

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Valley Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 581 NC Highway 16 South Taylorsville, NC 28681	

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and resident representative interviews, the facility failed to complete a comprehensive discharge summary that included the name of the home health company and their contact information and failed to ensure education regarding catheter care was provided to the Resident Representative prior to discharge for 1 of 3 residents reviewed for discharge (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included stroke and neuromuscular dysfunction of bladder. Review of Resident #1's discharge Minimum Data Set assessment revealed him to be severely cognitively impaired and was coded as having an indwelling urinary catheter. Review of Resident #1's electronic medical record revealed a discharge summary document dated 08/07/25 and titled CCH Bridge to Home Discharge Summary - v2 that it was still in progress. Additional review of the document revealed there was no information in the Social Services section regarding home health nor was there documentation that education was provided to either Resident #1 or his responsible party regarding catheter care. Resident #1 was discharged to his home on [DATE]. An interview with Nurse #1 via telephone on 08/25/25 at 2:26 PM revealed she completed the discharge note and indicated she had completed the nursing section of the discharge summary. She reported the day of Resident #1's discharge, she had discussed Resident #1's discharge information with Resident #1's representative, which included therapy notes, and medications. Nurse #1 stated she also discussed Resident #1's wound care and asked if Resident #1's representative had questions regarding his urinary catheter which Nurse #1 reported Resident #1's representative stated no. Nurse #1 indicated that no official education regarding Resident #1's urinary catheter care was provided to Resident #1's representative and also indicated that she should have completed the catheter education on Resident #1's discharge summary. Nurse #1 reported she provided the discharge summary to Resident #1's representative. An interview with the Business Office Manager on 08/25/25 at 11:17 AM revealed she was currently serving in a dual role where she completed business office tasks and served as the facility's social worker. The Business Office Manager reported she had completed the social work section of Resident #1's discharge summary and stated before Resident #1 had discharged, she thought that Resident #1 would be receiving home health from Home Health Company #1 and had initially placed that information into the discharge summary but was notified on 08/11/25 by Resident #1's representative that Home Health Company #1 had not shown up to provide home health 5 days post Resident #1's discharge. The Business Office Manager stated at that time, she set up home health for Resident #1 through Home Health Company #2 and stated she had reopened Resident #1's discharge summary and removed Home Health Company #1 from the discharge summary and had forgotten to update the discharge summary with Home Health Company #2's information. She indicated that it should have been updated and the discharge summary closed. An interview with Resident #1's representative via telephone on 08/26/25 at 9:41 AM revealed Resident #1 did not have a urinary catheter prior to his hospitalization before being admitted to the facility. She stated she had not received any education upon discharge from any person at the facility regarding how to take care of a urinary catheter and stated she had no prior knowledge on how to care for a urinary catheter. Resident #1's representative stated she had to do her own research on how to care for Resident #1's urinary catheter until Home Health Company #2 began coming out to the home on [DATE]. Resident #1's representative reported she had not received any paperwork at the time of Resident #1's discharge other than a list of Resident #1's medications and some paper medication prescriptions. Multiple attempts to reach Home Health Company #2 via telephone were unsuccessful. An interview with the Administrator on 08/25/25 at 2:32 PM revealed it was her understanding that Resident #1's discharge summary was completed fully and there was a change in the home health provider, so the discharge summary was reopened to be edited. She reported that, ideally, when a change was made and verification was provided that a new home health provider was going to begin to see Resident #1, that the discharge summary should be updated and completed. She also indicated that if urinary catheter care education was provided, it should be marked in the discharge summary.</p>		