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	12/04/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations and staff interviews, the facility failed to remove 2 expired Bisacodyl suppositories, 10 expired omeprazole tablets in accordance with the manufacturer's expiration date, and 27 unidentifiable loose pills from the medication carts. The facility also failed to date 2 opened insulin pens per manufacturer's specification for 4 of 4 medication carts (A, B, C and D) reviewed for medication storage.The findings included: Review of the package inserts for insulin Glargine revealed it could be stored under refrigeration at 36 to 46 Fahrenheit (F) unopened until the expiration date. Once the insulin pen was opened and in use, it could be kept at room temperatures below 86 F for up to 28 days. Discarded the insulin after 28 days even if it still had insulin in it. a.During a medication storage audit conducted on 12/02/25 at 4:34 PM in the presence of Certified Medication Aide (CMA) #1, two (2) Bisacodyl rectal suppositories 10 milligrams (mg) that expired on 10/31/25 were found in the medication cart for A Hall and available for use. An interview was conducted with CMA #1 on 12/02/25 at 4:36 PM. He acknowledged that the 2 suppositories were expired and should be discarded. He did not notice the 2 expired suppositories in the medication cart and explained he typically checked the medication cart for expired medications at the end of the shift. During an interview conducted on 12/02/25 at 4:41 PM, Nurse #1 stated she was the supervising nurse for CMA #1. She confirmed the 2 Bisacodyl suppositories were expired and needed to be discarded. She expected the nurse who worked the previous shift to check the medication cart before shift transition to ensure the medication cart was free of expired medications. b. During a medication storage audit conducted on 12/02/25 at 5:00 PM in the present of Nurse #1, seventeen (17) unidentifiable loose tablets with different colors and shapes were found at the bottom of the drawer of medication cart for B Hall. Out of the 17 loose pills, 15 tablets were round shaped, and 2 tablets were oblong. An interview was conducted with Nurse #1 on 12/02/25 at 5:02 PM. She stated it was her first shift working with the medication cart for B Hall and added she was a visiting nurse from another facility. She explained she had just started the shift and did not have time to check the medication cart yet. Nurse #1 was unable to provide information related to the name of the loose pills and their expiration dates. She acknowledged that all the loose pills should be discarded. c. During a medication storage audit conducted on 12/02/25 at 5:17 PM in the presence of CMA #2, ten (10) unidentifiable loose tablets with different colors and shapes were found at the bottom of the drawer of medication cart for C Hall. Out of the 10 loose pills, 8 tablets were round shaped, and 2 tablets were oblong. In addition, 10 tablets of Omeprazole 20 mg that expired on 11/30/25 were also found in the medication cart and ready to be used. An interview was conducted with CMA #2 on 12/02/25 at 5:19 PM. He stated he had been instructed to check his medication cart each shift. He denied seeing any loose pills when he checked the medication cart for C Hall yesterday. CMA #2 indicated the expired Omeprazole that was found in the medication cart was his oversight. He acknowledged that all the loose pills and the expired Omeprazole should be discarded in a timely manner. d. During a medication storage audit conducted on 12/02/25 at 5:29 PM in the presence of CMA #3. Two (2) opened insulin Glargine pens that stored in room temperature were found in medication cart for D Hall without any opened date, and available for use. An interview was conducted with CMA #3 on 12/02/25 at 5:32 PM. She stated that as a CMA, she did not deal with insulin. The nurse was supposed to date the insulin once it was opened. During an interview conducted on 12/02/25 at 5:37 PM. Nurse #2 acknowledged that she was the supervisor nurse for CMA #3. She could not explain why both insulin pens in the medication cart for D Hall were not dated after they were opened and in use. It was her expectation for all the nurses to date the insulin pen or vial after it had been opened. A joint interview was conducted with the Director of Nursing (DON) and the Administrator on 12/02/25 at 5:48 PM. Both the DON and the Administrator stated it was their expectation for all the nursing staff to follow medication storage guidelines as specified by the manufacturer to ensure all insulin were dated after they were opened and discard all the expired and loose pills in a timely manner as indicated.