STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/02/25 through 6/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FM2911.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 6/02/25 through 6/05/25. Event ID# FM2911. The following intakes were investigated NC00230883, NC00229632, NC00225698, NC00225021 and NC00220083. 1 of 15 complaint allegations resulted in a deficiency. The Statement of Defiencies was amended on 6/25/25 at tag F628.	F 000		
F 628 SS=C	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner	F 628		7/1/25

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

Electronically Signed | 06/26/2025

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F 628	Continued From page 1	F 628		

responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

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F 628	Continued From page 4 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and	F 628		

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F 628	Continued From page 5 over-the-counter). This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to notify the resident and Resident Representative in writing of the reason for transfer/discharge to the hospital. The deficient practice affected 5 of 5 residents reviewed for hospitalization (Resident #28, Resident #24, Resident #2, Resident #47, and Resident #8). The following included: a.Resident #28 was admitted to the facility on 3/17/25. A review of Resident #28's Minimum Data Set (MDS) assessment dated 4/27/25 revealed the resident had severe cognitive impairment. A review of Resident #28's nursing progress note dated 5/26/25 revealed she was discharged to the hospital on 5/26/25 due to a critical low hemoglobin and altered mental status. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 5/26/25. b. Resident #24 was admitted to the facility on 12/31/24. A review of Resident #24's Minimum Data Set (MDS) assessment dated 4/22/25 revealed she was cognitively intact. A review of Resident #24's nursing progress	F 628	1. Residents 28,24,2,47,8 were all sent out to the hospital without the proper notification at the time of discharge from the facility 2. An audit was completed by the Social Worker of all residents that discharged from 5/21/25 to 6/21/25 to ensure the resident, Resident Representative and Ombudsman were notified in writing of the reason for transfer/discharge to the hospital and the bed hold policy when a resident transferred to the hospital completed by the administrator. 3. Social services and Licensed nurses will be reeducated by the Administrator or designee to ensure that residents and or resident representatives and ombudsman are notified in writing of the reason for transfer/discharge to the hospital. The Administrator or designee will be the person who will ensure all newly hired social services and licensed staff will be educated. 4.The Administrator or designee will review weekly for four weeks and then monthly for two months that residents and or resident representatives and ombudsman are notified in writing of the reason for transfer/discharge to the hospital. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. AOC Date 7/1/2025	

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notes revealed she was discharged to the hospital on 4/10/25 gastrointestinal bleeding and returned on 4/16/25.

Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 4/10/25.

c. Resident #2 was admitted to the facility on 2/12/24.

A review of Resident #2's Minimum Data Set (MDS) assessment dated 4/11/25 revealed he was cognitively intact.

A review of Resident #2's nursing progress notes revealed he was discharged to the hospital on 8/8/24 to have a tunneled catheter inserted for antibiotic administration and returned on 8/9/24.

Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 8/8/24.

d. Resident #47 was admitted to the facility on 2/17/23.

A review of Resident #47's Minimum Data Set (MDS) assessment dated 4/18/25 revealed he had moderate cognitive impairment.

A review of Resident #47's nursing progress notes revealed he was discharged to the hospital on 7/13/24 due to increases shortness of breath with difficulty breathing and returned on 7/17/24.

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F 628	Continued From page 7	F 628		

Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 7/13/24.

e. Resident #8 was admitted to the facility on 9/6/16.

A review of Resident # 8's Minimum Data Set (MDS) assessment dated 5/15/25 revealed she was cognitively intact.

A review of Resident #8's nursing progress notes revealed she was discharged to the hospital on 8/16/24 due to vomiting up blood and returned on 8/19/24.

Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 8/16/24.

An interview conducted with the Social Worker on 6/4/25 at 3:35 PM revealed she had not been sending a written notification of transfer/discharge to the resident or Resident Representative. The Social Worker stated she had been placing a follow-up phone call about the transfer to hospital and notifying the Resident Representative verbally. The Social Worker further stated she sometimes documented the conversation in her personal notebook or in the resident chart.

An interview conducted with the Administrator on 6/5/25 at 06:08 PM revealed she was aware a follow-up phone call was to be made to the resident or Resident Representative to inform

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F 628	Continued From page 8 them of the transfer to the hospital. The Administrator stated she expected that written notification of transfer/ discharge would be sent to the resident and Resident Representative when residents discharge to the hospital. The Administrator further stated that going forward all hospital discharges would be reviewed each day during the morning meeting to make sure the written notifications were sent out.	F 628		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 641		7/1/25

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F 641	Continued From page 9 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of use of anticonvulsant medication (Resident #55) and use of anticoagulant medication (Resident #55 and Resident #26) for 2 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #55 was admitted to the facility on 2/27/24 with diagnoses which included convulsions, stroke, and nontraumatic intracranial hemorrhage. Resident #55 had a physician order dated 12/17/24 for levetiracetam (anticonvulsant medication) oral tablet 1000 milligram (mg) give one tablet twice a day for seizure disorder. The Medication Administration Record for March 2025 and April 2025 revealed Resident #55 was administered the levetiracetam as ordered. Review of Resident #55's current and discontinued physician order for March 2025 through April 2025 revealed no orders for an anticoagulant medication. Review of the Minimum Data Set (MDS) quarterly assessment dated 4/04/25 revealed Resident #55 had severe cognitive impairment and was not coded for the use of anticonvulsant medication. The assessment further noted that Resident #55	F 641	1.Resident #55 MDS was modified on 6/4/2025 by MDS Coordinator to correctly code anticonvulsant and remove anticoagulant. Resident #26 MDS was modified on6/4/2025 by the MDS coordinator to remove the coding of anticoagulant education. 2. An audit was completed of the residents who are coded for anticoagulation and anticonvulsants for accuracy completed by the MDS coordinator on 6/23/2025 to ensure that their MDS assessment is accurately coded and consistent with the order. 3. MDS coordinators will be reeducated 6/26/2025 by the Administrator or designee to ensure that MDS assessments for are coded accurately for residents receiving anticoagulant and anticonvulsant medication. Administrator or designee will be the person who will ensure all newly hired MDS Coordinators will be educated. 4. The Administrator or designee will review weekly four residents for four weeks and then four residents monthly for two months to ensure residents that receive anticoagulants and anticonvulsants are coded accurately on the MDS assessment and consistent with the order. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action	

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F 641	Continued From page 10 was coded for the use of an anticoagulant medication. An interview was conducted on 6/04/25 at 12:02 pm with the MDS Nurse who confirmed Resident #55 did not have a physician order for an anticoagulant medication. The MDS Nurse revealed she must have mistakenly clicked anticoagulant medication instead of anticonvulsant medication for Resident #55 when she completed the assessment. During an interview on 6/05/25 at 4:20 pm with the Administrator she stated the MDS Nurse was responsible to ensure that Resident #55's MDS assessment was accurately coded. 2. Resident #26 was admitted to the facility on 11/27/24 with diagnoses which included stroke. Review of Resident #26's current and completed physician orders for February 2025 through March 2025 revealed no orders for anticoagulant medication. The Minimum Data Set (MDS) end of Medicare Part A assessment dated 3/06/25 revealed Resident #26 had moderate cognitive impairment and was coded for use of an anticoagulation medication. During an interview on 6/04/25 at 12:02 pm with the MDS Nurse she confirmed Resident #26 was not prescribed an anticoagulant medication. The MDS Nurse stated she must have incorrectly coded Resident #26's MDS assessment in the area of anticoagulant medication. An interview was conducted on 6/05/25 at 4:20	F 641	5. AOC Date 7/1/2025	

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F 641	Continued From page 11 pm with the Administrator. She stated the MDS Nurse was responsible to ensure that Resident #26's MDS assessment was accurately coded.	F 641		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to provide an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities for 1 of 1 resident reviewed for activities (Resident #55). The findings included: Resident #55 was admitted to the facility on 2/27/24 with diagnoses which included cognitive communication deficit and nontraumatic intracranial hemorrhage (bleed in the brain tissue that occurs without any trauma). The Minimum Data Set (MDS) annual assessment dated 2/21/25 revealed Resident #55	F 679	1. Resident #55 continues to reside at the facility resident is provided an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities. The documentation of his one on one region being meet is now noted in his medical record and activity tracker 2. An audit was completed of the residents who do not participate in group activities to ensure residents are provided an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities and ensure that the documentation of their activities in in their medical records. The audit was	7/1/25

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F 679	Continued From page 12 had severe cognitive impairment and no speech. Resident #55's assessment of daily and activity preferences revealed it was important for family or significant other to be involved in the care discussion and he enjoyed listening to music. There were no other activity preferences noted. Resident #55's care plan last reviewed on 4/09/25 revealed Resident #55 was dependent on staff for meeting emotional and social needs with a goal to maintain involvement in cognitive stimulation and social activities. The care plan had interventions which included providing the resident with materials for individual activities as desired, invite the resident to scheduled activities, and ensuring that the activities the resident is attending were compatible with physical and mental capabilities. Review of the Kardex (resident care guide) revealed Resident #55's activities were to include one to one (1:1) program, group events, group programs, and self-directed activity. Review of the activity participation record for the month of May 2025 revealed no documentation that Resident #55 participated in any facility activity. Review of the 1:1 program record for the month of May 2025 revealed no documentation that Resident #55 had participated in any 1:1 activity. Review of the group events, group programs, and self-directed activity record for the month of May 2025 revealed no documentation that Resident #55 had participated in any group events, group programs, or self-directed activity.	F 679	completed by the activity director on 6/25/2025 3. Activities Director was be reeducated by the Administrator or designee 6/26/2025 to provide an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities. Administrator or designee will be the person who will ensure all newly hired activity staff will be educated. 4. The Administrator or designee will review weekly five residents for four weeks and then five residents monthly for two months to ensure residents are provided an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. AOC Date 7/1/2025	

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F 679	Continued From page 13	F 679		

Observations were conducted on 6/02/25 at 10:32 am and 11:28 am revealed Resident #55 was in bed with his head turned toward the window and the wall mounted television was turned on. Resident #55 turned and made eye contact with the surveyor upon entering the room but he was unable to participate in an interview. There was no radio observed in Resident #55's room.

A telephone interview was conducted on 6/02/25 at 11:26 am with Resident #55's RP who revealed she was concerned that the facility did not include the resident in activity programs. The RP stated that Resident #55 was only in the room in bed when she or other family visited the facility and was not observed to be engaged in any activities. The RP stated Resident #55 enjoyed watching football and basketball and listening to music before he was admitted to the facility. The RP stated she did not recall being asked by anyone at the facility what Resident #55's interests were.

Observations were conducted on 6/03/25 at 9:39 am, 12:37 pm, and 2:53 pm revealed Resident #55 was in bed with the wall mounted television turned on. There was no radio observed in Resident #55's room.

An interview was conducted with Nurse Aide (NA) #1 on 6/03/25 at 12:37 pm who revealed she did not observe Resident #55 in any facility group activities or any activity staff in the room with him when she worked. NA #1 stated she was not aware of any particular activity that Resident #55 enjoyed but she stated the television in the room was on all the time.

During an interview on 6/03/25 at 2:47 pm NA #2

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F 679	Continued From page 14 revealed she did not see Resident #55 participate in any facility activities. NA #2 stated she believed he liked to listen to the television so she left the television on for him. The Activity Director was interviewed on 6/03/25 at 2:53 pm who reported that resident 1:1 activities were documented in the electronic health record when the activity was completed and she attempted to complete resident 1:1 activities at least once weekly for 10 minutes. The Activity Director stated Resident #55 had been to one facility activity that she was aware of in the past, but he had not been taken to any activities during the last few months. She was unable to recall when Resident #55 participated in a 1:1 visit, group activity, or group event. The Activity Director stated Resident #55 had a television in his room and she believed he had a radio in the room as well that could be turned on by her or floor staff when he wanted. An interview was conducted with the Director of Nursing (DON) on 6/05/25 at 1:06 pm who revealed the Activity Director was responsible for determining what 1:1 activities would be appropriate for Resident #55. During an interview with the Administrator on 6/05/25 at 4:24 pm she revealed the Activity Director was responsible to provide Resident #55 with activities that addressed the needs of the resident.	F 679		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3) Social Security Act §1919 [42 U.S.C. 1396r]	F 727		7/1/25

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F 727	Continued From page 15 §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.-§1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 1 of 34 days reviewed for sufficient staffing. The findings included: A review of the daily posted nursing staff forms, daily nursing staff assignment sheets, and staff clock-in sheets from 5/01/25 through 6/03/25 was conducted.	F 727	1. No RN on duty at least 8 hours a day on 5/25/25. 2. All residents have the ability to be affected by this deficient practice. 3. Director of Nursing educated staff/staffing coordinator on 6/23/25 to provide 8 hours of consecutive RN coverage each day. Additionally, all newly hired staff will be educated on these policies and practices during orientation.	

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F 727	Continued From page 16 A review of the daily census posting sheets for 5/25/25 revealed no RN coverage for eight consecutive hours on 5/25/25. In an interview on 6/05/25 at 2:52 PM the Director of Nursing (DON) stated for staff call out, they would call the staffing agency for a nurse to fill an open position. She indicated as it was the Memorial holiday weekend, no facility or agency staff were available to fill the position on 5/25/25. In an interview on 6/05/25 at 11:54 AM the Clinical Vice President revealed they did not have a RN on 5/25/25 due to call out.	F 727	4. The Director of Nursing or designee will audit weekly for 4 weeks and then monthly for 2 months to ensure at least 8 consecutive RN hours per day. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. 5. AOC Date 7/1/2025	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a	F 732		7/1/25

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F 732	Continued From page 17 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to document accurate information on the daily nurse staffing sheets for 34 of 34 days (5/01/25 through 6/03/25) reviewed. The findings included: A review of the Staff Schedule/Assignment Sheets and daily Posted Nurse Staffing Information sheets for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25 revealed discrepancies in the areas of number of unlicensed staff (including Medication Aides (MAs) actual hours worked and actual nursing staff who worked. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2	F 732	1. The posted Nurse staffing form was updated on 6/4/2025 to adequately reflect the number of medication aides actual hours worked and number of actual licensed staff worked by shift. 2. All residents have the potential to be affected by the deficiency, however, the facility permanently updated the document on date to reflect the number of medication aides actual hours worked and number of actual licensed staff worked by shift. 3. The staffing coordinator and Director of Nursing will be reeducated by the Administrator to ensure they utilize the new form that reflects the number of medication aides actual hours worked and number of actual licensed staff worked by shift. Additionally, all newly hired persons for these roles will be educated on the staffing posting requirements.	

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F 732	Continued From page 18 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed staff (including Medication Aides (MAs) on 1st shift (7:00 AM - 3:00 PM) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed staff on 2nd shift (3:00 PM - 11:00 PM) (including MAs) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed on 3rd shift (11:00 PM - 7:00 AM) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25,	F 732	4. The Administrator will complete a weekly audit for 4 weeks and then monthly for 2 months to ensure the posted nursing staffing reflects the number of medication aides actual hours worked and number of actual licensed staff worked by shift. Results of these audits will be presented to the Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. 5. AOC Date 7/1/2025	

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F 732	Continued From page 19 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. An interview was conducted with the Staffing Scheduler on 6/05/25 at 2:53 PM who revealed she was responsible for completing the Daily Staffing Hours data sheets and confirmed the assignment data sheets were the actual staff that worked on a specific date. She reported she was trained to document the staffing hours for licensed and unlicensed staff for 2 twelve-hour shifts for all licensed and unlicensed staff. In an interview on 6/05/25 at 2:27 PM the Clinical Vice President stated the daily staffing information was documented as 2 twelve-hour shifts versus 3 eight-hour shifts for unlicensed staff. In an interview on 6/05/25 at 2:24 PM the Administrator reported with the way the daily staffing was listed, it looked like the actual unlicensed staff hours were off.	F 732		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		7/1/25

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F 755	Continued From page 20 §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to have effective systems in place for the return of discontinued controlled medications to the pharmacy which resulted in the controlled medication being diverted from the medication storage cart for 1 of 2 residents reviewed for misappropriation of residents' property (Resident #44).	F 755	1. Resident #43 continues to reside at the facility. 2. An audit was completed by the Director of Nursing to ensure discontinued controlled medications are removed from the nurses cart and med storage and to ensure that the medications are either returned or destroyed. The audit was completed by the director of nursing 06/25/2025.	

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F 755	Continued From page 21 The findings included: Review of the Disposal of Medications Policy dated 1/24 read in part: "Discontinued medications and/or medications left in the nursing care center, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition. Resident #44 was admitted to the facility on 4/21/23. Review of a physician's order for Resident # 44 dated 11/15/24 read, Oxycodone (a narcotic pain medication) 5 milligrams (mg) by mouth every six hours as needed for pain. The order was discontinued on 11/29/24. Review of the quarterly Minimum Data Set Assessment dated 12/2/24 revealed the resident was cognitively intact and was on a scheduled pain medications regimen. He received opioid medication during the lookback period. A review of the December 2024 narcotic/control substance count sheet revealed on 12/9/24 Medication Aide #1 received the medication cart with 22 narcotic cards, and the count was validated by Nurse #3. Review of the pharmacy packing slip dated 11/26/24 revealed the facility received 8 doses of Oxycodone/Acetaminophen 5/325 mg for Resident #44. Review of the November 2024 MAR revealed no doses of Oxycodone/Acetaminophen 5/325 mg were administered to Resident #44 before it was	F 755	3. All licensed staff will be educated on ensuring discontinued controlled medications and/or medications left in the nursing care center, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition completed by the Director on nursing on 6/28/25. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Director of Nursing or designee will review weekly for four weeks and then monthly for two months that discontinued medications and/or medications left in the nursing care center, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. AOC Date 7/1/2025	

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F 755	Continued From page 22	F 755		

discontinued on 11/29/24.

A review of the initial allegation report dated 12/9/24 revealed the facility became aware of the misappropriation of facility property on 12/9/24 at 2:45 PM when the Director of Nursing (DON) reconciled the narcotic medications and found that the counts were not correct as documented. An allegation of misappropriation of resident property was submitted for Resident #44 and Medication Aide #1 was suspended pending the outcome of the investigation. The initial report was submitted by the previous Administrator.
A review of the 5-day investigation report dated 12/13/24 revealed the allegation of misappropriation of facility property was substantiated. Medication Aide #1 was terminated on 12/10/24. The DON noted the number of narcotic sheets, and the number of narcotic cards was off by two. Resident #44 was found to be missing a medication card containing 8 Oxycodone/Acetaminophen 5/325 (milligram) mg tablets. This medication had been discontinued and the medication card had not been removed by the Nursing Administration from the medication cart.

An attempt to interview Medication Aide #1on 6/5/25 at 3:45 PM was unsuccessful.

An attempt to contact Nurse #3 on 6/5/25 at 3:48 PM was unsuccessful.

An interview was conducted with the facility Pharmacist on 6/5/25 at 4:04 PM. The Pharmacist verified Resident #44's Oxycodone had not been returned to the pharmacy. The Pharmacist stated the facility was supposed to remove the medication from the medication cart

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F 755	Continued From page 23	F 755		

and return the medication back to the pharmacy. The Pharmacist stated a medication disposition was sent back with all medications returned for pharmacy disposal. She added that narcotic medications were placed in a bag and sealed in addition to their being locked in the plastic bin they were sent back in. The Pharmacist stated the facility had a contract with the pharmaceutical company and they did monthly checks of the medication carts to include checking for discontinued medications.

An interview was conducted with the previous Director of Nursing (DON) on 6/5/25 at 4:47 PM. She confirmed she was the DON at the time of the medication diversion incident. The DON stated she had come out of the clinical meeting and checked her mailbox outside her door. The previous DON indicated she noticed there was one individual controlled drug record placed in her mailbox on her office door. The previous DON stated she became suspicious because the controlled drug record appeared randomly. The previous DON stated she immediately went to the medication cart to reconcile the narcotics. The previous DON stated the count was off by two narcotic count cards on the 200 Hall Medication Cart on 12/9/24. The previous DON stated one of the two missing narcotic count cards was located during the audit of the 200 Hall medication cart. The previous DON indicated there were 21 narcotic control sheets documented instead of 22 which were verified at the beginning of the shift by Nurse #3. The previous DON further stated she determined the narcotic medication card that belonged to Resident #44 which contained 8 Oxycodone/Acetaminophen 5/325 mg tablets was missing. The previous DON stated at the time of the incident that Nursing Administration was to

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F 755	Continued From page 24 remove the narcotic medication from the medication cart when the medication were discontinued but there was no specific time frame as to when the discontinued medications were removed from the medication cart. Two nurses were to verify and sign off the amount of medication that was left on the medication card that was being returned to the pharmacy. The amount being returned was documented on to the return medication disposition document (a document that tracks the final location of a medication). The previous DON stated the medication was placed in a sealed pharmacy bag and the sealed bag was then placed in a locked tote with the pharmacy return medication disposition. The previous DON stated the transporter picked up the medication and documentation of the receipt of medication was handed to the nurse for the return. The previous DON stated Medication Aide #1 was terminated on 12/13/24 and charges were filed related to the allegation. An interview was conducted with the Administrator on 6/5/25 at 6:08 PM. The Administrator stated the previous Administrator submitted the investigation report. She stated she had no concerns about misappropriation of resident property since becoming Administrator of the facility.	F 755		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations	F 838		7/1/25

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(including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

§483.71(a) The facility assessment must address or include the following:
§483.71(a)(1) The facility's resident population, including, but not limited to:
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;
(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures

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F 838	Continued From page 26	F 838		

and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident

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F 838	Continued From page 27 representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Facility Assessment, the facility failed to ensure the staffing plan considered specific staffing needs for each unit and shift as required and failed to evaluate contracted services utilized by	F 838	1.The facility assessment was updated to ensure the staffing plan contains specific staffing needs for each unit and shift staffing needs in these areas based on changes to the resident population . In	

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F 838	Continued From page 28 the facility to provide necessary care for its residents during normal operations and emergencies which had the potential to affect 64 of 64 residents. The findings included: Review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse) and Certified Nursing Assistants (CNAs) noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. In addition, the Facility Assessment did not note if a contract or other agreement was in place related to the provider who was responsible for the provision of goods, facility management services, emergency services, transportation, and dialysis services for the facility. An interview was conducted with the Administrator on 6/05/25 at 2:24 PM who indicated she was not aware of the requirement to specifically address the nurse staff shift information according to each unit. She reported she was not aware they needed to list the contract services used at the facility in the Facility Assessment. She indicated she would expect all the contract services to be listed and reviewed annually.	F 838	addition the provider contracts are in place for transport, medical services and emergency services 2. All residents have the ability to be affected by the deficiency. 3. The administrator will be reeducated by RVPO regarding the facility assessment was updated to ensure the staffing plan considered specific staffing needs for each unit and shift as required and failed to evaluate contracted services utilized by the facility to provide necessary care for its residents during normal operations and emergencies completed 6/26/2025 4. The Administrator or designee will review weekly for four weeks and then monthly for two months that the facility assessment continues to be updated to ensure the staffing plan contains specific staffing needs for each unit and shift staffing needs in these areas based on changes to the resident population . In addition the provider contracts are in place for transport, medical services and emergency services. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.	
F 925 SS=E	Maintains Effective Pest Control Program	F 925		7/1/25

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F 925	Continued From page 29 CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to maintain an effective pest control program as evidenced by the presence of flies that affected resident rooms 5 of 12 rooms observed on the 300 Hall (Room #301, Room #308, Room #309, Room #310, and Room #311). The findings included: Review of the pest control service inspection report dated 5/14/25 revealed the interior and exterior of the facility for general pests as well as spreading granular around the exterior of the foundation of the building. The service inspection report further noted that rodent stations were inspected and baited, the attic was baited for roaches, and a wasp nest was removed on the exterior of the building. There was no mention of a fly program service. a. An observation of Room #308 on 6/02/25 at 10:41 am was conducted. Multiple flies were visible in the room and were observed landing on the residents beds, over bed tables, heads and arms. The three residents present at the time of the observation were able to swat the flies away. An observation of Room #308 on 6/03/25 at 12:30 pm was conducted and flies were visible in the room on resident beds and overbed tables. Resident #4, who had moderate cognitive	F 925	1. Rooms 301, 308, 309, 310, 311 were inspected by the Maintenance Director for flies and treated as needed. 2. The Maintenance Director completed an audit of the remaining resident rooms to inspect them for the presence of flies. The pest control vendor will inspect for flies on their next scheduled monthly visit. 3.The Maintenance Director was reeducated by the Regional Director of Operations on 6/26/2025 to maintain an effective pest control program that includes preventing flies. 4. The Maintenance Director will conduct a weekly audit for the next four weeks and then monthly for two months of at least 5 rooms per audit to ensure that the facility maintains an effective pest control program that includes preventing flies .Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. AOC Date 7/1/2025	

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impairment, stated the flies were horrible.

b. An observation of Room #311 on 6/02/25 at 10:52 am was conducted. Many flies were visible in the room on resident beds, residents head, upper body, and bedside table. The two residents present at the time of the observation were able to swat the flies away.

c. An observation of Room #301 on 6/02/25 at 11:11 am was conducted. Many flies were visible in the room and were observed to land on the residents head and arms. The two residents present at the time of the observation were able to swat the flies away.

d. An observation of Room #310 was conducted on 6/02/25 at 11:28 am and flies were observed landing on the blanket, hands, face, and head. Two of the three resident present during the observation were able to swat the flies away.

Resident #1 was observed waving his hands by his head to remove flies. Resident #1, who was cognitively intact, reported the flies were always in the room and bothered him.

An observation of Room #310 on 6/03/25 at 2:45 pm was conducted and flies were observed around the resident's head and face. One of the two residents present during the observation was able to swat the flies away.

e. An observation of Room #309 on 6/05/25 at 11:24 am was conducted. The resident was observed in bed sleeping with multiple flies on his legs, back, head, and arms. The resident was able to swat away the flies.

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An observation of the smoking area was conducted on 6/05/25 at 3:45 pm with the Maintenance Director. The Residents were observed to be sitting outside the smoking exit door under a gazebo with a raised garden bed to the right of the exit door. The smoking area was clean and without debris or garbage. The Maintenance Director lifted the insect trap located at the smoking entrance and it was observed to have some flies attached to the glue strips but the glue strips were not completely covered. The smoking exit door was opened by the Maintenance Director and the blower fan, located on the wall at the smoking exit door, turned on automatically when the door was opened. No flies were observed to enter the facility at the time of the observation when the door was opened and the blower fan was on.

During an interview with Nurse Aide (NA) #2 on 6/03/25 at 2:45 she revealed flies have been pretty bad and she stated they are in most rooms on the 300 Hall. NA #2 stated she believed the flies got in by the smoking door area because the residents go out so often to smoke.

An interview was conducted on 6/05/25 at 11:26 am with Housekeeper #1 who revealed he did not spray any chemicals for flies at the facility. He stated the Maintenance Director was responsible for the treatment of flies.

An interview was conducted with the Director of Nursing (DON) on 6/05/25 at 1:04 pm who revealed the flies had never been as bad as they were right now. The DON stated she believed the flies were entering the facility from the smoking area door because the door was opened for extended periods of time to allow for all the

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residents to exit and enter. The DON stated the smoking exit door had a blower that would turn on when the door opened to reduce the amount of flies and an insect trap (a wall-mounted fixture with a blue light and glue strips that attracted and trapped flies) was right at the smoking area entrance. She stated the flies were still getting in the facility because of the amount of time it took to get the residents in the door.

An interview was conducted with the Maintenance Director on 6/05/25 at 3:24 pm. The Maintenance Director revealed that he was responsible to maintain the insect traps in the facility by changing out the light bulbs and replacing the glue traps. He stated the facility had 6 large wall mounted insect traps in the resident halls and he had started to place smaller insect traps in resident rooms but had not yet gotten to the 300 Hall. The Maintenance Director stated he changed the insect traps by the smoking entrance about every 2 weeks and the other insect traps lasted longer, like once a month. The Maintenance Director stated he did not maintain documentation for how often he changed the glue traps and lights for the insect traps.

During an interview on 6/05/25 at 4:31 pm with the Administrator she revealed the facility had identified the need for insect traps in resident rooms and the facility had been working on getting insect traps ordered and installed. The Administrator stated with the weather warming up the number of flies in the facility had increased.