STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Valley Center for Nursing and Rehabilitatio	1900 W 1st Street Winston-Salem, NC 27104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, responsible party and staff interviews, the facility failed to provide written conclusions and resolutions of grievances reported by the Responsible Party (RP) for 1 of 1 resident (Resident #225) reviewed for grievances.Findings included: The review of the facility's policy on Resident and Family Grievances with a copyright date of 2024 read in part: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. The procedure of the policy included: In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s).iv. A statement as to whether the grievance was confirmed or not confirmed.v. Any corrective action taken or to be taken by the facility as a result of the grievance.vi. The date the written decision was issued. Resident #225 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included: end-stage renal disease and diabetes mellitus. The most recent Minimum Data Set assessment dated [DATE] indicated Resident #225 was moderately, cognitively impaired. Review of the facility's grievances revealed two grievances (7/8/24 and 1/13/25) reported to the facility's Social Services department by Resident #225's RP. On 7/8/24 the resident's RP reported concerns about the cleanliness of Resident #225's room and concerns about the resident's wound treatment. The investigation and resolution revealed staff from the nursing department spoke with the RP regarding the resident's dressing change and frequency; and the environmental services' supervisor informed the RP the resident's room was deep cleaned. The RP also reported a grievance to the Social Services department on 1/13/25 concerning Resident #225's unclean bathroom. The findings of the investigation by the Environmental Services department and the resolution of the cleaning of the bathtub and floor and the refilled soap dispenser were verbally reported to the RP by the Environmental Services Manager. Each of these grievance forms documented the investigation results and resolution steps were verbally communicated to the RP but no written documentation of the investigations' conclusions and resolutions was sent to the RP as follow-up. During a telephone interview on 8/28/25 at 8:56 a.m., Resident #225's RP indicated the facility frequently did not communicate with him when he had concerns about the resident's care. He had filed grievances with Social Services, but the facility did not follow-up with him. During an interview on 8/29/25 at 1:05 p.m., the facility's Director of Social Services revealed she began working at the facility in January 2025. She stated after reviewing the notebook of copies of Grievance Response Letters maintained by the previous Director of Social Services, the letters sent to the complainants were discontinued after October 2024. She stated that she was not made aware of the federal requirement of notifying a complainant in writing of the conclusion and resolution of his/her reported grievance.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure residents were provided clean footwear for 1 of 5 residents dependent on staff for Activities of Daily Living (ADL) care (Resident #4). Findings Included: Resident #4 was admitted to the facility on [DATE] with diagnoses that included Dementia and enlarged prostate gland with an indwelling catheter. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was assessed as severely cognitively impaired with no behaviors or rejection of care. Resident #4 was assessed as requiring substantial / maximum assistance for toileting hygiene and partial / moderate assistance personal hygiene. The care plan dated 7/3/25 revealed Resident #4 was care planned for ADL self-care deficit related to Dementia. The goal indicated Resident #4 will maintain current level of function through the review date. Interventions included provide sponge bath when a full bath or shower cannot be tolerated and make sure shoes are comfortable and not slippery. During an observation on 8/25/25 at 11:20am, Resident #4 was observed walking from his bedroom towards writer. Resident approached writer wearing yellow socks with purple stripes. Both socks were saturated with a liquid substance. Resident #4 wore plaid pajama pants that were saturated with a liquid substance down the back of his right pants leg. Visible wet footprints were coming from the resident's room door. At the foot of the residents' bed on the floor a small wet area was observed with multiple wet footprints surrounding the area. During an observation on 8/26/25 at 9:30am, Resident #4 was observed lying in bed on his left side wearing a hospital gown and yellow socks with two purple stripes with light brown stains on the bottom of both socks. During an observation on 8/26/25 at 11:25am, Resident #4 was observed lying in bed on his back with his legs crossed at the feet wearing yellow socks with two purple stripes with light brown stains on the bottom of both socks. During an observation on 8/27/25 at 8:40am, Resident #4 was observed wearing gray sweatpants with gray nonskid footies. During an interview on 8/27/25 at 9:10am, Nursing Assistant (NA) #1, indicated she was assigned to the resident. NA #1 further indicated she applied the yellow socks with purple stripes on Resident #4 the morning of 8/25/25. She stated she was not assigned to the resident on 8/26/25. NA #1 also indicated she removed the same yellow socks with purple strips she applied to the resident the morning of 8/25/25 the morning of 8/27/25. During an interview on 8/27/24 at 9:20am, Medication Aide (MA) #1, indicated Resident #4 normally lets staff groom him. She indicated the resident wore a leg bag because of his catheter. During an interview on 8/27/25 at 9:40am, the Unit Manager #1 indicated Resident #4 would mess with his leg bag sometimes. She indicated frequent checks were implemented to ensure Resident #4 was not disconnecting his leg bag from the catheter. Unit Manager #1 stated she was not aware the resident wore the same yellow socks with purple stripes from 8/25/25 through 8/27/25. She stated NA #2 told her she changed the residents' socks on 8/26/25. During an interview on 8/27/25 at 10:00am, NA #2 indicated she put gray socks on Resident #4 on 8/26/25. She stated she could not remember what socks he had on prior to her getting him dressed after lunch. She indicated she put the soiled clothing in a bag and placed it in the soil linen room. During an interview on 8/29/25 at 10:17am, the Assistant Director of Nursing (ADON) indicated staff were instructed to replace the resident's socks as needed. The ADON indicated he did not know why Resident #4 would have the same socks on for multiple days in a row. The ADON stated he would follow up with the unit manager and reinforce the importance of proper footwear to the unit staff.