PRINTED: 01/27/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	e) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C 42/2025	
NAME OF P	ROVIDER OR SUPPLIER	0.102.11		STREET AD	DDRESS, CITY, STATE, ZIP CODE	1 01/	13/2025	
VALLEY N	URSING AND REHABIL	TATION CENTER			GHWAY 16 SOUTH SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FO	00				
	to conduct a complain team was onsite 1/2/2 was obtained offsite of allegation was validate	ered the facility on 1/2/2025 and investigation. The survey 2025. Additional information on 1/3/2025 and the credible ded on 01/13/25. Therefore, nged to 1/13/2025. Event						
	3 of the 12 complaint	225334, and NC00225692. allegations resulted in 00225334 and NC00225692						
	Immediate Jeopardy	was identified at:						
		580 at a scope and severity 1/2024 and was removed						
	_	600 at a scope and severity 1/2024 and was removed						
		584 at a scope and severity 7/2024 and was removed						
		714 at a scope and severity 1/2024 and was removed						
	The tags F600 and F Quality of Care.	684 constituted Substandard						
E 500	A partial extended su	-		00			4/44/05	
F 580	Notify of Changes (In	jury/Decline/Room, etc.)	F 5	80			1/14/25	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI	E		TITLE		(X6) DATE	

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.

Electronically Signed

01/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345247	B. WING		C 01/13/2025
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 01110/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 580	Continued From pag	e 1	F 58	30	
SS=J	CFR(s): 483.10(g)(14	4)(i)-(iv)(15)			
	consult with the resic consistent with his or representative(s) wh (A) An accident involves in injury and I physician interventio (B) A significant charmental, or psychosod deterioration in healt status in either life-the clinical complications (C) A need to alter that a need to discontinuous treatment due to advect commence a new for (D) A decision to trarresident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informat is available and proven physician. (iii) The facility must resident and the resimble when there is-(A) A change in room as specified in §483. (B) A change in resident law or regulation (e)(10) of this section (iv) The facility must	nediately inform the resident; lent's physician; and notify, ther authority, the resident en there isving the resident which has the potential for requiring n; age in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or s); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or asfer or discharge the ility as specified in iffication under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph in record and periodically mailing and email) and			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345247	B. WING		0.	C 1/13/2025	
	ROVIDER OR SUPPLIER URSING AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIEN			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 580	that is a composite of §483.5) must disclosits physical configurations that comprigant, and must specify and	coosite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various ise the composite distinct ify the policies that apply to be en its different locations. T is not met as evidenced View, and Resident, Resident RP), facility staff, Nurse and Medical Director interviews anotify the Medical Director of mented allergy to aspirin with intestinal bleed, recent fall as wimmobility for further dicoagulation. Resident #1's doncerns to the Director of 2/11/2024 regarding Resident anticoagulant after falling at granultiple fractures of her bine. Resident #1 had a to aspirin and the NP ant Director of Nursing to the MD for further y also failed to notify the NP bus doppler study (an liagnose blood clots) on the completed until the 12/28/2024, Resident #1 and besident #1 be transferred to artment (ED). Upon arrival, ignosed with extensive deep	F 58	F580 On 12/11/2024, the facility failed to Medical Director of Resident #1 documented allergy to aspirin bashistory of gastrointestinal bleeding family soconcern and request for orders for anticoagulation. The facility for an and pain was improving and was getting worse 12/18/24 to 12/27/24 and that Reswas not as mobile as she had been previously. On 12/27/2024, the facility failed to Nurse Practitioner that an ordered doppler could not be completed be next week. On 12/28/2024, Resident #1 and family insisted on being transferred Emergency Department for evaluation.	sed on g, and further cility also er that s not from sident #1 en o notify d venous efore the her ed to the ation		
	the Emergency Dep Resident #1 was dia vein thrombosis (DV	artment (ED). Upon arrival,		-	nts		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _				C 13/2025
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	10/2020
				58	81 NC HIGHWAY 16 SOUTH		
VALLEY N	IURSING AND REHABIL	ITATION CENTER		T	AYLORSVILLE, NC 28681		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	∍ 3	F :	580			
	clots), and admitted.	revent or break up blood The deficient practice sidents (Resident #1) in condition.			12/28/2024 A change in Condition was completed by a Nurse and Resident #1 was transferred to Hospital.		
	Immediate jeopardy to the facility failed to not Resident #1 had a do and the Resident's R was not receiving an jeopardy was remove facility implemented a immediate jeopardy remain out of complia severity of "D" (no acminimal harm that is ensure education is consistent of systems put into place the findings included Hospital records from 12/2/2024 revealed Fa fall and was found orthopedics was consistent with the findings included the f	pegan on 12/11/2024 when potify the Medical Director that poumented allergy to Aspirin P was concerned that she anticoagulant. Immediate and on 1/7/2025 when the a credible allegation of emoval. The facility will ance at a lower scope and tual harm with a potential for not immediate jeopardy) to completed and monitoring are effective. 1: 1: 1: 1: 1: 1: 1: 1: 1: 1			Corrective action for residents identifie as having the potential to be affected be the same deficient practice: On 01/06/2025, an audit of all residents with significant changes between 11/27/2024 & 12/27/2024 was conduct by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on additional failures to notify provider delayed studies, treatment or transfer identified. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 01/06/2025, all licensed nurses, medication aides, and certified nursing assistants were educated by the Direct of Nursing (DON) and the Assistant	y s ed vith of	
	was in the ED. Ortho of Resident #1's fract intervention and recopain control and mon Resident #1 received injections while in the discharge to the facili #1 was discharged to and was not prescrib discharge. Resident #1 was adn 12/2/2024 with diagn	pedics stated they felt none ures required surgical mmended admission for itoring of functional status.	ne E		Director of Nursing (ADON) on requirement to notify physician of all significant changes in condition to ensitimely treatment or transfers. Licensed nurses, medication aides and certified nursing assessments newly hired, including agency, will receive in-service before working their initial shift. Direct of Nursing and/or Staff Development coordinator will be responsible for ensuring education is received. Facility administrator communicated this responsibility on 01/06/2025.	ent to notify physician of all t changes in condition to ensure atment or transfers. Licensed nedication aides and certified assessments newly hired, agency, will receive in-service orking their initial shift. Director g and/or Staff Development or will be responsible for neducation is received. Facility ator communicated this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			1	C 13/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	13/2025	
	101.52.1.01.1.00.1.2.2.1				81 NC HIGHWAY 16 SOUTH			
VALLEY N	URSING AND REHABILI	TATION CENTER			AYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	÷ 4	F 5	580				
		one), and a history of a (bleeding in the digestive			Indicate how facility plans to monitor its performance to make sure solutions ar sustained:			
		m Data Set (MDS) dated lesident #1 was cognitively			Director of Nursing and/or Assistant Director of Nursing to audit Pain scores using our vital sign report. 5 times per week x 6 weeks, Weekly x 6 weeks,	3,		
	Assistant Director of I Resident #1's Respon requested for Resident				Director of Nursing or designee will aud Notify of Physician for 5 times per wee 6 weeks, Weekly x 6 weeks, using 24- hour report sheet. Director of Nursing of designee will audit Pain Scores 5 times	k x or		
	Aspirin. Resident #1	order was received for nad an allergy to Aspirin. was discontinued. The RP ation due to enoxaparin			per week x 6 weeks, Weekly x 6 weeks Director of Nursing or designee will aud intervention for pain for 5 times per we x 6 weeks, Weekly x 6 weeks, using 24	dit ek		
	RP explained that Re medical history of gas	spital. Resident #1 and the sident #1 had a past strointestinal bleeding. ed to Resident #1 and RP,			hour report. Results of these audits will be broug before the Quality Assurance and	ht		
	that anticoagulation tl	nerapy would put Resident and a gastrointestinal bleed.			Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.			
	#1 was noted to have in her left lower extrement documented to have and a positive Homar knee when the person their head in her left leadeep vein thrombos recommended a veno Resident #1 to be not lower extremity.	7/2024 revealed Resident increased pain and swelling mity. Resident #1 was 2+ edema, increased pain, a's sign (pain behind the ns toes are pointed towards ower extremity, indicative of sis/blood clot). The NP ous doppler study and for n-weight bearing to her left						
	revealed Resident #1	ation form dated 12/27/2024 was ordered an in-house of the left lower extremity						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345247	B. WING			1	C 13/2025	
	ROVIDER OR SUPPLIER URSING AND REHABILI			5	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	1 017	13/2025	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580		e 5 dema and pain as well as	F :	580				
		n left lower extremity until						
	authored by Nurse #2 requested to go to the swelling, and tendern was hurting in the cal her pelvic area. An ul ordered but the comp 12/27/2024 or over th (12/28/2024-12/29/20 RP were concerned a which is why they rec ED. Nurse #2 spoke was a special section.	ess. Resident #1 stated she f, behind the knee, and in trasound doppler was eany was not available on the weekend 124). Resident #1 and the about the pain and swelling, fluested her to be sent to the with the RP and the RP was ent #1 at the hospital. The called prior to calling Services (EMS) and a						
	Resident #1 had requ Resident #1's left leg toes), painful, and ter doppler study ordered performed before nex documented as havin 0-10 on the numerical moderate pain) in the lower leg. Nurse #2 a	I by Nurse #2, revealed uested to go to the ED. was swollen (from hip to nder to touch. The venous d 12/27/24 was unable to be at week. Resident #1 was ag pain of a 4 on scale of I pain scale (indicative of left knee, groin, and left						
	#1 presented to the E evaluation of bilateral	/28/2024 revealed Resident ED from the facility for lower extremity swelling, over the last 2 weeks. A						

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		345247	B. WING			044		
NAME OF D	ROVIDER OR SUPPLIER	343247	B: Wiito	STREET ADDRESS, CITY	V STATE ZID CODE	01/	13/2025	
NAIVIE OF PI	ROVIDER OR SUPPLIER			•	,			
VALLEY N	URSING AND REHABIL	ITATION CENTER		581 NC HIGHWAY 16 S				
				TAYLORSVILLE, NC	28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	e 6	F 5	580				
	bilateral venous dopp the ED which reveale thrombosis in the left (bones in the lower le edema. Resident #1" and placed on a hepa later transition to Eliq An interview was con am via telephone with stated she had gone Nursing (DON) on 12 concern about Reside anticoagulant due to swelling in her legs, a clots. The RP stated blood thinner shots a	oler study was conducted in and right leg. A tibia/fibula eg) x-ray revealed diffuse was admitted to the hospital arin infusion with plans to uis, an anticoagulant. ducted on 1/6/2025 at 11:34 in Resident #1's RP. The RP to speak with the Director of e/11/2024 regarding her ent #1 not being on an her immobility/fractures, and a family history of blood Resident #1 had received t the hospital prior to ity and was concerned that						
	pm with the NP. The notification from the A Resident #1's RP had be placed on an antic she ordered aspirin to was later the same dabout Resident #1 had the NP stated she in to the Medical Directoregarding anticoagulation after the last time she saw 12/27/2024 for left leg Resident #1 was hav swelling to her left lover the left lover t	ation. The NP verbalized she w-up regarding 12/11/2024. The NP stated Resident #1 was on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL [*] IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C 13/2025
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	13/2025
VALLEY I	NURSING AND REHABIL	ITATION CENTER			NC HIGHWAY 16 SOUTH YLORSVILLE, NC 28681		
(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 580	Continued From page	e 7	F	580			
F 36U	study of the left lower recommended Resid bearing to the left leg had swelling and a pot time, but did not notice. The NP stated she would not be perform. The NP stated she would not be perform. The NP stated she would not be completed but wouting until Monday to be completed but woutified if the venous have been performed following week at whice considered sending on an interview was composed by the RP was concerned on anticoagulation, woredness to her leg. The NP evaluate Resident wenous doppler study stated she had called venous doppler study would not be looked at the DON stated she delay in obtaining a worth word was composed to the NP was an interview was composed to the DON's office on the	r extremity and ent #1 be non-weight. The NP stated Resident #1 be sitive Homan's sign at that be any redness or warmth. The as not aware, and was not the venous doppler study and the venous doppler study are duntil the following week. The venous doppler study would have been okay with for the venous doppler study would have wanted to be doppler study could not a until the first of the arch point she would have Resident #1 to the ED. I ducted on 1/6/2025 at 12:59 to EDON stated she had first that Resident #1 was not as not ambulatory and had the DON stated she had the transport of the resident #1 on 12/27/2024 and a review or was ordered. The DON I the scheduler for the read until Monday (12/30/24). The bout the renous doppler study and		580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 01/13/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		11/13/2025	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 580	reach out to the Medguidance regarding a stated she cared for and noted swelling to time, and stated she because of the rash. #1's left leg was not time. The ADON state complain of pain who hydrocortisone crear she cared for Reside swelling from her hip and had pain and ter ADON stated the NF doppler study on 12/conducted until the fistated the company venous doppler stud. An interview was corp m with the Medical Director stated he had after admission to the since. The Medical Estaff, nor the NP had concerns regarding Incompany to the new process of the side of the stated if he seed on the side of the swelling in her leg, he venous doppler stud 12/27/2024. The Mewould have known the stated if he would have known the would have known the stated in	call the NP instructing her to lical Director for additional anticoagulation. The ADON Resident #1 on 12/25/2024 of Resident #1's left leg at that assumed it was normal. The ADON stated Resident red warm to touch at that ted Resident #1 did not en she applied the m. The ADON stated after ent #1, she developed to the toes on the left side of the roes on 12/27/2024. The P had ordered a venous 12/24 which could not be collowing week. The ADON had up to 7 days to complete	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	ULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			1	C 1 3/2025	
	ROVIDER OR SUPPLIER URSING AND REHABI	LITATION CENTER		STREET ADDRESS, 581 NC HIGHWAY TAYLORSVILLE,		1 0	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	wanted to be notified events on 12/27/2022 An interview was composed with the Assistant Administration concerns that she feashe should consulted. The Administrator with jeopardy on 1/6/2022 The facility provided allegation of immediate likely to suffer, as a result of the noncerns of the notification of the notificatio	al Director did not specify if he d about the anticoagulant and 24. Inducted on 1/6/2025 at 5:31 and Administrator. The ator stated if the NP had selt like she could not handled at the Medical Director. It as notified of immediate is at 6:08 pm. If the following credible is in the property is a serious adverse outcome as	F	80	DEFICIENCY)			
	previously. On 12/27/2024, faci Practitioner that an onot be completed be On 12/28/2024, Resinsisted on being tra	sident #1 and her family ansferred to the Emergency uation and was transferred to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI			NSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345247	B. WING _			01	C / 13/2025		
	ROVIDER OR SUPPLIER	ITATION CENTER		581 N	ET ADDRESS, CITY, STATE, ZIP CODE IC HIGHWAY 16 SOUTH LORSVILLE, NC 28681	, 0.	710/2020		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 580	Continued From pag	e 10	F t	580					
		ith concerns regarding at risk for this deficient							
		ith complaints of leg pain and d symptoms of a blood clot) ficient practice.							
	On 12/28/2024, Resi facility.	dent #1 discharged from the							
	significant changes to 12/27/2024 was con- Nursing (DON) and A (ADON) with no addi	udit of all residents with between 11/27/2024 & ducted by the Director of Assistant Director of Nursing tional failures to notify studies, treatment or transfer							
	DON of all residents intolerance to aspirir and reviewed for any anticoagulation orde residents identified. I with ordered diagnos delayed; no other residents	rs with no additional No other residents identified stic studies that were sidents identified with and swelling or concerns							
	process or system fa	e entity will take to alter the illure to prevent a serious m occurring or recurring, and be complete							
	aides, and certified r	ensed nurses, medication oursing assistants were octor of Nursing (DON) and							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE COMP	SURVEY LETED
		345247	B. WING			1	13/2025
	ROVIDER OR SUPPLIER	TATION CENTER	1	5	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 017	13/2023
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	requirement to notify changes in condition or transfers. Licensed and certified nursing a hired, including agency prior to working their Nursing and/or Staff I be responsible to ensemble	of Nursing (ADON) on physician of all significant to ensure timely treatment dinurses, medication aides assessments who are newly by, will receive in-service initial shift. Director of Development coordinator will sure education is received. communicated this 6/2025. Ited of the following: uld be scheduled same day on perform study on same day on be notified by licensed the of study. dical providers given to condition should be corder, unless otherwise orders are unable to be corder to ensure any new cer is then implemented If nurse is to document ew orders, to include eemed necessary by an extender is to be made rise of all residents with	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		345247	B. WING _				C / 13/2025
	ROVIDER OR SUPPLIER URSING AND REHABIL	ITATION CENTER		581 I	EET ADDRESS, CITY, STATE, ZIP CODE NC HIGHWAY 16 SOUTH LORSVILLE, NC 28681	, <u></u>	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		BE.	(X5) COMPLETION DATE
F 580	Continued From pag	e 12	F t	580			
	admission or readmidentified aspirin alle						
		sistants and medication langes in condition should					
		ediate jeopardy allegation proved by an ad hoc QAPI 25.					
	responsibility for con	acility administrator notified DON of esponsibility for completion of this immediate copardy allegation removal on 01/06/2025.					
	Alleged date of IJ rei	moval: 01/07/2025.					
	conducted on 1/13/2 revealed residents widentified and their panticoagulation was conducted regarding from 11/27/2024 throthere were no other diagnostic testing. In staff (Nurses, Medicarevealed staff had reordered studies perforder was written, if performed the day it the provider of the expectation or shoult hospital, and the Meaware of residents was admission to determine their provider of the expectation or shoult hospital, and the Meaware of residents was admission to determine their particular testing the residents was admission to determine their performed the day it the provider of the expectation or shoult hospital, and the Meaware of residents was admission to determine their provider of the particular testing their performance of the performance of the particular testing their performance of the particular testing their performance of the performance of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345247	B. WING				C 13/2025	
	ROVIDER OR SUPPLIER	TATION CENTER	ı	5	TREET ADDRESS, CITY, STATE, ZIP CODE 81 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	017	13/2023	
(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 APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 600 SS=J	CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's mi §483.12(a) The facilit §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion; This REQUIREMENT by: Based on record revi Responsible Party (R Medical Director inter protect a resident's rig when they failed to no Resident #1 had a do with a history of gastr with fracture, and new when Resident #1's fa the Director of Nursin was not receiving ant Practitioner instructed Nursing to reach out guidance an anticoag communicate or colla Director herself. The recognize the serious swelling that started of to act on the severity	right to be free from abuse, ation of resident property, efined in this subpart. This part to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is in not met as evidenced fiew, and staff, Resident, P), Nurse Practitioner, and views, the facility failed to got to be free from neglect of the Medical Director that incumented allergy to aspiring ointestinal bleed, recent fall wimmobility on 12/11/24 amily expressed concerns to g (DON) that Resident #1 icoagulant. The Nurse of the Assistant Director of the Medical Director for gulation and failed to borate with the Medical facility further failed to	F	600	F 600 Facility failed to recognize the seriousne of leg swelling and pain manage resider #1 pain notify the medical director of a documented aspirin allergy with a histor of GI bleed for further anticoagulation orders the nurse practitioner neglected communicate with the medical director and ensure the resident received necessary care and services necessary medical evaluation and treatment. Corrective action taken for residents affected by alleged deficient practice 12/28/202 A change in Condition was completed by a Nurse and Resident #1 was transferred to Hospital. Corrective action for residents identified as having the potential to be affected by the same deficient practice:	nt ry to /	1/14/25	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY NURSING AND REHABILIT	TATION CENTER		58	B1 NC HIGHWAY 16 SOUTH		
VALLET NORSING AND REHABILIT	IATION CENTER		T/	AYLORSVILLE, NC 28681		
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lower extremity. On 1 noted to have increase positive Homan's sign when the person's toe head, indicative of a d clot), and increased prextremity. The facility medical attention whe doppler study could not three days after it was 12/28/2024, Resident increased swelling, par lower extremity and at was transferred to the Emergency Medical S #1 was diagnosed with thrombosis (DVT) of b placed on a heparin in medication used to proclots), and admitted. For the hospital since she facility. Deep vein through a day and palmonary elife-threatening. The different for 1 of 3 residents (Reneglect. Immediate jeopardy by facility failed to notify the Resident #1 had a docand the RP was concerciving an anticoaguland pain indicative of Immediate jeopardy when the facility imple	pain and swelling to her left 2/27/2024, Resident #1 was ed edema (swelling), a (pain behind the knee s are pointed towards their eep vein thrombosis/blood ain to her left lower failed to seek emergent in they knew a venous of be scheduled for at least to ordered on 12/27/24. On #1 continued to have in, and redness to her left their (Resident #1) request, hospital at 10:45 am via ervices (EMS). Resident in extensive deep vein to the lower extremities, was infusion (blood thinning event or break up blood Resident #1 has remained in was transferred from the imbosis (DVT) can be very blood clot formed in a deep and travel to the lungs, embolism which can be efficient practice occurred esident #1) reviewed for egan on 12/11/24 when the the Medical Director that cumented allergy to aspiringened about Resident #1 not ulant, had increased edema deep vein thrombosis. Tas removed on 1/7/2025	F	600	On 1/6/25 100% audit of all residents in skin and pain assessments conducted and documented in medical record, to include interview questions, for non interviewable residents Observation by Don, ADON or designee with additional findings addressed and provider notified 100% education was completed with a staff to include facility policy on abuse, and neglect. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 01/06/2025, all licensed nurses, medication aides, and certified nursing assistants were educated by the Direct of Nursing (DON) and the Assistant Director of Nursing (ADON) on requirement to notify physician of all significant changes in condition to ensutimely treatment or transfers. Licensed nurses, medication aides and certified nursing assessments newly hired, including agency, will receive in-service before working their initial shift. Direct of Nursing and/or Staff Development coordinator will be responsible for ensuring education is received. Facility administrator communicated this responsibility on 01/06/2025. Indicate how facility plans to monitor its performance to make sure solutions ar sustained: On 01/06/2025 Director of Nursing and/or Assistant Director of Nursing to	olled.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		INSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
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				581 N	NC HIGHWAY 16 SOUTH				
VALLEY I	NURSING AND REHABIL	LITATION CENTER		TAY	LORSVILLE, NC 28681				
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F 600	Continued From page 15		F 6	600					
	facility will remain ou scope and severity of potential for minimal jeopardy) to ensure monitoring systems. The findings included. This tag is cross-referenced. The tag is cross-r	at of compliance with a lower of "D" (no actual harm with a harm that is not immediate education is completed and put into place are effective. d: erenced to: ord review, and Resident, le Party (RP), facility staff, NP), and Medical Director of failed to notify the Medical #1's documented allergy to of a gastrointestinal bleed, are, and new immobility for ling anticoagulation. Resident essed concerns to the DON) on 12/11/2024		r v N F V s a v r c t t	audit Pain scores, using our 24-hour eport sheet. 5 times per week x 6 weeks, Weekly x 6 weeks, Director of Nursing or designee will audit Notify of Physician 5 times per week x 6 weeks Weekly x 6 weeks, using 24-hour repsheet. Director of Nursing or designee audit Pain Scores 5 times per week x weeks, Weekly x 6 weeks, using 24-leport sheet. Director of Nursing or designee will audit intervention for paimes per week x 6 weeks, Weekly x 6 weeks, using 24-hour report sheet. Results of these audits will be brought before the Quality Assurance Performance Improvement Committee monthly with the QAPI Committee esponsible for ongoing compliance.	of s, cort e will 6 nour n. 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		345247	B. WING			1	13/2025	
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TO UNE OF TH	NOVIBER OR GOLF EIER				581 NC HIGHWAY 16 SOUTH			
VALLEY N	IURSING AND REHABIL	ITATION CENTER			TAYLORSVILLE, NC 28681			
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F 600	Continued From page	e 16		600				
. 000			'	000				
	(Resident #1) review	ed for change in condition.						
		rd review, and Resident,						
		e Party (RP), facility staff,						
	,	P), and Medical Director						
		failed to seek emergent						
		en Resident #1 who had a						
		e and pelvic fractures and						
		py prior to admission,						
	I -	ed leg swelling, pain and an						
		oler study (a non-invasive that uses sound waves to						
		on in the body's veins and						
		scheduled for at least three						
		ered. On 12/27/2024,						
		ed to have increased edema						
	(swelling), a positive	Homan's sign (pain behind						
	the knee when the pe	erson's toes are pointed						
	towards their head, ir	ndicative of a deep vein						
	thrombosis/blood clo	t), and pain to her left lower						
		y failed to seek emergent						
		en they knew a venous						
		not be scheduled for at least						
	-	s ordered. On 12/28/2024,						
	Resident #1 continue							
		edness to her left lower ansferred to the hospital at						
	-	ency Medical Services						
	(EMS). Resident #1							
	, ,	thrombosis (DVT) of both						
	-	s placed on a heparin						
		ng medication used to						
	,	blood clots), and admitted.						
	·	dent #1 has remained in the						
	hospital since she wa	as transferred from the						
		rombosis (DVT) can be very						
	_	a blood clot formed in a deep						
		and travel to the lungs,						
	causing a pulmonary	embolism which can be						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ITATION CENTER	1	581 NC	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 16 SOUTH RSVILLE, NC 28681				
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F 600	for 1 of 3 residents (I change in condition. F714: Based on record Resident Responsibly Practitioner, and Merfacility Nurse Practitic communicate and condition on 12/11/2024 that From anticoagulant (blood to prevent blood clot and sustaining multiplumbar (lower back) as she had been price the Assistant Director contacted the NP on NP ordered aspiring which will be a listed allergy gastrointestinal bleed ADON to consult the guidance regarding a #1 and failed to react 12/27/2024 Resident at which time Resides swelling, and a position behind the knee whe pointed towards their vein thrombosis/blood extremity. Resident who hospital on 12/28/20 with the serious advettrombit to her bilater requiring anticoagula deficient practice was advetting the serious advetting anticoagula deficient practice was adventised to the condition of the serious advetting anticoagula deficient practice was adventised to the condition of the process of of	deficient practice occurred Resident #1) reviewed for ord review, staff, Resident, e Party (RP), Nurse dical Director interview the oner (NP) failed to allaborate with the Medical int #1's RP voiced concerns resident #1 was not receiving and thinning medication, used as after having a fall at home ole fractures of the pelvis and spine, and was not as mobile for to admission to the facility. For of Nursing (ADON) 12/11/2024 at which time the which was later discontinued by due to a history of ding. The NP instructed the Medical Director for further anticoagulation for Resident the out to the MD herself. On the #1 was evaluated by the NP and #1 had pain, increased in the person's toes are read, indicative of a deep decided clot) in her left lower the was transferred to the 24 where she was diagnosed are outcome of deep vein al lateral lower extremities, attion, and hospitalization. The	F	600					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		3111012023	
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F 600	pm with the DON. The neglect would include bed without changing resident, and not treat reported it. The DON Resident #1 experier facility had provided the Nurse Practitione DON stated as soon go to the Emergency she was sent. The Administrator was jeopardy on 1/6/2025. The facility provided allegation of immedial Identify those recipies are likely to suffer, as a result of the noncontral the medical director as a received necessary of medical evaluation and On 12/28/2024, Resifacility and was admit blood clots to her bilds.	anducted on 1/13/2025 at 2:07 the DON stated examples of the staff letting someone lay in the general pain when a resident to stated she had not felt like the need neglect because the sinterventions such as having the evaluate Resident #1. The the as Resident #1 requested to to Department on 12/28/2024, the following credible that jeopardy removal: the following credible that jeopardy removal: the serious adverse outcome as impliance: the cognize the seriousness of the manage Residents #1's cal director of a documented thistory of a Gastrointestinal the anticoagulation orders. The the resident recessary	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ITATION CENTER		58	TREET ADDRESS, CITY, STATE, ZIP CODE 11 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	1 017	13/2023
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F 600	On 01/06/2025, All reuser defined assess documented in the minterview questions, fresidents, and observed (DON), Assistant Direct Unit manager (UM) on non-interviewable restindings addressed a On 01/06/2025, an awith significant changes status outside of residuassessments complecurrent was conducted (DON) and Assistant to identify any unadd pain or swelling. Aud Condition user definer revealed no additional Specify the action the process or system fare adverse outcome from when the action will be unadded to 01/06/2025, the Development (SDC) education for all licential and condition. Nursing status outsides and certified no Neglect as it is related up on reported and a condition. Nursing status outsides and certified in the process of system fared and a condition. Nursing status outsides and certified no Neglect as it is related up on reported and a condition. Staff Developed and of Staff Developed and of Staff Developed and Staff De	esidents had skin and pain ments conducted and edical record to include for all interviewable vation by Director of Nursing ector of Nursing (ADON), r Wound Care Nurse for sidents with additional and provider notified. Indit of all residents noted ge in condition (changes in dents baseline) ted from 11/27/2024 to ed by the Director of Nursing Director of Nursing (ADON) ressed new or worsening it of einteract Change in ed assessments (UDA) all concerns noted. It entity will take to alter the eilure to prevent a serious moccurring or recurring, and the complete: ON, ADON, Staff and Unit Managers began used nurses, medication arising aides on Abuse and do to not acting or following seessed pain or changes in aff newly hired, including meservice education prior to nift. Director of Nursing ment coordinator will be deducation is received.	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY
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F 600	Continued From page 20 On 1/6/25 Abuse and neglect policy was		F 60	00		
		trator prior to providing staff es to policy are required at				
	cues Pharmacological ar interventions for pair - Failing to act on pa considered neglect Medical provider m changes in condition - Provider orders and implemented timely Changes in condition have timely follow up interventions. This credible allegating removal plan was read hoc QAPI meeting. Facility administrator responsibility for com	nd non-pharmacological and swelling. in or change in condition is ust be notified of any to include acute pain. In the include pain should to to ensure effectiveness of the include approved by an g on 01/06/2025.				
	01/06/2025. Alleged IJ removal date is 01/07/2025.					
	conducted on 1/13/2 on 1/6/2025 revealed for any concerns/new been notified of the co was in pain, and if a	diate jeopardy removal was 025. Initial audits conducted d residents were assessed w findings, if a provider had concern/finding, if a resident resident had any new or Concerns were identified				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE COMP	SURVEY LETED
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NAME OF PROPERTY OF GUIDNIES	345247	B. WING	OTDEET ADDRESS SITE OF THE SID SOCI		01/	13/2025
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING AND REHABILITAT	TION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	E	(X5) COMPLETION DATE
serious bodily injury, or n the events that cause the abuse and do not result in the administrator of the fa officials (including to the	ws with facility staff red education on neglect, dressing pain (bother dicators), administering repharmacological d/or swelling, acting on a fying a provider with condition, and following effectiveness. The roval date of 1/7/2025 dations A)(B)(c)(1)(4) to allegations of abuse, mistreatment, the facility at all alleged violations at exploitation or injuries of unknown ation of resident property, at but not later than 2 a is made, if the events involve abuse or result in not later than 24 hours if a allegation do not involve in serious bodily injury, to facility and to other State Survey Agency and where state law provides arm care facilities) in we through established		609			1/14/25

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER URSING AND REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	,	·	
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F 609	Survey Agency, with incident, and if the a appropriate correction. This REQUIREMENT by: Based on record refacility failed to report the state survey agest reviewed for neglect. The findings included the findings included. The Administrator, Aregional Nurse Constate Surveyor on 1 that affected Resided. An interview was compared an allegation abuse coordinator (tresponsible for filling agency. The ADON the Administrator has Report following the neglect on 1/6/2025	ate law, including to the State in 5 working days of the lleged violation is verified are action must be taken. T is not met as evidenced are an allegation of neglect to ency for 1 of 3 residents are (Resident #1). d: Assistant Administrator, and asultant #1 were notified by a 1/6/2025 at 6:08 pm of neglect nt #1. Inducted on 1/13/2025 at 2:00 at Director of Nursing at Stated that when anyone on of abuse or neglect, the he Administrator) was a report with the state survey stated she was not sure if d filed an Initial Allegation notification of allegation of Complaint Intake Unit for the	F 6	,	eported identified fected by udited the sand other gative mic ent		
	1/13/2025 at 12:48 µ not filed a report for related to Resident; An interview was co pm with the Director	om revealed the facility had an allegation of neglect #1. nducted on 1/13/2025 at 2:07 of Nursing (DON). The DON is required file a 2-hour		Indicate how facility plans to me performance to make sure solu sustained: Beginning 1/14/25, The Adminited Assistant Administrator or DON Grievance Log weekly and aud reports for trends or patterns.	onitor its itions are strator, I will review it the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF DE	ROVIDER OR SUPPLIER	343247	1 2	271	REET ADDRESS, CITY, STATE, ZIP CODE	01/	13/2025
NAIVIE OF FI	NOVIDER OR SUFFLIER				1 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING AND REHABILI	TATION CENTER					
				IA	YLORSVILLE, NC 28681		
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F 609	Continued From page	÷ 23	F6	609			
	for filing reports to the she did not think that report after being manneglect on 1/6/2025 a should have been a reasonable of the An interview was compared with the Assistant Administrate family member allege Administrator was resulted the state immediately Administrator verbalization because Resident #1	nistrator, was responsible e state. The DON stated the Administrator had filed a de aware of the allegation of at 6:08 PM and stated there eport made. ducted on 1/13/2025 at 2:15 Administrator. The for stated when a resident or d abuse or neglect, the eponsible for filing a report to . The Assistant teed that a report had not eation of neglect on 1/6/2025			of the Administrators audits of the reports will be brought before the Quali Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoi compliance. All New Administrator and DON will trained during new Hire Orientation on Reporting.	the ng	
F 684 SS=J	pm with the Director of Director of Clinical Ophad not filed a report neglect was made on Clinical Operations stan abatement (plan to problem) for the alleg state was already awithere was no reason. The Administrator was interview on 1/13/202 Quality of Care CFR(s): 483.25 § 483.25 Quality of care	ducted on 1/13/2025 at 3:31 of Clinical Operations. The perations stated the facility after the allegation of 1/6/2025. The Director of ated the facility had written o correct the immediate ation of neglect and the are of the allegation and to report it to the state. s not available for an 5.	F€	684			1/14/25

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING _			01/	13/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEVA	ILIDONO AND DELIADILI	TATION CENTED		5	81 NC HIGHWAY 16 SOUTH		
VALLETIN	URSING AND REHABIL	TATION CENTER		T	AYLORSVILLE, NC 28681		
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	Continued From page applies to all treatments facility residents. Base assessment of a resident residents received accordance with professor practice, the comprehestare plan, and the resident resident residents received accordance with professor practice, the comprehestare plan, and the resident responsible Party (Responsible Party (R	and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. The is not met as evidenced ew, and Resident, Resident P), facility staff, Nurse end Medical Director failed to seek emergent en Resident #1 who had a end pelvic fractures and popy prior to admission, end leg swelling, pain and an end pelvic fractures and end endicative of a teast three end. On 12/27/2024, end to have increased edema endicative of a deep vein end, and pain to her left lower of failed to seek emergent end they knew a venous		684	F684 POC Corrective action taken for residents affected by alleged deficient practice: Resident #1 was transferred to the hospital on 12/28/24. Corrective action for residents identified as having the potential to be affected be the same deficient practice: On 1/6/25 the Director of Nursing (DON and Nursing Leadership team which includes the Assistant Director of Nursi (ADON) and Unit Managers, assessed current facility residents via a head-to-to-body audit and pain assessment to ensure that no other resident was	d y N) ng all	DATE
	three days after it wan Resident #1 continue swelling, pain, and re extremity and was tra 10:45 am via Emerge (EMS). Resident #1 extensive deep vein to lower extremities, wanted to the swell extensive deep vein to the swell extensive deep vein to the swell extremities, wanted to the swell extremities and the swell extremities are the swell extremities.	dness to her left lower Insferred to the hospital at Incy Medical Services			experiencing pain, leg swelling, or redness with no additional residents identified. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 1/6/25 the DON, ADON, Staff Development (SDC) and Unit Manager	g	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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VALLETIN	IURSING AND REHABILI	HAHON CENTER		T	TAYLORSVILLE, NC 28681		
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F 684	Continued From page	e 25	F 6	684			
F 004	prevent or break up be As of 1/6/2025, Reside hospital since she was facility. Deep vein the dangerous because a vein can break loose causing a pulmonary life-threatening. The of or 1 of 3 residents (Fechange in condition. Immediate jeopardy be when Resident #1 has behind the knee indictor thrombosis and the occuld not be schedule Immediate jeopardy when the facility impleatingation of immediate facility will remain out scope and severity of potential for minimal lifeopardy) to ensure emonitoring systems pure monitoring systems pure findings included Hospital records from 12/2/2024 revealed Rafall and was found to Orthopedics was conwas in the Emergence Orthopedics stated the fractures required sur recommended admissimonitoring of function received subcutaneous	plood clots), and admitted. Hent #1 has remained in the last transferred from the rombosis (DVT) can be very a blood clot formed in a deep and travel to the lungs, embolism which can be deficient practice occurred desident #1) reviewed for desident #1 manual form that is not immediate desident #1 had experienced and that into place are effective. It is a 11/25/2024 through desident #1 had experienced to have multiple fractures. Soulted while Resident #1 by Department (ED). The properties of the place of th		584	began education for licensed nurses, medication aides and certified nursing assistants on assessing and respondir to pain and signs/symptoms of blood clots. Licensed nurses, medication aid and certified nursing assistants newly hired, including agency, will receive in-service prior to working their initial s Director of Nursing and/or ADON will be responsible to ensure education is received. Facility administrator communicated this responsibility on 01/06/2025. Indicate how facility plans to monitor its performance to make sure solutions are sustained: Beginning 1/14/25 the 24- hour Report from each unit are being reviewed by the DON, ADON or a unit manager to identify any residents with leg swelling or pain requiring follow-up from provider. The audits will be done 5 times per week for weeks, then weekly for 6 weeks to ensure the provider has been notified and appropriate interventions are in place the address any residents with leg swelling pain. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	es, hift. be s re sshe atify se or 6 sure so g or	
	facility will remain out scope and severity of potential for minimal I jeopardy) to ensure e monitoring systems p The findings included Hospital records from 12/2/2024 revealed R a fall and was found t Orthopedics was conwas in the Emergenc Orthopedics stated th fractures required sur recommended admis monitoring of function received subcutaneous thinning shots given to	to of compliance with a lower f "D" (no actual harm with a charm that is not immediate ducation is completed and out into place are effective. 11/25/2024 through desident #1 had experienced to have multiple fractures. sulted while Resident #1 y Department (ED). They felt none of Resident #1's regical intervention and sion for pain control and that status. Resident #1			DON, ADON or a unit manager to iden any residents with leg swelling or pain requiring follow-up from provider. The audits will be done 5 times per week for weeks, then weekly for 6 weeks to ensithe provider has been notified and appropriate interventions are in place to address any residents with leg swelling pain. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee	se or 6 sure to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		11/13/2023
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F 684	12/2/2024 with diagn pelvic fractures, fract (lower back and tailb gastrointestinal bleed tract). Resident #1's medica #1 had an allergy to a reactions and severit A therapy note dated was to address Resident #1 was edu movement in decreas Resident #1 performe elevated, to sitting at with maximum assist management. Resid increase in time for tract, had impairmer extremities, and utiliz needed pain medicat during the assessme 7 on a scaled of 0 -10 Pain assessments da Resident #1 had a panumerical pain scale severe pain) at 6:20 a of 10 on the numerical moderate pain) at 3:3	nitted to the facility on oses which included multiple ure of the lumbosacral spine one), and a history of a I (bleeding in the digestive al record revealed Resident aspirin with unknown y. 12/6/2024 revealed nursing dent #1's pre-treatment pain. cated on need for sing pain from fracture. ed supine, head of bed the edge of bed transfer ance for lower extremity ent #1 required significant ransfer due to pain. Im Data Set (MDS) dated Resident #1 was cognitively not on both sides of her lower red a wheelchair, received as ions, had pain frequently not period and rated pain at a p. Atted 12/11/2024 revealed ain level of 8 out of 10 on the of 0 to 10 (indicative of am and a pain level of 5 out al pain scale (indicative of	F 6	84		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 684	Resident #1's Respirequested anticoaguand the Nurse Practorder was received an allergy to Aspirin discontinued. The function due to enoxaparin, at the hospital. Resexplained that Residhistory of gastrointe provided education anticoagulation ther risk for developing at An NP note dated 1 #1 was evaluated procongestion and was and trace edema in The NP ordered a comedication used to breathing treatments. A care plan dated 1: #1 acute pain relate interventions which analgesia as ordered if interventions were complaint is a significant past experience of passive and trace of passive process.	Finursing (ADON), revealed consible Party (RP) had allant therapy for Resident #1 itioner (NP) was notified. An for Aspirin. Resident #1 had a The order for Aspirin was RP requested anticoagulation an anticoagulant, being given ident #1 and the RP dent #1 had a past medical stinal bleeding. The ADON to Resident #1 and RP, that apy would put Resident #1 at a gastrointestinal bleed. 2/11/2024 revealed Resident er staff request due to chest noted to have congestion bilateral lower extremities. The est x-ray, guaifenesin break up mucous), and s. 2/13/2024 revealed Resident do multiple fractures with included administering do and notifying the physician unsuccessful or if current ideant change from residents	F	684				
	#1 was evaluated for x-ray. Resident #1 or cough, congestion, a lower extremities. F revealed central pul (when blood pools in	Illowing an abnormal chest was noted to have increased and trace edema in bilateral Resident #1's chest x-ray monary venous congestion instead of flowing properly).						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 684	Continued From pag		F	684				
	to treat edema and to monitor for a decr	luid retention) and staff were ease in symptoms.						
	Resident #1 was pre	lated 12/13/2024 revealed scribed furosemide 40 nouth once daily for venous s.						
	12/18/2024, authore (DON), revealed Res	documentation dated d by the Director of Nursing sident #1 was noted to have ver extremity and was isone cream.						
	-	lated 12/18/2024 revealed ain level of 7 out of 10 on the at 9:59 pm.						
	revealed Resident#	cation form dated 12/18/2024 1 had a rash to her left lower rdered hydrocortisone cream wice daily for 5 days.						
	#1 was evaluated for extremities and a "dr lower extremity. Resitching and was note bilateral lower extremerecommended hydrogen and the strength of the streng	2/18/2024 revealed Resident r a rash to bilateral lower ry, rough, red rash" to the left sident #1 complained of mild red to have trace edema to nities. The NP recortisone cream 1% to be wer extremity twice daily for 5						
	#1 was noted to have in her left lower extre documented to have and a positive Homa	2/27/2024 revealed Resident e increased pain and swelling emity. Resident #1 was 2+ edema, increased pain, en's sign in her left lower ecommended a venous						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
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F 684	A a provider commun 12/27/2024 revealed in-house venous doplextremity with diagno well as non-weight be until the doppler studi. A nursing note dated authored by the DON was notified that a venot be available befor "fine with that knowle her to the Emergency. Vital signs dated 12/2 Resident #1's blood prate was 75 beats per 19 (normal is between minute), a temperatur Fahrenheit, and an ox 98%. A nursing note dated authored by Nurse #2 requested to go to the (ED) for left leg pain, Resident #1 stated shehind the knee, and ultrasound doppler was not available on weekend (12/28/2024 and the RP were conditions).	Resident #1 to be her left lower extremity. ication form dated Resident #1 was ordered an oler study of the left lower ses of edema and pain as earing on left lower extremity es were available. Friday, 12/27/2024, revealed Resident #1's RP mous doppler study would be Monday. The RP was dge" and declined to send a Department (ED). 8/2024 at 7:47 am revealed be ressure was 128/70, heart or minute (normal is between ninute), a respiration rate of in 12 to 20 breaths per	F	584					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page	÷ 30	F	684			
1 004	Change of condition of 12/28/2024, authored Resident #1 had requirement to touch. The ordered 12/27/24 was before next week. Re as having pain of a 4 numerical pain scale in the left knee, groin, #2 attempted to notify was no answer, a me An EMS report dated facility had notified disregarding a sick persor #1's room at 10:31 ar facility, staff advised broken her pelvis on 11/27/2024, starting 2 had noticed her left loswell, and a week age leg. Facility informed and had ordered a dobe available until later why they wanted to the hospital. EMS obtain which time Resident #182/74 (normal is 120 beats per minute (norminute), a respiration minute (normal is 120 temperature of 98.8 d 8 out of 10 on the nur of severe pain). Resi	documentation dated by Nurse #2, revealed lested to go to the lent (ED). Resident #1's left in hip to toes), painful, and venous doppler study sunable to be performed sident #1 was documented on scale of 0-10 on the (indicative of moderate pain) and left lower leg. Nurse of the physician, but there ssage was left. 12/28/2024 revealed the spatch at 10:18 am on. EMS arrived at Resident in. Upon arrival to the EMS that Resident #1 had both sides around weeks ago Resident #1 lower leg was starting to to began to feel pain in the EMS the MD was aware suppler study which would not in the following week which is ansfer Resident #1 to the ed vital signs at 10:41 am at if 1 had a blood pressure of 10/80), a heart rate of 90 mal is 60 to 100 beats per rate of 18 breaths per to 20 breaths per minute), a legrees, and a pain level of merical pain scale (indicative dent #1 was transferred to am. While enroute to the stered 4 milligrams of		084			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTR	(X3) DATE SURVEY COMPLETED		
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F 684	#1 presented to the E evaluation of bilateral which had worsened bilateral venous dopp the ED which reveale thrombosis in the left (bones in the lower leedema. Resident #1 and placed on a hepalater transition to Eliq An interview was con am via telephone with stated while she was experienced left lowe Resident #1 stated she swelling and pain that Resident #1 stated the continued to get worse so swollen on Christon tried to prop her leg uwas much tighter than stated on 12/27/2024 swollen." Resident #1 "achy" pain and rated on the numerical pain the NP evaluated her a test to be done at the stated on 12/28/2024 8:00 am and informed and swelling had gott she thought she need Prior to Resident #1's Resident #1 recalled	vein). /28/2024 revealed Resident ED from the facility for lower extremity swelling, over the last 2 weeks. A eler study was conducted in d extensive deep vein and right leg. A tibia/fibula eg) x-ray revealed diffuse was admitted to the hospital arin infusion with plans to uis, an anticoagulant. ducted on 1/6/2025 at 11:41 at the facility she had r leg pain and swelling. ne noticed increased leg t began on 12/18/2024.	F	84			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 684	Continued From page		F	684			
		ducted on 1/6/2025 at 11:34					
		n Resident #1's RP. The RP					
		to speak with the Director of					
	- ' '	1/11/2024 regarding her					
		ent #1 not being on an					
		her immobility/fractures, and a family history of blood					
		Resident #1 had received					
	blood thinner shots a						
		ity. The RP stated Resident					
		NP on 12/18/2024 at which					
		ration to her left leg as well					
		diagnosed with a "rash."					
		cility contacted her on					
		planned discharge and					
		vhich time she expressed					
	her concern over Res	sident #1's swollen left leg.					
		ooke with the DON again on					
	12/27/2024, at which	time she expressed concern					
		ontinuing to have swelling					
		g. The RP stated the DON					
		Resident #1 at which time					
		is doppler study. The RP					
		N nor any facility staff					
		lent #1 sent to the hospital					
		ther evaluation. The RP					
		a call on 12/28/2024 at 8:08					
		ne call log) from Resident #1					
		as hurting/more swollen and to go to the hospital. The RP					
		facility at 10:08 am and					
		ty call EMS to have Resident					
	#1 transferred to the	=					
		stated she received a phone					
		ff member at 10:21 am, at					
		rted EMS had been called.					
		Resident #1 arrived at the					
		udy was performed in the					
		was diagnosed with blood					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 684	on heparin. An interview was con pm with Nurse Aide (I worked on night shift facility and stated the with Resident #1 was time she noticed Res little red" and swollen #1 stated Resident #1 at which time she not Nurse #1 was unavai An interview was con pm with NA #3. NA # dayshift (7:00 am to 7 was assigned Resident #1's left leg other leg and stated NP on 12/27/2024. An interview was con pm with Nurse #3. N dayshift (7:00 am to 7	ducted on 1/5/2025 at 12:55 NA) #1. NA #1 stated she (7:00 pm to 7:00 am) at the last night that she worked on 12/26/2024 at which ident #1's left leg was "a , "nothing too serious." NA 1 expressed she was in pain ified Nurse #1. lable for interview. ducted on 1/5/2025 at 1:24 3 stated she worked 7:00 pm) on 12/27/2024 and	F	684				
	including 12/27/2024. #1's legs started swe 12/25/2024. Nurse # evaluated her (unsure cream to be administ swelling in Resident # and when she was as 12/27/2024 and had to	Nurse #3 stated Resident lling before Christmas, 3 stated she the NP had e of date) and ordered ered. Nurse #3 stated the #1's left leg had worsened esigned Resident #1 on the DON come assess in her. Nurse #3 was unable						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRU	(X3) DATE SURVEY COMPLETED		
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F 684	pm with Nurse #4. N nightshift and had be 12/25/2024. Nurse # not able to ambulate, bedbound mostly. No had been admitted to her hip and always had a survey had a sunable to recall I swelling to her left or An interview was con- am with NA #2. NA #4 dayshift and was ass 12/28/2024. NA #2 s Resident #1 between noticed Resident #1 sof her left leg, redness warmness to the toud #1 had also expresses stated She immediate stated Resident #1 wellater that morning on An interview was com- pm with NA #4. NA #4 dayshift and assisted on 12/28/2024. NA #8 Resident #1's room as (between 7:00 am and complaining about her #4 stated Resident #1 hip down to her toes, redness towards the lower leg, and stated pain. NA #4 stated s Nurse #2.	ducted on 1/5/2025 at 1:51 urse #4 stated she worked en assigned Resident #1 on 4 stated Resident #1 was required full assist, and was urse #4 stated Resident #1 the facility with an injury to ad a lot of pain. Nurse #4 Resident #1 having any right leg. ducted on 1/6/2025 at 10:30 t2 stated she worked igned Resident #1 on tated when she rounded on 7:30 am and 8:00 am, she she had noticeable swelling is near the ankle, and th. NA #2 stated Resident ted pain in her left leg. NA #2 tely notified Nurse #2 and as transferred to the hospital 12/28/2024. ducted on 1/5/2025 at 4:48	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		' IDENTIFICATION NUMBER: '		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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F 684	dayshift and 12/28/20 Resident #1 for the fi Medication Aide (MA Resident #1. Nurse i approached by a staf remember who) abou swollen. Nurse #2 st #1's left leg was sign the right leg, had red ankle, was warm to ti behind the knee, the Nurse #2 stated Resi asked to have Reside evaluation. Nurse #2 on-call provider and teleft a message for a red she then decided to or An interview was corp m with the Rehabilit Rehabilitation Director seen by both Occupa Physical Therapy (Physical Therapy (Physical Therapy) Director stated Resid assessed by OT on 1 required moderate as stand. The Rehabilit Resident #1 was initi 12/6/2024 at which ti much due to pain and assistance with trans Rehabilitation Director foot drop and require injury. The Rehabilit worked with Residen time he was able to a The Rehabilitation Director and the staff of	urse #2 stated she worked 024 she was assigned rst time. Nurse #2 stated 0) #1 was also assigned #2 stated she was if member (unable to 0 tt Resident #1's left leg being 0 ated she assessed Resident 0 ificantly more swollen than 0 ness from the knee to the 0 ne touch, and painful (from 0 calve, and the pelvic area). 0 dent #1's RP called her and 0 ent #1 sent to the hospital for 0 stated she tried to call the 0 chere was no answer, so she 0 return call. Nurse #2 stated 0 call EMS. 0 ducted on 1/5/2025 at 3:16 0 ation Director. The 0 or stated Resident #1 was 0 stitional Therapy (OT) and 0 or stated Resident #1 was 0 or stated Resident #1	F 6	84				

STATEMENT (AND PLAN OF	DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		. ,	(X3) DATE SURVEY COMPLETED		
		345247	B. WING			C 01/13/2025
	ROVIDER OR SUPPLIER	LITATION CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CORSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	minor swelling to nur Director stated the R 12/27/2024 over conhaving leg swelling a Resident #1 not bein Rehabilitation Direct RP's concerns to nur who). An interview was corpm with the NP. The notification from the Resident #1's RP habe placed on an antishe ordered aspirint was later contacted #1 having an allergy instructed the ADON direction regarding a stated she had evaluated she had evaluated she had evaluated she ordered guaifenesin, and bre stated she evaluated following an abnormate central pulmonary was he ordered furosem administered daily for evaluated Resident arash to her left lower bilateral lower extremordered hydrocortisc administered to the I day for 5 days. The	or stated he reported the rising staff. The Rehabilitation RP reached out to him on accerns regarding Resident #1 and overall concern about ag ready for discharge. The or stated he reported the rising staff (unable to recall and overall concern about ag ready for discharge. The or stated he reported the rising staff (unable to recall and overall concern about the resident (unable to recall and overall concern about the received ADON on 12/11/2024 that and requested Resident #1 to coagulant. The NP stated to be administered daily and by the ADON about Resident to aspirin. The NP stated she also to refer to the MD for further unticoagulation. The NP stated Resident #1 on request for chest congestion and #1 had trace edema to mitties and a congested cough red a chest x-ray, athing treatments. The NP is Resident #1 on 12/13/14 all chest x-ray which revealed and enous congestion and stated and enous congestion and stated and extremity, trace edema in mitties, and stated she	F 68	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	, ,	TE SURVEY MPLETED
		345247	B. WING_			C 1/13/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		1/13/2025
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	extremity. The NP st an in-house venous of extremity and recoming non-weight bearing to Resident #1 had swe sign at that time, but or warmth. The NP st venous doppler study until the following we would have been oka	welling to her left lower sated that she had ordered doppler study of the left lower mended Resident #1 be to the left leg. The NP stated elling and a positive Homan's did not notice any redness stated she was not aware the y would not be performed ek. The NP stated she ay with waiting until Monday er study to be completed but	Fé	684		
	would have consider the ED if it could not after Monday. The N Resident #1 on multi admitted to the facilit Resident #1's history An interview was con pm with the ADON.	ed sending Resident #1 to have been obtained until IP stated she had seen ple occasions since she was y and was familiar with				
	#1's RP voiced conce being on an anticoagy contacted the NP, at ordered, and later dis Resident #1 had an a stated she did not recreach out to the MD fregarding anticoagula Resident #1 was see due to a rash on her hydrocortisone crean stated she cared for land noted swelling to time, and stated she because of the rash. #1's left leg was not recontacted the noted swelling to time, and stated she because of the rash.	erns about Resident #1 not ulant. The ADON stated she which time aspirin was scontinued after realizing allergy to aspirin. The ADON call the NP instructing her to for additional guidance ation. The ADON stated in by the NP on 12/18/2024 left lower leg at which time in was ordered. The ADON Resident #1 on 12/25/2024 in Resident #1's left leg at that assumed it was normal. The ADON stated Resident red or warm to touch at that ted Resident #1 did not				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345247	B. WING				C 13/2025
	ROVIDER OR SUPPLIER	ITATION CENTER		581	REET ADDRESS, CITY, STATE, ZIP CODE NC HIGHWAY 16 SOUTH YLORSVILLE, NC 28681	1 017	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 684	she cared for Reside swelling from her hip and had pain and ter the NP had ordered which could not be oweek. The ADON st the RP had declined ED on 12/27/2024. #1 was sent to the Ereturn to the facility. An interview was corp m with the DON. T spoken to Resident #1 had been prescribed rash when she was capplied. The DON s from the RP on 12/2 was upset about an #1 not being able to Resident #1's left leg she had the NP eval 12/27/2024 and a veordered. The DON s scheduler for the ver told the order would Monday. The DON sabout the delay in obstudy and verbalized	en she applied the m. The ADON stated after ent #1, she developed to her toes on the left side anderness. The ADON stated a venous doppler study conducted until the following ated that per documentation to send Resident #1 to the The ADON stated Resident D on 12/28/2024 and did not and to the Don stated she had first the Polymer of the ADON stated she had first the Polymer of the ADON stated she had first the Polymer of the ADON stated she had first the Polymer of the ADON stated she had first the Polymer of the ADON stated she received a call the ADON stated the ADON	F	584			
	of the venous dopple Resident #1 to the h declined. An interview was con pm with the Medical	told the RP about the delay er study and offered to send ospital at which time the RP adducted on 1/5/2025 at 4:17 Director. The Medical ad seen Resident #1 shortly					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345247	B. WING _			C 01/13/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 286	1	1 01/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	
F 684	since. The Medical staff, nor the NP had concerns regarding Director stated if he 12/11/2024 regardin have referred to orth whether Resident #1 anticoagulation was Director stated if Reswelling in her leg, h venous doppler stud 12/27/2024. The Me would have known the and Resident #1 had he would have consistent ED. The Administrator was jeopardy on 1/6/2025. The facility provided allegation of immedial lightly those recipies those who are likely outcome as result of the facility failed to seriousness of bilater resident #1. Reside fall with fractures in and was not as mob previously and was in prevent blood clot) in to seek necessary in On 12/28/24 resident	e facility but had not seen her Director stated the facility I reached out to him with Resident #1. The Medical had been contacted on g anticoagulation, he would opedics and evaluated was ambulatory to see if needed. The Medical sident #1 had redness and e would have ordered a y to have been performed on edical Director stated if he nere would have been a delay I increased pain and swelling, dered sending Resident #1 to as notified of immediate at 6:08 pm. The following credible at jeopardy removal: The following and pain for int #1 had a recent history of iner lumbar spine and pelvis it is as she had been not on an anticoagulant (to nedication. The facility failed	F	584		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		TE SURVEY
		345247	B. WING _			C 01/13/2025
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	71110/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Dreak up blood clots On 1/6/25 the Direct Nursing Leadership Assistant Director of Managers, assessed via a head-to-toe bo assessment to ensue experiencing pain, leadditional residents Specify the action the process or system fradverse outcome from when the action will On 1/6/25 the DON, (SDC) and Unit Mar licensed nurses, menursing assistants of to pain and signs/sy Licensed nurses, menursing assistants of	ded on a heparin (used to b) drip. for of Nursing (DON) and team which includes the foursing (ADON) and United all current facility residents day audit and pain are that no other resident was begin swelling or redness with no identified. The entity will take to alter the ailure to prevent a serious of occurring or recurring, and be complete: ADON, Staff Development that agers began education for dication aides and certified in assessing and responding mptoms of blood clots. Bedication aides, and certified ewly hired, including agency, the prior to working their initial	F6	·		
	Development coordi ensure education is administrator comm 01/06/2025. Education included: -How to recognize d a blood clot -Symptoms: Pain, S Warmth, Positive Ho -Explaining the serio	nator will be responsible to received. Facility unicated this responsibility on eep vein thrombosis (DVT) is welling, Discoloration,				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED
		345247	B. WING			C 01/13/2025
	ROVIDER OR SUPPLIER URSING AND REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		01710/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 684	Continued From page families so they can As of 01/06 /2025, 2 at least five days we unit manager to ider swelling or pain requestion of the Administrator corresponsibility of revision DON, ADON and Unterpretation of the Administrator responsibility for corresponsibility for corresponding to the conducted on 1/13/2 revealed residents we presense of pain, if and for new/worseni with facility nursing so Aides, Nurse Aides)	ge 41 make informed decisions. 4-hour report will be reviewed ekly by the DON, ADON or a natify any residents with legularing follow-up from provider. In the least of the ewing 24-hour reports to the natify and approved by an gon 01/06/2025. In notified DON of appletion of this credible ate jeopardy removal plan on moval: 01/07/2025. Indiate jeopardy removal was 2025. Initial audits conducted were evaluated for the approvider had been notified, and leg swelling. Interviews staff (Nurses, Medication revealed staff had received)				
	condition, and how to a medical provide nursing staff were all recognizing the sign vein thrombosis and of the development Facility nursing staff explain the seriousn thrombosis to the re	s and symptoms of a deep recognizing the seriousness of a deep vein thrombosis. verbalized they were to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345247	B. WING _				C 13/2025
	ROVIDER OR SUPPLIER	TATION CENTER		58	REET ADDRESS, CITY, STATE, ZIP CODE 1 NC HIGHWAY 16 SOUTH NYLORSVILLE, NC 28681	1 011	13/2023
(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 684		e 42 atment. The immediate e of 1/7/2025 was validated.	F 6	84			
F 697 SS=G	Pain Management		F 6	97			1/14/25
	provided to residents consistent with profes the comprehensive properties and the residents' goard the residents' goard the residents' goard the resident Resident Resident, Resident Resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident's pain to hand it got worse until requested to go the hand it got worse until requested to go the hand requested that Resident #1's RP call and requested to the fact to have an elevated by the formal is 120/80) and numerical pain scale.	are that pain management is who require such services, sisional standards of practice, erson-centered care plan, als and preferences. The is not met as evidenced sew, Nurse Practitioner (NP), esponsible Party (RP), and acility failed to manage a stent #1) when she ad pain combined with on 12/18/2024 in her left ident #1 reported she had ser left leg on 12/18/2024 she called her family and ospital on 12/28/2024. Sed the facility on 12/28/2024 esident #1 be sent to the issed pain and swelling in her Medical Services (EMS) illity and noted Resident #1 blood pressure of 182/74 d pain of 8 out of 10 on a (indicative of severe pain). For phine (narcotic pain ms (mgs) to Resident #1 hospital. Resident #1 thospital. Resident #1 The deficient practice was aree residents reviewed for			POC for F697 Corrective action taken for residents affected by alleged deficient practice: Resident #1 was discharged to the hospital on 12/28/24. Corrective action for residents identifie as having the potential to be affected by the same deficient practice: On 01/06/2025, all residents had skin a pain assessments conducted and documented in the medical record. The assessments included pain interview questions for all interviewable residents and physical head-to-toe observations all non-interviewable residents. These assessments were conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Mana and Wound Nurse. All findings were addressed, and provider was notified. care plan updates were required. Assessments were documented in	e e s, of	

PRINTED: 01/27/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 01/13/2025	
NAME OF P	ROVIDER OR SUPPLIER	2.02.0	<u> </u>	.5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	13/2023
	101.52.1.01.1.00.1.2.2.1				881 NC HIGHWAY 16 SOUTH		
VALLEY N	URSING AND REHABILI	TATION CENTER			TAYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	÷ 43	F	697			
	The findings included	:			electronic Medical Records.		
	Resident #1 was adm 12/2/2024 with diagnor pelvic fractures, fractic (lower back and tailbut gastrointestinal bleed tract). A care plan dated 12/#1 had acute pain reliwith interventions whi administer analgesia changes in usual rout decrease in functional of motion, withdrawal notify the physician if successful or if the cusignificant change fro experience of pain.	nitted to the facility on obses which included multiple ure of the lumbosacral spine one), and a history of a divided for the digestive divided for the factures included for staff to the per order, observe/report time, sleep patterns, all abilities, decreased range or resistance to care, and to interventions were not the facture of the factures of			Measures put in place or systemic changes made to ensure deficient practice will not recur: On 01/06/2025, all licensed nurses and medication aides were educated by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) of effective assessment of pain, documentation of assessment and administration of appropriate interventificulting physician notification when a change occurs outside of the prescribe plan of care, to effectively manage pair Nursing Assistants were educated on identifying and reporting signs/symptor of pain to the nurse. Licensed nurses, medication aides, nursing assistants newly hired, including agency nurses, receive in-service education prior to	ons d n. ms	
	Resident #1 was orde oxycodone-acetamine every 4 hours as nee	ophen 5-325 milligrams (mg) ded for pain. Medication Administration			working their initial shift, with administr and DON to ensure this occurs. Pain i assessed as ordered and as needed. Director of Nursing and Assistant Director of Nursing will track employee □s education.	S	
	12/8/2024, revealed Fineeded (PRN) pain m	Resident #1 had received as			Indicate how facility plans to monitor its performance to make sure solutions ar sustained:		
	12/8/2024 revealed R intact, had impairmer extremities, utilized a	Im Data Set (MDS) dated Resident #1 was cognitively It on both sides of her lower wheelchair, received as ions, received scheduled			The Director of Nursing and Assistant Director implemented audits of all documented pain levels to ensure pain control interventions are effective beginning 01/14/25. These audits will be conducted 5 times weekly for 6 weeks.	oe	

Facility ID: 953152

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345247	B. WING _				C 13/2025
	ROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		1 011	10/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	pain frequently during rated pain at a 7 on a The December 2024 through 12/11/2024, received as needed (oxycodone-acetamin effective. A physician's order d Resident #1 was orde three times a day for 9:00 pm) for pain in a oxycodone-acetamin. The December 2024 through 12/17/2024, received as needed (oxycodone-acetamin effective. An interview was con am via telephone with stated while she was experienced left lower around 12/18/2024. For noticed worsened leg began on 12/18/2024. A change in condition 12/18/2024 at 11:45 a Director of Nursing (I had edema and "redr There was no pain st that time. A pain assessment of	men in the last 5 days, had gethe assessment period and a scaled of 0 -10. MAR, from 12/9/2024 revealed Resident #1 had PRN) pain medication, ophen 5-325 mg, and it was atted 12/11/2024 revealed ered acetaminophen 650 mg pain (9:00 am, 2:00 pm, and ddition to the as needed ophen. MAR, from 12/12/2024 revealed ered acetaminophen 650 mg pain (9:00 am, 2:00 pm, and ddition to the as needed ophen. MAR, from 12/12/2024 revealed ered acetaminophen 5-30 pm, and it was ophen 5-325 mg. and it was ducted on 1/6/2025 at 11:41 in Resident #1. Resident #1 at the facility she had r leg pain and swelling Resident #1 stated she is swelling and pain that it.	F	697	then 3 times weekly for 6 weeks, then once weekly for 6 weeks to ensure that pain control interventions are effective. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.		

	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		, ,	(X3) DATE SURVEY COMPLETED		
		345247	B. WING _			C 01/13/2025
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	71710/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 697	pain scale and was or received oxycodone 9:59 pm there was a out of 10. There was The medication adm as effective. The December 2024 through 12/25/2024, received as needed oxycodone-acetamin 12/22/2024 at 9:28 plevel of 3 out of 10. identified. The medicationer was coram via telephone wit stated the swelling a worse, and recalled I Christmas (12/25/2021 leg up and stated he than normal. An interview was corpm with Nurse #4. Normal normal. An interview was corpm with Nurse #4. Normal normal. An interview was corpm with Nurse #4. Normal normal. An interview was corpm with Nurse #4. Normal normal. An interview was corpm with Nurse #4. Normal normal. According to the December 2024 through 10 normal normal.	out of 10 on the numerical documented as having 5-325 mg. On 12/18/2024 at documented pain level of 7 is no source of pain identified. Inistration was documented MAR, from 12/22/2024 revealed Resident #1 had (PRN) pain medication, ophen 5-325 mg on m for a documented pain There was no source of pain cation administration was	F 6	97		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONST		(X3) DATE COMP	SURVEY
		345247	B. WING _				C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2020
VALLEYN	UIDOINO AND DELLADIL	TATION CENTER		581 NC H	IIGHWAY 16 SOUTH		
VALLEYN	URSING AND REHABIL	TATION CENTER		TAYLOR	SVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 46	F	697			
	administration of PRN 4:48 pm on 12/26/202	l medications given after 24.					
	pm with Nurse Aide (I worked on night shift facility and stated the with Resident #1 was time she noticed Res little red" and swollen #1 stated Resident #1 at which time she not unable to recall if Nur medication for pain. Nurse #1 was unavai An interview was con am via telephone with stated on 12/27/2024 swollen." Resident #1 "achy" pain and rated on the numerical pair the NP evaluated her a test to be done at the An interview was con am via telephone with stated she spoke with which time she expre Resident #1 continuir in her left leg. The RF NP evaluate Residen ordered a venous dop	ducted on 1/6/2025 at 11:41 In Resident #1. Resident #1 In her left leg was "really I stated she experienced an I the pain as an 8-9 out of 10 In scale. Resident #1 stated on 12/27/2024 and ordered the facility. I ducted on 1/6/2025 at 11:34 In Resident #1's RP. The RP In the DON on 12/27/2024, at issed concern about the pain as welling and pain P stated the DON had the it #1 at which time they opler study. The RP stated any facility staff offered to int to the hospital on					
	A pain assessment co	onducted on 12/27/2024, by					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345247	B. WING		C 01/13/2025	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	1 0111012020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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 APPRI DEFICIENCY)	JLD BE COMPLETION	
F 697	Continued From pa	ge 47	F 69	7		
	7:00 pm, revealed F 8 out of 10 on the n of severe pain). Th administrations of a	A) #2, between 7:00 am and Resident #1 had a pain level of umerical pain scale (indicative ere were no documented s needed nophen 5-325 mg on				
	pm with MA #2. MA	onducted on 1/5/2025 at 3:27 A #2 stated she worked on stated she was unable to				
	pm with NA #3. NA dayshift (7:00 am to was assigned Resid Resident #1's left le other leg and stated swelling and Reside	anducted on 1/5/2025 at 1:24 #3 stated she worked 9 7:00 pm) on 12/27/2024 and dent #1. NA #3 stated g was more swollen than the I Nurse #3 was aware of the ent #1 was evaluated by the NA #3 was unable to recall if any pain.				
	pm with Nurse #3. dayshift (7:00 am to assigned Resident including 12/27/202 #1's legs started sw 12/25/2024. Nurse previously evaluate cream to be adminis swelling in Resident and when she was 12/27/2024 she had Resident #1's leg w 12/27/2024 Resider she was unable to resident and the start of the star	Nurse #3 stated she worked of 7:00 pm) and had been #1 on multiple occasions, 4. Nurse #3 stated Resident relling before Christmas, #3 stated the NP had desident #1 and ordered stered. Nurse #3 stated the the thick the stated Resident #1 on the DON come assess ith her. Nurse #3 stated on the thick the stated on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345247	B. WING _			C 01/13/2025	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, 2581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	ZIP CODE	01/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 697	NP come back to evitime a venous dopp An interview was copm with the NP. The saw Resident #1 was pain at which time Fincreased pain and extremity. The NP san in-house venous extremity and recomnon-weight bearing Resident #1 had swelf sign (pain behind the are pointed towards extremity, indicative thrombosis/blood clostated Resident #1 time of the visit. A follow up interview at 12:43 pm with the no further commentand stated to refer to the visit and stated to refer to the visit and swelling had go she thought she need the prior to Resident #1 Resident #1 stated to refer the prior to Resident #1 stated to resident #1 stated to resident #1 Resident #1 stated to resident #1 Resident #1 stated to resident	#3 stated the DON had the raluate Resident #1 at which ler study was ordered. Inducted on 1/3/2025 at 4:00 Inducted on 1/3/2025 at 4:00 Inducted on 1/3/2025 at 4:00 Inducted on 1/3/2024 for left leg lesident #1 was having swelling to her left lower stated that she had ordered doppler study of the left lower limended Resident #1 be to the left leg. The NP stated elling and a positive Homan's expected knee when the persons toes their head in her left lower of a deep vein lot) at that time. The NP did complain of pain at the ray was conducted on 1/13/2025 exp. The NP stated she had a sabout Resident #1's pain	F	697			
	was documented as	MAR revealed Resident #1 having received mg as scheduled daily					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			C 01/13/2025	
	ROVIDER OR SUPPLIER	TATION CENTER	1	58	REET ADDRESS, CITY, STATE, ZIP CODE 1 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681	<u>, </u>	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 697	read to the second seco		F	697			
	was documented as I	4 at which time Resident #1 nospitalized for the 9:00 am en 650 mg by Medication					
	am via telephone with stated she received a am (per her cell phon	ducted on 1/6/2025 at 11:34 n Resident #1's RP. The RP n call on 12/28/2024 at 8:08 he call log) from Resident #1					
	thought she needed t stated she called the	as hurting/more swollen and o go to the hospital. The RP facility at 10:08 am and ty call EMS to have Resident hospital for further					
	am with NA #2. NA # dayshift and was ass 12/28/2024. NA #2 s Resident #1 between noticed Resident #1 s of her left leg, rednes warmness to the touc #1 had also expresse leg. NA #2 stated she	igned Resident #1 on tated when she rounded on 7:30 am and 8:00 am, she she had noticeable swelling s near the ankle, and ch. NA #2 stated Resident ed she had pain in her left e immediately notified Nurse ent #1 was transferred to the					
	pm with NA #4. NA # dayshift and assisted on 12/28/2024. NA # Resident #1's room a (between 7:00 am an complaining about he #4 stated Resident # hip down to her toes.	ducted on 1/5/2025 at 4:48 44 stated she worked with caring for Resident #1 44 stated when she went in t the beginning of the shift d 8:00 am) Resident #1 was er left leg being swollen. NA 1 had swelling from her left NA #4 stated there was bottom of Resident #1's left					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C 13/2025
	ROVIDER OR SUPPLIER	TATION CENTER		581	REET ADDRESS, CITY, STATE, ZIP CODE I NC HIGHWAY 16 SOUTH YLORSVILLE, NC 28681	<u>, </u>	10/2020
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	97 Continued From page 50		F	697			
		Resident #1 was in a lot of the reported the concerns to					
	pm with Nurse #2. Nayshift and 12/28/20 Resident #1 for the fi she was approached to remember who) at being swollen. Nurse Resident #1's left leg swollen than the righ knee to the ankle, was painful (from behind a pelvic area). Nurse #2 experiencing pain in Nurse #2 stated Residuation. Nurse #2 on-call provider and teft a message for a she then decided to a Services (EMS).	ducted on 1/5/2025 at 12:48 urse #2 stated she worked 024 she was assigned rest time. Nurse #2 stated by a staff member (unable rout Resident #1's left leg of #2 stated she assessed was significantly more releg, had redness from the rest warm to the touch, and the knee, the calve, and the rest stated Resident #1 was rer left leg at that time. dent #1's RP called her and rent #1 sent to the hospital for restated she tried to call the releg was no answer, so she return call. Nurse #2 stated reall Emergency Medical ducted on 1/6/2025 at 1:00 of Nursing (DON). The DON					
	DON stated she had day Resident #1 was 12/27/2024, about Re The DON stated she on 12/27/2024 and stany pain and stated s"get up and walk to the stated Resident #1 wacetaminophen as or stated she was unsur	ar with Resident #1. The spoken with the RP on the supposed to be discharged, esident #1's leg being red. went to Resident #1's room ated Resident #1 was not in the witnessed Resident #1 he bathroom." The DON as given her scheduled dered on 12/27/2024 and the why Resident #1 had not dose of acetaminophen on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			C 01/13/2025	
	ROVIDER OR SUPPLIER	ITATION CENTER		581	REET ADDRESS, CITY, STATE, ZIP CODE I NC HIGHWAY 16 SOUTH YLORSVILLE, NC 28681	1 017	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 697	would have complair expected the nurse to and if the pain did not expected the nurse to oxycodone-acetamin DON was unable to not given any pain man and pain	on stated if Resident #1 and of pain, she would have of administer acetaminophen, of improve, she would have of then administer ophen as ordered. The explain why Resident #1 was dedication on 12/28/2024. If 12/28/2024 revealed the dispatch at 10:18 am don. EMS arrived at Resident and the EMS that Resident #1 had both sides around 2 weeks ago Resident #1 dower leg was starting to do began to feel pain in the dital signs at 10:41 am at and a blood pressure of and a blood pressure and a pain level of and and and a pain level of and and and a pain level of and and and and a pain level of and and and and a pain level of and	F	697			

		1 ' '		(X3) DATE SURVEY COMPLETED		
	345247	B. WING		C 01/13/2025		
	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	JLD BE COMPLETION		
Continued From page	e 52	F 69	7			
admitted to the hospi	tal and placed on a heparin					
		F 71	4	1/14/25		
§483.30(e)(1) Except (e)(4) of this section, tasks to a physician a or clinical nurse spec (i) Meets the applica this chapter or, in the specialist, is licensed (ii) Is acting within th defined by State law; (iii) Is under the supe §483.30(e)(4) A phys task when the regula physician must performance.	t as specified in paragraph a physician may delegate assistant, nurse practitioner, ialist who- ble definition in §491.2 of case of a clinical nurse as such by the State; e scope of practice as and rvision of the physician. sician may not delegate a tions specify that the rm it personally, or when the					
§483.30(f) Performar NFs. At the option of State in a NF (including tas specify must be performated by a nurse practitione physician assistant with facility but who is worth physician. This REQUIREMENT by:	nce of physician tasks in a, any required physician task sks which the regulations ormed personally by the be satisfied when performed er, clinical nurse specialist, or who is not an employee of the rking in collaboration with a		POC for F714			
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page revealed diffuse eder admitted to the hospi infusion with plans to anticoagulant. Physician Delegation CFR(s): 483.30(e)(1) §483.30(e) Physician §483.30(e)(1) Except (e)(4) of this section, tasks to a physician a or clinical nurse spec (i) Meets the applica this chapter or, in the specialist, is licensed (ii) Is acting within th defined by State law; (iii) Is under the supe §483.30(e)(4) A phys task when the regula physician must perfor delegation is prohibit facility's own policies §483.30(f) Performar NFs. At the option of State in a NF (including tas specify must be perfor physician) may also b by a nurse practition physician assistant w facility but who is wor physician. This REQUIREMENT by:	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant. Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) §483.30(e) Physician delegation of tasks in SNFs. §483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician. §483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. §483.30(f) Performance of physician tasks in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant. Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) §483.30(e) Physician delegation of tasks in SNFs. §483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician. §483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician in prohibited under State law or by the facility's own policies. §483.30(f) Performance of physician tasks in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced by:	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 52 revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant. Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) \$483.30(e) (7) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist, is licensed as such by the State; (iii) Is acting within the scope of practice as defined by State law, and (iii) Is under the supervision of the physician. \$483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. \$483.30(f) Performance of physician task in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician sassistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced by:		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345247	B. WING			01/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEYN	IURSING AND REHABIL	ITATION CENTER	581 NC HIGHWAY 16 SOUTH				
VALLETIN	ONOMO AND REHADIE	TATION GENTER		T.	AYLORSVILLE, NC 28681		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 714	Continued From pag Resident Responsibl Practitioner, and Med facility Nurse Practitic communicate and co Director after Reside on 12/11/2024 that R an anticoagulant (blot to prevent blood clots and sustaining multip lumbar (lower back): as she had been pric The Assistant Director contacted the NP on NP ordered aspirin we due to a listed allergy gastrointestinal bleed ADON to consult the guidance regarding at #1 and failed to react 12/27/2024 Resident at which time Reside swelling, and a positic behind the knee whe pointed towards their vein thrombosis/bloo extremity. Resident hospital on 12/28/20 with the serious advet thrombosis to her bile extremities, requiring hospitalization. The	e 53 e Party (RP), Nurse dical Director interview the oner (NP) failed to illaborate with the Medical int #1's RP voiced concerns desident #1 was not receiving od thinning medication, used is) after having a fall at home ole fractures of the pelvis and spine, and was not as mobile or to admission to the facility. Or of Nursing (ADON) 12/11/2024 at which time the or thich was later discontinued or due to a history of ding. The NP instructed the Medical Director for further anticoagulation for Resident th out to the MD herself. On if #1 was evaluated by the NP on #1 had pain, increased ove Homan's sign (pain on the person's toes are in head, indicative of a deep d clot) in her left lower #1 was transferred to the 24 where she was diagnosed orse outcome of deep vein ateral lateral lower in anticoagulation, and deficient practice was esidents (Resident #1)		714		I on d y s if	
	the NP failed to colla Director for guidance concerns raised by F	began on 12/11/2024 when borate with the Medical about anticoagulation Resident #1's RP. Immediate and on 1/8/2025 when the			the provider Collaborative Agreement. The NP was educated on when she should consult with the MD based on review of scope of practice and collaborative provider agreement.	io.	

PRINTED: 01/27/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG		l ,	С	
		345247	B. WING _			01/13/2025		
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEVI	HDOING AND DELIAD	II ITATION CENTED		31 NC HIGHWAY 16 SOUTH				
VALLETIN	URSING AND REHAB	ILITATION CENTER		T/	AYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE	
F 714	Continued From pa	nge 54	F 7	F 714				
	facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance with a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.				On 1/7/25 the Medical Director/Senior partner of provider group educated the MD and all attending Physicians and or call that the NP should consult with MD any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practic defined by the North Carolina Medical	in		
	The findings includ	ed:			Board and North Carolina Board of Nursing.			
	A Collaborative Practice Agreement (Nurse Practitioner) revealed "the undersigned Nurse Practitioner ("NP") and the undersigned physician ("Physician") agree that NP shall practice in collaborative practice with Physician in accordance with terms of this Collaborative Practice Agreement (this "Agreement")." The "Physician shall be continuously available for communication, consultation, collaboration, referral, and evaluation of care provided by NP. Consultation, which may include telecommunication, with Physician shall occur, at a minimum, (i) in any circumstance where NP feels uncertain regarding management of any patient problem or concern; (ii) when medical management is beyond NP's scope of practice; and (iii) when a patient requests the involved Physician." The Collaborate Practice Agreement was signed by the NP on 11/23/2024 and the Medical Director on 11/24/2024.				On 1/7/25 The Medical Director informathe Administrator and DON that the ME and NP will have weekly meetings to ensure ongoing collaboration, and the will report any results of the meetings to Administrator and DON. The practice administrator of the provious group will ensure all new Medical Docton Attending Physicians and midlevel Practitioner's be educated on the expectation for collaboration with the Medical Director in any circumstance regarding medical management needing higher level of care or beyond his/her scope of practice defined by the North Carolina Medical Board and North Carolina Board of Nursing. Indicate how facility plans to monitor its performance to make sure solutions an sustained:	MD o der ors,		
	Resident #1 was ac 12/2/2024 with diag pelvic fractures, fra (lower back and tai gastrointestinal ble tract).			Beginning 1/14/25, the Medical Director required to submit ongoing weekly report of his weekly meetings with the Nurse Practitioner to the Administrator. The Administrator will review and audit the reports for trends or patterns. The results	orts			
	Resident #1's medi	cal record revealed Resident			of the Administrator audits of the Medic	al		

Facility ID: 953152

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345247	B. WING			C 01/13/2025		
	ROVIDER OR SUPPLIER URSING AND REHABILI			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			13/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		D BE COMPLET		
F 714	4 Continued From page 55		F ·	714				
	4 Continued From page 55 #1 had an allergy to aspirin with unknown reactions and severity. A nursing note dated 12/11/2024, authored by the Assistant Director of Nursing (ADON), revealed Resident #1's Responsible Party (RP) had requested to be placed on anticoagulant therapy and the Nurse Practitioner (NP) was notified. An order was received for Aspirin. Resident #1 had an allergy to Aspirin. The order for Aspirin was discontinued. The RP requested anticoagulation (blood thinning medication, used to prevent blood clots) due to enoxaparin (an anticoagulant injection used to prevent blood clots) being given at the hospital. Resident #1 and the RP explained that Resident #1 and the RP explained that Resident #1 had a past medical history of gastrointestinal bleeding. The ADON provided education to Resident #1 and RP, that anticoagulation therapy would put Resident #1 at risk for developing a gastrointestinal bleed. An interview was conducted on 1/3/2025 at 4:00 pm with the NP. The NP stated she received notification from the ADON on 12/11/2024 that Resident #1's RP had requested Resident #1 to be placed on an anticoagulant. The NP stated she ordered aspirin to be administered daily and was later contacted by the ADON about Resident #1 having an allergy to aspirin. The NP stated she instructed the ADON to refer to the MD for further direction regarding anticoagulation. The NP stated she did not reach out or collaborate with the MD because she had instructed the ADON to do so.				Director reports will be brought before Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoi compliance. Date of completion: 1/14/25	the		
	#1 was evaluated for extremities and a "dry	/18/2024 revealed Resident a rash to bilateral lower /, rough, red rash" to the left dent #1 complained of mild						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONST	(X3) DATE SURVEY COMPLETED			
		345247	B. WING _			C 01/13/2025		
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 017	10/2020	
				581 NC H	HIGHWAY 16 SOUTH			
VALLEY N	IURSING AND REHABIL	HAHON CENTER		TAYLOR	RSVILLE, NC 28681			
(X4) ID PREFIX TAG			ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 714	Continued From page	e 56	F	14				
	itching and was noted bilateral lower extrem	d to have trace edema to nities. The NP recommended n 1% to be applied to the left						
	#1 was noted to have in her left lower extre documented to have and a positive Homan recommended a veno	/27/2024 revealed Resident increased pain and swelling mity. Resident #1 was 2+ edema, increased pain, n's sign. The NP pus doppler study and for n-weight bearing to her left						
	revealed Resident #1 venous doppler study with a diagnosis of ed non-weight bearing o	provider communication form dated 12/27/2024 evealed Resident #1 was ordered an in-house enous doppler study of the left lower extremity with a diagnosis of edema and pain as well as on-weight bearing on left lower extremity until ne doppler studies were available.						
	authored by the DON was notified that a ve not be available befo	note dated 12/27/2024, I, revealed Resident #1's RP nous doppler study would re Monday. The RP was dge" and declined to send y Department (ED).						
	am via telephone with stated she had gone Nursing (DON) on 12 concern about Reside anticoagulant due to swelling in her legs, a clots. The RP stated blood thinner shots a admission to the facili	ducted on 1/6/2025 at 11:34 In Resident #1's RP. The RP to speak with the Director of //11/2024 regarding her ent #1 not being on an her immobility/fractures, and a family history of blood Resident #1 had received t the hospital prior to ity. The RP stated Resident IP on 12/18/2024 at which						

OLIVIER	O T OIK MEDIO/ IIKE &	WEDIO/ ND GEITTIGEG					7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345247	B. WING				13/2025
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
VALLEVI	ILIDEING AND DEHADII	ITATION CENTED		5	81 NC HIGHWAY 16 SOUTH		
VALLETIN	IURSING AND REHABIL	HATION CENTER		Т	AYLORSVILLE, NC 28681		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 714	Continued From page		F	714			
	time she had discolor						
	_	diagnosed with a "rash."					
		cility contacted her on					
		planned discharge and					
		which time she expressed					
		sident #1's swollen left leg.					
		poke with the DON again on time she expressed concern					
	'	ontinuing to have swelling					
	and pain in her left le						
	had the NP evaluate						
		is doppler study. The RP					
	_	ON nor any facility staff					
		dent #1 sent to the hospital					
	on 12/27/2024 for fur	ther evaluation. The RP					
	stated she received a	a call on 12/28/2024 at 8:08					
	am (per her cell phor	ne call log) from Resident #1					
	, ,	as hurting/more swollen and					
	_	to go to the hospital. The RP					
		facility at 10:08 am and					
		ty call EMS to have Resident					
	#1 transferred to the	•					
		stated she received a phone ff member at 10:21 am, at					
		rted EMS had been called.					
	' '	Resident #1 arrived at the					
		udy was performed in the					
		was diagnosed with blood					
		ower extremities and started					
	on heparin.						
	-	12/28/2024 at 10:25 am,					
		2, revealed Resident #1					
		e Emergency Department					
		swelling, and tenderness.					
	Resident #1 stated she was hurting in the calf, behind the knee, and in her pelvic area. An						
		as ordered but the company 12/27/2024 or over the					
	was not available Ull	12/21/2027 OF UVELUIC	1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345247	B. WING				C
	20,4252.02.0422.452	345247	D. WING _			01/	13/2025
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY N	IURSING AND REHABILI	TATION CENTER			31 NC HIGHWAY 16 SOUTH AYLORSVILLE, NC 28681		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 714	714 Continued From page 58		F	714			
	and the RP were con	I-12/29/2024). Resident #1 cerned about the pain and y they requested her to be					
	Resident #1 had requered Emergency Department leg was swollen (from tender to touch. The vordered 12/27/24 was before next week. Reas having pain of a 4 numerical pain scale in the left knee, groin, attempted to notify the no answer, a message. An interview was con am via telephone with stated while she was experienced left lowe.	by Nurse #2, revealed lested to go to the lent (ED). Resident #1's left in hip to toes), painful, and levenous doppler study is unable to be performed sident #1 was documented on scale of 0-10 on the (indicative of moderate pain) is, and left lower leg. Nurse #2 le physician, but there was le was left. ducted on 1/6/2025 at 11:41 in Resident #1. Resident #1					
	swelling and pain tha Resident #1 stated th continued to get wors so swollen on Christn tried to prop her leg u was much tighter than stated on 12/27/2024 swollen." Resident # "achy" pain and rated on the numerical pain the NP evaluated her a test to be done at th stated on 12/28/2024 8:00 am and informed	t began on 12/18/2024.					

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED		
		345247	B. WING		01/13/2025			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		01/13/2023		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 714	Continued From pag		F 7	4				
	Prior to Resident #1's Resident #1 stated the (NAs) commented or was. An EMS report dated facility had notified diregarding a sick persident #1's room at 10:31 at staff advised EMS the her pelvis on both sice.	on. EMS arrived at Resident m. Upon arrival to the facility, at Resident #1 had broken les around 11/27/2024.						
	Documentation revealed Resident #1 had noticed her left lower leg was starting to swell two weeks prior, and a week ago began to feel pain in the leg. Facility informed EMS the MD was aware and had ordered a doppler study which would not be available until later the following week which is							
	hospital. EMS obtain which time Resident 182/74 (normal is 12 beats per minute (no minute), a respiratior minute (normal is 12 temperature of 98.8 of	ransfer Resident #1 to the ed vital signs at 10:41 am at #1 had a blood pressure of 0/80), a heart rate of 90 rmal is 60 to 100 beats per to 20 breaths per minute), a degrees, and a pain level of moricel pain acade (indicative						
	of severe pain). Resi the hospital at 10:45 milligrams (mg) of mo	merical pain scale (indicative dent #1 was transferred to am. EMS administered 4 orphine for pain h a catheter inserted in a						
	12/28/2024 revealed the ED from the facili lower extremity swell over the last 2 weeks	rtment (ED) note dated Resident #1 presented to ty for evaluation of bilateral ing, which had worsened b. A bilateral venous doppler in the ED which revealed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			C 01/13/2025
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	•	01/13/2023
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 714	Continued From page 60 extensive deep vein thrombi in the left and right leg. A tibia/fibula (bones in the lower leg) x-ray revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant. Resident #1 remained in the hospital and did not return to the facility. As of date, she was still in the hospital was unsure of her actual discharge date from the hospital to another Skilled Nursing Facility. An interview was conducted on 1/6/2025 at 5:31 pm with the Assistant Administrator. The Assistant Administrator verbalized there was an agreement between the NP and the Medical Director regarding caring for residents. The Assistant Administrator stated if the NP needed guidance she was to reach out to the Medical Director. An interview was conducted on 1/7/2025 at 9:32 am with the Medical Director. The Medical Director stated that he collaborated with the NP by reading her notes. The Medical Director stated that he was never notified by the NP or any of the facility staff regarding Resident #1. The Medical Director stated he would have only expected the NP to reach out if there was a		F 7	714		
	handling. The Medic been notified about a swelling to Resident ordered a venous do a day. The Medical doppler study would indicating a blood cle Resident #1 on an a Director stated if he	In not feel comfortable cal Director stated if he had the increase in pain and #1's left leg, he would have oppler study to be done within Director stated if the venous have been positive, ot, he would have started nticoagulant. The Medical would have been made oppler study could not have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345247	B. WING _			C 01/13/2025	
	ROVIDER OR SUPPLIER URSING AND REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 714	Continued From page 61		F	714			
	was ordered, he wou	I the following week after it all have considered sending D if she had experienced an swelling.					
	The Administrator wa jeopardy on 1/7/2029	as notified of immediate 5 at 11:10 am.					
		the following credible ate jeopardy removal:					
		ents who have suffered, or serious adverse outcome as mpliance:					
	communicate and co Director (MD) after F concerns regarding a NP ordered Aspirin a	actitioner (NP) failed to ollaborate with the Medical Resident #1's family voiced anticoagulation therapy. The and later discontinued due to y and because of history of ding.					
	guidance of how to p consult with nor colla regarding the resider risk factors for Deep should have had coa to the hospital for Do diagnose a blood clo	oration to the Assistant ADON) instead of					
	12/28/24 where she	nsferred to the hospital on was diagnosed with blood lower extremities. Resident ulation and hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345247	B. WING			C 1/13/2025	
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		•			
(X4) ID PREFIX TAG	(EACH DEFICI	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 THE APPROPRIATE	(X5) COMPLETION DATE	
F 714	On 1/7/25 the MD the last thirty days collaboration was identified at risk. Specify the action process or system adverse outcome when the action w On 1/7/25 the Adr Director and NP at the MD and NP cowith each other. Now any circumstance management nee beyond his/her scoulaborative provider group ed Physicians and or with MD in any circumstance or with MD in any circu	audited residents seen within by the NP to ensure if further required. No residents the entity will take to alter the failure to prevent a serious from occurring or recurring, and will be completed: ministrator met with the Medical and reviewed the expectations of formunicating and collaborating IP should consult with MD in regarding medical ding a higher level of care or ope of practice. The agreement ders was reviewed, no changes provider agreement. The NP when she should consult with review of scope of practice and	F 71	4			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED C 01/13/2025	
		345247	B. WING _				
NAME OF PROVIDER OR SUPPLIER VALLEY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	CITY, STATE, ZIP CODE 6 SOUTH		
(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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 714	of the meetings to Ad This credible allegation removal reviewed and QAPI meeting on 1/7. Facility administrator for credible allegation removal on 01/07/25. Alleged IJ removal date	s to ensure ongoing MD will report any results ministrator and DON. on of immediate jeopardy d approved by an AD Hoc //25. notified MD of responsibility n of immediate jeopardy ate is 1/8/2025	F 7	14			
	conducted on 1/13/20 revealed the Medical resident visits for the further issues presen staff revealed the Nurcollaborate with the Nany issues/concerns resident. Facility nurwere also to alert nur issues/concerns so the could ensure follow-the Nurse Practitioner and revealed they had recollaborating about repractitioner verbalize was supposed to read Director if there was a something out of her	an issue in question or if scope needed to be ediate jeopardy removal					

Facility ID: 953152