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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, and staff and resident interviews, the facility failed to act upon grievances that were reported by the Resident Council and communicate the facility's efforts to address grievances voiced during Resident Council meetings for 2 of 2 consecutive months: June 2025, and July 2025.The findings included:a. A review of the Resident Council minutes completed by the Activities Director dated 6/24/25 revealed the following grievances were expressed: housekeeping does not take out their trash, nursing assistants take their time putting the residents to bed, 3rd shift nurses are sleeping in the day room and not answering call bells, laundry was not being sent up in a timely manner. A review of the grievances for the month of June 2025 revealed no Resident Council grievances were submitted. b. A review of the Resident Council minutes completed by the Activities Director dated 7/23/25 revealed the following grievances were expressed: second shift does not help residents into bed timely, television time in the day room is not being shared with residents and missing personal items. There was no documented discussion or resolution of the previous month's grievances. A review of the grievances for the month of July 2025 revealed no grievances were submitted. A Resident Council meeting was held on 8/27/25 at 11:00 AM with Residents #30, #83, #90 #161, # 189, 217. During the meeting, Resident #90, the resident council president, expressed that the Resident Council had voiced several grievances in the past two months which had not been fully addressed, and the staff have not communicated the facility's efforts in addressing their grievances. An interview with the Activities Director on 8/28/25 at 10:57 AM revealed that he was not aware that he needed to document resident council grievances or to communicate the facility's efforts in addressing the grievances.An interview with the Administrator on 8/29/25 at 12:45 PM revealed that Resident Council grievances should have been documented and the follow up to those grievances should have been provided to the Resident Council members at the next meeting.

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

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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.

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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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to notify the North Carolina Medicaid Uniform Screening Tool (NC MUST), that is the State Mental Health or Intellectual Disability Authority, when a significant change in condition was identified for a resident with a mental disorder and failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation for PASRR Level II for 2 of 3 residents reviewed for significant change in condition (Resident #10 and Resident # 204). The findings included: 1. The resident's electronic medical record (EMR) included information from the North Carolina Medicaid Uniform Screening Tool (NC MUST). This record revealed Resident #10 was evaluated and found to have a PASRR Level I determination with a start date of 10/28/18. The PASRR Level I evaluation assessed the resident for the appropriateness of nursing facility placement and no further PASRR screening was required unless a significant change occurred with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. The Level I designation specified there was no end date and no limitation unless the resident had a change in condition. Resident #10 was admitted to the facility on [DATE]. His cumulative diagnoses included a diagnosis of schizoaffective disorder, bipolar type and post-traumatic stress disorder. Resident #10's electronic medical record revealed a hospital psychiatric care coordination note dated 7/11/24 which revealed a problem list and noted a diagnosis of other schizophrenia on 8/11/22 and a diagnosis of post-traumatic stress disorder dated 6/7/19. Physician order dated 3/19/25 revealed a new order for .5 milligrams of Ativan three times a day for anxiety. This medication was discontinued on 7/22/25. Physician order dated 7/23/25 revealed an order for quetiapine fumarate 200 milligrams to be administered at bedtime for bipolar disorder. A psychiatric quarterly treatment plan and progress note dated 7/25/25 indicated Resident #10 has had a decline in mental status and anxiety symptoms had worsened since her previous treatment plan. An interview was conducted on 8/28/25 at 9:27 AM with the Director of Social Services and she indicated she did not realize Resident #10 had diagnosis of schizoaffective disorder and post-traumatic stress disorder added to the diagnosis list after the initial level I PASRR screening had been completed. She further revealed that she and the social work assistants were not aware that Resident #10 and a decline in mental status and anxiety symptoms and therefore did not initiate a Level II PASRR screening. The Director of Social Services also indicated that a Level II PASRR screening should have been initiated for Resident #10 due to having a serious mental illness and a noted decline in mental status, anxiety symptoms and changes in treatment. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing on 8/28/2025 at 9:41 AM. She indicated that due to Resident #10 having a diagnosis of a serious mental illness with a change in behaviors and treatments he should have been screened for a level II PASRR. 2. The review of the PASRR Level 1 determination dated 8/3/23 for Resident #204, read in part: “No further PASRR screening is required unless a significant change occurs with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. Resident #204 was originally admitted to the facility on [DATE] with diagnoses which included moderate dementia with mood disturbance, and anxiety. Review of the quarterly Minimum Data Set, dated [DATE] indicated Resident #204 was moderately, cognitively impaired with the diagnoses of depression, mood disorder, and anxiety. The clinical record revealed Resident #204's diagnoses was updated on 11/4/24 to include bipolar disorder. A review of the Psychiatric Progress Note dated 8/1/25 revealed Resident #204's past medical history included the diagnosis of bipolar disorder for which he was ordered and received Seroquel (an antipsychotic medication) for mood disorder. Review of the facility's records indicated Resident #204 was not referred to the state-designated authority for a Level II PASRR evaluation post his bipolar disorder diagnosis. During an interview on 8/29/25 at 9:49 a.m. the facility's Director of Social Services revealed she began working at the facility in January 2025. She indicated she was not aware Resident #204 had a diagnosis of bipolar disorder added to her list of diagnoses after the initial level 1 PASRR. The Director of Social Services acknowledged a Level II PASRR screening request should have been submitted to the state's mental health authority when Resident #204's mental status changed resulting in the diagnosis of bipolar disorder.

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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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to keep food preparation areas, floors and food service equipment clean, free from debris and/or dried spills during two kitchen observations. The facility failed to clean the ceiling vents located over the food preparation and food service areas. These practices had the potential to affect food served to residents. The findings included:During a kitchen tour on 8/25/25 at 10:32 AM, the following observations were made with the Dietary Manager:a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. b. The 4-plate warmers had 4 rows of clean plates stored inside the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around. c. The 6-compartment steam table had floating food particles in standing water, the lids of the steam table had large volumes of dried food and greasy build up around edges.d. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside and the fryer also had a heavy grease and food build-up inside and outside. Food products were observed behind the fryer and on the floor that included paper products, dried meats and vegetables.e. The floor area under the stoves, oven, preparation tables, steam tables were sticky with old food debris when walking across the floor. f. All 10 meal carts with dry food products stored in them had dried liquids, food crumbs and particles inside. The outside of all 10 carts also had dried liquids running down the fronts/sides of the cart.g. The 3 ceiling vents had large volumes of black dust/debris blowing over the steam table, clean dry dishware storage racks, food service and preparation surfaces.h. The microwave had large amounts of dried food and liquid products on the inside and outside.An interview was conducted on 8/25/25 at 10:30 AM with the Dietary Manager (DM) who stated the dietary staff were required to wipe down kitchen equipment after each meal and deep clean weekly in accordance with the kitchen cleaning checklist. The DM stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly. The DM acknowledged the identified kitchen equipment and ceiling vents had not been cleaned in accordance with the checklist. An interview was conducted on 08/25/25 at 12:24 PM with the Maintenance Assistant who stated that he was unaware of the cleaning process for the kitchen vents or the grease container because he was recently hired. A follow-up observation and interview were conducted on 8/27/25 at 11:27 AM with the Dietary Manager (DM) and Regional Director of Dietary Services who observed the meals were placed in the dirty meal carts and delivered to the main dining rooms and on the halls of 4 floors. The ceiling fans had not been cleaned from the initial tour on 8/25/25. Staff was observed preparing meals with dust particles were blowing overtop of the food prep table and steam table. The steam tables continue to have food particles in water. An interview was conducted on 8/27/25 at 11:27 AM with the Regional Director of Dietary Services who stated the DM and Assistant Dietary Manager (ADM) was responsible for ensuring the kitchen equipment and floors were cleaned in accordance with the kitchen cleaning checklist. The Regional Director of Dietary Services acknowledged the vents needed to be cleaned and stated the dietary staff and maintenance staff were responsible for ensuring the vents were cleaned. An interview was conducted on 8/27/25 at 2:00 PM with the Regional Consultant for Maintenance and Environmental Services. He stated he was unable to confirm when the vents in the kitchen were last cleaned.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure the garbage and refuse was disposed of and keep 4 of 4 dumpsters and 1 of 1 grease interceptor container, and surrounding dumpster area clean and free from debris. This practice had the potential to attract pests and rodents. The findings included:During an initial tour observation on 8/25/25 at 10:00 AM, 4 dumpsters and 1 grease interceptor container located near a wooded area at the back of the facility. The dumpsters had several bags of garbage and refuse overflowing from the tops. In addition, there were loose paper products, boxes, food products, mattresses, furniture, old pallets, clothing, and a blanket outside of the dumpster containers littering the ground and surrounding areas. The grease interceptor container was leaking grease on the ground along with the trash onto the parking lot. A follow-up observation and interview were conducted on 8/25/25 at 10:15 AM with the Dietary Manager revealed the trash bags filled with garbage left on the ground had been removed, however the surrounding area had not been thoroughly cleaned evidenced by the remaining paper and food products and grease was still on the ground around the sides and backs of the dumpsters. The Dietary Manager stated the dietary and housekeeping staff were responsible for cleaning the dumpsters daily. An observation and interview were conducted on 8/25/25 at 11:40 AM with the Administrator who acknowledged the condition of the dumpster area and the overflowing grease interceptor container. She stated the dumpster area has been in this condition for some time and stated housekeeping, dietary and maintenance staff were responsible for ensuring the dumpster and surrounding area cleaned and maintained daily.An interview was conducted on 8/25/25 at 3:20 PM with the Regional Consultant for Maintenance and Environmental Services who stated the housekeeping, dietary and maintenance were responsible for ensuring the dumpster area was cleaned daily. He further stated he was unaware of when grease interceptor container had been cleaned. He stated it should have been cleaned monthly.An interview was conducted on 8/27/25 at 11:00 AM with the Dietary Manager (DM) and Regional Director of Dietary Services who both stated the maintenance staff were also responsible to ensure the grease receptor was cleaned daily and free of any long-standing grease or debris. The Regional Director of Dietary Service acknowledged the grease interceptor had not been cleaned consistently for several months.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews with staff and the Medical Director, the facility staff failed to utilize a blood glucose meter (glucometer) assigned to Resident #11 and used a glucometer that was assigned to another resident, Resident #141, to check Resident #11's blood glucose level. In addition, the staff member did not disinfect the glucometer before or after obtaining Resident #11's blood glucose level and would have had no way to know if another staff member had previously disinfected the glucometer assigned to another resident. Glucometers can become contaminated with blood and must be disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens. There were no residents with documented blood borne pathogens in the facility at the time of the observation. The deficient practice occurred for 1 of 2 staff members observed for glucometer use (Nurse #1). Immediate Jeopardy began on 8/28/2025 when Nurse #1 was observed performing a blood glucose level check on Resident #11 using Resident #141's assigned glucometer without disinfecting the glucometer per the glucometer manufacturer's instructions and the disinfectant wipes manufacturer's recommendations before or after using the glucometer on Resident #11. Immediate Jeopardy was removed on 8/29/2025 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems was in place and employee education was completed. The findings included: The facility's policy that was implemented on 12/1/2022 and reviewed on 1/1/2025 indicated glucometers would be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant after each use and according to manufacturer's instructions regardless of whether they were intended for a single resident or multiple use. A review of the manufacturer's instructions for the glucometer used when Resident #11's blood glucose level was checked on 8/28/2025 at 9:42 am indicated the glucometer should be cleaned of any dirt, blood, or other bodily fluids from the exterior of the glucometer before performing the disinfecting procedure. The instructions further stated that the glucometer should be cleaned with two disposable, germicidal wipes after each use, one wipe to clean the glucometer and the second to disinfect the glucometer. The manufacturer's instructions for the disposable germicidal wipes used by the facility stated a glucometer should be wiped with a pre-moistened wipe on the surface of the glucometer remaining visibly wet for 2-minutes, additional wipes should be used to maintain wetness for the entire 2-minutes and then allow the surface to air dry after every blood glucose level check. Resident #11 was admitted to the facility on [DATE] with a cumulative list of diagnoses that included diabetes. Resident #141 was admitted to the facility on [DATE] with a cumulative list of diagnoses that included diabetes. Resident #141 did not have a diagnosis of a communicable disease. On 8/28/2025 at 9:42 am an observation and interview were conducted with Nurse #1 during a medication administration observation. During the observation Nurse #1 was observed to look through her medication cart and then removed a glucometer from the medication cart that was in a plastic bag and carried it into the resident's room without cleaning or disinfecting the glucometer. The name on the glucometer was not visible while Nurse #1 obtained Resident #11's blood glucose level. During the observation Nurse #1 checked Resident #11's blood glucose level and then placed the glucometer and storage bag on the table in front of the resident after sticking her finger and the name on the storage bag and glucometer were for another resident, Resident #141. Upon exiting Resident #11's room Nurse #1 stated she could not find Resident #11's glucometer in the medication cart and used Resident #141's glucometer which she stated was new and had not been used before, since the resident had just moved to unit from another unit. Review of the history for Resident #141's glucometer showed several previous blood glucose levels recorded. Nurse #1 placed Resident #141's glucometer on the medication cart and stated she would replace Resident #141's glucometer and obtain a new glucometer for Resident #11. Nurse #1 stated there were glucometers in the facility's supply room and she should have called down to get a replacement glucometer for Resident #11 but was anxious because of the observation. Nurse #1 stated she had been educated regarding how to clean the glucometer and stated they should be cleaned with disinfectant wipes after each time they were used. Nurse #1 opened the medication cart and identified the germicidal wipes used to clean the glucometer. She stated the glucometer should be cleaned with one wipe and then another wipe was to