STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Valley Center for Nursing and Rehabilitation	1000 College Street Wilkesboro, NC 28697

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for 1 of 3 residents (Resident #1) reviewed for wound care.The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus and bilateral below knee amputations (BKKA).Review of Resident #1's medical record revealed a physician order start date of 06/18/25 to cleanse the left below knee amputation (BKA) incision with wound cleanser then apply a petrolatum dressing (a wound dressing made of a fine mesh gauze infused with petrolatum and 3% bismuth and tribromophenate blend) then secure with gauze wrap and ACE bandage daily and as needed. The medical record also included a physician order for a start date of 06/19/25 for the right BKA to cleanse the incision with wound cleanser then apply a petrolatum dressing then secure with gauze wrap and ACE bandage daily and as needed.Review of Resident #1's 06/2025 TAR revealed there was no documentation on 06/21/25, 06/25/25, 06/27/25, 06/27/28, 06/28/25, 06/29/25 and 06/30/25 to indicate the treatment was completed as ordered.Review of Resident #1's medical record revealed a physician start date of 07/04/25 to cleanse the left BKA incision with wound cleanser then paint with betadine then apply a petrolatum dressing and secure with gauze wrap and ACE bandage daily and as needed. The medical record also included a physician order for a start date of 07/04/25 for the right BKA to cleanse the incision with wound cleanser then paint the incision with betadine then apply a petrolatum dressing then secure with gauze wrap and ACE bandage daily and as needed.Review of Resident #1's Treatment Administration Record (TAR) for 07/2025 revealed there was no documentation on 07/04/25 and 07/05/25 that the treatments had been completed as ordered.Attempts were made to interview Nurse #1 who worked on 06/21/25 but the attempts were unsuccessful.An interview was conducted on 07/16/25 with Nurse #2 who confirmed she worked on 06/25/25 for the day shift (7:00 AM - 7:00 PM). The Nurse explained that she normally signed off her treatments after she completed them, but she was really busy towards the end of June but ensured she completed the treatment as ordered.An interview was conducted on 07/16/25 at 9:30 AM with Nurse #3 who confirmed she worked the day shift on 06/27/25, 06/28/25, 06/29/25, 07/02/25 and 07/03/25. The Nurse explained that it took her several days to learn the facility's electronic medical record and that she had to go to the TAR to sign off for the treatments, but Nurse #3 assured that the treatments were completed as ordered.An interview was conducted with Nurse #4 on 07/17/25 at 10:20 AM who confirmed she worked 06/30/25, 07/04/25 and 07/05/25 on the day shift. The Nurse explained that she was aware of Resident #1's bilateral BKA (BBKA) stump dressings and assured the dressings were completed but she forgot to sign off on the TAR. During an interview with the Director of Nursing (DON) on 07/16/25 at 5:45 PM the DON reported that she educated nurses to sign off for the treatments as they completed them and that was her expectation. The DON stated that the treatments were being done.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record reviews and staff interviews, the facility failed to identify the need for Enhanced Barrier Precautions (EBP) for Resident #2 with an unhealed surgical wound and failed to implement their infection control policy when Nurse #2 did not apply a gown when performing wound care for Resident #2. In addition, Nurse #2 failed to change gloves and perform hand hygiene after cleansing wounds and applying the ordered dressing on Resident #2 and Resident #3. This occurred for 1 of 1 staff member observed for infection control practices. The findings included:Review of the facility's Enhanced Barrier Precautions policy dated 2025 revealed: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 2. Initiation of EBP: b. An order for enhanced barrier precautions will be obtained for residents for unhealed surgical wounds.Review of the facility's Hand Hygiene policy dated 2025 revealed: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. 1. Staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in but not limited to the attached hand hygiene table. 6. The use of gloves does not replace hand hygiene. If your tasks require gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.Review of the facility's policy for Clean Dressing Change dated 2024, revealed: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination. 9. Loosen the tape and remove the existing dressing. 10. Remove gloves pulling inside out over the dressing and discard into appropriate receptacle. 11. Wash hands and put on clean gloves.1. An observation was made of Nurse #2 performing a surgical wound dressing change to Resident #2 on 07/16/25 at 2:50 PM. There was no EBP sign posted on or near the Resident's door. The Nurse sanitized her hands and donned gloves but did not don a gown, then proceeded to remove the existing dressing from the back of Resident #2's neck. Without removing her gloves and performing hand hygiene and applying new gloves, the Nurse proceeded to pick up the gauze soaked with wound cleanser and cleansed the wound. Nurse #2 then removed her gloves and performed hand hygiene and applied new gloves then applied the ordered dressing and secured it with a border dressing. The Nurse then removed her gloves and performed hand hygiene.An interview was conducted with Nurse #2 on 07/16/27 at 3:20 PM. The Nurse acknowledged there was no EBP sign posted on or around Resident #2's door. The Nurse was asked if a surgical wound constituted EBP and the Nurse stated she honestly did not know because it had been changed several times. The Nurse stated if Resident #2 should have been on EBP then she was aware that she should have applied a gown as well as gloves. Nurse #2 was asked to retrace the steps of the dressing change process and when the Nurse stated that she removed the old dressing she immediately stated she did not change her gloves and wash her hands, and she should have. The Nurse stated she just forgot the change her gloves. An interview was conducted with the Infection Preventionist (IP) on 07/16/25 at 3:35 PM. The IP explained that it was her responsibility to manage the infection control system in the facility, but she had not been doing it for long. The IP stated surgical wounds should have EBP posted, and it was an oversight on her part that Resident #2 did not have an EBP sign posted on her door. She stated Nurse #2 should have donned both gloves and gown for the dressing change procedure.During an interview with the Director of Nursing (DON) on 07/16/25 at 5:45 PM the DON acknowledged that there was no EBP sign posted on Resident #2's door and stated per the facility's policy on EBP there should have been a sign posted to inform the staff that the EBP should be followed. The DON indicated Nurse #2 should have changed her gloves and performed hand hygiene after she removed the old dressing.2. An observation was made of Nurse #2 performing a wound (skin tear) dressing change to Resident #3 on 07/16/25 at 3:10 PM. The Nurse sanitized her hands and donned gloves then proceeded to remove the existing dressing from the Residents left shin which was saturated with serosanguinous (bloody) drainage. Without removing her gloves and performing hand hygiene and applying new gloves, the Nurse proceeded to pick up the gauze soaked with wound cleanser and cleansed the wound. Nurse #2 then removed her gloves and performed hand hygiene and applied new gloves then applied the ordered dressing and secured it with a border dressing. The Nurse then removed her gloves and performed hand hygiene.An interview was conducted with Nurse #2 on 07/16/27 at 3:20 PM. Nurse #2 was asked to retrace the steps of the dressing change process and when the Nurse stated that she removed the old dressing she immediately stated she did not change her gloves and wash her hands just like she did not change them with the other