STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to protect a resident's right to be free from resident to resident physical abuse when a severely cognitively impaired resident (Resident #43) with a history of aggressive behaviors grabbed and pulled a moderately cognitive impaired resident (Resident #7) to the floor. Resident #43 was observed on top of Resident #7 with his hands around his neck in an attempt to choke him. Resident #43 and Resident #7 were alone in the main dining room at the time of the altercation until separated by dietary staff. Resident #7 and Resident #43 were not injured, and Resident #43 was sent to the hospital for a psychiatric evaluation and returned with no changes made to his current medications. The deficient practice occurred for 1 of 5 residents reviewed for abuse. Findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury (a brain injury caused by an outside force that may cause reasoning and judgement problems), obsessive-compulsive disorder (uncontrollable and recurring thoughts or repetitive behaviors or both), and dementia. A review of the Psychiatry Medical Doctor (MD) progress note dated 05/06/24 revealed Resident #7 received ongoing psychiatric services, and his past medical history included multifactorial dementia (two or more types of dementia), traumatic brain injury, depression, and anxiety. The MD noted Resident #7 was initially referred due to an altercation with a male peer and had demonstrated intermittent bouts of agitation. Resident #7 had no recent altercations or increased agitation, his mood was stable, and the MD made no changes to his medications. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7's cognition was moderately impaired with no physical or verbal behaviors during the lookback period. Resident #7 walked independently and had no falls since the previous assessment and was taking antianxiety and antidepressant medications. Resident #43 was admitted to the facility on [DATE] with diagnoses including Asperger's syndrome (a neurological and developmental disorder affecting how one interacts with others, communicates, and behaves), attention and concentration deficit, anxiety disorder, paranoid personality disorder (a pervasive distrust and suspicion of others), and history of traumatic brain injury. The admission MDS assessment dated [DATE] revealed Resident #43's cognition was severely impaired with no physical or verbal behaviors identified but rejection of care occurred 1 to 3 days during the lookback period. The MDS indicated Resident #43 was taking antianxiety medication, independently used a wheelchair for mobility, and had no falls since admission. A review of the Nurse Practitioner (NP) progress note revealed on 08/13/24, Resident #43 was evaluated after nursing reported he had replaced the salt and pepper with hot sauce in dining room. The NP's physical exam described Resident #43 speech as hyper verbal (excessive), and his thought pattern as tangential (a disturbance in one's thought process and ability to focus). The NP made no changes to Resident #43's medications or plan of care. A review of a psychotherapy comprehensive assessment dated [DATE] revealed Resident #43 was evaluated for behaviors of verbal outburst, expressions of anger, and intrusive social interactions. The psychotherapist recommended to continue follow up visits. A review of the progress note documented by Nurse #1 on 09/15/24 at 11:00 AM revealed someone was heard yelling in the hallway they're fighting. Nurse #1 entered the dining room, noticed condiments on the floor, and heard Resident #7 or Resident #43 yell, he thinks he is the boss. Resident #43 and Resident #7 were separated for safety, the NP was notified and provided an order to send Resident #43 to the emergency room for a psychiatric evaluation. An attempt to interview Nurse #1 on 06/26/25 at 12:23 PM was unsuccessful. A review of the nurse progress note dated 09/15/24 at 11:10 AM documented by the former Assistant Director of Nursing (ADON) revealed she was notified Resident #7 was involved in a physical altercation with another resident while in the main dining room. The former ADON noted Resident #7 was assessed after the altercation and had no injuries, denied pain, and his range of motion was within normal limits.A review of the weekly skin observation dated 09/15/24 at 11:30 AM revealed the former ADON documented Resident #7 had no skin issues. A review of the Initial Allegation Report revealed on 9/15/24 at 4:00 PM an incident of resident abuse was reported. The details of the report read in part, Resident #7 and Resident #43 were in the main dining room when staff heard a commotion. Staff reported they saw Resident #7 and Resident #43 on the floor and Resident #43 had his hands around Resident #7's neck. Staff pulled Resident #43 off Resident #7. No injuries to either resident. Resident #43 was sent to the emergency room for a psychiatric evaluation and placed on one to one supervision when returned. Resident #7 received a head to toe examination by the nurse. Staff education was started on identifying and managing violent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with residents, staff, and the law enforcement agent, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 2 of 2 residents reviewed for misappropriation of residents' property (Resident #30 and #59).The findings included: The facility's Abuse, Neglect, Exploitation, and Misappropriation of Resident property policy, last revised on July 11, 2024, revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property. Resident #30 was admitted to the facility on [DATE] with diagnoses including age-related osteoporosis and chronic back pain. The physician's order dated 12/04/22 revealed Resident #30 had an order to receive one tablet of oxycodone 10 mg by mouth 2 times daily for pain. The April 2024 Medication Administration Record (MAR) revealed Nurse #3 had administered one tablet of oxycodone 10 mg to Resident #30 on 04/15/24 at 6:00 PM. Further review of the MAR indicated Resident #30 had received her scheduled oxycodone as ordered throughout the month in April 2024. A review of the controlled substance declining sheets for Resident #30's oxycodone from 03/27/24 through 04/29/24 revealed Nurse #3 signed out two tablets of oxycodone 10 mg for Resident #30 on 04/15/24 at 6:00 PM. She administered one tablet of oxycodone to Resident #30 and wasted the remaining tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the Check by column. Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated 07/13/23 revealed Resident #59 had an order to receive one tablet of oxycodone 5 mg by mouth 2 times daily for chronic pain syndrome. A review of the MAR for April 2024 revealed Nurse #3 had administered one tablet of oxycodone 5 mg to Resident #59 on 04/17/24 at 8:00 AM. Further review of the MAR indicated Resident #59 had received his scheduled oxycodone as ordered throughout the month in April 2024.A review of the controlled substance declining sheets for Resident #30's oxycodone from 03/27/24 through 04/29/24 revealed Nurse #3 signed out two tablets of oxycodone 10 mg for Resident #30 on 04/15/24 at 6:00 PM. She administered one tablet of oxycodone to Resident #30 and wasted one tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the Check by column.A review of the controlled substance declining sheets for Resident #59's oxycodone from 04/13/24 through 04/27/24 revealed Nurse #3 signed out two tablets of oxycodone 5 mg for Resident #59 on 04/17/24 at 8:00 AM. She administered one tablet of oxycodone to Resident #59 and wasted the remaining tablet without having any witness to verify and check the disposal of the wasted controlled medication as no signature was documented under the Check by column. A review of the initial allegation report dated 06/11/24 revealed the facility became aware of the misappropriation of residents' property on 06/11/24 at 2:00 PM when 2 tablets of oxycodone (a semi-synthetic narcotic analgesic for pain) had potentially been diverted (1 tablet of oxycodone 5 milligrams (mg) for Resident #59 and another tablet of oxycodone 10 mg for Resident #30) by Nurse #3. The facility reported the incident to the North Carolina Division of Health Service Regulation (DHSR) on 06/12/24 at 1:23 PM and the local law enforcement on 06/12/24 at 2:00 PM as there was a reasonable suspicion of crime against Resident #30 and Resident #59.The 5-day investigation report dated 06/19/24 revealed on 06/11/24, the former Director of Nursing (DON) was notified by the Corporate Clinical Director that a potential drug diversion had occurred in a sister facility that involved Nurse #3 who worked as an agency nurse. The former DON checked with the facility's Scheduler immediately and found that Nurse #3 had picked up 2 shifts in the facility in April 2024. The former DON audited the controlled substance declining sheets and found that potential drug diversions could have been done by Nurse #3 as she wasted 1 tablet of oxycodone 5 mg for Resident #59, and 1 tablet of oxycodone 10 mg for Resident #30 without any witnesses nor signature from another nurse to verify the waste of the oxycodone on the controlled substance declining sheets. The allegation of diversion of Residents' drugs was substantiated as the facility unable to confirm the actual waste of controlled medications at the time of documentation. The attempt to conduct a phone interview with Nurse #3 on 06/26/25 at 1:25 PM was unsuccessful. She was unavailable and did not return the call. The pharmacy invoice dated 06/13/24 revealed the facility replaced and paid for the missing one tablet of oxycodone 10 mg for Resident #30 and one tablet of oxycodone 5 mg for Resident #59. An attempt to conduct an interview with Resident #30 on 06/24/25 at 2:56 PM was unsuccessful. She was unable to engage in the interview. During an interview conducted on 06/24/25 at 3:04 PM, Resident #59 could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff, the facility failed to ensure staff implemented their abuse policy and procedure for reporting when the facility failed to report abuse allegations to the State Survey Agency within the specified timeframes and failed to notify the county Adult Protective Services (APS). This affected 1 of 8 residents reviewed for abuse (Resident #1). The findings included:The facility's policy titled, North Carolina Resident Abuse Policy last revised 07/11/24 revealed in part; all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON), and the applicable State Agency. If the event that caused the allegation involved an allegation of abuse or serious bodily injury, it should be reported to the North Carolina Division of Health Service Regulation (DHSR) immediately, but not later than 2 hours after the allegation is made. The Administrator or designee will ensure that a completed Initial Allegation Report is submitted to DHSR in the required timeframe. The Administrator or designee will ensure that a report of the investigation is submitted within 5 working days of the allegation using the DHSR Investigation Report. A further review of the facility's policy titled North Carolina Resident Abuse Policy, under the Reporting allegations to other agencies, read in part as follows: Allegations requiring investigation include abuse of a resident. Follow Adult Protective Service (APS) Statutes for reporting allegations to the local Department of Social Services (DSS/APS).Resident #1 was admitted to the facility on [DATE] with diagnoses including delusional disorder, psychotic disorder, and Parkinson's disease. The annual Minimum Data Set (MDS) assessment dated [DATE] coded Resident #1 with intact cognition. She had adequate hearing and vision with clear speech. The MDS indicated Resident #1 receiving antianxiety and antipsychotic in the 7-day assessment period. A review of the facility submitted 24-hour initial report dated 06/11/24 completed by the former Administrator specified an allegation of abuse for Resident #1 was reported by Assistant Director of Nursing (ADON) to the former Administrator on 06/11/24 at 1:47 PM. The report indicated Medication Aide #1 (MA) noted a small, discolored area on Resident #1's right eyebrow bone and reported her finding immediately to ADON. When Resident #1 was interviewed by the former Administrator and the Social Services Director (SSD), she stated that Nurse Aide (NA) #3 and Nurse #2 had hit her and splashed water on her face on 06/10/24 in the evening. The former Administrator suspended both staff members mentioned in the incident immediately and began the investigation by conducting a full skin assessment for Resident #1 and later for the rest of the residents in the facility. The facility submitted the initial report to DHSR on 06/11/24 at 9:12 PM. DHSR was notified 7 hours and 25 minutes after the former Administrator was made aware of the incident. The facility unsubstantiated the allegation of abuse but there was no documentation of notification of APS/DSS. During a phone interview conducted on 06/26/25 at 11:29 AM, the former Administrator acknowledged that she was the Abuse Coordinator and responsible for notifying abuse allegations to the applicable local and state agencies in accordance with the policy and procedure. She stated that she was made aware of the incident on 06/11/24 at around 2:00 PM and started the investigation immediately. She explained there were a couple of other incidents that occurred on the same day, and she was overwhelmed and distracted. She added she should have submitted the initial report to DHSR within 2 hours after she was made aware of the alleged abuse incident and notified the APS. During an interview conducted on 06/26/25 at 12:35 PM, the current Administrator expected the former Administrator to follow the regulation to report abuse allegation to DHSR as required within 2 hours and APS within a reasonable timeframe. The facility provided the following corrective action plan with a completion date of 06/13/24:Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:On 6/11/2024 the Regional Director of Clinical Services notified the Director of nursing of a drug diversion by an agency nurse in a sister facility, in accordance with our Quality Assurance Performance Improvement program, leadership implemented the following corrective action measures:06/11/2024- Director of Nursing notified Administrator and staff scheduler and confirmed this agency nurse had been working in the facility in April of 2024. 06/12/2024- Director of nursing then audited the narcotic declining sheets for the days this nurse worked in April 2024 and discovered Agency LPN had wasted two controlled medications from two residents without a witness documented in the controlled Substance declining sheet. Director of Nursing and the Assistant Director of Nursing called this nurse several times during the investigation on 06/11/2024 and 06/12/2024 and never received an answer or a return

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with Registered Dietitian (RD) #1 and staff, the facility failed to follow the physician's order to provide nutritional supplements for 1 of 5 residents reviewed for nutrition (Resident #36). Findings included: Resident #36 was admitted to the facility 01/06/20 with a diagnosis including non-Alzheimer's dementia. Review of Resident #36's physician orders revealed an order dated 05/23/24 for a 4-ounce nutritional shake three times a day with meals and an order dated 09/05/24 for a frozen nutritional treat twice a day. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was severely cognitively impaired, had weight gain, and was on a physician prescribed weight-gain regimen. Resident #36's nutrition care plan last updated 05/06/25 revealed she had an increased nutrition/hydration risk related to receiving a mechanically altered diet. Interventions included providing her diet and supplements as ordered. A progress note written by Registered Dietitian #2 on 06/12/25 read in part as follows: Significant weight gain review: 18.8% x 180 days. CBW [Current Body Weight] is 129 [pounds]. History of weight fluctuations and has had a weight gain goal. Weight last month was 126.4 lbs. Weight 90 days ago was 123.2 lbs. Weight 180 days ago was 108.6 lbs, borderline underweight. Weight gain has been beneficial. Receives [frozen nutritional treat] twice a day and [nutritional] shake three times a day with meals. Resident has variable acceptance of supplements. Continue other supplements at this time for variable intake with a history of weight fluctuations. Registered Dietitian (RD) #2 was unavailable for interview during the survey. An observation of Resident #36's lunch meal ticket on 06/23/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat and a 4-ounce nutritional shake. An observation of Resident #36's meal tray at the same time and date revealed the frozen nutritional treat and nutritional shake were not provided with her lunch meal. An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed residents should receive nutritional supplements as ordered by the physician and he was not sure why Resident #36 did not receive her supplements on 06/23/25. An observation of Resident #36's lunch meal ticket on 06/25/25 at 12:17 PM revealed she was to receive a 4-ounce frozen nutritional treat and a 4-ounce nutritional shake. An observation of Resident #36's meal tray at the same date and time revealed the frozen nutritional treat and nutritional shake were not provided with her lunch meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dietary Aide who was responsible for checking meal trays for accuracy before they left the kitchen on 06/25/25 was unavailable for interview during the survey. An interview with Registered Dietitian (RD) #1 on 06/25/25 at 1:10 PM revealed residents should receive their nutritional supplements as ordered. A follow-up interview with RD #1 on 06/25/25 revealed the physician order for Resident #36's frozen nutritional treat was discontinued the evening of 06/23/25. She stated a RD or the Dietary Manager had to manually go into the dietary computer system and update the meal tray tickets but since that had not occurred, staff were still expected to provide items as listed on the meal tray ticket. RD #1 did not provide a reason as to why Resident #36's meal tray ticket had not been updated. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all residents to receive nutritional supplements as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews with Registered Dietitian #1, Speech Therapist, and staff, the facility failed to follow the physician's diet order to provide a mechanically altered diet (a texture-modified diet which restricts foods that are difficult to chew or swallow) for 1 of 5 residents reviewed for nutrition (Resident #36). Findings included: Resident #36 was admitted to the facility 01/06/20 with a diagnosis including non-Alzheimer's dementia. Review of Resident #36's physician orders revealed an order dated 04/26/24 for a mechanical soft diet. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was severely cognitively impaired and received a mechanically altered diet. Resident #36's nutrition care plan last updated 05/06/25 revealed she had an increased nutrition/hydration risk related to receiving a mechanically altered diet. Interventions included providing her diet and supplements as ordered. An observation of Resident #36's lunch meal ticket on 06/23/25 at 12:33 PM revealed she was to receive a mechanical soft diet. An observation of Resident #36's meal tray at the same time and date revealed she received 2 whole boneless chicken breasts on her plate. On 06/23/25 at 12:35 PM the Surveyor intervened and showed Administrator #2 Resident #36's meal ticket and plate. Administrator #2 confirmed whole chicken breasts were not considered mechanically soft and removed Resident #36's lunch plate before she began eating. An interview with Nurse Aide (NA) #4 on 06/23/25 at 12:45 PM revealed she set-up Resident #36's lunch meal tray on 06/23/25 and did not notice she received whole chicken breasts instead of mechanically altered chicken. The cook who plated the lunch meal and the dietary aide who checked meal trays for accuracy before they left the kitchen on 06/23/25 were unavailable for interview during the survey. An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed residents should receive the diet as ordered by the physician and he was not sure why Resident #36 did not receive the correct meal on 06/23/25. An interview with Registered Dietitian (RD) #1 on 06/25/25 at 1:10 PM revealed residents should receive their diet texture as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Speech Therapist (ST) on 06/27/25 at 8:25 AM revealed Resident #36 had not been on her caseload since mid-2024, but the diet recommendation of mechanical soft was still active. She stated residents who received a mechanical soft diet had difficulty with either chewing or swallowing and whole chicken breasts were not considered mechanically soft. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all residents to receive diets as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to label, date, and store food items in accordance with professional standards for food service safety in 1 of 1 kitchen; discard food with signs of spoilage in 1 of 1 reach-in cooler; store food off the floor, label and date food items, and remove a dented can in 1 of 1 dry storage room; and remove an opened and undated beverage in 1 of 3 nourishment rooms (West Wing nourishment room). Findings included: 1. An initial observation of the kitchen on 06/23/25 at 9:12 AM revealed the following: (a). 3 unlabeled and undated bins containing white powder-like substances (b). an opened and undated 16-ounce box of baking soda stored on a shelf (c). an opened and undated 32-ounce bottle of lemon juice with a label stating refrigerate after opening stored on a shelf. The bottle of lemon juice was room temperature. (d). an opened and undated 16-ounce box of cornstarch stored on a shelf An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed the bins contained sugar, flour, and grits and should have been labeled and dated. He further stated the box of baking soda and cornstarch should have had a label and date, and the lemon juice should have been labeled and dated and placed in the cooler or discarded. He stated he recently hired a number of new employees and he felt when they completed their training that would decrease the likelihood of items not being labeled and dated or being stored correctly. An interview with the Administrator on 06/27/25 at 11:47 PM revealed all food items should be labeled and dated and stored correctly. 2. An observation of the reach-in cooler on 06/23/25 at 9:25 AM revealed an unopened bag of chopped cabbage with multiple brown spots stored on the shelf. The bag of cabbage did not have an expiration or best-by date. An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed food items should be used or discarded before showing signs of spoilage and he was not sure why the cabbage was in the cooler. An interview with the Administrator on 06/25/25 at 11:47 AM revealed he expected all food items to be used or discarded before showing signs of spoilage. 3. An observation of the dry storage room on 06/23/25 at 9:32 AM revealed the following: (a). a 25-pound bag of self-rising flour laying on the floor (b). 2 35-pound boxes of vegetable oil stored on the floor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Hill Health & Rehab Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(c). 1 box of corn cereal stored on the floor (d). 1 box of rice cereal stored on the floor (e). a bin of 13 packs of undated graham crackers stored on a shelf (f). 1 dented 50-ounce can of cream of chicken soup available for use stored on a shelf with other cans An interview with the Dietary Manager on 06/24/25 at 1:10 PM revealed no food items should be stored on the floor, dented cans should not be stored with regular canned goods, and all food items in the dry storage room should have a label and expiration or use-by date. He stated he recently hired a number of new staff and once he was able to complete their training that would decrease the likelihood of food items being incorrectly stored. An interview with the Administrator on 06/27/25 at 11:47 AM revealed no food should be stored on the floor, dented cans should be removed and discarded or returned to the supplier, and all food items should be labeled and dated. 4. An observation of the [NAME] Wing nourishment room on 06/23/25 at 11:00 AM revealed an opened and undated box containing a nutritional supplement stored in the freezer. An interview with the Dietary Manager on 06/23/25 at 11:02 AM revealed he cleaned out nourishment refrigerators and freezers daily Monday through Friday and he was not sure why there was an opened and undated supplement in the freezer. An interview with the Administrator on 06/27/25 at 11:47 AM revealed he expected all opened beverage items in nourishment room refrigerators or freezers to be labeled and dated.