

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 01/08/2026
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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to follow professional standards of practice for the safe administration of medications for 1 of 1 resident reviewed for self-administration of medications (Resident #65). Resident #65, who had been assessed as unable to self-administer medications, had medications left at his bedside without nursing supervision. The findings included: Resident #65 was admitted to the facility on [DATE] with diagnoses that included respiratory failure and generalized muscle weakness. Resident #65's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and had no behaviors or rejection of care. A Self-Medication assessment dated [DATE] revealed Resident #65 was assessed as unable to self-administer medications. An observation on 1/05/26 at 8:42 AM revealed Resident #65 lying in his bed with his head raised. A medication cup, on his bedside table within reach, contained 3 round light green pills, 3 round white pills, 1 smaller round white pill, 2 oval white pills and 2 round dark orange pills. An additional medication cup containing an amber liquid was also observed on the bedside table. Resident #65 indicated he knew what all his pills were because he had been taking them for so long that he was able to recognize them. He revealed the nurse would leave his pills with him and return later to get the empty cups. Resident #65 indicated he could take his pills by himself and didn't need anyone watching him. He declined to name the medications in the cup. An interview on 1/05/26 at 10:28 AM with Nurse #3 revealed Resident #65 asked her to leave his medications with him as he wanted to take them by himself. She indicated it was his preference to have his medications left, and he would become angry if you stood over him to watch him take his medication. Nurse #3 revealed she didn't know if Resident #65 had been assessed as safe to self-administer his medications and stated she should not have left the medication on his bedside table and walked out of his room. On 1/07/26 at 9:41 AM an interview with the Director of Nursing (DON) revealed the admitting nurse should complete self-medication assessment and communicate the outcome to the nurses on the hall. She indicated Nurse #3 should not have left Resident #65's medications by his bedside to self-administer as he had been assessed as unable to self-administer. The DON revealed she was aware of the incident and had begun education to nurses on resident self-administration of medications. An interview conducted on 1/08/26 at 11:02 AM with the Administrator revealed that Resident #65 should not have had his medications left at the bedside for self-administration. The Administrator stated that Resident #65 required reassessment for self-administration of medications and that nursing staff would be re-educated on the facility's process for resident self-administration of medications.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff and Nurse Practitioner interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.69% for 1 of 4 residents observed during the medication administration (Resident #6).The findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses that included hypertension.Review of Resident #6's physician orders revealed an order dated 11/07/25 for folic acid (a vitamin critical for making new cells to prevent anemia) 800 micrograms (mcg) by mouth once a day. There was an order dated 11/26/25 for carvedilol (used to treat high blood pressure) 6.25 milligrams (mg) by mouth twice a day for hypertension. Hold for systolic blood pressure below 100 and heart rate below 60.On 01/06/26 at 8:30 AM an observation of a medication pass was conducted with Nurse #1. The Nurse prepared medications for Resident #6 which included carvedilol 6.25 mg and administered the medication to the Resident without assessing the Resident's blood pressure and heart rate before giving Resident #6 the carvedilol. During the same medication observation, Nurse #1 did not administer the folic acid 800 mcg to Resident #6.At 9:30 AM on 01/06/26 an interview was conducted with Nurse #1 who explained that she did not notice the parameters for the blood pressure and heart rate that was attached to the carvedilol order and stated it must have been added since the last time she worked with Resident #6. The Nurse stated she must have overlooked the order for the folic acid. On 01/07/2026 at 10:07 AM an interview was conducted with the Nurse Practitioner (NP) who stated that she was already aware of the medication errors that Nurse #1 had made. She explained that there were parameters on the carvedilol for a reason because it could drop the blood pressure and heart rate and that it would be necessary for a base reading to be obtained before the medication was given. The NP stated Nurse #1 should have read the medication record closer to obtain the blood pressure and heart rate prior to administration of the medication. The NP stated that medications were ordered for a reason, and she expected the nurses to give the medications that were ordered. She stated Nurse #1 should have looked closer at the medication administration record to avoid making errors.An interview was conducted with the Director of Nursing (DON) on 01/07/2026 at 2:45 PM, who explained that she was aware of the medication errors made by Nurse #1 not administering the folic acid and not checking the blood pressure and heart rate for Resident #6. The DON stated that the provider who entered the order for the carvedilol did not set up the parameters for the blood pressure and heart rate correctly in the system because if they had, the system would not have allowed Nurse #1 to check it off as being given without the parameters being documented. The DON stated the Nurse should have checked each medication order three times to prevent the medication errors.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>Based on observation, record review and staff interviews, the facility failed to secure controlled substance medications under a double lock in 1 of 3 medication rooms reviewed for medication storage (Main medication room).The findings included:On 01/07/26 at 11:15 AM the unlocked refrigerator in the Main medication room was checked for medication storage along with the Director of Nursing (DON). The observation yielded four bottles of liquid lorazepam (benzodiazepine) with 30 ml each and two bottles of liquid morphine (opioid pain reliever) with 30 ml each, which are controlled substances. The liquid lorazepam and the liquid morphine were in a box affixed to the inside of the refrigerator, but the box was unlocked. The DON explained that Nurse #2 had the key to the box and the box should be always locked.At 11:30 AM on 01/07/26 an interview was conducted with Nurse #2 who confirmed that she had the key to the controlled substance locked box in the refrigerator that contained the lorazepam and morphine. The Nurse explained that she counted the medications with the third shift nurse earlier that morning and she must have forgotten to lock the box back after the medications were counted.An interview was conducted with the Administrator on 01/09/26 at 2:55 PM. The Administrator indicated her expectation was that the controlled substances be locked up no matter if they were in the medication cart or refrigerator.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when the Wound Nurse did not doff (remove) her gloves, perform hand hygiene and don (put on) clean gloves before moving to a second wound on Resident #10. The deficient practice occurred for 1 of 4 staff members observed for infection control practices (Wound Nurse).The findings included: Review of the facility's policy and procedure entitled Hand Hygiene and dated October 2023 read in part:Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:Immediately before touching a resident.Before performing an aseptic taskAfter contact with blood, body fluids, or contaminated surfaces.After touching a residentAfter touching the resident's environmentBefore moving from working on a soiled body site to a clean body site on the same resident; andImmediately after glove removal. A wound treatment observation was made on 01/06/26 at 10:01 AM on Resident #10 with the Wound Nurse. The Wound Nurse donned a clean gown and clean gloves. She then removed the old dressing from Resident #10's left hip, doffed her gloves, sanitized her hands, donned clean gloves and cleaned the wound to Resident #10's left hip. While wearing the same gloves the Wound Nurse then applied collagen powder with silver alginate to the left hip wound. The Wound nurse then proceeded to move to the next wound located on Resident #10's right ankle without doffing her gloves and sanitizing her hands. The Wound Nurse applied skin prep (skin protectant film) to the right ankle. She then collected all of her supplies and threw them into the trash can. The Wound Nurse doffed her gown, gloves and washed her hands. An interview conducted on 01/06/26 at 10:21 AM with the Wound Nurse revealed she was aware that she had not sanitized her hands and changed her gloves between the dressing changes on Resident #10's left hip and right ankle. She stated there was a lot going on in the room which made her nervous and she had just moved to the next wound without thinking. The Wound Nurse stated she had received ongoing education on infection control and dressing changes, that it was just a mistake. An interview on 01/07/26 at 2:22 PM with the Director of Nursing (DON) and Infection Preventionist revealed they both were aware of the Wound Nurse's errors during wound care. The DON said the Wound Nurse had been provided with additional education regarding doffing and donning and sanitizing in between wound care. The DON and Infection Preventionist stated it was their expectation for the Wound Nurse to follow infection control best practices to avoid introducing microorganisms into the wounds. An interview on 01/07/26 at 11:28 AM with the Administrator revealed she would expect the Wound Nurse to follow the Hand Hygiene policy for wound care.</p>