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	03/14/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on observations and interviews with residents and staff, the facility failed to maintain repair or replace damaged bed power cord for 2 of 12 (Room#101 and Room#103) resident rooms on 1 of 4 resident halls reviewed for maintaining a safe, clean, and homelike environment. The findings included: a.On 3/11/25 at 11:16 AM an observation of room [ROOM NUMBER] b bed revealed the bed remote and power cord lying on top of the bed. Electrical tape was wrapped around multiple areas of the bed's power cord. Further observation revealed the outer protective wire coating was broken, torn, or missing exposing 3 inner color-coded wires spanning the length of the visible portion of the power cord as it attached under the bed. The resident in room [ROOM NUMBER] was interviewed on 3/11/25 at 3:30 PM. She stated the bed power cord wire had been damaged and wrapped with electrical tape for as long as she had been in the room. A follow-up observation of room [ROOM NUMBER] b bed on 3/14/25 at 11:30 AM found the bed cord unchanged. b.On 3/11/25 at 3:42 PM an observation of room [ROOM NUMBER] b bed revealed the bed remote and the power cord laying on top of the bed. Black electrical tape was wrapped around the cord in 5 locations. Upon closer observation, the power cord's outer wire covering was missing sections of the protective covering. The inner color-coded wires were exposed and visible without electrical tape covering the inner wires. The resident stated during the observation that the bed remote power cord had been damaged for 2 years without repair. On 3/14/25 at 11:30 AM an observation of room [ROOM NUMBER] b bed and 103 b bed with the Maintenance Director revealed the bed cords to be unchanged. The Maintenance Director stated the bed power cords were damaged and replacement power cords had been ordered 2-3 weeks prior. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview with the Maintenance Director was conducted on 3/14/25 at 11:51 AM. He stated a replacement cord for a bed was ordered 2-3 weeks prior when he was made aware of the damaged cord by an administrative staff who was conducting a round in room [ROOM NUMBER] room. The Maintenance Director presented an invoice dated 2/17/25 for one replacement bed power cord. The ordered cord was delivered to the facility earlier in the week and the replacement cord did not fit the bed in room [ROOM NUMBER] and another power cord needed to be ordered. He stated the cord had not been reordered, and he would place an order on the current day (3/14/25). The Maintenance Director said he would replace room [ROOM NUMBER] b bed with a manually operated bed until the correct cord had arrived. The Maintenance Director went on to state he was unaware how many of the bed power cords needed to be replaced in the facility, and he would conduct an audit, he was not aware of room [ROOM NUMBER] b bed's damaged bed cord. The Maintenance Director stated room [ROOM NUMBER] b bed and 103 b bed's damaged power cords did not have frayed or exposed inner wires, the outside coating of the power cords was cracked and missing in some places and he felt the damaged cords did not pose an electric shock hazard. He reported he had placed electrical tape around the damaged cords at some point and could not recall how long it had been. Additionally, the Maintenance Director reported he did not have a specific routine audit of the bed cords but did monthly checks of the mattresses that would include looking at the bed power cords. The Administrator was interviewed on 3/14/25 at 12:17 PM and stated the damaged bed cords should have been repaired or replaced when they were identified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, staff, resident and Medical Director interviews, the facility failed to follow physician orders for checking a diabetic resident's blood glucose levels twice daily for 2 of 2 residents with physician orders for blood sugar monitoring (Resident #23 and Resident #17). The findings included: 1. Resident #23 was admitted to the facility on [DATE]. His medical diagnoses included: Diabetes Mellitus Type-2. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. Resident #23 had a care plan for Diabetes Mellitus type-2 dated 2/28/25. The care plan interventions read, fasting serum blood sugar as ordered by doctor. Review of Resident #23's active physician orders for March 2025 revealed the following orders: - An order dated 2/17/25 that read, Lantus (long-acting insulin)100 unit/ milliliter (ml), inject 20 units subcutaneously at bedtime. - An order dated 2/21/25 entered by the Medical Director that read, blood glucose (BG) twice daily. Review of the electronic medical record revealed the following blood glucose results: - A result of 125 obtained on 2/20/25 - A result of 193 obtained on 2/25/25 There were no other blood glucose results documented in the electronic medical record An interview was conducted with Resident #23 on 3/12/25 at 2:04 PM. He said it had been a while since his blood glucose had been checked at the facility. Resident #23 said he felt like he had not experienced any symptoms of high or low blood sugar. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #1 on 3/12/25 at 2:20 PM. Nurse #1 stated Resident #23 did not get blood glucose checks and he did not have an order to check them. After she reviewed his active physician order, Nurse #1 verbalized Resident #23 did have an active order for blood glucose checks twice a day. She opened the blood glucose order entry details and reviewed the order. After reviewing the order entry details, Nurse #1 explained the order had been entered in by the Medical Director. She further explained the order did not show up on Resident #23's Medication Administration Record (MAR) because the order had been entered incorrectly. Nurse #1 stated she did not know to check Resident #23's blood glucose because the order did not pull to the MAR to let her know to check it. Nurse #1 reported there was not a process she was aware of for checking orders entered by providers to ensure they were entered correctly. An interview was conducted with the Medical Director on 3/13/25 at 1:37 PM. The Medical Director reported she had been notified about Resident #23's blood glucose order being entered She said the staff did not know to check Resident #23's blood glucose because she had not entered the order correctly to pull to the MAR. An interview was conducted with the Director of Nursing (DON) 3/14/25 at 4:44 PM. The DON explained the order for Resident #23's blood glucose checks had been entered by the Medical Director incorrectly and did not pull to the MAR to for the nurses to see. The DON stated the nurses did not know to check his blood glucose because it was not on the MAR. The DON explained orders were reviewed during the morning clinical meeting. She reported an orders report from the prior day was pulled and the orders were reviewed from the printed report. The DON stated order entry was not checked for the orders when they were reviewed during the morning meeting. The DON said there was not a current process for a second check of orders entered by providers to ensure they had been entered correctly. An interview was conducted with the Administrator on 3/14/25 at 4:50 PM. The Administrator said staff had not known to check Resident #23's blood glucose because the order had been entered incorrectly by the Medical Director. The Administrator said there should be a process for checking orders entered by providers to ensure they were entered correctly. 45272 2. Resident #17 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus. Resident #17 had a care plan dated 6/25/24 for type 2 diabetes dated 6/25/24 with interventions that included to monitor blood glucose checks as ordered. Resident #17 had a physician's order dated 12/14/24 for dulaglutide pen-injector 1.5 milligrams to inject 3 milligrams subcutaneously weekly every Saturday. (Dulaglutide is a once-a-week injection drug prescribed to treat type 2 diabetes mellitus.) Resident #17 had a physician order dated with a start date 1/10/25 and end date 1/20/25 for fingerstick glucose (blood sugar check) two times daily (BID) before meals. A review of Resident #17's Medication Administration Record (MAR) for January 2025 found blood glucose checks were not initialed as completed on 1/10/25 through 1/18/25 at 6:00 AM and 4:30PM. On 1/19/25 Nurse #2 had initialed blood glucose check was completed at 4:30 PM and the blood sugar level was not documented on the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #2 was interviewed on 4/14/25 at 12:53 PM. She stated she was assigned to Resident #17 on some of the days the blood glucose checks were not completed. Nurse #2 said she was not aware Resident #17 had an order blood glucose checks two times daily before meals from 1/10/25 through 1/18/25. Nurse #2 confirmed that Resident #17 did have an order for blood glucose checks beginning on 1/10/25 and was not able to explain why the blood sugar checks were not completed, and confirmed Resident #17 had a current order to check blood sugars. Nurse #2 stated she always followed physician orders and completed all blood sugar checks. The Medical Director was interviewed on 3/14/25 at 1:38 PM. She stated the order for Resident #17 to receive blood sugar checks was written on 1/10/25 by the Nurse Practitioner. The Medical Director stated the Nurse Practitioner did not correctly enter the order into the electronic chart and it was not visible for the nurses to see. The Medical Director stated the NP and herself had not received much training for entering orders in the electronic medical chart and did not enter the orders correctly. An interview was conducted with the Director of Nursing (DON) 3/14/25 at 4:44 PM. The DON explained the order for Resident #17's blood glucose checks had been entered by the Nurse Practitioner incorrectly and did not pull to the MAR to for the nurses to see. The DON stated the nurses did not know to check his blood glucose because it was not on the MAR. The DON explained orders were reviewed during the morning clinical meeting. She reported an orders report from the prior day was pulled and the orders were reviewed from the printed report. The DON stated order entries were not reviewed to ensure they had been made visible for nurses to see on the MAR. The DON said there was not a current process for a second check of orders entered by providers to ensure they had been entered correctly. An interview was conducted with the Administrator on 3/14/25 at 4:53 PM. The Administrator said staff had not known to check Resident #17's blood glucose because the order had been entered incorrectly by the Nurse Practitioner. The Administrator said there should be a process for checking orders entered by providers to ensure they were entered correctly.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record review, and staff, Medical Director, and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendations to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident (Resident #46) who received an antipsychotic medication. In addition, the facility failed to follow pharmacy recommendations that had been signed by the physician to add a 14-day stop date for a prn (as needed) psychotropic medication for a Resident #17. This deficient practice occurred for 2 of 5 residents reviewed for pharmacy recommendations (Resident #46 and Resident #17). The findings included: 1. Resident #46 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, anxiety disorder, and major depressive disorder. A review of Resident #46's active physician's orders revealed the following orders: -An order dated 7/10/24 that read, olanzapine (antipsychotic medication) 2.5 milligrams (mg) give one tablet by mouth one time a day every Tuesday, Thursday, and Saturday for schizophrenia. -An order dated 12/24/24 that read, olanzapine 5 mg by mouth daily for schizophrenia. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 was cognitively intact. He was not documented for behaviors or rejection of care. The MDS documented that he received antipsychotic medication. Review of the Consultant Pharmacist's pharmacy consultation reports revealed an AIMS assessment was recommended on 10/12/24, 12/7/24, and on 2/9/25. (Abnormal Involuntary Movement Scale is a scale to measure abnormal involuntary movements in patients taking antipsychotic medications). The pharmacy recommendations dated 10/12/24, 12/7/24, and 2/9/25 read, please monitor for involuntary movements now and at least every 6 months or per facility protocol. It is recommended that monitoring frequency increase following does adjustments. The comments read, [Resident #46] receives olanzapine which may cause involuntary movements, including tardive dyskinesia (abnormal involuntary movements caused by medications), but an abnormal involuntary movement scale (AIMS), or other appropriate assessment was not documented in the medical record within the previous 6 months. -The pharmacy recommendation dated 10/12/24 was signed by the Director of Nursing (DON) on 10/24/24. Under DON comments it read, recommendations added to orders. -The pharmacy recommendation dated 12/7/24 was signed by the Director of Nursing on 12/23/24. Under DON comments it read, order updated with recommendation. -The pharmacy recommendation dated 2/9/25 was signed by the Director of Nursing on 2/19/25. Under DON comments it read, followed recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/14/25 at 11:15 AM with the Consultant Pharmacist. The consultation report recommendations for Resident #46 from 10/24/24, 12/23/24, and 2/19/24 were for an AIMS assessment to be completed due to Resident #46 receiving an antipsychotic medication. The Consultant Pharmacist stated he kept sending the recommendation because he did not see an AIMS assessment that had been done. An interview was conducted with the Director of Nursing on 3/14/25 at 10:14 AM. She reported she was responsible for reviewing and ensuring pharmacy recommendations were completed. The DON explained she had misunderstood what the pharmacy recommendations for Resident #46 were asking for. The DON explained she had added to monitor for involuntary movements now and at least every 6 months as an order and added it to the olanzapine medication order for Resident #46. The DON reported she had not realized the pharmacy recommendations indicated an AIMS assessment needed to be completed for Resident #46. An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director stated the facility should follow pharmacy recommendations. An interview was conducted with the Administrator on 3/14/25 at 4:44 PM. The Administrator said Resident #46 should have had an AIMS completed and the pharmacy recommendations should have been followed. The Administrator stated she was not sure why the DON missed the recommendation to do an AIMS. 45272 2. Resident #17 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus, depression, and anxiety. Resident #17's quarterly Minimum Data Set (MDS) dated [DATE] coded her as severely cognitively impaired. She was coded for taking an antidepressant. Resident #17 had a physician's order dated 7/23/24 for trazadone Hcl oral tablet 50 milligrams give one tablet by mouth as needed (PRN) for insomnia at bedtime. The physician's order was discontinued on 11/25/24. Pharmacy recommendations from July 2024 through February 2025 for Resident #17 were reviewed: A recommendation dated 7/26/24 read in part Resident #17 had a PRN antidepressant trazadone without a stop date. The physician's response was to add a 14-day stop date and was signed dated 8/14/24. The pharmacy recommendation dated 9/9/24 repeated the recommendation, with the same physician response. A pharmacy recommendation dated 11/13/24 read in part Resident #17's prescriber accepted a pharmacy recommendation to add a stop date to PRN trazadone on 8/15/24, but the order has not been processed. The pharmacy recommendation was signed by the Director of Nursing on 11/25/24 and noted the order for trazadone PRN was discontinued 11/25/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated on 3/14/25 at 10:25 AM the pharmacy recommendation to place a stop date on the PRN trazadone was overlooked by her in the August 2024 pharmacy review and she did not discontinue the medication until 11/24/24 pharmacy recommendation found it. The DON stated until recently, she was not retaining or scanning the pharmacy recommendations into the electronic charting when she received them from the consulting pharmacist. The DON said she was faxing the physician responses to the pharmacy recommendations to the pharmacy, and she thought the pharmacy was changing the orders. The Consultant Pharmacist was interviewed on 3/14/25 at 11:15 AM and stated PRN psychoactive medications should have a 14-day stop date. He said he had made recommendations for a 14-day stop date for any PRN psychoactive medications a resident received that did not include a stop date and they were sent to the DON monthly. The Medical Director was interviewed on 3/14/25 at 1:37 PM. She stated her orders should be followed to add a 14-day stop date to the antipsychotic medication. The Administrator stated on 3/14/25 at 4:53 PM the DON was faxing signed physician pharmacy recommendations to the pharmacy. The DON did not know she needed to make the changes in Resident #17's orders.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on record reviews and staff interviews the facility failed to provide dental services for 1 of 1 (Resident #17) residents reviewed for providing emergency dental services. The findings included: Resident #17 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus and heart failure. Resident #17 was care planned for oral and dental health problems on 06/25/24 with interventions that included monitor document and report any signs or symptoms of oral problems needing attention and provide mouth care. Resident #17 had a physician order dated 7/23/24 for dental consultation as needed. A provider progress note dated 11/25/24 read in part the resident had a lesion in the left lower buccal (cheek) fold along the edge of the left lower denture. The resident is agreeable to an alteration to the lower denture area. The provider wrote that a dental consult would be beneficial to make some alterations along the lower edge of the left lower denture. Resident #17 had a physician order dated 11/25/24 that read; dental referral to evaluate lower full denture which is causing recurrent buccal trauma. Resident #17's quarterly Minimum Data Set (MDS) assessment dated [DATE] coded her as severely cognitively impaired. She was coded for loose or broken dentures and yes for difficulty, pain with swallowing chewing. She required a therapeutic and mechanically altered diet and needed set-up assistance with eating. A Provider Progress Note dated 2/3/25 read in part, Resident #17 was seen for sore area on the left side of her mouth and jaw. The resident had issues with her denture causing recurrent trauma to her inner left mouth area in the last few months. The denture needed to be modified, and the dental consultation was not completed. Resident #17 had an approximately .5 to 1 centimeter laceration and the left lower buccal fold that was adjacent to the sharp edge of her lower denture. The provider note wrote Resident #17 had an appointment in-house for a dental consultation on 2/5/25. A nursing progress note dated 2/8/25 written by Nurse #1 read Resident #17 had a sore area on her left inner cheek. The resident stated it was very sore, and magic mouthwash did not help much. The resident's bottom denture was very loose, and the resident's family was concerned. A note was left for the Physician to evaluate and advise. Attempts to interview Nurse #1 were unsuccessful. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note written by a provider dated 2/11/25 read in part the resident was seen at the request of Resident #17's family for a follow-up concern regarding a mouth lesion. The resident had been seen for this concern numerous times starting in the fall of 2024 when a dental consult was placed. The progress note wrote, it was determined the lesion was caused by the lower denture defect and required an alteration. The family did not want to take the resident out for dental care and the request was put in for residency care by the traveling dentist. She was scheduled to see the dentist at this location and was postponed until later in the week of 2/10/25 -2/14/25. The provider wrote the resident did not wear her bottom dentures that caused difficulty when eating. The progress note went on to say the provider had confirmed the dentist was coming to the facility later in the week of 2/10/25-2/14/25. The provider requested special attention that the resident was seen and if for some reason the resident was not seen by the dentist, the resident needed to be seen as soon as possible. A note written on 3/6/25 by the Transportation Driver read Resident #17 will be seen by the dentist on 5/29/25 at 11:00 AM. Resident #17 had a physician order dated 03/09/25 that read; lidocaine viscous (used to numb red, swollen, and painful sores in mouth) mouth and throat solution 2% with direction to place and dissolve 15 milliliters buccally before meals for left lower buccal lesion for 14 days and discontinue if lesion is healed. A review of Resident #17's March 2025 Medication Administration Record (MAR) found the resident received the lidocaine viscous as ordered. A review of the in-house dentist and dental hygienist visits and notes dated 10/30/24 through 3/10/25 was completed. Resident #17 was not seen by the hygienist or the dentist. The business office manager (BOM) was interviewed on 3/13/25 at 3:28 PM. The BOM stated Resident #17's family initially did not want to enroll the resident into the dental program because they thought the resident was going to be a short-term resident. The family later decided the Resident #17 was going to be a long-term resident, and she was enrolled in the dental program on 1/27/25 by the resident's family. The residents' information along with physician order was sent to the in-house dental provider on 2/10/25. The BOM said the facility was unaware the resident was not seen on 3/10/25 and would be seen on the next visit to the facility on [DATE] and was unsure if the dental provider did emergent visits. A follow-up interview with the BOM on 3/13/25 at 3:56 PM was conducted. The BOM stated the dental provider was called and asked if Resident #17 could be seen emergently. The dental provider told the BOM a triage form could be filled out and sent to the dental provider and a regional dentist would review and develop a plan of care for the resident. The BOM stated the facility was unaware of the triage form and the form would be completed on 3/13/25 and sent to the dental provider for Resident #17. Furthermore, the BOM said the dental provider told her the dentist needed to see Resident #17 for an evaluation prior to the dental hygienist providing any oral care. On 3/10/25 the dental hygienist was at the facility and Resident #17 had not been evaluated by a dentist and was not included on the list to be seen. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 3/14/25 at 4:53 PM. She stated the facility did attempt to schedule Resident #17 a dentist appointment when the referral was written but was unable to find a dentist to accept the residents insurance. The Administrator said if the facility was aware of the triage option for the resident, it should have been completed and submitted soon after the resident was signed up with the in-house dentist. The resident was not included on the dental provider list to be seen on 3/10/25 because the dentist had not evaluated Resident #17. The Administrator said Resident #17 should have been seen on 3/10/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50046 Based on observations, record review, and staff and Medical Director interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) for a resident (Resident #23) with a feeding tube and a resident with a wound (Resident #32) when Nurse #1 failed to wear a gown while administering a tube feeding for Resident #23 and the Wound Care Nurse failed to wear a gown while performing wound care for Resident #32. This deficiency occurred for 2 of 2 staff members reviewed for infection control practices (Nurse #1 and the Wound Care Nurse). The findings included: Review of the facility's policy and procedure dated August 2022 entitled Enhanced Barrier Precautions read in part: Enhanced Barrier Precautions (EBP) are used as an infection control intervention to reduce the spread of multidrug-resistant organisms (MDROs) to residents. EBP's employ targeted gown, and glove use during high-contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact care activities requiring the use of gown and glove for EBP include: Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ ventilator; wound care (any skin opening requiring a dressing). EBPs are indicated for residents with wounds and/or indwelling medical devices, regardless of MDRO colonization. 1. An observation was completed on 3/12/25 at 2:20 PM of Nurse #1 accessing Resident #23's gastrostomy feeding tube and administering his tube feeding. The nurse performed hand hygiene using hand sanitizer and donned clean gloves. She did not don a gown. Nurse #1 checked placement of the feeding tube, flushed the tube with water, administered a bolus tube feeding through the tube, flushed the tube with water, and replaced the stopper at the end of the tube. She disposed of the trash, removed her gloves, and performed hand hygiene using hand sanitizer. An interview was conducted with Nurse #1 on 3/12/25 at 2:30 PM. Nurse #1 said the EBP sign on the outside of Resident #23's room door was for Resident #23's roommate. She explained the EBP sign was hung above or below the name on the door to identify who in the room the EBP were for. She reported she had received education on EBP and that residents with indwelling devices and wounds should have EBP. She said she should have known Resident #23 needed EBP since he had a feeding tube, but said she did not think about it. Nurse #1 reported she should have worn a gown and gloves when she did Resident #23's tube feeding. An interview was conducted with the Infection Preventionist (IP) on 3/14/25 at 9:39 AM. She explained residents with indwelling devices and chronic wounds should have EBP in place. She said Nurse #1 should have worn a gown and gloves when administering Resident #23's tube feeding. The IP said she thought Nurse #1 may have been nervous and just forgot. She said Nurse #1 had received education on EBP and should have known Resident #23 needed EBP since he had a feeding tube. (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	03/14/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director reported she was familiar with EBP. She stated the facility should use and follow EBP for residents with feeding tubes. An interview was conducted with the Director of Nursing (DON) and Administrator on 3/14/25 at 4:44 PM. The DON said residents with wounds and indwelling devices should have EBP in place. She explained nurses should follow EBP and should wear a gown and gloves for residents who require EBP. The DON reported Nurse #1 should have worn a gown when administering Resident #23's tube feeding. The Administrator added the facility has plenty of personal protective equipment (PPE) and that it was just human error. 2. An observation and interview was completed on 3/13/25 at 12:37 PM with the Wound Care Nurse. The Wound Care Nurse was observed performing wound care to Resident #32's right foot wound. The Wound Care Nurse said the wound was classified as a vascular wound and betadine was being applied to the wound because of maceration around the wound. She performed hand hygiene using hand sanitizer, donned gloves, and removed the dressing from the bottom of Resident #32's right foot and placed the dressing in the trash. She removed her gloves, performed hand hygiene using hand sanitizer, and donned new gloves. She cleaned the wound with normal saline, she removed her gloves and performed hand hygiene using hand sanitizer. She donned new gloves, applied betadine to the wound, and covered the wound with a foam dressing. She removed her gloves and performed hand hygiene using hand sanitizer. An additional interview was conducted with the Wound Care Nurse on 3/14/25 at 8:52 AM. She reported she had not worn a gown when performing Resident #32's wound care because she was not on EBP. The Wound Care Nurse reported EBP were used if a resident grew out an organism on a wound culture, but that EBP was not used for other wounds. The Wound Care Nurse stated she was not sure if residents with wounds should have EBP. She said she thought chronic wounds may need EBP but that she would check and let the surveyor know. The Wound Care Nurse returned after a few minutes and said she checked with the Infection Preventionist (IP) and was told anyone with chronic wounds needed EBP. She reported she was not aware Resident #32 needed EBP and that was why she did not use EBP and wear a gown when she did her wound care. The Wound Care Nurse said she had received education on EBP. An interview was conducted with the IP on 3/14/25 at 9:39 AM. She explained residents with indwelling devices and chronic wounds should have EBP in place. The IP reported gown and gloves should be worn when performing wound care. The IP said Resident #32 had not had EBP in place because the IP was not aware of her wound. She reported there should be better communication between herself and the Wound Care Nurse about wounds. The IP said the Wound Care Nurse had received education on EBP, she said she was not sure why the Wound Care Nurse did not remember Residents with wounds needed EBP. An interview was conducted with the Medical Director on 3/14/25 at 1:37 PM. The Medical Director reported she was familiar with EBP. She stated the facility should use and follow EBP for residents with wounds. An interview was conducted with the Director of Nursing (DON) and Administrator on 3/14/25 at 4:44 PM. The DON said residents with wounds and indwelling devices should have EBP in place. She said there was miscommunication between the IP and Wound Care Nurse and that was why Resident #32 did not have EBP in place. She explained nurses should follow EBP and wear gown and gloves for resident who required EBP. The Administrator added the facility has plenty of personal protective equipment (PPE) and that it was just human error.