23 revealed isk for falls related to cons included educate reventative fall interventions; ive fall interventions and I bell within reach and use; PT/OT/Speech Therapy eat as necessary per maintain resident's needed here was no care plan to	F 7	<u> </u>				
	evaluation dated on 0 #1 was unable to pro to his cognitive status transfers indicated he	ogress notes for the initial 09/08/23 revealed Resident vide his mobility ability due s. Resident #1's baseline for e was totally dependent, and the use of mechanical lift.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345223	B. WING	B. WING		C 01/17/2024	
	ROVIDER OR SUPPLIER	CENTER		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 HEBRON ROAD ENDERSONVILLE, NC 28739	<u>, </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 700			F	700			
		e PT was unable to assess elchair mobility due to					
	09/12/23 assessed R impaired cognitively a 2-person assistance use and transfers occextensive 2-person a locomotion did not ocperiod and no falls ha Resident #1 was always	um Data Set (MDS) dated esident #1 as being severely and needed extensive with bed mobility and toilet curred 1 to 2 times using esistance. Walking, or cur during the lookback and occurred since admission. The entire transfer is the entire transfer of					
	MDS dated 09/12/23 would be long term cawas a fall risk due to limited mobility. Staff incontinence due to n repositioning to reliev risk for pressure ulce						
	09/21/23 Resident #1 services for refusing abilities on discharge mobility tasks revealed and required 100% of cueing. In summary F from therapy, "due to participation due to ce techniques used to in not working."	ognitive status and dementia crease participation were					
		ocumented by the nurse on skin assessment identified					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345223	B. WING		C 01/17/2024	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	1 01/11/2024	
(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 APPROFICIENCY)	D BE COMPLETION	
F 700	Continued From page Resident #1 had a ne the sacrum.	e 21 w pressure ulcer wound on	F 70	0		
	A second bed rail ass revealed no changes assessment and indic benefit from the use of positioning and altern were PT and OT. Nor the use of side rails wintegrity issues or decliving such as mobility obtained from the rep on 09/28/23. The bed include the use of an entrapment or type of assessment was sign. During a telephone in PM Nurse #1 confirm the admission (09/07, assessment (9/27/23) he was able to use be repositioning and the #1 explained she con assessments and rev or put the resident at resident was cognitive bed, was a high fall ri why or how they wou not recommend. Nurse had dementia and was recalled the Respons during the admission agreed bed rails woull Nurse #1 stated most	cated Resident #1 would of side rails to aid in latives attempted that failed he of the potential risks from were checked including skin cline in other areas of daily with Informed consent was presentative of Resident #1 arail assessment did not air mattress as a risk for fibed rails used. The field by Nurse #1. Interview on 01/11/24 at 1:29 ed she had completed both (23) and second bed rail of the field provided from the field of the field rails for turning and yield did not restrict him. Nurse heleted the bed rail iewed if rails were beneficial risk. She explained if a fiely impaired, climbed out of sk or did not understand led use a bed rail she would see #1 stated Resident #1 as unable to consent and ible Party (RP) was present bed rail assessment and d make Resident #1 safer.				
	Nurse #1 stated most was able to use the b					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345223	B. WING _		01	C /17/2024	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	•	71772024	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	Continued From page	e 22	F 7	00			
		y order dated 10/04/23 ng pressure mattress was Resident #1.					
	revealed the nurse specification delivered and placed mattress on the bed indicated the represe assured the mattress Resident #1 would fit there was no contrain rails, and it could be	ote written on 11/20/23 boke to the company who the alternating pressure air for Resident #1. The note entative from the company is placed on the bed of any standard bed frame and indication for the use of side used with or without rails.					
		e alternating pressure air on the bed from 10/04/23					
	11/14/23. The hospita #1 was unable to pro advanced dementia a	charged to the hospital on al notes indicated Resident vide any history due to and was receiving wound loer on the sacrum. Resident ack to the facility on					
	at 9:25 AM with Nurs when first admitted (\$\footnote{1}\$ the hospital (11/14/23) and would grab the b during care but after hospital that's when t	w was conducted on 01/11/24 e Aide (NA) #2. NA #2 stated 0/7/23) and before going to 3), Resident #1 followed cues led rail and pull himself over coming back from the the behaviors increased, and for assist with activities of d not follow cues.					
	Review of the palliati	ve care Nurse Practitioner					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		345223	B. WING	B. WING		C 01/17/2024		
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, S' 1510 HEBRON ROAD HENDERSONVILLE, NO				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRE CROSS-REFERE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 700	#1 was referred for symedical decision make for a wound on the saremained total care as a mechanical lift for tregetting out of bed. A telephone interview at 1:46 PM with Mediworked on the same located during her she through the morning she did not see Residul her he passed av 11/19/23. MA #1 revewent to see what hap saw was Resident #1 mattress and bed rail and half out the bed.	11/17/23 revealed Resident amptom management and sing related to dementia and acrum. The note indicated he nd was bedbound requiring ransfer but was not currently was conducted on 01/10/24 cation Aide (MA) #1 who unit Resident #1's room was iff on the night of 11/18/23 of 11/19/23. MA #1 stated then the tight until NA #2 way the next morning on aled the staff on the unit pened and stated what she	F	700				
	#1 revealed staff had care needs and he di request care and was She revealed Reside and not let go as a be them to reposition for Review of the facility' statement from NA#1 part, "Doing my 5:00 was on the floor in be notify the nurse. The at 3:00 AM. I changed down on his back." A #1's statement dated "At 3:00 AM I went in	from falling to the floor. MA to anticipate Resident #1's d not use the call light to s a 2-person assist with care. Int #1 would grab the bed rail shavior, but he did not use mobility during care. Is investigation revealed a dated 11/19/23 that read in AM rounds I noticed resident where the bed rail. I went to last time I did a round was d resident and he was laying clarification was made to NA 11/19/23 and read in part, the room to change brief laying on his back holding						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	· ,	TE SURVEY MPLETED
	345223 B. WING			C 01/17/2024		
NAME OF P	ROVIDER OR SUPPLIER	040220		STREET ADDRESS, CITY, STATE, ZIP C	•	1/1//2024
				1510 HEBRON ROAD	001	
VALLEY H	IILL HEALTH & REH	AB CENTER		HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 700	Continued From բ	page 24	F 7	700		
	the rail and fightin coming out of the right side to hold his brief. When I I lowest position. A #1's room and no in rail and his bod floor with his brief some his blanket. was rising up and went out of the rowalked back to row	leg as usual. His left leg was bed. I redirected his arms to the conto the rail so I could change eft the room put the bed in the t 5:15 AM I walked into Resident ticed he was laying with jaw line by was on left side of bed on thalfway off with the sheets and I walked over to see if his chest down and noticed it wasn't. I com to find nurse. She and I com, and she confirmed deceased. I assist to get into the las." Other staff statements westigation did not provide d to the position they saw being made aware he had e his body was moved.				
	PM NA #1 confirm 11/18/23 from 6:4 and was assigned stated when she flaying on his left selft leg bent under sitting on the floor, but his hand his jaw was left leg bent under sitting on the floor, but his hand his jaw was left leg bent under selft leg bent under selft leg bent under selft leg bent under selft leg bent under leg was and heeded a medescribed when selft leg bent l	ned she worked on the night of 5 PM to 11/19/23 at 7:15 AM at to care for Resident #1. NA #1 found Resident #1, he was side towards the window with the r right leg and his buttocks. His lower body was lying on nead was on the bed face up reaning and/or pressing into the even the rails. She stated the air the bed, quarter bilateral rails bed was always kept low to ad Resident #1 was combative as a 2-person assist with care chanical lift for transfer. She he provided care Resident #1 he bed rails and not let go was a did not follow cues to use the himself over onto his side for bed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345223	B. WING			C 01/17/2024		
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER		•	151	REET ADDRESS, CITY, STATE, ZIP CODE 10 HEBRON ROAD ENDERSONVILLE, NC 28739				
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 700	on 11/19/23 at 7:55 A by NA #1 that Reside bed. Resident #1 was and Emergency Medicalled. The on-call Nu Medical Doctor and A During a telephone in PM Nurse #2 confirm nurse for Resident #1 through the morning or revealed she was not #1 and had only beer times. She described with Resident #1 he confused. During her 11/19/23 NA #1 said room and when she ethe bed to the side by #1 halfway on the floor and described Reside buttocks on the floor and his back up again head was laying on this chin and neck we checked for a pulse a felt warm to touch bur Nurse #3 if she would stated Nurse #3 did not told her to call the Ad that was what she did A telephone interview at 11:26 AM with Nurse was and Employed The Nurse was a felt warm to touch bur Nurse #3 did not told her to call the Ad that was what she did	as note written by Nurse #2 M revealed she was alerted int #1 partially fell from the assessed with no pulse local Services (EMS) was urse Practitioner for the administration were notified. Atterview on 01/10/24 at 5:48 led she was the assigned on the night of 11/18/23 of 11/19/23. Nurse #2 livery familiar with Resident in his assigned nurse a few during her conversations did not make sense and was shift on the morning of she needed to come to the lentered, she walked around of window and found Resident or and halfway on the bed lent #1 was sitting on his with his arms bedside him linest the side of the bed. His line mattress facing up and line against the bed rail. She lind described Resident #1 thad no pulse. She asked did check Resident #1 and line that and line that and line that a pulse. Nurse #3 ministrator then EMS and did. I was conducted on 01/11/24 se #3. Nurse #3 described	F	700				
		morning of 11/19/23 when and stated the top half of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345223	B. WING	B. WING			C 01/17/2024	
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER			15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 HEBRON ROAD ENDERSONVILLE, NC 28739	1 011	11/2024		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 700	lower body was on the facing the window. Note that shoulder and necessity and it appeared to he position to the floor a seeing Resident #1 be and it appeared to he #1 from sliding off the bed. The lead Em (EMT) documented in was dispatched for a scene staff reported thalfway off the bed arrailing." The EMT not lying on the floor in a one's back) and descend without breaths), pull pale and cool to touck A telephone interview at 2:13 PM with the lead arrailing on the EMS Resident #1 was laying on one's back) position one's back) position. He stated the country the stated the fact they arrived at the fact Resident #1's head we During the assessmentice any bruising of the resident or see and the fact that the fac	ras on the mattress and his e floor with his legs out and curse #3 stated Resident #1's k were braced into the bed he was caught in the rail. He was in the lowest and it was alarming to her raced against the bed rail or the bed rail kept Resident be bed onto the floor. Accident report revealed on Resident #1 had fallen from hergency Medical Technician harrative read in part, "EMS fall and when arrived on the hey found Resident #1 lying and his head was stuck in the ed they found Resident #1 supine position (flat on ribed the resident as apneic seless, and the skin was	F T	700				
	Maintenance Director	stated he had worked at mately one- and one-half						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			C		
		345223	B. WING				/17/2024	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	17/2024	
	101.52.1 01. 00. 1 2.2.1				1510 HEBRON ROAD			
VALLEY H	ILL HEALTH & REHAE	3 CENTER			HENDERSONVILLE, NC 28739			
0(0) 15	CLIMMADY	STATEMENT OF DEFICIENCIES			<u> </u>		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 700	Continued From pa	ge 27	F	700				
	years and the bed r	ail safety inspection audit						
	dated 11/19/23 was	the first one he had done						
		ent. He stated he was unable						
		on or records of bed rail safety						
		one prior to the new company						
		orted either him or the						
		ant placed bed rails but could						
		ed the rails on Resident #1's r Resident #1's fall he						
		safety inspections and used						
	the bed rail assessr							
	all beds with rails a							
		g when a new mattress/air						
		d. He confirmed maintenance						
	_ ·	completing the bed safety						
	inspections and ins	talling bed rails. He stated he						
	completed a bed ra	il safety inspection on						
		nt #1 with the air mattress in						
		and there were no negative						
	_	ne guidelines of the facility's						
		ed. He stated there were						
		vitched out if it stopped						
	rails.	lent might be put in a bed with						
		on 01/11/24 at 3:22 PM the						
		lled a company used by the						
		ir mattress on the bed and it						
	was placed to assis							
		him having a pressure ulcer stated she did recognize						
		al risk for entrapment related						
	•	23 and reiterated Resident #1						
		the bed rail. She started an						
		entified one other resident						
	-	, but the bed did not have rails						
		led the Interdisciplinary Team						
	· · · · · · · · · · · · · · · · · · ·	staff were educated to report						
		jes to maintenance and if bed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345223	B. WING	B. WING		C 01/17/2024		
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER				STREET ADDRESS, 1510 HEBRON ROA HENDERSONVIL		1 011	11/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 700	She revealed either the Maintenance Assistant checking the bed rails tool but had no record checks were done for 11/19/23. During a telephone in PM the Medical Doctor required extensive as activities of daily living impaired. The MD standard Resident #1's abilities rail and if the resident awareness to be safe the explained a bedsito be done that provide Resident #1's abilities he would raise the quibeneficial. The MD standard revenue the provide the mould raise the quibeneficial.	safety inspection was ontinued her audits to changes and beds with rails. The Maintenance Director or the was responsible for so using the safety inspection as to show bed rail safety. The Resident #1 prior to the terview on 01/16/24 at 1:04 or (MD) stated Resident #1 sistance from staff for grand was cognitively the details and the staff or grand was cognitively the staff or the	F	700				
	capability that he coumobility. For cognitive MD stated he would conference of safely using the beathemselves if there were against the beathemselves against the beathemselves of the beathemselves if there were against the beathemselves are some of the safely provided to the	ely impaired residents the question if they were capable d rail and could free as a situation when they rail. PM the Administrator was jeopardy. the following corrective correction date of 11/20/23:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345223	B. WING _			C 01/17/2024	
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	ODE	0111112024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 700	been affected by the Resident #1 expired On 11/19/2023, facil investigation for the clinical nursing team full. Address how the factoresidents having the the same deficient p On 11/19/2023, the Social Services, Nur Maintenance, complidentified all resident mattresses. On 11/19/2023, bed reviewed/completed	ose residents found to have deficient practice; on 11/19/2023. Ity IDT team completed an alleged incident, the regional reviewed the investigation in lility will identify other potential to be affected by ractice; DT team, which included:	F	700	Y)		
	to bed rails and updaindicated, licensed in were updated on changes to the second state of the second stat	reviewed care plans related ates made to the care plan as ursing staff and CNA staff anges to care plans on the updated immediately on the care plan. DON/Designee reviewed all mattress to ensure that they sed on recommendations and healing, comfort, and/or only one other resident has was recommended by the trol related to an unstageable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
	345223 B. WING			١,	C 01/17/2024		
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739		01/17/2024			
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 700	for that resident at et was determined to be resident, this resident. On 11/19/2023, the Sexplained the risks a appropriate residents and obtained the info. On 11/19/2023, DON updated the restrainter rails as per company. On 11/19/2023, the Sexplained the restrainter rails as per company. On 11/19/2023, the Sexplained the restrainter company bed sa FDA Bed Dimension. No negative findings. On 11/19/2023, the Sexplained air matter appropriately. Address what measures systemic changes material deficient practice will be bed residued to 11/19/2023. The Sexplained the systemic changes material to 11/19/2023, the Sexplained the systemic changes material to 11/19/2023, the Sexplained the Bed Rail Policy at th	on of worsening of that wound and of life. This intervention is appropriate for this at did not have bed rails. SSW/Designee called and and benefits of the bed rails to and or responsible parties formed consent. I/Designee reviewed and a decision trees for the side and policy. Maintenance completed the Bed and Bed and non all beds in the facility fety inspection policy and all Limit recommendations I/DS nurse/designee and the side and bed and	F 70				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345223	B. WING		C 01/17/2024
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739	1 0111112024
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 700	inspection policy. On 11/19/2023, the L entrapment, restraints On 11/19/2023, the L in house nursing staff rail assessment accudecision tree assessments assessments as the based the bed rail assess the staff will complete a based the staff will complete as the staff will be staff will complete as the staff will complete as the staff will complete as the staff will be staff wi	ed identification and safety NHA educated all staff on	F 70	0	
	utilization, this assess admission and period any significant ADL of On 11/19/2024 Educatorders, as well as ensable to utilize the bed licensed nursing staff On 11/19/2023, education appropriate linen for	sment will be done on ically as needed, including nange. ation on following physician suring that the resident is rails was completed with all . ation provided with all staff or air mattresses.			
	by phone and educat 11/19/2023. Ongoing to all newly hired staff On 11/19/2023, LNH/Nursing team on notifiensuring that mainter and assessment is collidate how the facil	ducated either in person or ion was completed on education will be provided f as well as any agency staff. A educated the IDT and fication of new mattress and eance/designee is aware, empleted. Ity plans to monitor its sure that solutions are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345223	B. WING	B. WING		C 01/17/2024	
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739			
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page	÷ 32	F	700			
	Ongoing Quality Assu Improvement:	ırance and Performance					
	11/19/2023, DON/Des admissions for bed ra weeks, then monthly	il assessments weekly x 4					
	frame, mattress chan rails to ensure that the	esignee will audit any bed ges, or any changes to bed e bed safety inspection has kly x 4 weeks, then monthly					
	11/19/2023, the result forwarded to the facili further review and rec	ty QAPI committee for					
	and Medical Director,	held with the DON, LNHA RDCS, and the ID team on and the QAPI plan put in an additional					
	Alleged date of comp	liance: 11/20/23					
	01/17/24 and concluded implemented an access on 11/20/23 once state and the corrective access implemented during at 11/20/23. Interviews staff, revealed the faction the facility's bed repolicy, entrapment, relicensed nursing staff when and how to communications.	ptable corrective action plan if education was completed ition plan was reviewed and a QAPI meeting held on with staff, including agency ility had provided education all policy, safety inspection					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345223	B. WING			C 01/17/2024	
NAME OF PROVIDER OR SUPPLIER VALLEY HILL HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON ROAD HENDERSONVILLE, NC 28739		01/17/2024	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	bed rail utilization and residents no longer no staff were also able to proper fit of the mattre ensure there were no and who they inform i identified. Observation the facility revealed by the bed unless the resussessment and safe before installation of the monitoring tools that is completed weekly/more staff or staf	I who to inform when eeded bed rails. Nursing overbalize checking for ess with the bed rail to gaps or other risks for injury f any concerns were ons conducted of all beds in eed rails were not installed on	F	700			