STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care and Rehabilitation	551 Kent Street Andrews, NC 28901

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident, staff, and Nurse Practitioner interviews, the facility failed to ensure medications were administered as prescribed by the physician when Medication Aide #1 administered medications to Resident #1 that were prescribed for Resident #2. The medications included doxepin (antidepressant), lamotrigine (anticonvulsant), folic acid (vitamin B9) and acetaminophen (analgesic). The deficient practice affected 1 of 3 residents reviewed for medication errors.The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral vascular disease, hypertension, hyperlipidemia and unspecified convulsions.Review of Resident #1's admission Minimum Data Set assessment dated [DATE] indicated the Resident was cognitively intact.Review of Resident #1's physician orders revealed orders for:- acetaminophen 500 milligrams (mg) by mouth at bedtime dated [DATE],- levetiracetam (anticonvulsant) 1000 mg by mouth twice a day dated [DATE],- atorvastatin (statin) 40 mg by mouth at bedtime dated [DATE],- melatonin (sedative) 3 mg by mouth for sleep dated [DATE],- metoprolol (antihypertensive) 25 mg by mouth every 12 hours dated [DATE],- cetirizine (antihistamine) 10 mg by mouth one time only for rash/swelling dated [DATE].Review of Resident #1's Medication Administration Record (MAR) for [DATE] revealed the Resident was administered acetaminophen, atorvastatin, melatonin and levetiracetam. The MAR indicated that metoprolol was held and the cetirizine was administered on [DATE] at 11:27 PM.Resident #2 was admitted to the facility on [DATE] with diagnoses that included epilepsy, insomnia, vitamin B deficiency and polymyalgia rheumatica.Review of Resident #2's physician orders revealed the following medications were to be administered at 7:00 PM- doxepin 25 mg by mouth at bedtime for sleep dated [DATE],- lamotrigine 300 mg by mouth twice a day for epilepsy dated [DATE],- folic acid 400 micrograms by mouth twice a day for vit B deficiency dated [DATE] and- acetaminophen 1000 mg by mouth four times a day for pain dated [DATE].Review of a Medication Variance Report dated [DATE] at 8:35 PM written by the Assistant Director of Nursing (ADON) indicated in part that Medication Aide (MA) #1 administered medications to Resident #1 who was in bed A that belonged to Resident #2 bed B. Bed A was not labeled (on the door) and the room change had not yet been updated in the computer system. The MA stated she greeted Resident #1 by saying Resident #2's name and Resident #1 looked at her and responded appropriately. The medications were administered before the error was realized. Resident #1's vital signs were taken every 15 minutes. The ADON notified the family, and the on-call physician service gave instructions to obtain vital signs every one hour for four hours and then every four hours for eight hours. The family was notified of the orders.Review of Resident #1's medical record revealed the vital signs documented on [DATE] and [DATE] were obtained as ordered and were within normal limits.An interview was conducted with Resident #1 on [DATE] at 9:10 AM who explained that she remembered being given her roommate's medications (could not name the medications) when she was moved to a different room. She stated she was sent to the emergency room but came back the same day and was not given any treatment. Resident #1 continued to explain that she did not have a negative reaction from the medications.An interview was conducted with Medication Aide #1 on [DATE] at 12:20 PM. The MA explained that she reported to work on the evening shift on [DATE] and had started the (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication pass. She stated the nurse instructed her to start with Resident #2 because the Resident stated she felt like she was going to have a seizure. When she got to Resident #2's room, there was only one name on the door, so she thought Resident #2 was the only resident in that room. The MA prepared Resident #2's medications that were due to be given at 7:00 PM and opened the door and saw Resident #1 in bed A. The curtain was pulled so she could not see bed B. She called Resident #2's name in which Resident #1 looked at the MA and answered yes, so the MA gave Resident #2's medications to Resident #1. The MA continued to explain that Resident #1 asked her to raise the head of her bed and when she went to the foot of the bed and cranked the bed, she noticed that someone was lying in bed B (Resident #2). The MA stated she immediately went to the computer to see who was in bed B and discovered that it was Resident #2 by looking at the Resident's picture on the computer. The MA reported that she went to find the nurse and saw the ADON at the nursing desk and she reported that she made a medication error to the ADON, but she did not know who the resident was because the name was not on the door. The ADON happened to be on the phone with the Director of Nursing at the time who informed the ADON that they had moved Resident #1 temporarily into Resident #2's room because Resident #1's roommate had expired and it was going to be a while before the funeral home could pick her up. The MA stated that she and the ADON looked at Resident #2's medical record to identify which wrong medications had been given to Resident #1. The ADON then called the family and the on-call physician service to report the medication error, but she did not know what new orders were given to the ADON. The MA stated they watched Resident #1 closely throughout the night and obtained her vital signs numerous times and her vital signs were within normal limits. She reported that Resident #1 was sleepy but was easily aroused when they went into render care. The MA explained that she gave Resident #1 her due medications except her blood pressure medication (metoprolol). When asked why the MA made the medication error she stated she was in a hurry to give Resident #2 her medication to prevent a seizure and she felt that if Resident #1's name had been put on the door she would have recognized there were two residents in the room and made sure she identified the correct resident before she made the medication error.During an interview with the Assistant Director of Nursing on [DATE] at 11:00 AM, the ADON explained that she was working the evening shift on [DATE] when MA #1 came to the nursing desk and reported that she had just made a medication error. The MA explained that she had given Resident #2's medications to her roommate (Resident #1). There was only one name on the door which was Resident #2 and she prepared Resident #2's medications and gave them to Resident #1 who was in bed A. The ADON stated she was on the phone with the DON at the time and the DON informed her that they moved Resident #1 to Resident #2's room for a while because her roommate had died and it was going to be a while before the funeral home picked the resident up and Resident #1 did not want to stay in the room with the deceased resident. The ADON continued to explain that she assessed Resident #1 and called the on-call physician and while she waited for the physician to return her call, she called the Resident's family and reported the medication error. The ADON stated that when the physician called back, she reported the medication error of giving Resident #1 the doxepin, folic, acetaminophen and lamotrigine and the physician gave her an order to administer a one-time dose of cetirizine 10 mg and to monitor her vital signs every hour for four hours and then every four hours for eight hours. She stated she had obtained vital signs more often than what she was told and monitored her throughout the night and Resident #1 slept most of the night. The ADON also reported that she went over each medication with the physician that was given to Resident #1 in error and what the Resident's vital signs were, and the physician instructed her to give Resident #1 her due nighttime medications except for the antihypertensive (metoprolol) because the other medications could lower her blood pressure. The ADON stated she counseled the MA on the five rights of a safe medication administration and observed her administer more medications that night that included Resident #1's medications.An interview was conducted with Nurse #1 on [DATE] at 11:00 AM. The Nurse explained that she came on duty on [DATE] at 7:00 AM and received in report that Resident #1 had been given her roommate's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. The Nurse stated she monitored Resident #1 throughout the shift and she was sleepy but easily aroused when she was spoken to. She stated the family was at the facility and wanted her to send her to the emergency room to evaluate her for the drowsiness, so she sent her to the emergency room.An interview was conducted with Nurse #2 on [DATE] at 2:45 PM who explained that she was on duty [DATE] at 12:10 AM and received a verbal report from the emergency room that Resident #1 would be coming back to the facility. The report included that they obtained labs and an electrocardiogram (EKG) and they were all within normal limits for Resident #1. There were no new orders for the Resident. The Nurse reported that Resident #1 slept throughout the night and had no complaints.An interview was conducted with the Nurse Practitioner (NP) on [DATE] at 3:30 PM who explained that on [DATE] she was asked to visit Resident #1 because on [DATE] she had been given another resident's medications including lamotrigine, acetaminophen and doxepin. The staff called the on-call physician who gave orders to administer cetirizine and to hold Resident #1's blood pressure medication that night. The NP continued to explain that she was notified the next day that Resident #1 seemed lethargic which did not surprise her because the doxepin could be given for insomnia but her vital signs were stable. The family insisted on the Resident being sent to the emergency room. The NP reported she saw Resident #1 on [DATE] and reviewed the emergency room notes which showed normal complete blood counts, normal complete metabolic panel, normal urinalysis and no acute changes on the EKG and she was sent back to the facility. The NP stated when she saw Resident #1 on [DATE] she was awake and smiling and back to her usual self. She stated she would have held the melatonin which could attribute her lethargy but other than that she would have given the same orders as the on-call physician gave. The NP indicated the medication errors were not considered to be significant but unfortunate and was grateful that the facility acted quickly to counteract the reactions Resident #1 might could have had related being given the wrong medications.The Director of Nursing was not available for interview.An interview was conducted with the Administrator on [DATE] at 4:00 PM who explained she was notified of the medication error the next morning on [DATE]. Resident #1 was closely monitored by the staff, but her family wanted her sent to the hospital, so the Director of Nursing called the physician and got an order to send her to the emergency room on [DATE]. The Administrator continued to explain that the decision to move Resident #1 temporarily was her decision because she did not want to be in the room with the deceased roommate. She stated she expected the MA to honor the five rights for safe medication administration and if she had, there would not have been a medication error made. The Administrator added that she did not discount that the medication error was not serious because it was.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Medical Director interviews, the facility failed to provide care in a safe manner when staff assisted a resident with muscle weakness, dementia, and was bedbound with incontinence care. The resident fell off the side of the bed onto the floor, was bleeding from her head, and immediately transferred to the hospital for treatment. A hospital x-ray (imaging test for body's internal structures) revealed Resident #3 had suffered a laceration to the left side of the scalp and neck fractures during the fall. Resident #3 received treatment at the hospital on 5/30/26 and was discharged back to the facility on 5/31/26. The deficient practice occurred for 1 of 3 residents for the prevention of accidents (Resident #3). Findings included: Resident #3 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus, muscle weakness, bedbound, atrial fibrillation (irregular heart rhythm), osteoarthritis (deterioration of protective cartilage that cushions the end of bones), and dementia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was moderately cognitively impaired, had been assessed as being dependent on staff for all activities of daily living (ADL), transfers, mobility, and was always incontinent of bladder and bowel. Review of revised care plan dated 3/16/26 revealed Resident #3 required assistance with all activities of daily living related to history of right hip fracture on admission. Interventions included required maximum assistance from staff to complete tasks safely and encouraged Resident #3 to participate to the fullest extent possible with each interaction. Review of nursing progress note dated 5/30/25 written by Nurse #1 revealed she and Nurse Aide (NA) #1 were in Resident #3's room for incontinence care. Resident #3 was assisted with rolling onto her right side with NA #1 on one side and Nurse #1 on the other. Resident #3 suddenly rolled off the bed and into the floor face down. Nurse #1 immediately noted that there was blood coming from what appeared to be the side of Resident #3's head. Nurse #1 informed staff not to move resident, Emergency Medical Services (EMS) were called immediately, and Resident #3 was transported to the hospital. Resident #3 was at baseline when EMS arrived and remained conscious the entire time. Responsible person and physician were notified, and report was called in to the hospital nurse. An interview with Nurse #1 on 6/04/26 at 11:34 AM revealed she worked at the facility on 1st shift (7:00 AM to 7:00 PM), was scheduled to work on 5/30/26, and had been assigned to Resident #3. She stated earlier in her shift on 5/30/26, NA #1 had asked her if she would assist her with Resident #3's next incontinence care round so that she could assess a possible red area on Resident #3's bottom and see if it required any treatment or cream. Nurse #1 revealed around 6:40 PM was when NA #1 asked if she would assist her with Resident #3's incontinence care and assess the possible red area on her bottom. She stated NA #1 had gotten Resident #3's incontinent care supplies together prior to them entering the room and she had brought with her a medicated cream to apply if needed. She revealed Resident #3's bed was located by the window, and upon entering the room NA #1 positioned herself on the right side of the bed with her back towards the door and facing the window and Nurse #1 positioned herself on the left side of the bed with her back to the window and facing door. She stated that she informed Resident #3 about completing her incontinence care and assessing her bottom for any red areas and would apply some medicated cream if needed and Resident #3 agreed. Nurse #1 revealed NA #1 assisted with raising Resident #3's bed to waist level and while Resident #3 was lying on her back, NA #1 began cleaning Resident #3's front area. She stated after NA #1 was finished cleaning Resident #3's front area, they tucked her brief between the legs and rolled Resident #3 onto her right-side facing NA #1 so she could assess Resident #3's bottom. She revealed as she reached to pull Resident #3's brief down in the back she observed that Resident #3 was using the bathroom, so she pulled the back of her brief up to allow her time to finish. Nurse #1 stated that during this time Resident #3 remained rolled onto her right side and she and NA (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#1 remained standing on each side of her bed. She revealed about 2 minutes later she went to pull Resident #3's brief down in the back to see if she had finished and Resident #3 moved her left leg over her right and started to roll towards NA #1 and off the bed. She stated the incident happened so fast that she was trying to grab her from the other side of the bed, and she believed NA #1 also tried to catch her on her side of the bed, but she just fell so quickly neither of them were able to stop from her falling. Nurse #1 revealed she ran to the other side of the bed and saw that Resident #3 appeared to be bleeding from her head, so she instructed NA #1 not to touch her, ran to the door and yelled for help, and immediately called 911. She stated the Nurse Supervisor came into the room and she informed her not to touch or move Resident #3 that EMS was on their way, she stated Resident #3 remained conscious and at baseline during the incident and only complained of her head hurting. Nurse #1 revealed EMS responded quickly, assessed Resident #3, and transported her to the hospital. She stated she also contacted Resident #3's Responsible Party (RP) and the physician. She revealed Resident #3 returned to the facility the following day on 5/31/26 with scalp laceration that required 4 staples, neck fractures that required her to wear a C-collar for the next 12 weeks, and scheduled pain medications. A telephone interview with NA #1 on 6/04/26 at 2:13 PM revealed she had worked 1st shift (7:00 AM to 7:00 PM) at the facility for the past year and had been assigned to work with Resident #3 on 5/30/26. She stated earlier that day she had asked Nurse #1 if she would assist her with changing Resident #3 so that she could assess a possible red area that she had seen earlier on Resident #3's bottom. She revealed around 6:40 PM she had informed Nurse #1 that she was ready for Resident #3's incontinence care, collected all the incontinent care supplies they would need, and she and Nurse #1 entered into Resident #3's room to complete her incontinence care. NA #1 stated she was on the right side of the bed with her back towards the door and facing the window and Nurse #1 was on the left side of the bed facing the door with her back to the window. She revealed they spoke with Resident #3 and told her what they were about to do, raised her bed to waist level, and while Resident #3 was still lying on her back she pulled her brief down and cleaned her front area. She stated she and Nurse #1 rolled Resident #3 onto her right side facing her so Nurse #1 could clean her and assess her bottom but when Nurse #1 went to pull down Resident #3's brief down in the back she observed her using the bathroom so Nurse #1 pulled the brief back up and they waited for Resident #3 to finish. She revealed while they were waiting Resident #3 remained on her right side with her left leg on top of or behind her right leg and as Nurse #1 was going to pull down the back of Resident #3's brief to check if she was finished, Resident #3 moved her left leg over right leg and just started rolling towards her off the bed. NA #1 stated that it was an accident, she tried to stop her from falling but everything happened so fast and she just could not stop her from rolling onto the floor. She revealed Nurse #1 came around the bed and they both noticed that Resident #3 was bleeding from what appeared to be her head, but she was still talking. She stated Nurse #1 immediately yelled for help and instructed no one to touch or move Resident #3, called 911, and EMS came and transported her to the hospital. Review of hospital admission summary dated [DATE] revealed Resident #3 presented for evaluation after a fall out of bed. Resident #3 experienced a fall, laceration to left frontal scalp that was not actively bleeding on arrival, currently at mental status baseline, normal range of motion and neck supple, and had no other complaints. X-ray ordered for head, chest, abdomen, and pelvis to assess for any further injuries. Review of hospital Discharge summary dated [DATE] revealed Resident #3 was treated following a fall from her bed at her skilled nursing facility that resulted in trauma. On presentation, she was noted to have a 4-centimeter (cm) scalp laceration that had been repaired with staples. Initial evaluation included advanced imaging, which revealed nondisplaced fractures (broken or cracked bone that remain aligned in normal position) of the anterior (front ring of cervical vertebrae) and posterior arch (back portion of top vertebrae of spine) of C1 (topmost bone of neck) and a nondisplaced type III odontoid fracture (stable break at the base of the C2 vertebrae); x-ray of brain, chest, abdomen, and pelvis showed no acute injuries. Neurosurgery was consulted and recommended nonoperative management with a cervical collar (C-collar) to be worn 24 hours a day for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12 weeks, with outpatient follow-up. Resident #3 was deemed appropriate for return to her skilled nursing facility from a neurosurgical standpoint. Therapeutic interventions included maintenance of cervical spine precautions and pain management. Occupational therapy (OT) assessed her as total assist for ADL and functional mobility, consistent with her baseline, and signed off with no acute OT needs at discharge; her rehabilitation potential was poor, and she was bedbound at baseline. Review of nursing progress note dated 5/31/26 revealed Resident #3 would be returning to the facility with staples to laceration to left side of head, C1 anterior and posterior fracture, and Type III odontoid non-displaced fracture. Resident #3 must wear C-collar 24 hours a day for the next 12 weeks and follow up with neurologist in 3 to 4 weeks. Resident #3 returned from hospital via EMS with family at her side. C- collar was in place and Resident #3 was safely transferred to bed and positioned for comfort. Pain medication was administered, bed was in lowest position, and call- light within reach. A telephone interview with the Medical Director on 6/04/26 at 2:49 PM revealed she was familiar with Resident #3 and was made aware of her fall on 5/30/26. She stated she could not recall the exact details on Resident #3's fall just that she had rolled out of bed during incontinence care with 2 people, was sent out to the hospital immediately, and suffered a scalp laceration that required 4 staples and C1 and C2 fracture that required C-collar to be worn for 12 weeks. She revealed Resident #3 would follow-up with neurology in 3 weeks to assess her healing, 4 staples would be removed in-house, scheduled and as needed pain medications were prescribed, and they would continue to monitor her pain and adjust her medications as needed. The Medical Director stated that she had no concerns or issues regarding Resident #3's care or her fall, she believed the fall was truly an accident and that staff responded appropriately by immediately calling 911 and not moving or touching Resident #3 until EMS arrived. An interview with the Administrator on 6/04/36 at 4:19 PM revealed she was familiar with Resident #3 and her fall. She stated that she believed she received a message about the fall and Resident #3 being sent out either the evening of Saturday 5/30/26 or the following morning and then spoke with staff and Resident #3's family about it that Monday morning. She revealed to her knowledge the fall was an accident and occurred while staff were changing Resident #3 and she moved her legs and rolled off the bed before staff could stop her. The Administrator revealed staff immediately responded by calling 911 and not touching or moving Resident #3 until EMS arrived and transported her to the hospital. She stated she did feel this incident was an accident but that staff do need to make sure they are following all procedures when providing incontinence care to include making sure the correct number of staff are present, position of staff at bedside, making sure they have care supplies gathered prior to beginning care, and knowing how much assistance was required with each resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.5% for 1 of 2 residents observed during the medication administration (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease with heart failure.Review of Resident #4's physician orders were orders for:- metolazone (diuretic used to treat fluid retention associated with heart failure) 2.5 milligrams (mg) by mouth one time a day for edema. Give 30 minutes before bumetanide, dated 03/13/26.- bumetanide 2 mg by mouth in the morning for edema. Give 30 minutes after metolazone is administered, dated 04/08/26.- fluticasone propionate suspension (corticosteroid used to treat seasonal allergies) one spray in each nostril twice a day for sinus congestion dated 04/13/26.Review of Resident #4's Medication Administration Record (MAR) for June 2026 revealed- metolazone (diuretic used to treat fluid retention associated with heart failure) 2.5 milligrams (mg) by mouth one time a day for edema. Give 30 minutes before bumetanide, dated 03/13/26.- bumetanide 2 mg by mouth in the morning for edema. Give 30 minutes after metolazone is administered, dated 04/08/26.- fluticasone propionate suspension (corticosteroid used to treat seasonal allergies) one spray in each nostril twice a day for sinus congestion dated 04/13/26.On 06/04/26 at 8:35 AM an observation was made of medication administration made by Medication Aide (MA) #2. The MA prepared Resident #4's medications which included fluticasone nasal spray, metolazone and bumetanide and took the medications into the Resident's room. The MA handed the cup of pills to Resident #4, and the Resident took the cup of pills. The MA handed the nasal spray to Resident #4 in which the Resident proceeded to spray two sprays into each nostril then handed the nasal spray back to the MA. The MA did not instruct the Resident on how many sprays to instill in each nostril.An interview was conducted with the Medication Aide on 06/04/26 at 2:30 PM. The MA was asked to review the medication cards for the metolazone and bumetanide and read the instructions of each medication then stated she did not pay close attention to the directions for the fluticasone nasal spray, metolazone and bumetanide and did not administer the fluticasone nasal spray, metolazone and bumetanide as ordered. The MA was asked how many nasal sprays were supposed to be administered to Resident #4 and she looked at the directions on the computer and stated, one spray. When the MA was asked how many sprays Resident #4 gave herself, she stated she did not know. The MA explained that she did not instruct the Resident on how many sprays to administer because the Resident was independent and administered the nasal sprays herself. She confirmed that she did not give the bumetanide and metolazone 30 minutes apart because she did not see the instructions on the medication card or physician order to administer the medications 30 minutes apart. During an interview with the Nurse Practitioner (NP) at 3:30 PM on 06/04/26. The NP explained that Resident #4 was prescribed both the metolazone and bumetanide because of her heart failure and when given 30 minutes apart the metolazone accentuates the bumetanide which enables the diuretics to be more effective to prevent edema when given as they were prescribed. If they were not administered as prescribed, then they will not work as well. The NP stated she expected the medications to be administered as ordered including the fluticasone nasal spray.The Director of Nursing was unavailable for interview.An interview was conducted with the Administrator on 06/04/26 at 5:00 PM who explained that she was surprised that MA #1 made the medication errors because she had been audited by the Assistant Director of Nursing and the pharmacist on past audits and always did well on her medication administration audits. Nevertheless, she expected the MA to honor the five rights of safe medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff and Nurse Practitioner, the facility failed to prevent a significant medication error for 1 of 3 residents reviewed for significant medication error (Resident #1). Medication Aide #1 administered Lyrica (a medication that treats nerve pain by calming overactive nerves in your body and can also treat epilepsy by preventing and managing seizures) to Resident #1 that was prescribed for Resident #2, and that Resident # 1 had a documented allergy to. Resident #1 had no significant adverse reaction related to being administered the Lyrica.The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral vascular disease and unspecified convulsions.Review of Resident #1's medical record revealed an allergy to Lyrica.Review of Resident #1's admission Minimum Data Set assessment dated [DATE] indicated the Resident was cognitively intact.Review of Resident #1's physician orders revealed orders for:- acetaminophen 500 milligrams (mg) by mouth at bedtime dated [DATE],- levetiracetam (anticonvulsant) 1000 mg by mouth twice a day dated [DATE],- atorvastatin (statin) 40 mg by mouth at bedtime dated [DATE],- melatonin (sedative) 3 mg by mouth for sleep dated [DATE],- metoprolol (antihypertensive) 25 mg by mouth every 12 hours dated [DATE],- cetirizine (antihistamine) 10 mg by mouth one time only for rash/swelling dated [DATE].Review of Resident #1's Medication Administration Record (MAR) for [DATE] revealed the Resident was administered acetaminophen, atorvastatin, melatonin and levetiracetam on [DATE] at 7:00 PM. The MAR indicated that metoprolol was held and the cetirizine was administered on [DATE] at 11:27 PM.Resident #2 was admitted to the facility on [DATE] with diagnoses that included polymyalgia rheumatica (an inflammatory disorder causing severe muscle pain and stiffness, predominantly in the shoulders, neck, and hips).Review of Resident #2's physician orders revealed an order for Lyrica 300 mg by mouth three times a day for pain dated [DATE].Review of Resident #2's Medication Administration Record for [DATE] revealed the Lyrica was documented as administered on [DATE] at 7:00 PM.Review of a Medication Variance Report dated [DATE] at 8:35 PM written by the Assistant Director of Nursing (ADON) indicated in part that Medication Aide (MA) #1 administered medications to Resident #1 who was in bed A that belonged to Resident #2 in bed B. Bed A was not labeled (on the door) and the room change had not yet been updated in the computer system. The MA stated she greeted Resident #1 by saying Resident #2's name and Resident #1 looked at her and responded appropriately. The medication was administered before the error was realized. Upon discovery, the medications that were administered to Resident #1 were reviewed thus noting that Resident #1 had an allergy to one of the medications (Lyrica). Resident #1's vital signs were taken every 15 minutes. The ADON notified the family and asked about prior reactions to Lyrica. The family stated that the Lyrica caused a rash and some swelling but had no difficulty breathing. The on-call physician service was notified about the medication error and the side effects reported by the family (for the Lyrica allergy). The physician gave instructions to administer cetirizine 10 mg one time and to monitor for any rash, swelling or other symptoms. The physician also gave orders to obtain vital signs every one hour for four hours and then every four hours for eight hours. The family was notified of the orders.Review of Resident #1's medical record revealed the vital signs documented on [DATE] and [DATE] were obtained as ordered and were within normal limits.An interview was conducted with Resident #1 on [DATE] at 9:10 AM who explained that she remembered being given her roommate's medication (could not name the medication) when she was moved to a different room. She stated she had taken the medication in the past and developed a rash and itching on her face. She stated she was sent to the emergency room but came back the same day and was not given any treatment to counteract the reaction. Resident #1 continued to explain that she did not develop a rash or itch, nor did she have a negative reaction from the medication.An interview was conducted with Medication Aide #1 on [DATE] at 12:20 PM. The MA explained that she reported to work on the evening shift on [DATE] and had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care and Rehabilitation	551 Kent Street Andrews, NC 28901

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started the medication pass. She stated the nurse instructed her to start with Resident #2 because the Resident stated she felt like she was going to have a seizure. When she got to Resident #2's room, there was only one name on the door, so she thought Resident #2 was the only resident in that room. The MA prepared Resident #2's medications that were due to be given at 7:00 PM and opened the door and saw Resident #1 in bed A. The curtain was pulled so she could not see bed B. She called Resident #2's name and Resident #1 looked at the MA and answered yes, so the MA gave Resident #2's medications to Resident #1. The MA continued to explain that Resident #1 asked her to raise the head of her bed and when she went to the foot of the bed and cranked the bed, she noticed that someone was lying in bed B (Resident #2). The MA stated she immediately went to the computer to see who was in bed B and discovered that it was Resident #2 by looking at the Resident's picture on the computer. The MA reported that she went to find the nurse and saw the ADON at the nursing desk and she reported that she made a medication error to the ADON, but she did not know who the resident was because the name was not on the door. The ADON happened to be on the phone with the Director of Nursing at the time who informed the ADON that they had moved Resident #1 temporarily into Resident #2's room because Resident #1's roommate had expired and it was going to be a while before the funeral home could pick her up. The MA stated that she and the ADON looked at Resident #1's medical record to see if she was allergic to any of the medications that were given to her and found that she was allergic to the narcotic (Lyrica). The ADON then called the on-call physician and the family to see what kind of reaction Resident #1 had to the medication and the family told her the Resident developed a rash. The ADON called the on-call physician back and informed them of what the family told her. The MA stated she did not know what other orders if any the on-call physician gave the ADON after that. The MA stated they watched Resident #1 closely throughout the night and obtained her vital signs numerous times and her vital signs were within normal limits. She reported that Resident #1 was sleepy but was easily aroused when they went into render care. The MA explained that she gave Resident #1 her due medications except her blood pressure medication (metoprolol). When asked why the MA made the medication error she stated she was in a hurry to give Resident #2 her medication to prevent a seizure and she felt that if Resident #1's name had been put on the door she would have recognized there were two residents in the room and made sure she identified the correct resident before she made the medication error. During an interview with the Assistant Director of Nursing on [DATE] at 11:00 AM, the ADON explained that she was working the evening shift on [DATE] when MA #1 came to the nursing desk and reported that she had just made a medication error. The MA explained that she had given Resident #2's medications to her roommate (Resident #1). There was only one name on the door which was Resident #2 and she prepared Resident #2's medication and gave it to Resident #1 who was in bed A. The ADON stated she was on the phone with the DON at the time and the DON informed her that they moved Resident #1 to Resident #2's room for a while because her roommate had died and it was going to be a while before the funeral home picked the resident up and Resident #1 did not want to stay in the room with the deceased resident. The ADON continued to explain that she went to see if Resident #1 was allergic to any of the medications that were given to her by mistake and discovered that she was allergic to Lyrica. She stated she assessed Resident #1 and took her vital signs which were in normal limits. She called the on-call physician and while she waited for the physician to return her call, she called the Resident's family to see what kind of reaction Resident #1 had to Lyrica. The family reported that she developed a facial rash. The ADON stated that by the time the physician called her back, Resident #1 reported she was having itching on her neck, but she did not have a rash. When the physician called back the ADON reported the medication error of giving Resident #1 the Lyrica for which she had an allergy to, and the physician gave her an order to administer a one-time dose of cetirizine 10 mg and to monitor her vital signs every hour for four hours and then every four hours for eight hours. She stated she had obtained vital signs more often than what she was told and monitored her throughout the night and she slept most of the night. The ADON also reported that she went over each medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the physician that was given to Resident #1 in error and what the Resident's vital signs were, and the physician instructed her to give Resident #1 her due nighttime medications except for the antihypertensive (metoprolol) because the other medications could lower her blood pressure. The ADON stated she counseled the MA on the five rights of a safe medication administration and observed her administer more medications that night that included Resident #1's medications.An interview was conducted with Nurse #1 on [DATE] at 11:00 AM. The Nurse explained that she came on duty on [DATE] at 7:00 AM and received in report that Resident #1 had been given her roommate's medication which included Lyrica that she had a known allergy to. The Nurse stated she monitored Resident #1 throughout the shift and she was sleepy but easily aroused when she was spoken to. She stated the family was at the facility and wanted her to send her to the emergency room to evaluate her for the drowsiness, so she sent her to the emergency room.An interview was conducted with Nurse #2 on [DATE] at 2:45 PM who explained that she was on duty [DATE] at 12:10 AM and received a verbal report from the emergency room that Resident #1 would be coming back to the facility. The report included that they obtained labs and an electrocardiogram (EKG) and they were all within normal limits for Resident #1. There were no new orders for the Resident. The Nurse reported that Resident #1 slept throughout the night and had no rash or complaints of itching.An interview was conducted with the Nurse Practitioner (NP) on [DATE] at 3:30 PM who explained that on [DATE] she was asked to visit Resident #1 because on [DATE] she had been given another resident's medications that included Lyrica and it was documented that she had an allergy to Lyrica which caused her have facial swelling and a rash. The staff called the on-call physician who gave orders to administer cetirizine and to hold Resident #1's blood pressure medication that night. The NP continued to explain that she was notified the next day that Resident #1 seemed lethargic, which did not surprise her. The family insisted on the Resident being sent to the emergency room. The NP reported she saw Resident #1 on [DATE] and reviewed the emergency room notes which showed normal complete blood counts, normal complete metabolic panel, normal urinalysis and no acute changes on the EKG and she was sent back to the facility. The NP stated when she saw Resident #1 on [DATE] she was awake and smiling and back to her usual self. She stated she would have held the melatonin which could attribute her lethargy but other than that she would have given the same orders as the on-call physician gave. The NP added that she considered the medication error to be significant but was grateful that the facility acted quickly to counteract the reaction of the Lyrica.The Director of Nursing was not available for interview.An interview was conducted with the Administrator on [DATE] at 4:00 PM who explained she was notified of the medication error the next morning on [DATE]. Resident #1 was closely monitored by the staff, but her family wanted her sent to the hospital, so the Director of Nursing called the physician and got an order to send her to the emergency room on [DATE]. The Administrator continued to explain that the decision to move Resident #1 temporarily was her decision because she did not want to be in the room with the deceased roommate. The Administrator stated she expected the MA to honor the five rights for safe medication administration and if she had, there would not have been a medication error made. The Administrator added that she did not discount that the medication error was not serious because it was.