STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification survey was conducted from 06/23/25 through 06/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 894P11.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 06/23/25 through 06/27/25. Event ID# 894P11. The following intakes were investigated: NC00218530, NC00218070, NC00218183, NC00219370, NC00220829, NC00222106, NC00222451, NC00223372, NC00226887, NC00228722, NC00231857, NC00232010, and NC00232064. On 07/28/25 the facility contacted the State Survey Agency to provide additional information that supported past noncompliance for tag F600, F602, and F609. The statement of deficiencies was amended and reposted to the facility. 9 of the 16 complaint allegations resulted in deficiency.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600	"Past Noncompliance - no plan of correction required"	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to protect a resident's right to be free from resident to resident physical abuse when a severely cognitively impaired resident (Resident #43) with a history of aggressive behaviors grabbed and pulled a moderately cognitive impaired resident (Resident #7) to the floor. Resident #43 was observed on top of Resident #7 with his hands around his neck in an attempt to choke him. Resident #43 and Resident #7 were alone in the main dining room at the time of the altercation until separated by dietary staff. Resident #7 and Resident #43 were not injured, and Resident #43 was sent to the hospital for a psychiatric evaluation and returned with no changes made to his current medications. The deficient practice occurred for 1 of 5 residents reviewed for abuse. Findings included: Resident #7 was admitted to the facility on 08/12/18 with diagnoses including traumatic brain injury (a brain injury caused by an outside force that may cause reasoning and judgement problems), obsessive-compulsive disorder (uncontrollable and recurring thoughts or repetitive behaviors or both), and dementia. A review of the Psychiatry Medical Doctor (MD) progress note dated 05/06/24 revealed Resident #7 received ongoing psychiatric services, and his past medical history included multifactorial dementia (two or more types of dementia), traumatic brain injury, depression, and anxiety. The MD noted Resident #7 was initially referred due to an altercation with a male peer and had demonstrated intermittent bouts of agitation. Resident #7 had no recent altercations or increased agitation, his mood was stable, and the MD made no changes to his medications. The quarterly Minimum Data Set (MDS) assessment dated 07/12/24 revealed Resident #7's cognition was moderately impaired with no physical or verbal behaviors during the lookback period. Resident #7 walked independently and had no falls since the previous assessment and was taking antianxiety and antidepressant medications. Resident #43 was admitted to the facility on 07/27/24	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 2 with diagnoses including Asperger's syndrome (a neurological and developmental disorder affecting how one interacts with others, communicates, and behaves), attention and concentration deficit, anxiety disorder, paranoid personality disorder (a pervasive distrust and suspicion of others), and history of traumatic brain injury. The admission MDS assessment dated 07/29/24 revealed Resident #43's cognition was severely impaired with no physical or verbal behaviors identified but rejection of care occurred 1 to 3 days during the lookback period. The MDS indicated Resident #43 was taking antianxiety medication, independently used a wheelchair for mobility, and had no falls since admission. A review of the Nurse Practitioner (NP) progress note revealed on 08/13/24, Resident #43 was evaluated after nursing reported he had replaced the salt and pepper with hot sauce in dining room. The NP's physical exam described Resident #43 speech as hyper verbal (excessive), and his thought pattern as tangential (a disturbance in one's thought process and ability to focus). The NP made no changes to Resident #43's medications or plan of care. A review of a psychotherapy comprehensive assessment dated 09/13/24 revealed Resident #43 was evaluated for behaviors of verbal outburst, expressions of anger, and intrusive social interactions. The psychotherapist recommended to continue follow up visits. A review of the progress note documented by Nurse #1 on 09/15/24 at 11:00 AM revealed someone was heard yelling in the hallway " they're fighting." Nurse #1 entered the dining room, noticed condiments on the floor, and heard Resident #7 or Resident #43 yell, "he thinks he is the boss." Resident #43 and Resident #7 were separated for safety, the NP was notified and provided an order to send Resident #43 to the emergency room for a psychiatric evaluation. An attempt to interview Nurse #1 on 06/26/25 at 12:23 PM was unsuccessful. A review of the nurse progress note dated 09/15/24 at 11:10 AM documented by the former Assistant Director of Nursing (ADON) revealed she was notified Resident #7	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 3 was involved in a physical altercation with another resident while in the main dining room. The former ADON noted Resident #7 was assessed after the altercation and had no injuries, denied pain, and his range of motion was within normal limits. A review of the weekly skin observation dated 09/15/24 at 11:30 AM revealed the former ADON documented Resident #7 had no skin issues. A review of the Initial Allegation Report revealed on 9/15/24 at 4:00 PM an incident of resident abuse was reported. The details of the report read in part, "Resident #7 and Resident #43 were in the main dining room when staff heard a commotion. Staff reported they saw Resident #7 and Resident #43 on the floor and Resident #43 had his hands around Resident #7's neck. Staff pulled Resident #43 off Resident #7. No injuries to either resident. Resident #43 was sent to the emergency room for a psychiatric evaluation and placed on one to one supervision when returned. Resident #7 received a head to toe examination by the nurse. Staff education was started on identifying and managing violent behavior." The former Administrator was named as the person preparing the report and included the date of her signature as 9/15/24. During a telephone interview on 06/26/25 2:51 PM, the former ADON revealed she did not witness the altercation between Resident #7 and Resident #42 on 09/15/24. She revealed the two residents were separated, had no injuries and Resident #43 was sent to the hospital for a psychiatric evaluation. The former ADON stated the main dining room was considered as the part of the residents' home and they were allowed access. She described Resident #7 walked without assistance and if "set off" his behavior was unpredictable. She revealed both Resident #7 and Resident #43 had a history of aggressive behaviors, and facility staff tried to be in the main dining room with the residents and discouraged them from being left alone. A review of the emergency room report dated 9/15/24 noted the reason of Resident #43's visit as aggressive behavior. The report revealed Resident #43 did not meet the criteria for an inpatient evaluation and he returned to facility with no changes to his current medications.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 4 A review of the progress note documented by Nurse #1 on 09/15/24 at 4:36 PM revealed Resident #43 returned to facility with no new orders. A review of the NP progress note revealed on 09/16/24 she was notified Resident #7 was involved in a physical resident to resident incident. The NP evaluated Resident #7 who denied pain and when asked what happened had difficulty finding the words. The NP's note revealed Resident #7 stated, "He's crazy, moving stuff around all the time" and hit his chest when trying to explain what happened. The NP noted Resident #7 was calm and cooperative, in no acute distress, and no changes were made to his medications or plan of care. A review of the facility's Investigation Report dated 09/18/24 summary read in part, "Resident #43 had taken the condiment container from the table Resident #7 was sitting at. When Resident #7 attempted to take back the condiments Resident #43 became agitated and lunged at Resident #7, and both landed on the floor." The report indicated there was no mental anguish and no physical injuries. It was determined Resident #43 started the altercation and based on a diagnosis of Asperger's and history of traumatic brain injury the allegation of abuse was unsubstantiated. The Investigation Report included witness statements from Nurse #1, Nurse Aide (NA) #1, the Cook, and Dietary Aide #1 and was completed by the former Administrator. A review Nurse #1's witness statement read in part, "On 09/15/24 to whom this may concern, I did not witness the altercation between the residents." An attempt to interview Nurse #1 on 06/26/25 at 12:23 PM was unsuccessful. A review of the Cook's witness statement read in part, "On 09/15/24, Resident #43 was on top of Resident #7 and was choking him." The statement revealed the Cook called for assistance from Dietary Aide #1 and they tried to get Resident #43 off Resident #7. The Cook's statement described Resident #43 was hitting and kicking and throwing condiments at Resident #7. A telephone interview was conducted on 06/25/25 at 3:19	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 5 PM with the Cook. The Cook revealed on 09/15/24, Dietary Aide #1 saw Resident #43 and Resident #7 were in the dining room arguing and called for her to help break it up. The Cook stated Resident #43 was sitting in his wheelchair, and she saw him grab Resident #7 by the arms and pull him to the floor. She described Resident #43 was kicking and screaming and stated she did not see Resident #43 choke Resident #7. The Cook's witness statement was read to her that indicated Resident #43 was on top of Resident #7 and was choking him. The Cook restated she did not witness Resident #43 choke Resident #7. She revealed education was provided on how to identify aggressive behaviors, and to ensure staff provided redirection to the residents. A review of Dietary Aide #1's witness statement read in part, "On 09/15/24 I looked out the kitchen door window and saw two residents fighting. Me and Dietary Aide #2 broke it up." During an interview on 06/25/25 at 2:13 PM, Dietary Aide #1 revealed he was in the kitchen and when he looked out the kitchen door window he saw two residents on the floor in the dining room. Dietary Aide #1 stated he saw Resident #43's hands around Resident #7's neck and he was choking him, and Resident #7 was yelling, "get him off me." Dietary Aide #1 revealed he yelled out, "they are fighting" and Dietary Aide #2 came out of the kitchen and got Resident #7 off the ground and they both helped Resident #43 back to his wheelchair. Dietary Aide #1 revealed there were no other staff members or residents in the dining room when the altercation happened. He revealed it was common for residents to be in dining room at different times and was unsure if an activity had recently ended or why they were in the dining room. Dietary Aide #1 revealed he received in-service education about handling aggressive resident behaviors. There was no witness statement from Dietary Aide #2 included in the Investigation Report. A telephone interview was conducted on 06/25/25 at 4:08 PM with Dietary Aide #2. Dietary Aide #2 revealed Resident #43 and Resident #7 were the only two in the dining room at the time of the altercation. He described he saw a staff member trying to separate the residents and stated Resident #43 was on top of Resident #7 and had his hands around Resident #7's neck. Dietary Aide #2 stated he helped Dietary Aide #1	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 6 get Resident #43 off the floor and back into the wheelchair and he heard Resident #7 state he was not hurt. Dietary Aide #2 revealed afterwards in-service education was provided related to aggressive resident behaviors. A review of NA #1's witness statement read in part, "On 09/15/24, I did not see anything from the altercation. A kitchen staff yelled out, they were fighting and when I got to the dining room the residents were already split up." During an interview on 06/26/25 at 2:02 PM, NA #1 revealed on 09/15/24 she was not in dining room and did not witness the physical altercation between Resident #43 and Resident #7. NA #1 revealed she tried to discourage residents from being in the dining room without staff present and tried to keep Resident #43 and Resident #7 apart from each other. She revealed Resident #43 was able to self-propel in his wheelchair and Resident #7 walked without assistance and both residents had access to the dining room. A review of the Psychiatry, MD progress note dated 09/23/24 revealed Resident #43 was seen by psychiatry for ongoing mental health support and pharmacology recommendations. The MD noted Resident #43 had impulsive and childlike behaviors with aggression and that his behaviors led to a physical altercation with a peer. The MD noted Resident #43 defended his actions using a childlike blame and his behaviors appeared as personality and intellectual and developmental disability (IDD) that were baseline character traits that were longstanding. The MD reviewed the current medications and made no changes. An attempt to interview the Psychiatry MD by phone on 06/27/25 at 10:19 AM was unsuccessful. During an interview on 06/23/25 at 10:50 AM, Resident #7 was unable to recall the physical altercation and did not share he was choked by the neck. Resident #7 denied anyone at the facility had hit or hurt him and indicated he felt safe at the facility. During a telephone interview on 06/26/25 at 11:30 AM, the former Administrator revealed she completed the Initial Allegation and Investigation Reports. She	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 7 revealed her reports indicated Resident #43's hands were around Resident #7's neck and she did not recall Resident #7 was actively being choked. She revealed the residents were separated, were not injured. Resident #43 was placed on one to one supervision and reviewed by psychiatry. She revealed due to Resident #43's diagnoses and not being aware of his behaviors she did not consider it as abuse and unsubstantiated the allegation. An interview was conducted on 06/27/25 at 12:50 PM with Director of Nursing (DON). The DON revealed she was not employed by the facility when the altercation occurred between Resident #7 and Resident #43. She revealed to prevent resident to resident altercations the facility staff were instructed to visualize and monitor residents throughout the day and to be aware of where residents were. She revealed resident behaviors were discussed during shift change and the Interdisciplinary Team meetings and facility staff were informed and knew to watch and provide redirection to prevent a resident to resident altercation. The facility provided the following corrective action plan with the completion date of 09/17/24: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/15/24 at approximately 11:00am staff heard yelling in the hallway "they're fighting". Nurse #1 immediately went to the dining room, observed condiments on the floor and heard Resident #7 on Resident #43 yelling "he thinks he is the boss". Staff witnessed Resident #43 had his hands around Resident #7's neck. Resident #43 and Resident #7 were immediately separated for safety, both were assessed, and no injuries were noted for either resident by the Assistant Director of Nursing on 9/15/2024 at 11:30 am. Optum Nurse Practitioner was notified by Nurse #1 on 9/15/2024 at 11:00 am and provided an order to send Resident #43 to the emergency room for psychiatric evaluation. Power of Attorney/responsible parties of both residents were notified by Director of Nursing on 9/15/24. The consulting psychiatrist was also notified of the altercation on 9/16/2024 by Nurse #1 and scheduled a follow-up visit on the 09/23/2024 by the Psychiatry	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 8 M.D. On 9/15/24 the facility notified the police department of the incident. On 9/15/24 Resident #43 returned to the facility with no new orders due to not meeting the criteria for inpatient evaluation at the hospital at which time he was place on 1:1 at the facility. On 9/15/24 the Administrator submitted an initial self-reported incident to the Department of Health and Human Services. On 9/16/24 the nurse practitioner evaluated Resident #7 who denied pain and when asked he had difficulty finding his words. Resident #7 stated "He's crazy, moving stuff around all the time" and hit his chest when trying to explain what happened. The nurse practitioner noted Resident #7 was calm and cooperative, in no acute distress, and no changes were made to his medications or plan of care. Resident #7 states that he feel safe at the facility. On 9/16/24 pharmacy consult for medication review was reviewed by Consultant Pharmacist. DON/Designee reviewed care plans, and no updates were required due to appropriate interventions were in place. This was completed on 09/15/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. Administrator/Director of Nursing/Designee reviewed last thirty days of progress notes to identify other potential like residents to identify poor impulse controlled behavior responses that would cause aggression toward others on 9/16/24. No negative findings were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Director of Nursing/designee educated 100% of facility staff related to abuse with special attention to verbal/physical aggression and identifying and managing violent behaviors. An educational handout that included	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 9 information on dealing with violent patients and understanding/managing challenging behaviors was used for this in-service. Staff not scheduled to work were educated via phone by the Administrator/designee. Completed on 9/16/24. Administrator/Director of Nursing/Designee educated 100% of Department Heads related to potential triggers behaviors and de-escalation process. Completed on 9/16/24. Director of Nursing/designee will educate all new hire employees during on boarding/orientation or before their next scheduled shift. The Director of Nursing was notified by the Administrator on 09/16/2024. Director of Nursing/Designee educated staff started on 9/15/24 that included identifying and managing violent behaviors and the dining room is considered a common area for the residents and there are no restrictions for residents being in common areas in the facility. Systematic Change implemented to prevent this from recurring: the facility changed having the condiments in the dining room to being served on resident meal trays. Kitchen Staff educated to serve condiments on resident trays moving forward. Completed 09/16/2024. Residents may ask for additional condiments if desired. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. The Administrator and Director of Nursing discussed the incident regarding the altercation between Resident #7 and Resident #43 on 9/15/24 and determined to have Ad Hoc Quality Assurance Process Improvement (QAPI) meeting. Ad Hoc QAPI was held 9/16/24 with the Interdisciplinary team to discuss the incident and educate the team on the interventions that were put into place to prevent further incidents. The Administrator/designee implemented the plan of correction to prevent further resident to resident incidents on 9/16/24. On 9/16/24 audits were put in place to monitor and maintain ongoing compliance; the facility will conduct dining room behavior audits daily for 5 days and 3 times per week for 12 weeks. The results from the audits will be submitted to the QAPI committee for further review and recommendations. Conclusion: On 09/23/2024, after the investigation conducted by the facility was complete, the Psychiatry M.D. noted	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 10 Resident #43 has a diagnosis of Asperger's and history of traumatic brain injury. The MD noted Resident #43 had impulsive and childlike behaviors with aggression and that his behaviors led to a physical altercation with a peer. The MD noted Resident #43 defended his actions using a childlike blame and his behaviors appeared as personality and intellectual and developmental (IDD) that were baseline character traits that were longstanding. The MD reviewed the current medications and made no changes. Based on the above information, the allegation of abuse was unsubstantiated due to resident not having intent. Alleged date of Compliance 9/17/24 The correction action plan was validated on 06/27/25 and concluded the facility had implemented an acceptable corrective action plan on 09/17/24 once staff education was completed and the corrective action plan was reviewed and implemented during a QAPI meeting held on 9/16/24. Interviews with staff, including agency staff, revealed the facility had provided education on their abuse policy and were able to verbalize an understanding of identifying residents with verbal and physical aggressive behaviors towards a resident and how to manage violent behaviors. Observations conducted revealed no condiments were left in the dining room and facility staff monitored and engaged with residents and were available to provide redirection. Review of the monitoring tools that began on 09/16/24 were completed weekly as outlined in the corrective action plan with no concerns identified. The facility's corrective action plan date of 09/17/24 was validated.	F0600		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with residents, staff, and the law enforcement agent, the facility failed to protect residents' rights to be free from	F0602	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 11 misappropriation of controlled medications for 2 of 2 residents reviewed for misappropriation of residents' property (Resident #30 and #59). The findings included: The facility's Abuse, Neglect, Exploitation, and Misappropriation of Resident property policy, last revised on July 11, 2024, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property. Resident #30 was admitted to the facility on 11/10/22 with diagnoses including age-related osteoporosis and chronic back pain. The physician's order dated 12/04/22 revealed Resident #30 had an order to receive one tablet of oxycodone 10 mg by mouth 2 times daily for pain. The April 2024 Medication Administration Record (MAR) revealed Nurse #3 had administered one tablet of oxycodone 10 mg to Resident #30 on 04/15/24 at 6:00 PM. Further review of the MAR indicated Resident #30 had received her scheduled oxycodone as ordered throughout the month in April 2024. A review of the controlled substance declining sheets for Resident #30's oxycodone from 03/27/24 through 04/29/24 revealed Nurse #3 signed out two tablets of oxycodone 10 mg for Resident #30 on 04/15/24 at 6:00 PM. She administered one tablet of oxycodone to Resident #30 and wasted the remaining tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the "Check by" column. Resident #59 was admitted to the facility on 02/03/23 with diagnoses including chronic pain syndrome. The physician's order dated 07/13/23 revealed Resident #59 had an order to receive one tablet of oxycodone 5 mg by mouth 2 times daily for chronic pain syndrome. A review of the MAR for April 2024 revealed Nurse #3	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 12 had administered one tablet of oxycodone 5 mg to Resident #59 on 04/17/24 at 8:00 AM. Further review of the MAR indicated Resident #59 had received his scheduled oxycodone as ordered throughout the month in April 2024. A review of the controlled substance declining sheets for Resident #30's oxycodone from 03/27/24 through 04/29/24 revealed Nurse #3 signed out two tablets of oxycodone 10 mg for Resident #30 on 04/15/24 at 6:00 PM. She administered one tablet of oxycodone to Resident #30 and wasted one tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the "Check by" column. A review of the controlled substance declining sheets for Resident #59's oxycodone from 04/13/24 through 04/27/24 revealed Nurse #3 signed out two tablets of oxycodone 5 mg for Resident #59 on 04/17/24 at 8:00 AM. She administered one tablet of oxycodone to Resident #59 and wasted the remaining tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the "Check by" column. A review of the initial allegation report dated 06/11/24 revealed the facility became aware of the misappropriation of residents' property on 06/11/24 at 2:00 PM when 2 tablets of oxycodone (a semi-synthetic narcotic analgesic for pain) had potentially been diverted (1 tablet of oxycodone 5 milligrams (mg) for Resident #59 and another tablet of oxycodone 10 mg for Resident #30) by Nurse #3. The facility reported the incident to the North Carolina Division of Health Service Regulation (DHSR) on 06/12/24 at 1:23 PM and the local law enforcement on 06/12/24 at 2:00 PM as there was a reasonable suspicion of crime against Resident #30 and Resident #59. The 5-day investigation report dated 06/19/24 revealed on 06/11/24, the former Director of Nursing (DON) was notified by the Corporate Clinical Director that a potential drug diversion had occurred in a sister facility that involved Nurse #3 who worked as an agency nurse. The former DON checked with the facility's Scheduler immediately and found that Nurse #3 had picked up 2 shifts in the facility in April 2024. The former DON audited the controlled substance declining sheets and found that potential drug diversions could	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 13 have been done by Nurse #3 as she wasted 1 tablet of oxycodone 5 mg for Resident #59, and 1 tablet of oxycodone 10 mg for Resident #30 without any witnesses nor signature from another nurse to verify the waste of the oxycodone on the controlled substance declining sheets. The allegation of diversion of Residents' drugs was substantiated as the facility unable to confirm the actual waste of controlled medications at the time of documentation. The attempt to conduct a phone interview with Nurse #3 on 06/26/25 at 1:25 PM was unsuccessful. She was unavailable and did not return the call. The pharmacy invoice dated 06/13/24 revealed the facility replaced and paid for the missing one tablet of oxycodone 10 mg for Resident #30 and one tablet of oxycodone 5 mg for Resident #59. An attempt to conduct an interview with Resident #30 on 06/24/25 at 2:56 PM was unsuccessful. She was unable to engage in the interview. During an interview conducted on 06/24/25 at 3:04 PM, Resident #59 could not recall the incident related to drug diversion that occurred more than a year ago. He stated he did not have any problem receiving his pain medication as ordered in the past one year and added his pain was under control most of the time. A phone interview was conducted with the former DON on 06/25/25 at 4:30 PM. She stated she was notified by the Corporate Clinical Director in June 2024 that a potential drug diversion had occurred in a sister facility that involved Nurse #3. She checked with the facility's Scheduler immediately and identified Nurse #3 had worked 2 shifts in the facility in April 2024. When she audited the controlled substance declining sheets for the days Nurse #3 worked, she found that Nurse #3 had wasted one tablet of oxycodone from two different residents without witness' signature documented in the controlled substance declining sheets. She and the Administrator called Nurse #3 several times during the investigation but never received a return call from Nurse #3. The facility submitted the initial allegation report to DHSR, filed report to the local law enforcement agency, notified the North Carolina Board of Nursing, the Medical Director, and Residents' Responsible Party within 24	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 14 hours after identifying the potential drug diversion. The 2 affected residents were assessed by the in-house physician without any negative effects noted. All active controlled substance declining sheets were audited to ensure appropriate documentation and validation of waste by a second nurse. She did not find any additional negative findings. She reviewed all nurse's progress notes and MARs without identifying any additional negative findings related to pain management at the time of the incident. She interviewed all the nursing staff without finding any additional incidents related to drug diversion. The allegation of diversion of resident drugs was substantiated as the facility was unable to confirm the true waste of controlled medication at the time of documentation. She started an in-service on identifying signs of drug diversion and the appropriate process for medication waste for all the nursing staff including agency staff and the newly hired. The in-service was completed within a couple days. During a phone interview conducted on 06/26/25 at 11:29 AM, the former Administrator stated the former DON conducted the audit of the controlled substance declining sheets with the assistance of a couple nurses. She did not participate in the auditing process. She reported the incident to DHSR within 24 hours after she was made aware by the former DON. During a phone interview conducted on 06/26/25 at 2:42 PM, the Detective stated he had reviewed the case and concluded no criminal charge would be filed as there was no camera footage or other evidence indicating Nurse #3 had diverted the controlled medications. He added Nurse #3 might have violated the facility's policy and procedure related to controlled substance documentation and it was not a criminal offense. An interview was conducted with the current DON on 06/27/25 at 10:03 AM. She stated she was not working at the facility when the drug diversion occurred on 06/11/24. After she assumed the role of DON, she started random audit at times for all the controlled substance declining sheets to minimize the risk of drug diversion in the facility. It was her expectation for the facility to remain free from misappropriation of medications. During an interview conducted on 06/27/25 at 12:35 PM, the Administrator stated it was his expectation for the	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 15 facility to remain free of drug diversion to minimize disruption in pharmaceutical services. The facility provided the following corrective action plan with a completion date of 06/13/24: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/11/2024 the Regional Director of Clinical Services notified the Director of nursing of a drug diversion by an agency nurse in a sister facility, in accordance with our Quality Assurance Performance Improvement program, leadership implemented the following corrective action measures: 06/11/2024- Director of Nursing notified Administrator and staff scheduler and confirmed this agency nurse had been working in the facility in April of 2024. 06/12/2024- Director of nursing then audited the narcotic declining sheets for the days this nurse worked in April 2024 and discovered Agency LPN had wasted two controlled medications from two residents without a witness documented in the controlled Substance declining sheet. Director of Nursing and the Assistant Director of Nursing called this nurse several times during the investigation on 06/11/2024 and 06/12/2024 and never received an answer or a return phone call. 06/12/2024 Director of Nursing notified the Medical Director, Nurse Practitioner, Administrator, Regional Director of Clinical Services, North Carolina Department of Health and Human Services, North Carolina Board of Nursing, and Henderson County Police Department, Omnicare Pharmacy representative and resident's responsible party of the findings. The two residents affected were assessed by the in house physician without any negative effects noted. 06/12/2024- Director of Nursing completed one hundred percent audit of active controlled substance declining sheets to ensure correct documentation and validation of any waste by a second nurse was completed and present on the sheets. No additional negative findings. 06/12/2024 the director of nursing reviewed all nursing progress notes and medication records-no negative findings noted regarding pain management for any resident at the time of each event. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 16 All residents receiving controlled pain medication have the potential of being affected. 06/12/2024- Director of Nursing completed one hundred percent audit of active controlled substance declining sheets to ensure correct documentation and validation of any waste by a second nurse was completed and present on the sheets. No additional negative findings. 06/12/2024 the director of nursing reviewed all nursing progress notes and medication records-no negative findings noted regarding pain management for any resident at the time of each event The Director of Nursing/Designee completed pain audits on all residents receiving narcotics on 06/11/2024. Interviews completed on all alert and oriented residents with a Brief Interview for Mental Status of 12 or above was completed by the Director of Social Services. A Wong Baker Scale was completed on all residents with a Brief Interview for Mental Status below 12 to determine if there was any pain. No negative findings noted. These audits were completed on 06/12/2024 by the Director of Nursing/Designee. During the facility investigation, documentation on the declining sheet on 04/15/2024 for resident #1, reflects that two oxycodone 10mg was removed from the blister pack with documented time of 6:00 pm. One line of the documentation reflects administration of the medication, the other line of documentation indicates a waste occurred. No second signature from another nurse to verify waste of medication present on declining inventory sheet. Documentation on the declined sheet dated 04/17/2024 for resident #2 reflects that two oxycodone 5mg tablets were removed of medication the blister pack with documented time of 8:00 am. One indicates a waste occurred. No second signature from another nurse to verify waste of medication present on declining inventory sheet. 06/12/2024 Director of Nursing/Designee completed 100% Audits on all narcotic sheets to determine if there was any further issues with possible diversion. No negative findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. The Director of Nursing/Designee educated (Detection of Drug Diversion in a Long-Term Care Facility: A	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 17 Multi-Victim Crime) all licensed nurses including agency and medication aides on drug diversion and medication rights. This education was completed on 06/12/2024. Nurses who were not working that day were educated via phone. Any licensed nurses on PTO/Vacation will be educated prior to working. All newly hired licensed nurses will be educated on said process during orientation. All agency licensed nurses will receive training prior to the start of their next shift. Indicate how the facility plans to monitor its performance and make sure that solutions are sustained: The Director of Nursing/Designee will audit five random narcotic sheets weekly, to ensure that there is no signs of drug diversion. This audit will be completed weekly for 12 weeks. The results of the audits will be in monthly facility QAPI x's 3 months by the Director of Nursing for further review and recommendations. The facility completed and accepted an ad hoc QAPI meeting 06/11/2024. Root cause analysis: The facility completed a thorough investigation to determine the root cause of the diversion. It is the facilities determination drug diversion did occur due to this nurse would not return phone calls to this facility and would not comply with sister facilities request. Alleged date of Compliance: 06/13/2024. The facility's corrective action plan with a correction date of 06/13/24 was validated on site by record review, observations, and interviews with nursing staff and the former DON. Medication Administration observations were conducted on 06/14/25 through 06/25/25 and it consisted of 25 medications, 5 different residents, and 4 Nurses. Controlled medication was seen pulled from the double-locked compartment in the medication cart during the medication pass observation. The nurse documented the retrieval of controlled medication in the controlled medication declining sheet precisely. Random samples of 3 controlled medications were pulled from each medication cart to verify accuracy and the controlled substance counts were consistent with the records in the declining count sheets.	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 18 An observation was conducted during a shift transition. The arriving and the departing nurses started the process by counting the total number of blister cards containing controlled medication in the double-locked compartment in the medication cart to verify the recorded balance in the count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the count sheet was consistent with the actual counts. The departing nurse read out the number of pills for each blister card from the controlled medication count sheets and the arriving nurse pulled the blister card to verify the quantity. After all the counts were completed without any discrepancies, the arriving nurse signed the controlled medication count sheet before the departing nurse passed the medication cart key to her. The surveyor did not have the opportunity to observe any waste of controlled medication during the survey. Interviews with several nursing staff working in different shifts confirmed they had received in-service training on "Abuse, neglect, misappropriation, reporting, code of ethics, and diversion" and "Definition, implications, and the policy and procedure of wasting narcotic medications". The training was conducted in-person by the former DON, and it included multiple examples and scenarios. Staff who had completed the training signed the in-service records. The training was completed on 06/12/2024. Review of audit records revealed 5 residents receiving controlled medications were audited by the DON or the designee once per week for 12 weeks by comparing controlled substance count sheets, MAR, and the controlled medication return sheets. The facility completed and accepted an ad hoc QAPI meeting 06/11/2024. The DON presented the findings of the audit tools to the Quality Assurance Performance Improvement Committee (QAPI) for 3 months. Interview with the former DON revealed she started the in-service immediately after the incident to re-educate all the licensed nurses and medication aides. She stated the interventions were successful as the facility did not have any similar drug diversion issues since then. The corrective action plan removal date of 06/13/24 was validated.	F0602		
F0609 SS = D	Reporting of Alleged Violations	F0609	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 19 CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with staff, the facility failed to ensure staff implemented their abuse policy and procedure for reporting when the facility failed to report abuse allegations to the State Survey Agency within the specified timeframes and failed to notify the county Adult Protective Services (APS). This affected 1 of 8 residents reviewed for abuse (Resident #1). The findings included: The facility's policy titled, "North Carolina Resident Abuse Policy" last revised 07/11/24 revealed in part; all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 20 (DON), and the applicable State Agency. If the event that caused the allegation involved an allegation of abuse or serious bodily injury, it should be reported to the North Carolina Division of Health Service Regulation (DHSR) immediately, but not later than 2 hours after the allegation is made. The Administrator or designee will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. The Administrator or designee will ensure that a report of the investigation is submitted within 5 working days of the allegation using the DHSR Investigation Report. A further review of the facility's policy titled "North Carolina Resident Abuse Policy", under the "Reporting allegations to other agencies", read in part as follows: "Allegations requiring investigation include abuse of a resident. Follow Adult Protective Service (APS) Statutes for reporting allegations to the local Department of Social Services (DSS/APS)." Resident #1 was admitted to the facility on 12/01/20 with diagnoses including delusional disorder, psychotic disorder, and Parkinson's disease. The annual Minimum Data Set (MDS) assessment dated 05/21/24 coded Resident #1 with intact cognition. She had adequate hearing and vision with clear speech. The MDS indicated Resident #1 receiving antianxiety and antipsychotic in the 7-day assessment period. A review of the facility submitted 24-hour initial report dated 06/11/24 completed by the former Administrator specified an allegation of abuse for Resident #1 was reported by Assistant Director of Nursing (ADON) to the former Administrator on 06/11/24 at 1:47 PM. The report indicated Medication Aide #1 (MA) noted a small, discolored area on Resident #1's right eyebrow bone and reported her finding immediately to ADON. When Resident #1 was interviewed by the former Administrator and the Social Services Director (SSD), she stated that Nurse Aide (NA) #3 and Nurse #2 had hit her and splashed water on her face on 06/10/24 in the evening. The former Administrator suspended both staff members mentioned in the incident immediately and began the investigation by conducting a full skin assessment for Resident #1 and later for the rest of the residents in the facility. The facility submitted the initial report to DHSR on 06/11/24 at 9:12 PM. DHSR was notified 7 hours and 25 minutes after the former	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 21 Administrator was made aware of the incident. The facility unsubstantiated the allegation of abuse but there was no documentation of notification of APS/DSS. During a phone interview conducted on 06/26/25 at 11:29 AM, the former Administrator acknowledged that she was the Abuse Coordinator and responsible for notifying abuse allegations to the applicable local and state agencies in accordance with the policy and procedure. She stated that she was made aware of the incident on 06/11/24 at around 2:00 PM and started the investigation immediately. She explained there were a couple of other incidents that occurred on the same day, and she was overwhelmed and distracted. She added she should have submitted the initial report to DHSR within 2 hours after she was made aware of the alleged abuse incident and notified the APS. During an interview conducted on 06/26/25 at 12:35 PM, the current Administrator expected the former Administrator to follow the regulation to report abuse allegation to DHSR as required within 2 hours and APS within a reasonable timeframe. The facility provided the following corrective action plan with a completion date of 06/13/24: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 6/11/2024 the Regional Director of Clinical Services notified the Director of nursing of a drug diversion by an agency nurse in a sister facility, in accordance with our Quality Assurance Performance Improvement program, leadership implemented the following corrective action measures: 06/11/2024- Director of Nursing notified Administrator and staff scheduler and confirmed this agency nurse had been working in the facility in April of 2024. 06/12/2024- Director of nursing then audited the narcotic declining sheets for the days this nurse worked in April 2024 and discovered Agency LPN had wasted two controlled medications from two residents without a witness documented in the controlled Substance declining sheet. Director of Nursing and the Assistant Director of Nursing called this nurse several times during the investigation on 06/11/2024 and 06/12/2024 and never received an answer or a return phone call. 06/12/2024 Director of Nursing notified the	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 22 Medical Director, Nurse Practitioner, Administrator, Regional Director of Clinical Services, North Carolina Department of Health and Human Services, North Carolina Board of Nursing, and Henderson County Police Department, Omnicare Pharmacy representative and resident's responsible party of the findings. The two residents affected were assessed by the in house physician without any negative effects noted. 06/12/2024- Director of Nursing completed one hundred percent audit of active controlled substance declining sheets to ensure correct documentation and validation of any waste by a second nurse was completed and present on the sheets. No additional negative findings. 06/12/2024 the director of nursing reviewed all nursing progress notes and medication records-no negative findings noted regarding pain management for any resident at the time of each event. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving controlled pain medication have the potential of being affected. 06/12/2024- Director of Nursing completed one hundred percent audit of active controlled substance declining sheets to ensure correct documentation and validation of any waste by a second nurse was completed and present on the sheets. No additional negative findings. 06/12/2024 the director of nursing reviewed all nursing progress notes and medication records-no negative findings noted regarding pain management for any resident at the time of each event The Director of Nursing/Designee completed pain audits on all residents receiving narcotics on 06/11/2024. Interviews completed on all alert and oriented residents with a Brief Interview for Mental Status of 12 or above was completed by the Director of Social Services. A Wong Baker Scale was completed on all residents with a Brief Interview for Mental Status below 12 to determine if there was any pain. No negative findings noted. These audits were completed on 06/12/2024 by the Director of Nursing/Designee. During the facility investigation, documentation on the declining sheet on 04/15/2024 for resident #1, reflects that two oxycodone 10mg was removed from the blister	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 23 pack with documented time of 6:00 pm. One line of the documentation reflects administration of the medication, the other line of documentation indicates a waste occurred. No second signature from another nurse to verify waste of medication present on declining inventory sheet. Documentation on the declined sheet dated 04/17/2024 for resident #2 reflects that two oxycodone 5mg tablets were removed of medication the blister pack with documented time of 8:00 am. One indicates a waste occurred. No second signature from another nurse to verify waste of medication present on declining inventory sheet. 06/12/2024 Director of Nursing/Designee completed 100% Audits on all narcotic sheets to determine if there was any further issues with possible diversion. No negative findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. The Director of Nursing/Designee educated (Detection of Drug Diversion in a Long-Term Care Facility: A Multi-Victim Crime) all licensed nurses including agency and medication aides on drug diversion and medication rights. This education was completed on 06/12/2024. Nurses who were not working that day were educated via phone. Any licensed nurses on PTO/Vacation will be educated prior to working. All newly hired licensed nurses will be educated on said process during orientation. All agency licensed nurses will receive training prior to the start of their next shift. Indicate how the facility plans to monitor its performance and make sure that solutions are sustained: The Director of Nursing/Designee will audit five random narcotic sheets weekly, to ensure that there is no signs of drug diversion. This audit will be completed weekly for 12 weeks. The results of the audits will be in monthly facility QAPI x's 3 months by the Director of Nursing for further review and recommendations. The facility completed and accepted an ad hoc QAPI meeting 06/11/2024. Root cause analysis: The facility completed a thorough investigation to determine the root cause of the diversion. It is the facilities determination drug	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0609 SS = D	Continued from page 24 diversion did occur due to this nurse would not return phone calls to this facility and would not comply with sister facilities request. Alleged date of Compliance: 06/13/2024. The facility's corrective action plan with a correction date of 06/13/24 was validated on site by record review, observations, and interviews with nursing staff and the former DON. Interview with several nursing staff working at different shifts confirmed they had received in-service training on "The Policy and Procedure for Reporting Abuse". The training was conducted in-person by the former DON/designee, and it included multiple examples and scenarios. Staff who had completed the training signed the in-service records. The training was completed on 06/11/2024. Review of audit records revealed 5 residents receiving controlled medications were audited by the former DON/designee once per week for a duration of 12 weeks by comparing controlled substance count sheets, MAR, and the controlled medication return sheets. The facility completed and accepted an ad hoc QAPI meeting 06/11/2024. The DON presented the findings of the audit tools to the Quality Assurance Performance Improvement Committee (QAPI) for 3 months. Interview with the former DON revealed she received training related to "The Policy and Procedure for Reporting Abuse" from the Regional Vice President of Operation to report abuse within 2 hours and notification of APS right after the incident. Then, she started the in-service to re-educate all the licensed nurses and medication aides. She stated the interventions were successful as the facility did not have any similar reporting issues since then. Review of audit records confirmed the DON/Designee had audited five random narcotic sheets weekly and completed for 12 weeks. The results of the audits were present by the DON in the monthly facility QAPI meeting for 3 months for further review and recommendations. The correction action plan removal date of 06/13/24 was validated.	F0609		
F0692 SS = D	Nutrition/Hydration Status Maintenance	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0692 SS = D	Continued from page 25 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with Registered Dietitian (RD) #1 and staff, the facility failed to follow the physician's order to provide nutritional supplements for 1 of 5 residents reviewed for nutrition (Resident #36). Findings included: Resident #36 was admitted to the facility 01/06/20 with a diagnosis including non-Alzheimer's dementia. Review of Resident #36's physician orders revealed an order dated 05/23/24 for a 4-ounce nutritional shake three times a day with meals and an order dated 09/05/24 for a frozen nutritional treat twice a day. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/17/25 revealed Resident #36 was severely cognitively impaired, had weight gain, and was on a physician prescribed weight-gain regimen.	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0692 SS = D	Continued from page 26 Resident #36's nutrition care plan last updated 05/06/25 revealed she had an increased nutrition/hydration risk related to receiving a mechanically altered diet. Interventions included providing her diet and supplements as ordered. A progress note written by Registered Dietitian #2 on 06/12/25 read in part as follows: "Significant weight gain review: 18.8% x 180 days. CBW [Current Body Weight] is 129 [pounds]. History of weight fluctuations and has had a weight gain goal. Weight last month was 126.4 lbs. Weight 90 days ago was 123.2 lbs. Weight 180 days ago was 108.6 lbs, borderline underweight. Weight gain has been beneficial. Receives [frozen nutritional treat] twice a day and [nutritional] shake three times a day with meals. Resident has variable acceptance of supplements. Continue other supplements at this time for variable intake with a history of weight fluctuations." Registered Dietitian (RD) #2 was unavailable for interview during the survey. An observation of Resident #36's lunch meal ticket on 06/23/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat and a 4-ounce nutritional shake. An observation of Resident #36's meal tray at the same time and date revealed the frozen nutritional treat and nutritional shake were not provided with her lunch meal. An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed residents should receive nutritional supplements as ordered by the physician and he was not sure why Resident #36 did not receive her supplements on 06/23/25. An observation of Resident #36's lunch meal ticket on 06/25/25 at 12:17 PM revealed she was to receive a 4-ounce frozen nutritional treat and a 4-ounce nutritional shake. An observation of Resident #36's meal tray at the same date and time revealed the frozen nutritional treat and nutritional shake were not provided with her lunch meal. The Dietary Aide who was responsible for checking meal	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0692 SS = D	Continued from page 27 trays for accuracy before they left the kitchen on 06/25/25 was unavailable for interview during the survey. An interview with Registered Dietitian (RD) #1 on 06/25/25 at 1:10 PM revealed residents should receive their nutritional supplements as ordered. A follow-up interview with RD #1 on 06/25/25 revealed the physician order for Resident #36's frozen nutritional treat was discontinued the evening of 06/23/25. She stated a RD or the Dietary Manager had to manually go into the dietary computer system and update the meal tray tickets but since that had not occurred, staff were still expected to provide items as listed on the meal tray ticket. RD #1 did not provide a reason as to why Resident #36's meal tray ticket had not been updated. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all residents to receive nutritional supplements as ordered.	F0692		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews with Registered Dietitian #1, Speech Therapist, and staff, the facility failed to follow the physician's diet order to provide a mechanically altered diet (a texture-modified diet which restricts foods that are difficult to chew or swallow) for 1 of 5 residents reviewed for nutrition (Resident #36). Findings included: Resident #36 was admitted to the facility 01/06/20 with a diagnosis including non-Alzheimer's dementia.	F0805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0805 SS = D	Continued from page 28 Review of Resident #36's physician orders revealed an order dated 04/26/24 for a mechanical soft diet. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/17/25 revealed Resident #36 was severely cognitively impaired and received a mechanically altered diet. Resident #36's nutrition care plan last updated 05/06/25 revealed she had an increased nutrition/hydration risk related to receiving a mechanically altered diet. Interventions included providing her diet and supplements as ordered. An observation of Resident #36's lunch meal ticket on 06/23/25 at 12:33 PM revealed she was to receive a mechanical soft diet. An observation of Resident #36's meal tray at the same time and date revealed she received 2 whole boneless chicken breasts on her plate. On 06/23/25 at 12:35 PM the Surveyor intervened and showed Administrator #2 Resident #36's meal ticket and plate. Administrator #2 confirmed whole chicken breasts were not considered mechanically soft and removed Resident #36's lunch plate before she began eating. An interview with Nurse Aide (NA) #4 on 06/23/25 at 12:45 PM revealed she set-up Resident #36's lunch meal tray on 06/23/25 and did not notice she received whole chicken breasts instead of mechanically altered chicken. The cook who plated the lunch meal and the dietary aide who checked meal trays for accuracy before they left the kitchen on 06/23/25 were unavailable for interview during the survey. An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed residents should receive the diet as ordered by the physician and he was not sure why Resident #36 did not receive the correct meal on 06/23/25. An interview with Registered Dietitian (RD) #1 on	F0805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0805 SS = D	Continued from page 29 06/25/25 at 1:10 PM revealed residents should receive their diet texture as ordered. An interview with the Speech Therapist (ST) on 06/27/25 at 8:25 AM revealed Resident #36 had not been on her caseload since mid-2024, but the diet recommendation of mechanical soft was still active. She stated residents who received a mechanical soft diet had difficulty with either chewing or swallowing and whole chicken breasts were not considered mechanically soft. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all residents to receive diets as ordered.	F0805		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews the facility failed to label, date, and store food items in accordance with professional standards for food service safety in 1 of 1 kitchen; discard food with signs of spoilage in 1 of 1 reach-in cooler; store food off the	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 30 floor, label and date food items, and remove a dented can in 1 of 1 dry storage room; and remove an opened and undated beverage in 1 of 3 nourishment rooms (West Wing nourishment room). Findings included: 1. An initial observation of the kitchen on 06/23/25 at 9:12 AM revealed the following: (a). 3 unlabeled and undated bins containing white powder-like substances (b). an opened and undated 16-ounce box of baking soda stored on a shelf (c). an opened and undated 32-ounce bottle of lemon juice with a label stating "refrigerate after opening" stored on a shelf. The bottle of lemon juice was room temperature. (d). an opened and undated 16-ounce box of cornstarch stored on a shelf An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed the bins contained sugar, flour, and grits and should have been labeled and dated. He further stated the box of baking soda and cornstarch should have had a label and date, and the lemon juice should have been labeled and dated and placed in the cooler or discarded. He stated he recently hired a number of new employees and he felt when they completed their training that would decrease the likelihood of items not being labeled and dated or being stored correctly. An interview with the Administrator on 06/27/25 at 11:47 PM revealed all food items should be labeled and dated and stored correctly. 2. An observation of the reach-in cooler on 06/23/25 at 9:25 AM revealed an unopened bag of chopped cabbage with multiple brown spots stored on the shelf. The bag of cabbage did not have an expiration or best-by date.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 31 An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed food items should be used or discarded before showing signs of spoilage and he was not sure why the cabbage was in the cooler. An interview with the Administrator on 06/25/25 at 11:47 AM revealed he expected all food items to be used or discarded before showing signs of spoilage. 3. An observation of the dry storage room on 06/23/25 at 9:32 AM revealed the following: (a). a 25-pound bag of self-rising flour laying on the floor (b). 2 35-pound boxes of vegetable oil stored on the floor (c). 1 box of corn cereal stored on the floor (d). 1 box of rice cereal stored on the floor (e). a bin of 13 packs of undated graham crackers stored on a shelf (f). 1 dented 50-ounce can of cream of chicken soup available for use stored on a shelf with other cans An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed no food items should be stored on the floor, dented cans should not be stored with regular canned goods, and all food items in the dry storage room should have a label and expiration or use-by date. He stated he recently hired a number of new staff and once he was able to complete their training that would decrease the likelihood of food items being incorrectly stored. An interview with the Administrator on 06/27/25 at 11:47 AM revealed no food should be stored on the floor, dented cans should be removed and discarded or returned to the supplier, and all food items should be labeled and dated.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON ROAD , HENDERSONVILLE, North Carolina, 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 32 4. An observation of the West Wing nourishment room on 06/23/25 at 11:00 AM revealed an opened and undated box containing a nutritional supplement stored in the freezer. An interview with the Dietary Manager on 06/23/25 at 11:02 AM revealed he cleaned out nourishment refrigerators and freezers daily Monday through Friday and he was not sure why there was an opened and undated supplement in the freezer. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all opened beverage items in nourishment room refrigerators or freezers to be labeled and dated.	F0812		