

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2024
NAME OF PROVIDER OR SUPPLIER  Valley Hill Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1510 Hebron Road Hendersonville, NC 28739	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014</b></p> <p>Based on observations, record review and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 sampled residents observed with medications left at bedside (Resident #127).</p> <p>Findings included:</p> <p>Resident #127 was admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes and chronic pain.</p> <p>A physician's order dated 03/20/24 for Resident #127 read, antacid oral tablet 500 milligrams (mg) - give two tablets by mouth at bedtime (8:00 PM) for supplement.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #127 had intact cognition.</p> <p>Review of Resident #127's medical record revealed no documentation he was assessed for self-administration of medications.</p> <p>Observations on 04/01/24 at 8:50 AM and 10:41 AM revealed Resident #127 lying in bed, sleeping soundly, with the overbed table pulled directly in front of him. Placed on top of the overbed table was a medicine cup containing one round white pill and one round pink pill.</p> <p>During an observation and joint interview with Resident #127 on 04/01/24 at 11:58 AM, Med Aide #1 stated the pills in the medicine cup were antacids and as far as she knew Resident #1 had not been assessed to self-administer his medications nor did he have a physician's order. Med Aide #1 was not sure who had administered Resident #127's antacid medication and stated the pills should not have been left unattended on his overbed table.</p> <p>During a joint interview with Med Aide #1 on 04/01/24 at 11:58 AM, Resident #127 stated he was not sure who brought him the medication that was left on his overbed table. When asked by Med Aide #1 why he didn't take the medication, Resident #127 replied, probably because I didn't know they were there.</p> <p>Nurse #4 was not working during the survey and unable to be interviewed.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/01/24 at 12:39 PM, Unit Manager #1 stated Resident #127's antacid medication should not have been left at bedside since Resident #127 had not been assessed to self-administer medications and he did not have a physician's order to self-administer medications.</p> <p>During an interview on 04/04/24 at 2:31 PM, the Director of Nursing (DON) explained self-administration of medication assessments were only done at the resident's request and could be completed by any nurse. The DON confirmed Resident #127 had not been assessed to self-administer medications and his antacid medication should not have been left unattended on the overbed table in his room. The DON stated nurses were expected to wait at bedside for residents to take their oral medications prior to leaving the room.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39037</p> <p>Based on observations and staff interviews the facility failed to ensure code status information was accurate throughout the paper and electronic medical record for 1 of 2 residents reviewed for advanced directives (Resident #18).</p> <p>Findings included:</p> <p>Resident #18 was admitted to the facility 01/03/24.</p> <p>Review of Resident #18's care plan initiated 01/05/24 revealed she had an advance directive as noted by having a Do Not Resuscitate (DNR) status.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was severely cognitively impaired.</p> <p>Review of Resident #18's electronic medical record (EMR) was conducted 04/04/24. The banner (an area at the top of the computer screen which contains important information about the resident) at the top of Resident #18's EMR revealed she had an advance directive which read DNR.</p> <p>A review of the Code Book (a book containing hard copies of advance directives) kept at the nurses' station revealed a signed MOST (Medical Order for Scope of Treatment) form dated 10/17/23 that indicated Resident #18 was a Full Code. The Code Book also contained a signed DNR form dated 01/03/24 for Resident #18.</p> <p>An interview with Unit Manager #1 on 04/04/24 at 1:52 PM revealed a resident's code status could be verified by checking the computer or the Code Book kept at the nurse's station. When Unit Manager #1 was shown the Code Book with conflicting documentation regarding Resident #18's code status, she stated she guessed the most recently signed advance directive would be followed, but code status would have to be clarified with the resident's family and physician.</p> <p>An interview with the Director of Nursing on 04/04/24 at 3:09 PM revealed a Code Book was kept at each nurse's station to allow for easy access to determine code status but nursing staff could also check the computer for code status. She stated if code status was changed or updated the old advance directive form should be removed from the Code Book, the correct advance directive form should be placed in the Code Book, and the EMR should reflect the correct code status. The DON stated the advance directive form in the Code Book should match the banner in the resident's EMR. She stated she did not have a specific process for ensuring residents' paper advance directives matched the code status in the residents' EMR, but maybe the Social Worker (SW) had a process for checking advance directives.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Social Worker on 04/04/24 at 3:27 PM revealed all invitations to care plan meetings provided to residents or family members listed the resident's code status and had a disclaimer that read along the lines of, If this (code status) information is not correct or if you have changed your mind, please notify us. She stated she also tried to check the Code Book monthly for accuracy, but if she was not able to review the book monthly, it was reviewed annually at the end of the year. The SW confirmed code status documentation should match in the residents' EMR and Code Book.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37014</p> <p>Based on observations, record review and staff interviews, the facility failed to prevent a resident with a court-appointed guardian who required supervision with leave of absences, a previous elopement attempt, and wore an elopement alarm monitoring device (Resident #127) from exiting the facility unsupervised and without staff knowledge. The facility also failed to prevent a resident with impaired cognition who had a history of exit seeking behavior and wore an elopement alarm monitoring device (Resident #67) from exiting the facility unsupervised and without staff knowledge. The deficient practice was for 2 of 5 sampled residents reviewed for accidents. On 04/11/23, Resident #127 was last seen in the facility at approximately 10:30 AM walking toward the dining room. At 11:15 AM Nurse Aide (NA) #1 went to look for Resident #127 and when Resident #127 was unable to be located inside the building, a Code [NAME] (missing person) was called at 12:00 PM and a facility-wide search was conducted by staff which included the outside perimeter of the building and surrounding areas. At approximately 1:10 PM, Resident #127 was found at a location off facility property and brought back to the facility by law enforcement. On 02/02/24, Resident #67 was last observed in the facility at approximately 7:10 AM walking toward the front lobby. At approximately 7:15 AM, as NA #2 and NA #3 were leaving work they observed Resident #67 outside in the facility parking lot squatted down between two parked cars. Resident #67 was escorted back into the facility by NA #2 and NA #3. There was a high likelihood Resident #127 and Resident #67 could have suffered serious injury, harm or death when they were outside the facility unsupervised.</p> <p>Findings included:</p> <p>1. Resident #127 was readmitted to the facility on [DATE] with diagnoses that included diabetes, end-stage renal disease, history of falls, depression, and generalized anxiety disorder.</p> <p>A State of NC Order on Motion for Appointment of Interim Guardian document dated 02/25/21 read in part, A hearing on the movant's Motion for the Appointment of an Interim Guardian was held on this day. From the evidence presented at the hearing, the Court makes the following specific findings of fact: 1) Respondent does not have capacity presently to manage medical care and appointments and has been hospitalized due to not attending medical appointments required to keep him alive, 2) Respondent is currently hospitalized with multiple serious medical conditions, and 3) Respondent will likely die if released from the hospital without assistance of a guardian. Based on these specific findings of fact, the Court concludes that there is reasonable cause to believe that the respondent is incompetent and that the respondent is in a condition that constitutes or reasonably appears to constitute an imminent or foreseeable risk of harm to the respondent's well-being, and there is immediate need for a guardian to provide consent or take other steps to protect the respondent.</p> <p>A State of North Carolina Letter of Appointment Guardian of the Person document dated 04/06/21 revealed Resident #127 was assigned a court-appointed Guardian with the reason marked as incompetent person.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A care plan initiated on 06/28/19 revealed Resident #127 had a communication problem related to language barrier. His primary language is Spanish. Interventions included to notify nurse of any changes in ability to communicate and possible factors which cause/make worse/improve any communication problems, speak on an adult level clearly and slower than normal, and validate Resident #127's message by repeating aloud.</p> <p>A care plan initiated on 11/18/22 revealed Resident #127 required supervision on Leave of Absence (LOA) from the facility due to poor safety awareness. Interventions included to educate Resident #127 and his Guardian on LOA policy and procedure and refer to Social Service/designee for review and reeducation if Resident #127 does not follow LOA procedures.</p> <p>A care plan initiated on 12/09/22 revealed Resident #127 was at risk for injury related to an attempted elopement that was stopped by staff before he exited the building, delirium related to believing he still had an apartment locally and expressing intent to leave the facility to go to his apartment or to Florida. Interventions included to monitor and report changes in behavior such as restlessness and pacing and provide diversional activities of interest such as offering a snack or playing music he enjoys.</p> <p>A care plan initiated on 12/15/22 revealed Resident #127 had an acute (sudden in onset) confusional state characterized by changes in consciousness, disorientation, environmental awareness or behavior. Resident #127 continues to have delusions and was recently started on antipsychotic medication. Interventions included to discuss feelings about placement, keep environmental noise/stimulation to a minimum, observe and report any changes in mental status, provide medications to alleviate agitation as ordered by the physician, and monitor/document side effects/effectiveness.</p> <p>A care plan initiated on 04/12/23 revealed Resident #127 had an impaired ability to make self-understood related to primary language other than English. Resident #127 spoke Spanish. Interventions included to arrange for an interpreter as needed, maintain eye contact when communicating, pronounce words correctly, and use an alternative method of communication such as flip chart or translator.</p> <p>A physician order for Resident #127 dated 12/20/22 read in part, check elopement alarm monitoring device via testing machine every day. The order was discontinued on 03/21/23.</p> <p>A physician order for Resident #127 dated 12/20/22 read in part, visually check elopement alarm monitoring device placement every shift. The order was discontinued on 03/21/23.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #127 with intact cognition. Resident #127 was independent with walking and locomotion and displayed no behaviors during the MDS assessment period.</p> <p>Review of Resident #127's medical record revealed an Elopement Assessment was completed on 12/09/22 that revealed Resident #127 was considered high risk for elopement. The assessment consisted of the following 4 sections:</p> <p>Mobility Status: Is the resident physically capable of leaving the facility? The answer was marked as 'yes.'</p> <p>Mental Status: Is resident alert and oriented times three? The answer was marked as 'no.'</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Wandering Behavior: Does the resident wander within the facility or have a history of wandering? Does the resident verbalize or exhibit exit seeking behavior? Both questions were answered 'yes.'</p> <p>History: Has there been previous history of attempted or actual elopement or unsafe wandering? The answer was marked 'yes.'</p> <p>There were no further elopement assessments completed after 12/09/22 until 04/11/23.</p> <p>A staff progress note dated 04/11/23 at 3:30 PM written by the Social Worker (SW) read in part, Guardian was notified of incident with Resident #127 as follows: 12:15 PM - notified facility was looking for resident; 1:38 PM - notified Resident #127 was located; 1:43 PM - notified Resident #127 was refusing to come into the facility; 2:20 PM - notified Resident #127 was sent to the hospital for involuntary commitment.</p> <p>The facility's investigation included an unsigned, typed document titled, Abatement Plan, that read in part: On 04/11/23 at 12:00 PM Resident #127 was identified as being on an unauthorized absence away from the facility. The facility initiated elopement procedures and Code [NAME] for Resident #127 at 12:10 PM when he could not be located within the facility. At 12:15 PM, local law enforcement was notified that Resident #127 was missing from the facility. At 1:00 PM, Resident #127 was located at a church in the neighborhood and brought back to the facility at 1:10 PM by law enforcement. Resident #127 refused to enter the facility and at 1:30 PM was taken by law enforcement to the hospital for an evaluation and possible involuntary commitment. Resident #127 returned to the facility from the hospital on 04/11/23 at 8:30 PM with no new orders or treatment.</p> <p>A handwritten witness statement dated 04/11/23 signed by Nurse Aide (NA) #1 read in part, I last saw Resident #127 around 10:30 AM. He was walking in the hallway as if he was going towards the dining room. After I passed Resident #127 in the hallway, I went on break. I came back around 11:00 AM - 11:15 AM and noticed he wasn't in his room or dining room. I went immediately and notified the nurse on duty that I didn't see him in either of those two places.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/05/24 at 11:58 AM, NA #1 confirmed she was Resident #127's assigned NA on 04/11/23 when he eloped from the facility and was told by Nurse #2 to watch him due to exit seeking behavior. NA #1 could not recall the exact time but said it was before lunch when she was doing her rounds and saw Resident #127 sitting out in the hall dressed in jeans, shirt, shoes and a jacket. She took a break and when she went back up the hall to check on him, she couldn't find him. She immediately told the Nurse, they both started looking for him everywhere and when they couldn't find him, Code [NAME] was called which she described was the facility's missing person procedure. She stated law enforcement was also notified (did not know who called), every inch of the facility was checked and then staff started searching the facility grounds and surrounding neighborhood even knocking on doors to homes in the area and stopping cars on the main road. NA #1 stated at one point during the search she recalled some staff stating he had been talking about going back to where he used to live when he was homeless and some staff (could not recall who) got into their cars, went to the location, found him and brought him back to the facility. NA #1 stated it was around 1:00 PM when Resident #127 was returned to the facility but he wouldn't go back inside so he was taken to the hospital for evaluation and believed he returned to the facility later that same day. She did not recall Resident #127 having any visible injuries or appear in any distress when he was brought back to the facility. NA #1 stated Resident #127 could make his needs known at times but had a communication barrier due to him speaking very limited English. She stated there was a staff member at the time who was fluent in Spanish and could translate for them when they (NAs) couldn't understand what it was he was needing. NA #1 stated she had provided his care frequently prior to his elopement on 4/11/23 and he had never previously displayed exit-seeking behaviors or made any attempts to leave the facility.</p> <p>A witness statement dated 04/11/23 signed by Nurse #2 read in part, I last saw Resident #127 at around 10:30 AM going up the hall toward the dining room. About 11:00 AM - 11:30 AM the Nurse Aide asked where Resident #127 was and I went to look for him and could not locate him. We called a Code [NAME] and all staff started searching the facility for Resident #127.</p> <p>During an interview on 04/10/24 at 9:10 AM, Nurse #2 confirmed she was Resident 127's assigned nurse on 04/11/23 when he eloped from the facility. Nurse #2 recalled she had not been employed at the facility long and was still getting to know Resident #127 and his routine which was typically keeping to himself either sitting in his room, activity room or dining room. Nurse #2 stated she never really noticed him displaying exit-seeking before 04/11/23. Nurse #1 stated on the morning of 04/11/23, Resident #127 was verbalizing wanting to leave and was observed by staff going to the exit doors. She informed the Director of Nursing (DON) and Social Worker (SW) how Resident #127 was acting and was told to keep a close eye on him. Nurse #2 instructed the NAs to keep an eye on Resident #127 and everyone did the best they could to keep him in sight. Around lunchtime, Nurse #2 stated she went to look for Resident #127 to give him his medications and couldn't find him. She along with the NAs started looking in the facility and when they couldn't find him, the Administrator and DON were notified and Code [NAME] was called. Nursing staff conducted a head count of all the residents and all staff started searching the facility premises looking for Resident #127. In addition, management staff left in their cars to search the surrounding neighborhood. Nurse #2 stated at the time of his elopement, Resident #127 had been refusing dialysis and was more confused. She was not really sure how he got out but thinks a visitor may have let him out the front door because he really didn't look like a typical resident. After Resident #127's elopement, the facility conducted elopement drills, re-education and instructed staff not to give the codes for the exit doors out to anyone who did not work at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 04/03/24 at 12:48 PM, Unit Manager #2 revealed she was no longer employed at the facility but was working on 04/11/23 when Resident #127 eloped. Unit Manager #2 recalled Resident #127 had refused to go to dialysis that day, she informed the Nurse Practitioner (NP) who ordered blood work and she (Unit Manager #2) went to Resident #127's room to draw his labs. She stated Resident #127 had started refusing to go to dialysis and when she provided him with education as to the importance of going he would still refuse, even when they tried different approaches to get him to go such as getting an outside transport company to take him because he didn't like the facility transport. Unit Manager #2 explained the more Resident #127 refused dialysis, the more confused he became and he started verbalizing he didn't want to be at the facility; however, he did not mention anything to her about wanting to leave the facility the morning of 04/11/23 when she drew his labs. Unit Manager #2 stated it was around 10:00 AM - 10:30 AM when she went into Resident #127's room and he was sitting on the side of his bed wearing a plaid shirt and jeans. She drew his labs and when she left his room, he was calm and in no distress. Unit Manger #2 stated she went on a break and then took the labs drawn to the hospital. She recalled she was only gone from the facility about 30 minutes when she was called and told Resident #127 was missing. She came back to the facility and everyone immediately started searching the facility and grounds for Resident #127. Unit Manager #2 stated she even walked around the perimeter of building but no one was able to locate Resident #127. Unit Manager #2 stated Resident #127 was later brought back to the facility by law enforcement but could not recall the time he returned. She recalled being informed Resident #127 had exited the building from the front entrance, she was not sure how, and walked to a church in the area but did not know the exact location or how far it was from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/04/24 at 2:31 PM, the DON recalled she had only been employed about a month when Resident #127 eloped from the facility on 04/11/23 and she had never observed him actually attempt to leave the facility prior to that day. The DON stated she personally never heard him make comments about wanting to leave but was told by other staff that a few days prior to him leaving the facility on 04/11/23 he had made comments about wanting to go see his girlfriend. The DON recalled Resident #127 used a walker for ambulation and had an elopement alarm monitoring device attached to his walker. She was not sure why the order for the elopement alarm monitoring device was discontinued on 03/21/23 and explained when he returned from the hospital the order must not have been queued back into the system to show up as an active order. The DON stated when she saw Resident #127 the morning of 04/11/23, he wasn't acting any differently than normal and did remember seeing the elopement alarm monitoring device attached to his walker. She recalled at one point she had tried to get him to allow her to place it on his lower extremity, which only aggravated him because he knew what it was and what it meant and he had refused to wear it. When they later determined he was missing and conducted the facility-wide search, the DON stated they found the elopement alarm monitoring device on the floor in his room that looked like it had been sawed when removed from his walker which she described as torn with jagged edges. She stated facility staff searched everywhere in the facility as well as the facility grounds and when Resident #127 was not located, she (DON) drove around the neighborhood in her car to look for him. The DON did not recall how Resident #127 was able to get out of the facility but remembered being told (could not recall by who) that he had walked to some location in the area, was fed a meal and then taken to a local church where the Pastor spoke Spanish. She was not sure where Resident #127 had walked or how far the location was from the facility. The DON stated when Resident #127 was found and brought back to the facility by law enforcement, he wouldn't come inside the facility and she went with the Administrator to the Magistrates office to obtain paperwork for an Involuntary Commitment (IVC). She couldn't recall the exact time but stated Resident #127 was sent to the hospital for an evaluation but returned to the facility later that same day (04/11/23) which she stated frustrated her because she wanted him medically evaluated due to his frequent refusals to receive dialysis. The DON restated Resident #127 had a history of refusing dialysis and a few weeks after his elopement he was sent out to the hospital for evaluation and passed away. When asked if Resident #127 was safe to be outside unsupervised, the DON stated Resident #127 was able to ambulate with the use of his walker but had the tendency to have poor judgement and decision making skills.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Valley Hill Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1510 Hebron Road Hendersonville, NC 28739	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/24/24 at 2:57 PM, the Administrator explained Resident #127's primary language was Spanish which created a language barrier but he did have limited English and often made comments about wanting to go back where he used to live when he was homeless or go see his girlfriend in another state. The Administrator further explained Resident #127 had a history of refusing dialysis and as a result was deemed incompetent to make healthcare decisions and granted a court-appointed Guardian. She stated it was normal for Resident #127 to sit at the front exit doors because that was where he would wait for transportation to take him to dialysis when he was willing to go. She could not recall when but stated at one point, they had to start sending a staff member with him to dialysis because he would wander away from the dialysis center. On 04/11/23, the Administrator stated she was at the facility when notified Resident #127 could not be located, a Code [NAME] was immediately called and a facility-wide search initiated but he could not be found. The Administrator recalled NA #1 was Resident #127's assigned NA on 04/11/23 and after she returned from break around 11:15 AM NA #1 didn't see Resident #127 in his room or dining room, she notified the nurse and they both started looking for him in the facility. When the nurse and NA #1 were unable to locate Resident #127 Code [NAME] was called at 12:00 PM and law enforcement notified. The Administrator stated facility staff searched everywhere in the facility and then expanded the search to the outside grounds and perimeters. She added at the time of his elopement, Resident #127 did have an elopement alarm monitoring device but he had removed it and it was found on the floor of his room when they searched the premises. She recalled it was around 1:10 PM when Resident #127 was located and brought back to the facility by law enforcement. She stated they had informed her Resident #127 walked to one of the neighborhood homes (not sure which one), he asked the homeowners for a ride and they took Resident #127 to a local church where the Pastor spoke Spanish and the Pastor had contacted law enforcement. When Resident #127 arrived back to the facility, he sat on the bench by the front entrance door refusing to go back inside. She explained a staff member employed at the time who was fluent in Spanish was talking to Resident #127 trying to convince him to go back inside the facility but he continued to refuse stating he would kill himself because he felt he was being locked up in the facility. At 1:30 PM, she went with the DON to the Magistrate's office to obtain IVC paperwork and he was sent to the hospital for evaluation but returned to the facility later that same day (04/11/23) and even though they felt he was too high functioning, he was moved to a room on the locked Memory Care Unit for safety. The Administrator stated after Resident #127's elopement, they did a root cause analysis and the best they could determine was some family members had learned the codes to the exit doors and must have let him out thinking he was a visitor because he didn't look like a typical resident of the facility. She stated they changed all the codes to the exit doors on 04/11/23 and facility staff were instructed not to give out the code to anyone and cover their hands when entering the code. The Administrator stated prior to his elopement, Resident #127 had been declining due to his frequent refusals of dialysis and sometime after returning to the facility on [DATE] he went on Hospice care, was sent out to the hospital in May 2023 and later passed away while at the hospital.</p> <p>An observation of the facility grounds was conducted on 04/10/24 08:40 AM. The front of the building sat just off a main road that inclined and curved throughout a residential area with a speed limit of 35 miles per hour. When standing at the front entrance, there was border wall on the opposite side of a circular driveway that led to/from the parking lot located on the right side of the building. There was also a sidewalk that started at the front entrance of the facility and along the side of the building to the parking area. At the end of the sidewalk and driveway was an exit on the left out to the main road and on the right was the facility sign and the parking lot. Houses and/or trees bordered the opposite side of the parking lot, back and left side of the building.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An online website named Weather Underground was used to obtain the outside weather in the Hendersonville area on 04/11/23 which noted at 10:54 AM the temperature was 59 degrees Fahrenheit (F), at 11:54 AM the temperature was 63 degrees F, at 12:54 PM the temperature was 66 degrees F, and at 1:54 PM the temperature was 68 degrees F.</p> <p>2. Resident #67 was admitted to the facility on [DATE] with diagnoses that included vascular dementia moderate with psychotic disturbance, bipolar disorder and hallucinations.</p> <p>A physician order for Resident #67 dated 12/12/23 read in part, check elopement alarm monitoring device via testing machine every day.</p> <p>A care plan initiated on 12/11/23 revealed Resident #67 has a diagnosis of vascular dementia, traumatic brain injury and behaviors which include, in part: wandering, rejecting care, packing up belongings and attempting to leave the facility using the fire exit button to open doors and becoming combative with staff when they attempt to prevent her from leaving. Interventions included one-to-one, every 15 minutes and/or every 30 minutes monitoring for safety as needed, attempt to redirect if/when she is resisting care, and monitor/report/document any mood changes to the nurse.</p> <p>A care plan initiated on 12/11/23 revealed Resident #67 had a diagnosis of vascular dementia which could cause her cognition to vary throughout the day requiring assistance with decisions. Interventions included reorient to date, time and place if appropriate, provide redirection if/when Resident #67 made inappropriate actions and monitor/report/document any changes in cognition.</p> <p>A care plan initiated on 12/12/23 revealed Resident #67 was at risk for elopement due to wandering, vascular dementia, traumatic brain injury, increased confusion at night, may be looking for family, thinks she works at the facility, and elopement alarm monitoring device to right ankle. Interventions included: may leave building when accompanied by staff or responsible adult, notify the Physician or Nurse Practitioner of exiting behavior, provide diversional activity PRN, and redirect from exit doors.</p> <p>A care plan initiated on 12/12/23 revealed Resident #67 had impaired cognitive function and thought processes related to dementia and head injury. Interventions included for staff to cue, reorient and supervise Resident #67 PRN.</p> <p>An activities of daily living Care Area Assessment (CAA) associated with the Minimum Data Set (MDS) assessment dated [DATE] read in part, Resident #67 has had no documented behavioral issues since admission. Per staff interview, Resident #67 will wander throughout the unit and at times, will push on exit doors. Resident #67 does wear an elopement alarm monitoring device for added safety. She was transferred from another facility due to working at that facility and knowing the codes to open the facility's exit doors.</p> <p>A physician order for Resident #67 dated 01/04/24 read in part, visually check elopement alarm monitoring device placement to right ankle every shift.</p> <p>The quarterly MDS assessment dated [DATE] assessed Resident #67 with moderate impairment in cognition. Resident #67 displayed no behaviors, was independent with walking and used an elopement alarm daily during the MDS assessment period.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #67's February 2024 Treatment Administration Record (TAR) revealed physician orders for staff to check the elopement alarm monitoring device via testing machine every day shift and to visually check the elopement alarm monitoring device placement to her right ankle every shift. Both orders were initiated as completed daily per physician order. On 02/04/24, Resident #67's elopement alarm monitoring device was noted functioning and intact on the right ankle, each shift.</p> <p>Review of Resident #67's medical record revealed an Elopement Assessment was completed on 03/06/24 that revealed Resident #67 was considered high risk for elopement. The assessment consisted of the following 4 sections:</p> <p>Mobility Status: Is the resident physically capable of leaving the facility? The answer was marked as 'yes.'</p> <p>Mental Status: Is resident alert and oriented times three? The answer was marked as 'no.'</p> <p>Wandering Behavior: Does the resident wander within the facility or have a history of wandering? Does the resident verbalize or exhibit exit seeking behavior? Both questions were answered 'yes.'</p> <p>History: Has there been previous history of attempted or actual elopement or unsafe wandering? The answer was marked 'yes.'</p> <p>A staff progress note dated 02/02/24 at 5:34 AM written by Nurse #3 read in part, Resident #67 woke up at 4:00 AM and has been exit-seeking ever since. Resident #67 gathered all her belongings and said, I'm going home and no amount of redirection would convince her otherwise. All staff have been alert and monitoring her movement between front and back/side exit. Resident #67 also seems to be aware that if you consistently push the door it will open and has been observed several times leaning her weight on the door.</p> <p>Telephone attempts for an interview with Nurse #3 on 04/05/24 at 10:16 AM, 04/10/24 at 10:16 AM and 04/10/24 at 12:14 PM were unsuccessful.</p> <p>A staff progress note dated 02/02/24 at 7:51 AM written by Unit Manager #1 read in part, Resident #67 was found in the parking lot outside of the facility hiding between two cars. One-to-one immediate intervention initiated. Resident #67 was assessed with no injuries. Family and Nurse Practitioner were notified.</p> <p>During an interview on 04/10/24 at 10:48 AM, Unit Manager #1 recalled on 02/02/24 at shift change, around 7:00 AM, she was notified by Nurse Aide (NA) #2 and NA #3 that Resident #67 was found outside the building in the parking lot. Unit Manager #1 stated upon assessment, Resident #67 had no injuries or signs of distress and was placed on one-to-one staff supervision. She was unable to recall what Resident #67's response was when asked why she went outside. Unit Manager #1 explained Resident #67 always went to the exit doors trying to get out stating she wanted to leave to go see her boyfriend.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's investigation included an unsigned, typed document titled, Abatement Plan, that read in part: Resident #67 exited the building on 02/02/24. Resident #67 had an elopement alarm monitoring device in place; however, the door did not alarm due to Resident #67 entering the code and a malfunction of the elopement alarm monitoring device sensor did not trigger the locking mechanism. Resident #67 was out of the facility for less than 5 minutes and was seen in the parking lot by staff and brought back inside the facility. Resident #67 had no injuries.</p> <p>A witness statement dated 02/02/24 obtained from the Receptionist read in part, Resident #67 was at the front door trying to push it open to get out when I arrived about 6:45 AM. She had all her clothes in bags. I went down to the nurses' station and had her moved from door before I left the door. When I was walking back up to my office, I saw NA #2 and NA #3 walking Resident #67 back down the hall. I had told them at the desk Resident #67 was up there trying to get out. They said she had been at the other door also during the night trying to get out. It was about 7ish when NA #2 and NA #3 found Resident #67 out in the parking lot. Resident #67 had let herself out.</p> <p>During a telephone interview on 04/10/24 at 10:31 AM, the Receptionist recalled on 02/02/24 she had just arrived at the facility at approximately 7:00 AM and as she was coming through the front entrance, Resident #67 was standing by the door inside the facility, fully dressed with all her belongings packed in bags. The Receptionist stated she opened the door, making sure it closed behind her, and told Resident #67 she needed to go back to her room and not be standing by the door. The Receptionist went down the hall to clock in and then stopped by the nurses' station per her usual routine to see if there were any discharges. As she was walking back up the hall toward the front where her office was located, she saw NA #2 and NA #3 walking Resident #67 down the hall. She recalled the NAs stating Resident #67 had gotten outside and they had found her in the parking lot. The Receptionist stated it was only about 10 minutes after she saw Resident #67 at the door when the NAs had brought her back into the building. She was not sure how Resident #67 got out of the building because she (Receptionist) made sure the key pad was covered when she entered the code to the door and the door had closed securely before she left the area. The Receptionist explained Resident #67 used to be a NA at another facility and could figure out the codes to the exit doors. She further stated it was normal routine for Resident #67 to push on the exit doors or try to enter codes to get the doors open and staff provided her with frequent redirection throughout the day. She stated Resident #67 was always cooperative with staff redirection but due to her cognition, it wasn't long before she was right back at the exit doors. The Receptionist stated right after it was discovered Resident #67 had gotten out of the building, she sat by the door until it was fixed that day by the Maintenance Director. In addition, staff received immediate re-education on elopement process/procedure, not giving out the codes to the exit doors and making sure you covered your hand when entering the code.</p> <p>A witness statement dated 02/02/24 that was obtained from Nurse Aide (NA) #4 read in its entirety, NA #4 stated that he left at approximately 7:12 AM and as he was leaving the facility, he saw Resident #67 walking toward the front lobby.</p> <p>Telephone attempts for an interview with NA #4 on 04/05/24 at 2:43 PM and 04/10/24 at 10:18 AM were unsuccessful.</p> <p>A witness state [TRUNCATED]</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>39037</p> <p>Based on observations, record review and staff interviews, the facility failed to train and verify competency for cleaning and disinfecting a glucometer according to manufacturers' recommendations using an Environmental Protection Agency (EPA) approved disinfectant cloth between residents. Agency Nurse #1 was observed not cleaning and disinfecting a shared glucometer between use of two residents (Resident #57 and Resident #62). Agency Nurse #1 was interviewed and reported she was unaware residents requiring blood sugar monitoring had assigned individual glucometers and was unfamiliar with the EPA approved disinfectant wipe's manufacturer's guidelines for contact time. This was for 1 of 1 nursing staff.</p> <p>The Immediate Jeopardy began on 04/03/24 when the failure to train and verify the competency of Agency Nurse #1 on the cleaning and disinfecting a glucometer resulted in the nurse's failure to clean and disinfect a glucometer between use of two residents. Immediate Jeopardy was removed on 04/05/24 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training.</p> <p>Findings included:</p> <p>Cross refer to tag F-880:</p> <p>Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens.</p> <p>In an interview with Agency Nurse #1 on 04/03/24 at 9:08 AM she stated this was her first shift at the facility. She stated she briefly wiped the glucometer in between checking the blood glucose for Resident #57 and Resident #62 and was not aware of any brand of glucometer that was required to be in contact with a cleaning/disinfection solution for a specified period of time. Agency Nurse #1 confirmed she had not received any training or education on how to disinfect glucometers from the facility prior to beginning her shift and was used to each resident having their own glucometer, which did not require cleaning in between uses unless there was visible blood on the glucometer. She stated she was not aware that each resident had their own glucometer and was unaware of any type of training/communication book was located at the nurses' station.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 04/03/24 at 10:02 AM the Director of Nursing (DON) was informed that Agency Nurse #1 did not follow the manufacturer's guidelines for use of an EPA-approved disinfectant for the recommended contact time for a shared glucometer. The DON stated each resident had their own glucometer, but this was Agency Nurse #1's first day in the facility and she probably wasn't aware. She stated the facility provided orientation for new and agency staff, but she was not sure what the orientation entailed because the Assistant Director of Nursing (ADON) handled training for agency staff. The DON was asked for the training record from the facility or staffing agency for Agency Nurse #1 indicating she had been trained on how to disinfect glucometers.</p> <p>Review of training and competency records for Agency Nurse #1 provided by the facility on 04/03/24 revealed there was no evidence the nurse had been trained on the procedure for cleaning and disinfecting a glucometer.</p> <p>An interview with the ADON on 04/03/24 at 10:36 AM revealed the facility recently changed the process of orientation for agency and facility staff. She stated the Scheduler and Business Office Manager assisted her with providing orientation training and each department head also provided education specific to their department. The ADON confirmed use of glucometer and glucometer disinfection were topics included in orientation but was unable to state who was responsible for completing the education. She stated agency staff should be aware of the policy and procedure for using and disinfecting glucometers and there should be a communication book at each nurses' station with information on how to use and disinfect glucometers that nursing staff could refer to. The ADON confirmed she had not provided any education regarding glucometer use and disinfection for Agency Nurse #1 prior to her beginning her shift on 04/03/24 and had not made her aware of the communication book at the nurses' station. The ADON was unable to describe how agency staff were notified of the communication book kept at the nurses' station. When asked to review the communication book for Agency Nurse #1's assigned hall the ADON was not immediately able to locate the communication book.</p> <p>An interview with the Business Office Manager on 04/03/24 at 2:12 PM revealed she was not involved in the orientation process for agency staff.</p> <p>An interview with the Scheduler on 04/03/24 at 2:16 PM revealed she was responsible for filling in gaps in the nursing staff schedule with agency staff when needed. She stated she was only responsible for obtaining licensing information and did not obtain any training information from staffing agencies. The Scheduler confirmed she did not provide any orientation training to agency staff.</p> <p>The Administrator and Director of Nursing were notified of Immediate Jeopardy on 04/04/24 at 8:32 AM.</p> <p>The facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Agency Nurse #1 completed a blood glucose check on Resident #57 and placed the blood glucose monitor she used back in the medication cart without cleaning the monitor. Agency Nurse # 1 was preparing to obtain Resident #62's blood sugar and picked up the same glucometer she had used on Resident #57 and wiped the glucometer with disinfecting wipe and failed to wait the 2-minute dwell time per manufacturer guideline of the disinfectant wipe and proceeded into the room of Resident #62 when the surveyor stopped the nurse because the glucometer had not been disinfected. Agency Nurse #1 had not checked any other resident's blood sugar prior to Resident #57.</p> <p>On 4/3/2024 Agency Nurse #1 was educated by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 4/3/2024 nurses and medication aides that were working on medication carts on 4/3/2024 were educated immediately by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.</p> <p>On 4/3/2024 The Director of Nursing/Designee started education with all licensed nurses and medication aides on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 Director of Nursing/designee started education for all licensed nurses and medication aides that each resident has been provided an individual blood glucose monitor labeled with residents' name and a non-porous container labeled with resident name and each resident's blood glucose monitor is to be kept separate and in each individual container and staff only use blood glucose monitor assigned to specific residents to obtain blood glucose. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 The Director of Nursing/designee started education with licensed nurses and medication aides on cleaning and disinfecting the blood glucose machines before and after each use by following the manufacturer's guidelines of cleaning and disinfecting the blood glucose monitor. The disinfectant wipes are to be an EPA registered disinfectant and staff were instructed to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 The Director of Nursing checked each medication cart and verified that each resident that requires blood glucose monitoring has an individual blood glucose meter that is labeled with the resident's name in non-porous container that is also labeled with each resident's name. There are 20 total residents that require blood glucose monitoring at this time.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/3/2024 The Director of Nursing/Designee placed the policy on cleaning and disinfecting the blood glucose machine, the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor in the communication book at each nurses' station. Guidance to refer to the manufacturer's guidelines of the disinfectant wipes available for contact times and to ensure the wipes are an EPA registered agent effective against blood borne pathogens.</p> <p>On 4/4/2024 The Director of Nursing placed a non-porous container labeled with each individual resident's name on each medication cart for each resident requiring blood glucose monitoring, each container contains a blood glucose monitor that is individually labeled with each resident's name.</p> <p>The Director of Nursing/Designee will educate all newly hired nurses and medication aides during orientation on the following:</p> <ol style="list-style-type: none"> <li>1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.</li> <li>2.) The dwell times for the EPA approved disinfectant for blood borne pathogens.</li> <li>3.) Each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.</li> <li>4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.</li> </ol> <p>The Director of Nursing/Designee will ensure all agency nurses have received the following education prior to working their first shift:</p> <ol style="list-style-type: none"> <li>1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.</li> <li>2.) The dwell times for the EPA approved disinfectant for blood borne pathogens.</li> <li>3.) Each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.</li> <li>4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.</li> </ol> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Valley Hill Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1510 Hebron Road Hendersonville, NC 28739	
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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/4/2024 The Nursing Home Administrator contacted the local Health Departments Communicable Disease Nurse to inform her of the F-880 Infection Control citation regarding cleaning and disinfection blood glucose monitors.</p> <p>Alleged date of Immediate Jeopardy removal is 04/05/24.</p> <p>The Immediate Jeopardy was removed on 04/05/24.</p> <p>The facility's credible allegation of Immediate Jeopardy was validated on 04/10/24 through staff interview and review of in-service training records. Nurses and medication aides were able to verbalize they had received training on the proper procedure for disinfecting the glucometer before and after use with an EPA-approved disinfecting wipe and ensuring contact time was performed per manufacturer's guidelines before they were allowed to begin their shift. Skill Competency for Point of Care Blood Testing Meter Disinfection and Use for nurses and medication aides was reviewed, and all received satisfactory scores. The credible allegation was validated, and the Immediate Jeopardy was removed on 04/05/24.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>47683</p> <p>Based on observation, staff interview, and record review the facility failed to ensure expired medications were removed from 2 of 4 locked medication carts (B hall and C hall).</p> <p>The findings included:</p> <p>1. An observation of the locked B hall medication cart on 04/04/24 at 10:14 AM with the Director of Nursing (DON) revealed in the cart was 1 opened bottle with 27 white calcium carbide tablets (a medication given for heartburn) with no dosage strength noted, that had an expiration date of 2/28/2024.</p> <p>An interview with the Director of Nursing (DON) on 04/04/24 at 10:17 AM revealed her expectation was all expired medication to be removed from the medication B hall medication cart. She stated that the medication was probably overlooked because it was a home medication. She stated they are developing a more thorough system for medication date checks. She indicated that the staff assigned to the medication carts should check the dates before they administer medications and staff should be checking the expiration dates on all the medications in the medication carts periodically.</p> <p>An interview on 04/04/24 at 10:14 AM with Medication Aide #1 revealed this was a medication Resident #5 was admitted with and did not take it any longer</p> <p>Record review of the physician's orders dated 1/8/24 revealed calcium carbonate oral tablet 1250 milligrams (MG). Give 1 tablet by mouth every 4 hours as needed for indigestion, heartburn.</p> <p>2. An observation of the locked C hall medication cart on 04/04/24 at 10:42 AM with the DON revealed in the cart was 1 medication card with 18 Omeprazole 20 MG Capsules (a medication given for heartburn), that had an expiration date of 2/29/2024</p> <p>An interview with the Unit Manager on 04/04/24 at 10:43 AM revealed the medication belonged to Resident #62 and he did not receive the medication. She stated that she tries to look through her medication cart once a shift for expired medications. She stated the medication must have been overlooked as she had not completed her daily medication cart check and she was not on the cart yesterday. She further stated it was the nurse who was assigned to the medication cart on each shift that was responsible for checking the medications expiration dates.</p> <p>An interview with the DON at 04/04/24 at 10:45 AM revealed that her expectation was there be no expired medications on the medication cart. She stated that the medication must have been overlooked during the previous cart check. She further revealed that the order for the omeprazole was discontinued on 10/31/23 and that Resident #5 had and as needed order for the calcium carbide tablets.</p> <p>Record review of the physician's orders revealed the omeprazole oral capsule delayed release 20 MG was discontinued on 10/31/2023.</p> <p>(continued on next page)</p>		

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F 0761  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	An interview with the Administrator on 4/5/24 at 5:05 PM revealed that her expectation is all expired medications be removed from the medication carts.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47683</p> <p>Based on observations and staff interviews the facility failed to discard expired food in 1 of 1 walk in coolers. These practices had the potential to affect food served to the residents.</p> <p>Findings included:</p> <p>An observation of the walk-in cooler on [DATE] at 09:43 AM revealed the following:</p> <p>A.) A container of shredded cheese with a preparation date of ,d+[DATE] and a use by date of ,d+[DATE].</p> <p>B.) A container of chili with a preparation date of ,d+[DATE] and use by date of ,d+[DATE].</p> <p>C.) A container of pureed fruit with a preparation date of ,d+[DATE] and a use by date of ,d+[DATE].</p> <p>An interview with the Cook/ Assistant on [DATE] at 09:44 AM revealed that their process was to check the walk-in cooler daily for expired food. She stated that her manager checked it last night and it must have just been overlooked.</p> <p>An interview with the Dietary Manager on [DATE] at 01:47 PM revealed that she and the Cook/ Assistant check the fridge every morning after breakfast for expired items. She revealed that she was unsure how the container of cheese was overlooked but her expectation was that all expired food be removed from the walk-in cooler.</p> <p>An interview with the Administrator on [DATE] at 5:05 PM revealed that her expectation was all expired food be removed from the kitchen walk-in cooler.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39037</p> <p>Based on observations, record review, and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions previously put in place following the infection control survey that occurred [DATE] in the area of Infection Prevention and Control (F-880), complaint and recertification survey that occurred [DATE] in the areas of Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and Infection Prevention and Control (F-880), complaint and recertification survey that occurred [DATE] in the areas of Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and Infection Prevention and Control (F-880), and a complaint investigation that occurred [DATE] in the area of Free of Accident Hazards/Supervision/Devices (F-689). This failure was for 3 deficiencies that were originally cited in the areas of Infection Prevention and Control (F-880), Free of Accident Hazards/Supervision/Devices (F-689), and Food Procurement, Store/Prepare/Serve/Sanitary (F-812) and were subsequently recited on the current recertification and complaint and investigation survey of [DATE]. The continued failure of the facility during five surveys of record in the same area showed a pattern of the facility's inability to sustain an effective QAA program.</p> <p>Findings included:</p> <p>This tag is cross referenced to:</p> <p>F880: Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens.</p> <p>During the complaint and recertification survey conducted [DATE] the facility failed to implement their policy and procedure for assessing and preventing Legionella which had the potential to affect 72 residents.</p> <p>During the complaint and recertification survey conducted [DATE] the facility failed to ensure visitors wore Personal Protective Equipment (gowns, goggles, and masks) when interacting with 1 of 2 residents on a quarantine unit.</p> <p>During the infection control survey conducted [DATE] the facility failed to ensure dietary staff wore a face mask for 1 of 2 dietary aides.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>F689: Based on observations, record review and staff interviews, the facility failed to prevent a resident with a court-appointed guardian who required supervision with leave of absences, a previous elopement attempt, and wore an elopement alarm monitoring device (Resident #127) from exiting the facility unsupervised and without staff knowledge. The facility also failed to prevent a resident with impaired cognition who had a history of exit seeking behavior and wore an elopement alarm monitoring device (Resident #67) from exiting the facility unsupervised and without staff knowledge. The deficient practice was for 2 of 5 sampled residents reviewed for accidents. On [DATE], Resident #127 was last seen in the facility at approximately 10:30 AM walking toward the dining room. At 11:15 AM Nurse Aide (NA) #1 went to look for Resident #127 and when Resident #127 was unable to be located inside the building, a Code [NAME] (missing person) was called at 12:00 PM and a facility-wide search was conducted by staff which included the outside perimeter of the building and surrounding areas. At approximately 1:10 PM, Resident #127 was found at a location off facility property and brought back to the facility by law enforcement. On [DATE], Resident #67 was last observed in the facility at approximately 7:10 AM walking toward the front lobby. At approximately 7:15 AM, as NA #2 and NA #3 were leaving work they observed Resident #67 outside in the facility parking lot squatted down between two parked cars. Resident #67 was escorted back into the facility by NA #2 and NA #3. There was a high likelihood Resident #127 and Resident #67 could have suffered serious injury, harm or death when they were outside the facility unsupervised.</p> <p>During the complaint investigation conducted [DATE] the facility failed to safeguard a cognitively impaired resident from an avoidable hazard when bed rails were used in conjunction with an alternating air mattress. The resident was found with no signs of life after experiencing a fall from a bed with bed rails in the up position. This occurred for 1 of 3 residents reviewed for accidents.</p> <p>F812: Based on observations and staff interviews the facility failed to discard expired food in 1 of 1 walk in coolers. These practices had the potential to affect food served to the residents.</p> <p>During the complaint and recertification survey conducted [DATE] the facility failed to maintain a clean vent cover for 1 of 2 ice machines.</p> <p>An interview with the Administrator on [DATE] at 12:44 PM revealed the QAA met monthly and reviewed any increase in areas such as pressure ulcers, reportables, falls, and any risk event. She stated the root cause of areas of concern were attempted to be determined and plans of action were developed. The Administrator stated she did not feel there was a breakdown in communication, or processes previously implemented as the situations were entirely different. She stated the QAA committee would be meeting later this month to review concerns identified during the current survey and evaluate the new processes put in place to determine if there were any areas that needed improvement. The Administrator stated she felt with the new processes implemented the facility would be able to achieve and maintain compliance.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39037</p> <p>Based on observations, staff interviews, and record review, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with manufacturer's recommended contact time for 2 of 3 residents whose blood glucose levels were checked (Resident #57 and Resident #62). This occurred while there was not a resident with known bloodborne pathogens in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instruction for disinfection, including the correct contact time, of the glucometer has the high likelihood of exposing residents to the spread of bloodborne pathogens.</p> <p>Immediate Jeopardy began on 04/03/24 when Agency Nurse #1 cleaned the glucometer between the two residents with an approved EPA disinfecting wipe but did not follow the manufacturer's recommendation for contact time. Immediate Jeopardy was removed on 04/05/24 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain 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 are put in place and to complete employee in-service training.</p> <p>The findings included:</p> <p>A review of the facility's policy entitled Glucometer/Point of Care Blood Testing and Disinfection Procedure last revised 12/27/23 read in part as follows:</p> <p>Policy: Whether shared or assigned to a singular resident, blood testing meters will be disinfected between each use (before use the clinical staff should assume the meter is dirty and disinfect before use) according to manufacturer instructions and infection prevention guidelines.</p> <p>Procedure:</p> <ul style="list-style-type: none"> <li>- Wipe meter using friction with recommended type of germicidal wipe.</li> <li>- Maintain visible wetness of meter for required kill time according to disinfectant instructions. Use multiple wipes if necessary. Do not reuse wipes.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The manufacturer's User Guide for the glucometer used at the facility included Caring for Your System. These instructions read in part, To minimize the risk of transmission of bloodborne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions below. The cleaning procedure is needed to clean dirt as well as blood and other body fluids on the exterior of the meter before performing the disinfection. The meter should be cleaned and disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed. We have validated [Brand Name] Germicidal Disposable Wipes for disinfecting the [Brand Name] meter. A list of additional products approved for cleaning and disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, Disinfectants were validated separately and only one cleaning/disinfection solution should be used on the device for the life of the device as the effect of using more than one cleaner/disinfectant interchangeably has not been evaluated.</p> <p>Review of the manufacturer's guidelines and instructions for use of the EPA approved disinfectant wipe used by the facility specified a contact time of two minutes for disinfecting the [Brand Name] glucometer.</p> <p>A review of a facility document titled Diagnosis Report dated 04/03/24 revealed there were no residents with known bloodborne pathogens residing in the facility.</p> <p>A continuous observation of Agency Nurse #1 passing medication and performing blood glucose monitoring on 04/03/24 from 8:10 AM through 9:08 AM was conducted. At 8:10 AM Agency Nurse #1 checked Resident #57's blood glucose and placed the blood glucose monitor in the top drawer of the medication cart without disinfecting the monitor. At 9:08 AM Agency Nurse #1 quickly wiped the same blood glucose monitor used to check Resident #57's blood sugar with a [Brand Name] disinfecting wipe that was sitting on top of the medication cart. No friction was observed when Agency Nurse #1 wiped the glucometer. She removed the bottle of test strips from the cart, applied gloves, removed an alcohol pad and lancet from the cart, placed the test strip in the blood glucose monitor, and crossed the threshold of Resident #62's door to check his blood glucose. Less than one minute had elapsed. At 9:08 AM surveyor stopped Agency Nurse #1 from completing the blood glucose check for Resident #62 because Agency Nurse #1 failed to disinfect the blood glucose monitor in accordance with manufacturer's guidelines after use on Resident #57.</p> <p>In an interview with Agency Nurse #1 on 04/03/24 at 9:08 AM she stated this was her first shift at the facility. She stated she briefly wiped the glucometer in between checking the blood glucose for Resident #57 and Resident #62 and was not aware of any brand of glucometer that was required to be in contact with a cleaning/disinfection solution for a specified period of time. Agency Nurse #1 confirmed she had not received any training or education on how to clean the glucometer prior to beginning her shift and was used to each resident having their own glucometer, which did not require cleaning in between uses unless there was visible blood on the glucometer. She stated she had not checked any other residents' blood glucose on 04/03/24 before checking Resident #57's at 8:10 AM. No timer was observed on Agency Nurse #1's medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with Unit Manager #1 on 04/03/24 at 9:13 AM revealed each resident had their own glucometer, but Agency Nurse #1 was probably not aware because that was her first shift at the facility. She stated each glucometer was different and required a different cleaning process and there was a binder at the nurses' station with information on how to clean different glucometers. Unit Manager #1 indicated the [Brand Name] disinfectant wipes sitting on top of Agency Nurse #1's medication cart were probably the wipes that should have been used for cleaning the glucometer after Resident #57's blood sugar check. She stated if the manufacturer of the [Brand Name] disinfecting wipes on the medication cart recommended a contact time of two minutes, then the glucometer should be in contact with the wipe for two minutes.</p> <p>On 04/03/24 at 10:02 AM the Director of Nursing (DON) was informed of the concern related to the facility's failure to follow the manufacturer's recommended contact time for a shared glucometer. During the interview the DON was informed Agency Nurse #1 checked Resident #57's blood sugar, placed the glucometer in the top drawer of the medication cart without cleaning the glucometer, administered medications to two residents, removed the glucometer used to check Resident #57's blood sugar at 8:10 AM, wiped the glucometer briefly with a [Brand Name] disinfecting wipe, gathered additional supplies for checking a blood glucose, walked to Resident #62's room, and was stopped during the observation before the shared glucometer could be used for a second resident. The DON stated each resident had their own glucometer, but this was Agency Nurse #1's first day in the facility and she probably wasn't aware. She stated glucometers should be cleaned after each use with [Brand Name] disinfecting wipes, have a contact time of two minutes with the glucometer, and then air dry. The DON stated after the disinfecting process was complete, the glucometer would be ready for use again.</p> <p>An interview with the Regional Director of Clinical Services on 04/04/24 at 5:57 PM revealed she had spoken with Agency Nurse #1, and Agency Nurse #1 confirmed she did not clean the glucometer after she checked Resident #57's blood glucose.</p> <p>The Administrator and Regional Director of Clinical Services were informed of the Immediate Jeopardy on 04/03/24 at 5:57 PM.</p> <p>The facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and</p> <p>Agency Nurse #1 completed a blood glucose check on resident #57 and placed the blood glucose monitor she used back in the medication cart without cleaning the monitor. Agency Nurse #1 was preparing to obtain Resident #62's blood sugar and picked up the same glucometer she had used on Resident #57 and wiped the glucometer with disinfecting wipe and failed to wait the 2-minute dwell time per manufacturer's guideline of the disinfectant wipe and proceeded into the room of Resident #62 when the surveyor stopped the nurse because the glucometer had not been disinfected. Agency Nurse #1 had not checked any other resident's blood sugar prior to Resident #57.</p> <p>On 4/3/2024 Agency Nurse #1 was educated by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On 4/3/2024 Nurses and Medication Aides that were working on medication carts on 4/3/2024 were educated immediately by the Regional Director of Clinical Services on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time.</p> <p>On 4/3/2024 The Director of Nursing/Designee started education with all licensed nurses and medications aide on the cleaning and disinfection of glucose monitoring machines using the manufacturer's guidelines of the blood glucose monitor and that the disinfectant wipes are to be an EPA registered disinfectant and to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 Director of Nursing/designee started education for all licensed nurses and medication aides that each resident has been provided an individual blood glucose monitor labeled with resident's name and a non-porous container labeled with resident name and each resident's blood glucose monitor is to be kept separate and in each individual container and staff only use blood glucose monitor assigned to specific residents to obtain blood glucose. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 The Director of Nursing/designee started education with licensed nurses and medication aides on cleaning and disinfecting the blood glucose machines before and after each use by following the manufacturer's guidelines of cleaning and disinfecting the blood glucose monitor. The disinfectant wipes are to be an EPA registered disinfectant and staff were instructed to follow the manufacturer's instructions for contact time. This education will be completed on 4/4/2024.</p> <p>On 4/3/2024 The Director of Nursing checked each medication cart and verified that each resident that requires blood glucose monitoring has an individual blood glucose meter that is labeled with the resident's name in non-porous container that is also labeled with each resident's name. There are 20 total residents that require blood glucose monitoring at this time.</p> <p>On 4/3/2024 The Director of Nursing/Designee placed the policy on cleaning and disinfecting the blood glucose machine, the manufacturer's guidelines for cleaning and disinfecting the blood glucose monitor in the communication book at each nurses' station. Guidance to refer to the manufacturer's guidelines of the disinfectant wipes available for contact times and to ensure the wipes are an EPA registered agent effective against blood borne pathogens.</p> <p>On 4/4/2024 The Director of Nursing placed a non-porous container labeled with each individual resident's name on each medication cart for each resident requiring blood glucose monitoring, each container contains a blood glucose monitor that is individually labeled with each resident's name.</p> <p>The Director of Nursing/Designee will educate all newly hired nurses and medication aides during orientation on the following:</p> <p>1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2024
NAME OF PROVIDER OR SUPPLIER  Valley Hill Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1510 Hebron Road Hendersonville, NC 28739	
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)		
<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2.) The dwell times for the EPA approved disinfectant for bloodborne pathogens.</p> <p>3.) Each resident has been provided an individual blood glucose monitor labeled with the resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.</p> <p>4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.</p> <p>The Director of Nursing/Designee will ensure all agency nurses have received the following education prior to working their first shift:</p> <p>1.) Policy and procedure for cleaning and disinfection of glucose monitoring machines before and after each use, following the manufacturer's guidelines for the machine.</p> <p>2.) The dwell times for the EPA approved disinfectant for bloodborne pathogens.</p> <p>3.) Each resident has been provided an individual blood glucose monitor labeled with the resident's name and a non-porous container labeled with resident name, which are located on each medication cart. Each resident's blood glucose monitor is to be kept separate in each individual container. Staff is to only use blood glucose monitor assigned to each specific resident to obtain blood glucose reading.</p> <p>4.) Policy and procedure for cleaning and disinfecting the blood glucose machine as well as the manufacturer guidelines for cleaning and disinfecting the blood glucose monitor can be found in the communication book at each nurse station.</p> <p>On 4/4/2024 The Nursing Home Administrator contacted the local Health Departments communicable disease nurse to inform her of the F880 Infection Control citation regarding cleaning and disinfection blood glucose monitors.</p> <p>Alleged date of Immediate Jeopardy removal is 04/05/24.</p> <p>The Immediate Jeopardy was removed on 04/05/24.</p> <p>The facility's credible allegation of Immediate Jeopardy removal was validated on 04/10/24 through staff interview and review of in-service training records. Staff were able to verbalize that each resident had their own individual glucometer which was stored on the medication cart, glucometers were to be cleaned before and after each use according to manufacturer's guidelines with an EPA-approved disinfectant for the recommended contact time. Information regarding disinfecting blood glucose monitoring could be found in the Communication Book at each nurses' station. Observations were conducted of all medication carts and revealed each resident had their own individual glucometer which was labeled with their name and serial number of their assigned glucometer. Observations also confirmed EPA-approved disinfectant wipes were stored on each medication cart. The credible allegation was validated, and the Immediate Jeopardy was removed on 04/05/24.</p>		