STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehabilitatio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews with facility staff, pharmacy staff, and hospice staff, the facility failed to protect a resident's right to be free from misappropriation of a narcotic medication, Hydrocodone-Acetaminophen, prescribed for pain management. This was for 2 of 2 residents reviewed for medication misappropriation (Resident #2 and Resident #3).The findings included:1. Resident #3 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease and had been receiving hospice services from Hospice Provider #1 since 4/4/2025.An interview with an Assistant Director of Hospice Care Provider #1, conducted on 2/19/2026 at 1:20 PM, revealed the following information. An after-hours triage call on 9/24/2025 reported that Resident #3 was experiencing left hip pain without an as-needed pain medication order. An after-hours nurse was dispatched to the facility on 9/24/2025 to assess Resident #3, and an order was sent to the pharmacy for Hydrocodone-Acetaminophen. (Hydrocodone-Acetaminophen is a narcotic medication.) A hospice nurse obtained a container of Hydrocodone-Acetaminophen from the local pharmacy and delivered it to the facility that evening. The Assistant Director stated that he did not have access to the payment records that would verify the quantity dispensed.Resident #3 had a physician's order initiated on 9/24/2025 Hydrocodone-Acetaminophen 5-325 milligrams (mg) to be administered as one tablet by mouth every 4 hours as needed for pain.An interview conducted with Pharmacist #2 from the local pharmacy on 2/20/2026 at 9:26 AM confirmed the local pharmacy dispensed 30 tablets of Hydrocodone-Acetaminophen for Resident #3, and the prescription was picked up on 9/24/2025 at 8:03 PM.The Director of Nursing (DON) reported on 2/17/2026 at 1:17 PM that the facility could not locate the medication monitoring/control record for Resident #3's Hydrocodone-Acetaminophen received from the local pharmacy on 9/24/2025.Documentation in a nursing progress note dated 9/25/2025 at 4:36 PM written by Unit Manager #1 revealed that Resident #3 was complaining of left hip pain. A hospice nurse assessed the resident, and a new order for Hydrocodone-Acetaminophen was initiated to be administered every 4 hours as needed.Documentation on Medication Administration Record (MAR) for September 2025 revealed Resident #3 was administered one tablet of Hydrocodone-Acetaminophen 5-325 mg on 9/25/2025, 9/26/2025, and 9/27/2025. According to the documentation, Resident #3 would have had 27 tablets remaining in the medication container from the local pharmacy.An interview was conducted with the facility's Pharmacy General Manager via telephone on 2/18/2026 at 10:46 AM. The General Manager stated that the pharmacy received an order to dispense 84 tablets of Hydrocodone-Acetaminophen 5-325 mg for Resident #3. The General Manager explained that 30 tablets of Hydrocodone-Acetaminophen 5-325 mg were delivered to the facility from the pharmacy for Resident #3 on 9/30/2025 at 7:53 PM and signed for by Nurse #1.The DON reported on 2/17/2026 at 1:17 PM that the facility was unable to locate the medication monitoring/control record for Resident #3's Hydrocodone-Acetaminophen 5-325 mg that was delivered on 9/30/2025.Documentation on Resident #3's October 2025 MAR revealed she was administered one dose of Hydrocodone-Acetaminophen on 10/2/2025 at 4:39 AM by Nurse #1.An interview was conducted (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Pharmacist #1 from the facility pharmacy via the telephone on 2/17/2026 at 2:16 PM. Pharmacist #1 confirmed a prescription for Hydrocodone-Acetaminophen was received on 10/3/2025 and 13 tablets were delivered to the facility on [DATE] at 3:06 AM for Resident #3. Pharmacist #1 stated that the pharmacy did not have any record of notification from the facility of any missing or diverted medications for Resident #3.Documentation on the October 2025 MAR revealed Resident #3 received a dose of Hydrocodone-Acetaminophen on 10/8/2025 at 5:41 PM. There were no other documented administrations of Hydrocodone-Acetaminophen to Resident # 3 in October 2025.The DON provided the following nursing assignment information on 2/17/2026 at 1:17 PM. Nurse #1 was assigned the medication cart on 10/1/2025 at 11:00 PM to 10/2/2025 at 7:00 AM. Medication Aide (Med Aide) #1 assumed responsibility of the medication cart from 10/2/2025 at 7:00 AM until 3:00 PM. Med Aide #2 assumed responsibility of the medication cart from 10/2/2025 at 3:00 PM until 11:00 PM. Nurse #1 reassigned the medication cart from 10/2/2025 at 11:00 PM until 10/3/2205 at 7:00 AM, at which time she reconciled the narcotics on the medication cart with Med Aide #1, transferring responsibility to Med Aide #1.Med Aide #2 was interviewed on 2/17/2026 at 1:59 PM. She stated that, because the incident involving the missing medication occurred several months earlier, she was unable to recall which resident was involved or the exact date of the occurrence. She recalled being interviewed at the time of the incident and reported that when she assumed responsibility for the medication cart, there were no discrepancies in the narcotic count. Med Aide #2 further recalled that the missing medication involved a medication container from an outside pharmacy and that when she completed the narcotic count with a nurse (Nurse #1), that medication container was present on the cart.An attempt was made to contact Nurse #1 on 2/17/2026 at 4:56 PM via the telephone; however, current contact information was not available, as her phone number was no longer active.Med Aide #1 was interviewed on 2/17/2026 at 1:40 PM and confirmed she worked the 7:00 AM to 3:00 PM shift on 10/2/2025 and 10/3/2025. Med Aide #1 stated that when she assumed the medication cart from Nurse #1 on 10/2/2025 at 7:00 AM, she observed 25 tablets in the local-pharmacy container and 30 tablets on a medication card of Hydrocodone-Acetaminophen for Resident #3. Med Aide #1 reported that during the narcotic count with Nurse #1 on 10/3/2025 at 7:00 AM, the Hydrocodone-Acetaminophen for Resident #3 was missing. Initially Med Aide #1 assumed the pain medication for Resident #3 had been discontinued and did not question Nurse #1. Med Aide #1 confirmed the narcotic count she conducted with Nurse #1 at 7:00 AM on 10/3/2025 appeared correct, in that the number of narcotic medications in the drawer on the medication cart matched the number of narcotics on the medication monitoring/control record for each resident. Med Aide #1 revealed that later in her shift on 10/3/2025, she noted that the prescription for Hydrocodone-Acetaminophen for Resident #3 had not been discontinued. Med Aide #1 indicated she then immediately notified the supervising nurse and the DON of the missing medication.On 2/17/2026 at 1:17 PM the DON provided a written statement with the details of an investigation of missing Hydrocodone-Acetaminophen for an unnamed resident. The written statement provided the following information: The Administrator and the DON were notified of missing narcotic medication on a medication cart on 10/2/2025. Med Aide #1 reported the medication missing and the narcotic medication was not on the cart at the beginning of her shift when she reconciled the narcotic medication count with Nurse #1. Med Aide #1 recalled a medication container but did not question Nurse #1 about the medication's absence during the narcotic medication count at the change of shift. The medication carts were checked to ensure the medication was not misplaced. A hospice nurse, who was already in the facility, was made aware of the misplaced medication and a new prescription was obtained and dispensed by the pharmacy. The DON interviewed Nurse #1, who recalled putting the narcotic medication in the drawer, but did not recall anything else. Med Aide #2 was (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed and remembered counting off with Nurse #1. The DON contacted the pharmacy and confirmed Nurse #1 signed for the narcotic medication. Based on interviews, diversion was not suspected but the medication was misplaced and then immediately replaced. Hospice was aware and was conducting its own investigation.On 2/17/2026 at 1:17 PM the DON was interviewed. The DON did not recall which resident was affected by the missing narcotic medication, but she believed it may have been Resident #2. The DON explained that she was notified during a clinical meeting on 10/3/2025 by Med Aide #1 that narcotic medication was missing from the medication cart. The DON clarified she was notified of the missing narcotic medication on 10/3/2025 and not on 10/2/2025 as previously indicated in her written statement.An interview was conducted with Unit Manager #1 on 2/18/2026 at 11:51 PM. Unit Manager #1 stated that on 10/3/2025 Med Aide #1 interrupted the morning clinical meeting at approximately 10:00 AM to inform the DON of a concern for missing Hydrocodone-Acetaminophen on the medication cart. The Unit Manager revealed that she and the DON checked the medication carts to see if the narcotic medication was misplaced. The Unit Manager stated that the narcotic medication was all accounted for on 10/3/2025 and no other discrepancies were found except for Resident #3's medication.The DON was interviewed on 2/17/2026 at 11:53 AM and stated that a hospice nurse informed her that hospice had their own process they needed to follow when narcotic medication went missing in a facility. The DON recalled the hospice nurse, whose name she could not remember, stating that the medication of hospice residents belonged to hospice, and hospice would conduct their own investigation and report findings to the appropriate authorities. The DON further explained that if the missing medication belonged to hospice, then it was not considered misappropriation of a resident's medication. The DON and the facility Administrator were interviewed on 2/18/2026 at 8:46 AM. The Administrator stated that facility investigated the missing Hydrocodone-Acetaminophen on 10/3/2025; however, all the documentation related to the investigation was lost or misplaced. The DON stated she contacted Nurse #1 on 10/3/2025 and informed her of her suspension and requested a written statement regarding the missing medication. The DON revealed Nurse #1 arrived for her previously scheduled shift at 11:00 PM on 10/3/2025 and was instructed again that she was suspended and needed to come into the facility in the morning to submit a statement. The DON explained Nurse #1 did not return to the facility for several days to submit a statement. The DON indicated when Nurse #1was interviewed, she had no recollection of what happened to the missing Hydrocodone-Acetaminophen or where she may have put the missing narcotic. The DON said that Nurse #1 had her employment terminated due to a lack of stewardship of the narcotics. The Administrator stated that situation did not appear to involve diversion of narcotics and was unclear. The Administrator recalled a hospice nurse informing her that the missing medication belonged to hospice and that hospice would conduct its own investigation and report findings to the authorities.An interview was conducted over the telephone with the Director of Patient Care Services, an Assistant Director, and Hospice Nurse #1 from Hospice Provider #1 on 2/17/2026 at 4:37 PM. Hospice Nurse #1 stated she was contacted by the facility on 10/3/2026, regarding a diversion of Resident #3's Hydrocodone-Acetaminophen, which included 30 tablets on a medication card and an unknown quantity in a medication container from a local pharmacy. Hospice Nurse #1 reported she notified her supervisor and obtained an additional order for Hydrocodone-Acetaminophen for Resident #3 from the hospice nurse practitioner at 12:35 PM on 10/3/2025. Hospice Nurse #1 stated the additional order was sent to the facility pharmacy for dispensing and delivery of the additional medication.The Director of Patient Care Services, the Assistant Director, and Hospice Nurse #1 all confirmed the medication Hydrocodone-Acetaminophen belonged to Resident #3 and not Hospice Provider #1.2. Resident #2 was admitted to the facility on [DATE] with a diagnosis of cerebrovascular disease and was receiving hospice care (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services from Hospice Provider #2 since 2/24/2025.Resident #2 had a physician's order initiated on 9/25/2025 for Hydrocodone-Acetaminophen 5-325 milligrams (mg) to be administered as one tablet by mouth every 8 hours for pain.An interview was conducted with Pharmacist #1, from the facility pharmacy, via the telephone on 2/17/2026 at 4:00 PM. Pharmacist #1 stated that 43 tablets of Hydrocodone-Acetaminophen were dispensed for Resident #2 and delivered on 9/26/2025 at 2:43 AM. The delivery included 30 tablets on a medication card and 13 tablets on another medication card. Nurse #1 signed for the medication upon delivery. Pharmacist #1 explained that the quantity provided should have lasted until 11/4/2025, if administered as ordered.The Director of Nursing (DON) reported on 2/17/2026 at 1:17 PM that the facility could not locate the medication monitoring/control record for Resident #2's Hydrocodone-Acetaminophen card of 30 tablets received on 9/26/2025. However, the DON provided the medication monitoring/control record for the 13-tablet card received on 9/26/2025, which indicated Resident #2 ran out of Hydrocodone-Acetaminophen on 10/5/2025, with the last dose administered at 2:00 AM. Documentation on the October 2025 Medication Administration Record (MAR) for Resident #2 revealed he received his Hydrocodone-Acetaminophen on a scheduled basis at 2:00 AM, 10:00 AM, and 6:00 PM daily. Medication Aide (Med Aide) #2 documented that Resident #2 did not receive his pain medication on 10/6/2025 at 6:00 PM and to refer to the nursing notes. The October 2025 MAR did not indicate Resident #2 missed any other scheduled doses of Hydrocodone-Acetaminophen.Documentation in the Medication Administration notes for Resident #2 dated 10/6/2025 at 5:07 PM written by Med Aide #2 revealed, Hydrocodone-Acetaminophen oral tablet 5-325 mg give 1 tablet by mouth every 8 hours for pain awaiting pharmacy per nurse.Med Aide #2 was interviewed on 2/17/2026 at 1:59 PM. Med Aide #2 stated she did not recall the circumstances under which Resident #2 did not have his scheduled Hydrocodone-Acetaminophen dose on 10/6/2025, but she likely notified the supervising nurse so that Hospice could be notified. Med Aide #2 stated she did not recall who the supervising nurse was on 10/6/2025.Hospice Nurse #2 was interviewed via the telephone on 2/18/2026 at 12:46 PM and provided the following information. Hospice Nurse #2 saw Resident #2 twice a week since he had been admitted to hospice services with Hospice Provider #2. On 10/6/2025 an after-hours call was received by Hospice Provider #2 that Resident #2 had run out of Hydrocodone-Acetaminophen. Hospice Nurse #2 stated she was responsible for ensuring Resident #2 had his pain medication and ordering more refills if needed. After reviewing the current medication orders and pharmacy dispensing information, she determined Resident #2 should not have run out of Hydrocodone-Acetaminophen until 11/4/2025. Hospice Nurse #2 stated she called the facility and was told Resident #2 ran out of Hydrocodone-Acetaminophen on 10/5/2025. Hospice Nurse #2 then called her manager and the facility pharmacy to confirm the dates and quantities of medication. Hospice Nurse #2 documented a medication error had occurred for Resident #2 because he should have had sufficient Hydrocodone-Acetaminophen to last until 11/4/2025. Hospice Nurse #2 contacted the Assistant Director of Nursing for the facility and was told that an active investigation for diversion of narcotics was underway. Hospice Nurse #2 visited the facility on 10/7/2025 and she spoke with Unit Manager #1, who showed her the Medication Monitoring/Control record book confirming that Resident #2 did not have any Hydrocodone-Acetaminophen left on the medication cart. Hospice Nurse #2 stated she spoke with the facility Administrator, who told her the facility has an open investigation into drug diversion, and they had a nurse who was suspected. The Administrator stated Hospice Nurse #2 would receive additional information after the facility completed their investigation; however, Hospice Nurse #2 reported she was never provided with further details. Hospice Nurse #2 stated she ordered more Hydrocodone-Acetaminophen for Resident #2 but could not recall the details of when it was received by the facility. Hospice Nurse #2 confirmed that medications provided through hospice (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	belong to Resident #2, not Hospice Provider #2.The General Manager of the facility's pharmacy was interviewed via the telephone on 2/18/2026 at 10:46 PM. The General Manager stated that 90 tablets of Hydrocodone-Acetaminophen were delivered to the facility for Resident #2 on 10/7/2025 at 2:33 AM. The General Manager stated that the facility had a valid prescription for Resident #2 to obtain the ordered Hydrocodone-Acetaminophen from the automated medication dispensing cabinet when he ran out on 10/5/2025.Med Aide #1 was interviewed on 2/17/2026 at 1:40 PM. Med Aide #1 stated that she notified the Director of Nursing on 10/3/2025 of missing Hydrocodone-Acetaminophen that belonged to another resident, and that she learned several days later that Resident #2 was missing Hydrocodone-Acetaminophen from the same medication cart.Unit Manager #1 was interviewed on 2/18/2026 at 11:51 AM. Unit Manager #1 stated that Hospice Nurse #2 determined that Resident #2's Hydrocodone-Acetaminophen was missing and notified the DON. Hospice Nurse #2 determined that Resident #2 should have had more medication than what was present, and that he had a whole card of 30 tablets missing from the medication cart.The DON and the facility Administrator were simultaneously interviewed on 2/18/2026 at 8:46 AM. The Administrator stated that facility had investigated the missing Hydrocodone-Acetaminophen that began on 10/3/2025, but all the documentation of the investigation were lost or misplaced. The DON stated she called Nurse #1 and informed her she was suspended on 10/3/2025, and that she needed to obtain a statement from her regarding the missing Hydrocodone-Acetaminophen. The DON revealed Nurse #1 arrived for her previously scheduled shift at 11:00 PM on 10/3/2025 and was instructed again that she was suspended and needed to come into the facility in the morning to submit a statement. The DON explained Nurse #1 did not come to the facility for several days to write a statement. The DON indicated Nurse #1 was interviewed, and she had no recollection of what happened to the missing Hydrocodone-Acetaminophen or where she may have put the missing narcotic. The DON said that Nurse #1 had her employment terminated due to a lack of stewardship of the narcotics. The Administrator stated the situation did not appear to involve diversion and was unclear. The Administrator recalled a hospice nurse stating the missing medication belonged to hospice and that hospice would conduct its own investigation and report to the proper authorities. The DON stated that the facility was informed by a hospice nurse that Resident #2 was missing 30 tablets of Hydrocodone-Acetaminophen, and she thought it was connected to the missing Hydrocodone-Acetaminophen reported on 10/3/2025. The DON confirmed she did not have any evidence of an investigation into Resident #2's missing Hydrocodone-Acetaminophen, but suspected Nurse #1 misplaced Resident #2's medication.An attempt was made to contact Nurse #1 on 2/17/2026 at 4:56 PM via the telephone; however, current contact information was not available, as her phone number was no longer active.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review, and interviews with staff, hospice staff, and pharmacy staff, the facility failed to implement their abuse policy regarding the investigation and reporting of an allegation of misappropriation of the narcotic medication Hydrocodone-Acetaminophen for 2 of 2 residents reviewed for misappropriation of medication (Resident #2 and Resident #3).The findings included:Record review of the facility abuse, neglect, and exploitation policy, dated as implemented on 12/1/2022, showed that during the investigation of abuse, to include misappropriation of resident property, the facility was required to exercise caution in handling of evidence that could be used in a criminal investigation, focus the investigation on determining if misappropriation occurred, and provide complete and thorough documentation of the investigation. The same policy, under reporting/response section, indicated that the facility would report all alleged violations to the state agency, adult protective services, and law enforcement when applicable within the required 24-hour timeframe if the allegation did not involve serious bodily injury. Additionally, the policy stated that the facility would report to the licensing authority any knowledge it had of actions by a court of law which would indicate an employee was unfit for service.1. Resident #3 had a physician's order initiated on 9/24/2025 Hydrocodone-Acetaminophen 5-325 milligrams (mg) to be administered as one tablet by mouth every 4 hours as needed for pain.An interview conducted with a Pharmacist (Pharmacist #2) from the local pharmacy on 2/20/2026 at 9:26 AM confirmed the local pharmacy dispensed 30 tablets of Hydrocodone-Acetaminophen for Resident #3, and the prescription was picked up on 9/24/2025 at 8:03 PM.Documentation in a nursing progress note dated 9/25/2025 at 4:36 PM, written by Unit Manager #1, revealed that Resident #3 was complaining of left hip pain. A hospice nurse assessed the resident, and a new order for Hydrocodone-Acetaminophen was initiated to be administered every 4 hours as needed.An interview was conducted with the facility's Pharmacy General Manager over the phone on 2/18/2026 at 10:46 AM. The General Manager stated that the pharmacy received an order to dispense 84 tablets of Hydrocodone-Acetaminophen 5-325 mg for Resident #3. The General Manager explained that 30 tablets of Hydrocodone-Acetaminophen 5-325 mg were delivered to the facility from the pharmacy for Resident #3 on 9/30/2025 at 7:53 PM and signed for by Nurse #1.Medication Aide (Med Aide) #1 was interviewed on 2/17/2026 at 1:40 PM. Med Aide #1 reported that during the narcotic count with Nurse #1 on 10/3/2025 at 7:00 AM, the Hydrocodone-Acetaminophen for Resident #3 was missing. Initially, Med Aide #1 assumed the pain medication for Resident #3 had been discontinued and did not question Nurse #1. Later in her shift on 10/3/2025, Med Aide #1 noted that the prescription for Hydrocodone-Acetaminophen for Resident #3 had not been discontinued and immediately notified the supervising nurse and the Director of Nursing (DON) of the missing medication.On 2/17/2026 at 1:17 PM the Director of Nursing (DON) provided a written statement with the details of an investigation of missing narcotic medication for an unnamed resident that went missing in October 2025. The written statement provided the following information: The Administrator and the DON were notified of missing narcotic medication on a medication cart on 10/2/2025. Med Aide #1 reported the medication missing and the narcotic medication was not on the cart at the beginning of her shift when she reconciled the narcotic medication count with Nurse #1. Med Aide #1 recalled a medication container but did not question Nurse #1 about the medication's absence during the narcotic medication count at the change of shift. The medication carts were checked to ensure the medication was not misplaced. A hospice nurse, who was already in the facility, was made aware of the misplaced medication and a new prescription was obtained and dispensed by the pharmacy. The DON interviewed Nurse #1, who recalled putting the narcotic medication in the drawer, but did not recall anything else. Med Aide #2 was interviewed and remembered counting off with Nurse #1. The DON contacted (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the pharmacy and confirmed Nurse #1 signed for the narcotic medication. Based on interviews, diversion was not suspected but the medication was misplaced and then immediately replaced. Hospice was aware and was conducting their own investigation.On 2/17/2026 at 1:17 PM the DON was interviewed after she provided the written documentation of the facility's investigation into the misappropriation of medication. The DON did not recall which resident was affected by the missing narcotic medication, but she thought it was Resident #2. The DON confirmed that the facility was unable to locate the medication monitoring/control record for Resident #3's Hydrocodone-Acetaminophen 5-325 mg that was delivered on 9/24/2025 or 9/30/2025. The DON explained she reviewed the nursing schedule from 10/1/2025 to 10/3/2025 and determined the only staff members with the responsibility of the medication cart were Nurse #1, Med Aide #2, and Med Aide #1. The DON stated Nurse #1 was assigned the medication cart on 10/1/2025 at 11:00 PM to 10/2/2025 at 7:00 AM. Med Aide #1 took over the responsibility of the medication cart on 10/2/2025 at 7:00 AM until 3:00 PM. Med Aide #2 took over the responsibility of the medication cart on 10/2/2025 at 3:00 PM until 11:00 PM. Nurse #1 was again assigned the medication cart on 10/2/2025 at 11:00 PM until 7:00 AM on 10/3/2025 when she reconciled the medication cart with Med Aide #1. The DON explained that she was notified during a clinical meeting on 10/3/2025 by Med Aide #1 that narcotic medication was missing on the cart. The DON confirmed notification occurred on 10/3/2025 and not on 10/2/2025 as her written statement suggested. The DON stated she immediately checked all medication carts and verified that medication monitoring/control records matched the controlled medication counts. The DON confirmed no discrepancies were found except for Resident #3's medication. The DON explained that she interviewed both Med Aide #1 and Med Aide #2 on 10/3/2025. The DON stated the Med Aides both remembered the medication container with Hydrocodone-Acetaminophen from the outside pharmacy being on the medication cart prior to the 11:00 PM to 7:00 AM ending on 10/3/2025. The DON stated she also interviewed Nurse #1 who did not recall where the narcotic medication was or how it went missing. The DON described Nurse #1's response as unprofessional; Nurse #1 was suspended and ultimately terminated.An interview was conducted with Unit Manager #1 on 2/18/2026 at 11:51 PM. Unit Manager #1 stated that on 10/3/2025, Med Aide #1 interrupted the morning clinical meeting at approximately 10:00 AM to inform the DON of a concern for missing Hydrocodone-Acetaminophen on the medication cart. The Unit Manager reported that she and the DON checked the medication carts to see if the narcotic medication for Resident #3 was misplaced. The Unit Manager stated that they checked the medication carts by comparing the medication monitoring/control record for each resident's-controlled medication to the amount of medication in the drawer. The Unit Manager confirmed that all the narcotic medication was all accounted for on 10/3/2025, and no other discrepancies were found except for Resident #3's Hydrocodone-Acetaminophen.The DON was interviewed on 2/17/2026 at 11:53 AM and stated that hospice nurse informed her that hospice had their own process for addressing missing narcotic medication in a facility. The DON recalled that the hospice nurse, whose name she could not remember, indicated the medication of a hospice resident, belonged to hospice, and hospice would conduct its own investigation and report to the appropriate authorities. The DON further explained that, based on this information, if the missing medication belonged to hospice, then it was not considered misappropriation from a resident. The DON and the facility Administrator were simultaneously interviewed on 2/18/2026 at 8:46 AM. The Administrator stated that facility investigated the missing Hydrocodone-Acetaminophen on 10/3/2025, but all the documentation of the investigation was lost or misplaced. The DON stated she called Nurse #1 on 10/3/2025 to inform her of her suspension and the need to provide a written statement regarding the missing medication. The DON reported Nurse #1 arrived for her previously scheduled shift at 11:00 PM on 10/3/2025, was reminded of her suspension, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was instructed to return in the morning to complete the statement. The DON explained Nurse #1 did not return for several days to provide the statement. The DON indicated when Nurse #1was interviewed, she had no recollection of what happened to the missing Hydrocodone-Acetaminophen or where she may have put the missing narcotic. The DON confirmed that Nurse #1 had responsibility for medication carts on other floors and hallways during her employment. The DON reported that Nurse #1 had her employment terminated due to a lack of stewardship of the narcotics. The Administrator stated that the situation did not seem like a diversion of narcotics and it didn't make sense. The Administrator explained the event was treated as a human resources issue rather than a case of medication diversion. The Administrator recalled a hospice nurse telling her that the missing medication belonged to hospice and not to the resident, and that hospice would conduct its own investigation and report to the authorities. The Administrator confirmed the facility did not report the misappropriation to the state agency, the local authorities, adult protective services, or a licensing agency. An interview was conducted over the telephone with the Director of Patient Care Services, an Assistant Director, and Hospice Nurse #1 from Hospice Provider #1 on 2/17/2026 at 4:37 PM. Hospice Nurse #1 revealed she was contacted on 10/3/2026 by the facility that Resident #3's Hydrocodone-Acetaminophen to include 30 tablets on a medication card and an unknown amount in a medication container from an outside pharmacy had been diverted from the facility. Hospice Nurse #1 stated she would have no way of investigating the diversion of medication in a facility due to a lack of knowledge of nursing staffing information. The Director of Patient Care Services added that Hospice Provider #1 nurses are not the ones to administer the narcotic medication and are not the ones with the responsibility of investigation or reporting of diversion in a facility. All three interviewees confirmed that the medication Hydrocodone-Acetaminophen belonged to Resident #3, not Hospice Provider #1.The facility Administrator was interviewed on 2/18/2026 at 1:15 PM. The Administrator stated that when she became aware of the allegation of misappropriation, she believed the payer source of the medication determined whether misappropriation from a resident had occurred. She explained that since hospice was the payer source for Resident #3's medication, she understood the diversion to affect hospice rather than the resident. Based on this understanding, the Administrator believed the misappropriation was not reportable and assumed hospice would conduct its own investigation and reporting. The Administrator noted that Nurse #1 had been in employment of the facility for 5 months at the time of the incident and had previously struggled with recalling information in an unrelated circumstance. The Administrator added that the facility had been moving office locations and the investigation of the missing Hydrocodone-Acetaminophen in October 2025 for Resident #3 was lost. Without documentation of the investigation, the Administrator declined to speculate what had occurred or what further actions the facility took.2. Resident #2 had a physician's order initiated on 9/25/2025 for Hydrocodone-Acetaminophen 5-325 milligrams (mg) to be administered as one tablet by mouth every 8 hours for pain.An interview was conducted with a Pharmacist #1 from the facility pharmacy via the telephone on 2/17/2026 at 4:00 PM. Pharmacist #1 stated the pharmacy dispensed 43 tablets of Hydrocodone-Acetaminophen for Resident #2, which were delivered on 9/26/2025 at 2:43 AM, 30 tablets on a medication card and 13 tablets on another medication card. The medication for Resident #2, delivered to the facility on 9/26/2025, was signed for by Nurse #1. Pharmacist #1 explained that the 43 tablets was enough medication to last until 11/4/2025, if administered as ordered.Documentation on the October 2025 Medication Administration Record (MAR) for Resident #2 revealed indicated that Hydrocodone-Acetaminophen was administered on a scheduled basis at 2:00 AM, 10:00 AM, and 6:00 PM daily. On 10/6/2025 at 6:00 PM, Medication Aide (Med Aide) #2 documented that Resident #2 did not receive his pain medication and noted to refer to the nursing (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes.Documentation in the Medication Administration notes for Resident #2 dated 10/6/2025 at 5:07 PM written by Med Aide #2 revealed, Hydrocodone-Acetaminophen oral tablet 5-325 mg give 1 tablet by mouth every 8 hours for pain awaiting pharmacy per nurse.Hospice Nurse #2 was interviewed via the telephone on 2/18/2026 at 12:46 PM and provided the following information. On 10/6/2025 an after-hours call was received by Hospice Provider #2 that Resident #2 had ran out of Hydrocodone-Acetaminophen. Resident #2 should not have run out of Hydrocodone-Acetaminophen until 11/4/2025. Hospice Nurse #2 called the Assistant Director of Nursing for the facility and was informed of an active investigation into diversion of narcotics was underway. Hospice Nurse #2 stated she spoke with the facility Administrator, who told her the facility has an open investigation into drug diversion, and they had a nurse who was suspected. The Administrator indicated Hospice Nurse #2 would receive additional information after the investigation concluded; however, Hospice Nurse #2 reported no further information was provided. Hospice Nurse #2 clarified Hospice Provider #2 did not own the medication and that the medication supplied through hospice belonged to Resident #2. Hospice Nurse #2 further explained that her role was limited to assessing symptom management for Resident #2 and that she did not have access to the information necessary to investigate narcotic diversion within a facility.An interview was conducted with the Senior Patient Care Manager for Hospice Provider #2 on 2/17/2026 at 2:27 PM. The Senior Patient Care Manager stated that the narcotic medication for Resident #2 did not belong to Hospice Provider #2. She explained that a hospice nurse from Hospice Provider #2 would check the amount of narcotic medication on the medication cart during each visit to verify administration and ensure medication orders were appropriate. The Senior Patient Care Manager reported that on 10/6/2025, she was informed by Hospice Nurse #2 that 30 tablets of Hydrocodone-Acetaminophen for Resident #2 had been diverted from the facility. She clarified Hospice Provider #2 was responsible for ensuring Resident #2's medication was reordered to prevent pain but did not have the responsibility for investigating or reporting narcotic diversion within the facility.During an interview, the Director of Nursing (DON) reported on 2/17/2026 at 1:17 PM that the facility could not locate the medication monitoring/control record for Resident #2's Hydrocodone-Acetaminophen card of 30 tablets received on 9/26/2025. However, the DON provided the medication monitoring/control record for the 13-tablet card received on the same date, which indicated Resident #2 ran out of Hydrocodone-Acetaminophen on 10/5/2025, with the last dose administered at 2:00 AM. The DON explained that she had initiated a diversion investigation on 10/3/2025. The DON stated she reviewed the nursing schedule from 10/1/2025 to 10/3/2025 and determined the only staff members with the responsibility of the medication cart were Nurse #1, Med Aide #2, and Med Aide #1. The DON stated she immediately went to all the medication carts throughout the facility and verified that the medication monitoring/control records for the residents on controlled medication matched the amount of controlled medication in the medication carts. The DON confirmed no discrepancies were found on any of the carts on 10/3/2025. The DON stated she also interviewed the staff with the responsibility of the nursing medication cart with the missing narcotic medication. Nurse #1, during her interview did not recall where the narcotic medication was or how it went missing. The DON indicated Nurse #1's response to the inquiry was unprofessional; Nurse #1 was suspended and then ultimately terminated from her employment with the facility.Unit Manager #1 was interviewed on 2/18/2026 at 11:51 AM. Unit Manager #1 stated that Hospice Nurse #2 determined that Resident #2's Hydrocodone-Acetaminophen was missing and notified the DON. Hospice Nurse #2 determined on 10/6/2025 that Resident #2 should have had more medication than what was present, and that he had a whole card of 30 tablets missing from the medication cart. Unit Manager #1 confirmed that she assisted the DON on 10/3/2025 in comparing the Medication Monitoring/Control Records for each (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident on her unit receiving controlled medication and comparing it to the amount of controlled medication in the drawer. Unit Manager #1 stated that neither the Medication Monitoring/Control Record for the 30 tablets of Hydrocodone?Acetaminophen nor the medication card was on the medication cart for Resident #2; therefore, the medication count appeared correct when it was checked on 10/3/2025.The DON and the facility Administrator were interviewed together on 2/18/2026 at 8:46 AM. The Administrator stated that facility did investigate the missing Hydrocodone-Acetaminophen beginning on 10/3/2025, but all the documentation of the investigation were lost or misplaced. The DON reported that she called Nurse #1 on 10/3/2025 to inform her of her suspension and the need to provide a written statement regarding the missing medication. The DON stated that Nurse #1 arrived for her previously scheduled shift at 11:00 PM on 10/3/2025, was reminded of her suspension, and was instructed to return in the morning to complete the statement. The DON explained that Nurse #1 did not return for several days to provide the statement. When interviewed by the DON, Nurse #1 stated she had no recollection of what happened to the missing Hydrocodone-Acetaminophen or where it might have been placed. The DON confirmed that Nurse #1's employment was terminated due to lack of stewardship of narcotics. The Administrator stated that it did not seem like a diversion of narcotics and it didn't make sense. The Administrator explained the event was treated as a human resources issue rather than a case of medication diversion. The Administrator remembered a hospice nurse telling her that the missing medication belonged to hospice and not to the resident. The Administrator recalled a hospice nurse informing her that the missing medication belonged to hospice and not to the resident, and that hospice would conduct its own investigation and report to the authorities. The DON stated that the facility was informed by a hospice nurse that Resident #2 was missing 30 tablets of Hydrocodone-Acetaminophen, and she believed this was connected to the missing Hydrocodone-Acetaminophen reported on 10/3/2025. The DON confirmed she had no documentation of an investigation into Resident #2's missing Hydrocodone-Acetaminophen, but she suspected Nurse #1 misplaced it.The facility Administrator was interviewed on 2/18/2026 at 1:15 PM and the following information was provided. The Administrator stated that when she became aware of the allegation of misappropriation, she believed the payer source of the medication determined whether misappropriation from a resident had occurred. She explained that since hospice was the payer source for Resident #2's medication, she understood the diversion to affect hospice rather than the resident. Based on this understanding, the Administrator believed the misappropriation was not reportable and assumed hospice would conduct its own investigation and reporting. The Administrator noted that Nurse #1 had been employed at the facility for five months at the time of the incident and had previously struggled with recalling information in an unrelated circumstance. She added that the facility was in the process of relocating offices, and documentation of the investigation into the missing Hydrocodone-Acetaminophen in October 2025 was lost. Without documentation, the Administrator declined to speculate on what occurred or what further actions were taken by the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews and record reviews, the facility failed to accurately document the administration of Hydrocodone?Acetaminophen, a narcotic medication, on the medication administration record for 1 of 2 residents reviewed for accurate narcotic documentation (Resident #2).The findings included:Resident #2 had a physician's order dated 9/25/2025 for Hydrocodone?Acetaminophen 5?325 mg to be administered as 1 tablet every 8 hours for pain, scheduled for 2:00 AM, 10:00 AM, and 6:00 PM.A telephone interview was conducted with Pharmacist #1 on 2/17/2026 at 4:00 PM. Pharmacist #1 reported that the pharmacy dispensed 43 tablets of Hydrocodone?Acetaminophen for Resident #2, delivered to the facility on 9/26/2025 at 2:43 AM. The supply consisted of one 30?tablet medication card and one 13?tablet medication card. Nurse #1 signed for the delivery. Pharmacist #1 stated that 43 tablets would have been sufficient to last until 11/4/2025 if administered as ordered.The Director of Nursing (DON) reported on 2/17/2026 at 1:17 PM that the facility was unable to locate the medication monitoring/control record for the 30?tablet card received on 9/26/2025. The DON did provide the monitoring/control record for the 13?tablet card, which showed that Resident #2 ran out of Hydrocodone?Acetaminophen on 10/5/2025, with the last documented dose removed from the medication cart at 2:00 AM.Documentation on the medication monitoring/control record for the 13?tablet card for Hydrocodone-Acetaminophen indicated that Nurse #1 removed the first dose at an unclear date in 2025 at 8:00 PM, an unscheduled administration time for Resident #2.Documentation on the September 2025 Medication Administration Record (MAR) indicated that Nurse #1 administered Hydrocodone?Acetaminophen to Resident #2 on 9/26/2025 at 2:00 AM. No additional doses administered by Nurse #1 were documented on the September 2025 MAR.The medication monitoring/control record for the 13?tablet card of Hydrocodone-Acetaminophen further indicated that Nurse #1 documented removing doses from the cart on 10/2/2025 at 8:00 PM and again at 060, an unclear military time entry. Both entries reflected unscheduled administration times. There was no documentation on the record of medication being removed for Resident #2 at the scheduled administration time of 2:00 AM on 10/2/2025 by Nurse #1. Documentation on the October 2025 MAR indicated that Nurse #1 administered Hydrocodone-Acetaminophen to Resident #2 on 10/2/2025 at 2:00 AM. An attempt was made to contact Nurse #1 on 2/17/2026 at 4:56 PM via telephone; however, current contact information was unavailable, as her phone number was no longer active.During an interview on 2/17/2026 at 1:17 PM, the DON stated she observed that Nurse #1 documented removing tablets from the 13?tablet medication card at unscheduled times that were not reflected on the MAR. The DON reported that she questioned Nurse #1 about these discrepancies during an investigation into possible misappropriation of Resident #2's Hydrocodone?Acetaminophen. According to the DON, Nurse #1 could not recall whether the medication had been administered or explain the discrepancies in the documentation. The DON acknowledged that the documentation on the medication monitoring/control record should match the documentation on the MAR for a clear accounting of the narcotic medication.