STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345478	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARNETT WOODS NURSING AND REHABILITATION CENTER	604 LUCAS ROAD , DUNN, North Carolina, 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/07/2025 through 07/10/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #U2V511.	E0000		08/06/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/07/2025 through 07/10/2025. Event ID #U2V511. The following intakes were investigated: 866472, 866474, and 866475. 4 of the 4 complaint allegations did not result in deficiencies.	F0000		08/06/2025
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is	F0605	"Past Noncompliance - no plan of correction required"	05/31/2025

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

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

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F0605 SS = D	Continued from page 1 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F0605		

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F0605 SS = D	Continued from page 2 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff interviews, the facility failed to ensure residents were free from chemical restraints when Medication Aide (Med Aide) #1 brought melatonin to the facility and administered melatonin to Resident #16 without a physician's order, administered an additional dose of melatonin to Resident #31 with an order for 3 milligrams (mg) of melatonin and administered an additional dose of melatonin to Resident #74 with an order for 10 mg of melatonin because “she wanted a quiet night”. The deficient practice occurred for 3 of the 9 sampled residents for medication administration (Resident #16, Resident #31 and Resident #74).	F0605		

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F0605 SS = D	Continued from page 3 The findings included: A review of an initial allegation report dated 05/29/2025 revealed Med Aide #1 administered melatonin to Resident #16, Resident #31 and Resident #74 without a physician's order. No physical or mental harm. A review of an investigation report dated 06/04/2025 revealed a summary that included over the counter melatonin bottles were identified in the facility sparking investigation to which the facility determined Med Aide #1 administered over the counter melatonin to three residents without a corresponding physicians order. Residents and staff were interviewed. Medication carts were audited. Residents' charts were reviewed. Residents involved in investigation have been evaluated with no negative outcome identified. Melatonin is a supplement most commonly used for insomnia and regulating sleep cycle. A review of a witness statement dated 05/29/2025 from Med Aide #2 revealed it was probably around 7:00 PM when she noticed the bottles. They were white with purple lids. 2 were 10 milligrams (mg) and one was 12 mg. When she opened the stock drawer they were sitting on the right side of the stock drawer. I can't remember if I pulled them and then told Nurse #1 or told Nurse #1 and then pulled them, but I put them in the cabinet in the nourishment room. A review of a witness statement dated 05/29/2025 from Nurse #1 revealed it was during that first med pass that Med Aide #2 and I noticed the melatonin. The Med Aide stated she saw it right when she opened her drawer with stock meds and notified her. I instructed her to pull it from the cart and place it in the cabinet in the nourishment room in the SPARK (Alzheimer's) unit. That was probably between 7:30-8:00 PM on 05/23/2025. A review of a witness statement from Med Aide #1 revealed she brought in 3 bottles of melatonin, 5mg, 10 mg and 12 mg on 05/22/2025. When asked if she brought them in before she stated, "No". She stated she did not give out the 12 mg, they were her personal pills. She gave 5 mg of melatonin to Resident #16, Resident #31 and Resident #74. The Med Aide was told they did not find 5 mg bottles and she stated, "she only gave 5 mgs". She stated Resident #31 was wandering, Resident #16 was up until 1:00 AM, sleepy and tired and Resident #74 was also tired. She did not alert the nurses of any changes in the residents' condition.	F0605		

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F0605 SS = D	Continued from page 4 a. Resident #16 was admitted to the facility on 07/01/2021 with diagnoses including hypertensive heart disease with heart failure. The diagnoses list included insomnia 04/25/2023, and Alzheimer's disease 01/13/2025. The quarterly Minimum Data Set (MDS) dated 04/28/2025 had Resident #16 coded as moderately cognitively impaired, and no behaviors were coded. The May 2025 Medication Administration Record (MAR) did not reveal an order for Melatonin. b. Resident #31 was admitted to the facility on 11/02/2021 with diagnoses including chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 06/25/2025 had Resident #31 coded as severely cognitively impaired. Resident #31 had inattention and disorganized thinking. There was no acute change in mental status from the residents' baseline. Required partial/moderate assistance with toileting and hygiene and was occasionally incontinent of bladder and always continent of bowel. The diagnoses list included insomnia 12/12/2023 and dementia 04/02/2024. May 2025 Medication Administration Record (MAR) revealed an order for Melatonin Tablet 3 MG. Give 3 mg by mouth at bedtime for insomnia. Start date 08/30/2022. Med Aide #1 signed the MAR on 05/22/2025 at 10:00 PM. An encounter note dated 05/23/2025 revealed the resident is an 82-year-old female with a history of dementia, anxiety, wandering behaviors, and insomnia, seen for a follow-up visit. She was resting calmly in bed, reporting no pain or discomfort, and appeared happy and in no overt distress. Staff reported that she is at her baseline in terms of mood and behavior, with no new concerns raised. She is cooperative with care and experiences occasional anxiety and wandering behaviors, which are manageable with redirection. Staff also noted that the Resident had been sleeping well and maintaining a good appetite. There have been no reports of hallucinations or delusions. Her current medication regimen will be continued, and her mood and behavior will be closely monitored. c. Resident #74 was admitted to the facility on	F0605		

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F0605 SS = D	Continued from page 5 08/12/2024 with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris. The quarterly Minimum Data Set (MDS) dated 04/11/2025 had Resident #74 coded as severely cognitively impaired and had memory problems. The diagnoses list included insomnia 08/16/2024 and dementia 01/31/2025. May 2025 Medication Administration Record (MAR) revealed an order for a melatonin oral tablet 10 mg. Give 10 mg by mouth at bedtime related to primary insomnia. Med Aide #1 signed the MAR as administered at 10:00 PM. An interview with Nurse #4 was conducted on 07/07/2025 at 3:01 PM. The Nurse stated she worked the Spark (Alzheimer's) unit 7:00 AM to 7:00 PM shift on 05/22/2025 and there were no bottles of melatonin on the cart when she left when she counted the cart with Med Aide #1 at 7:00 PM. She also stated she had never given any medications without a physician's order and had not known of this happening prior to this incident. Resident #74 did have anxiety but could be redirected. She further stated she had not seen any changes with all three Residents and was educated on the scope of practice and not to give meds without a physician order. Some non-pharmacological interventions with Resident #74 when she gets anxious were playing music, taking outside if the weather permits, giving snacks and she likes to look at her clothes. She further stated she had not seen any changes with Resident #74 after 05/22/2025. A telephone interview with Nurse #2 was conducted on 07/08/2025 at 3:24 PM. The Nurse stated she was familiar with Resident #16's care and worked 7:00 PM to 7:00 AM on 05/22/2025. She was asked if she bought in melatonin and stated, "No". Nurse #2 indicated days later she was notified by telephone a Med Aide gave melatonin without a physician's order and all nurses were to be included in the in service. She did not see Med Aide #1 give any residents melatonin and she had never given any residents medications without a physician's order. A telephone interview with Nurse #3 was conducted on 07/08/2025 at 3:37 PM. The Nurse stated she works the 7:00 PM to 7:00 AM shift and she did work the night of 05/22/2025. Nurse #3 indicated she did not see Med Aide #1 giving medications to residents without a physician's order and Nurse #3 had not given Residents	F0605		

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F0605 SS = D	Continued from page 6 melatonin without an order. The nurse also stated she did not notice any changes in the residents during that shift. An interview with Nurse Aide (NA #3) was conducted on 07/08/2025 at 10:52 AM. The NA stated she did work 7:00 PM to 7:00 AM shift with Resident #31 on 05/22/2025 and she did not see anyone give her medications. She also stated she had not seen any changes in the Resident #31s behaviors after the incident. A telephone interview with Nurse #5 was conducted on 07/08/2025 at 3:50 PM. The Nurse stated she did work 7:00 PM to 7:00 AM on 05/22/2025 and did not see anyone giving melatonin to residents. She also stated she had not given any medications without the physician's order. An interview with NA #1 was conducted on 07/08/2025 at 2:23 PM. The NA stated she works the 7:00 AM to 7:00 PM shift and she did work 05/23/2025, the morning after the incident. She recalled when a Med Aide #1 gave some residents melatonin because they had an in-service. NA #1 had not seen or heard of that happening until they educated them on having a physician's order to give melatonin. NA #1 further stated she did not see any changes in Resident #16 or anything out of the ordinary or she would have reported it to the nurse. An interview with Nurse #6 was conducted on 07/09/2025 at 10:52 AM. The nurse stated she worked from 7:00 AM to 7:00 PM on 05/23/2025. She counted the cart with Med Aide #1 on 5/23/2025 at 7:00 AM and Med Aide #1 never mentioned melatonin or giving it to residents. The top drawer of the medication cart was not open when they did a count. When she was about to start her med pass, she noticed 2 or 3 bottles of melatonin in the cart. She believed it was 10 mg and not all were opened. Nurse #6 stated she had not seen the bottles of melatonin in the cart before 05/23/25. The medication was in the cart that shift until Med Aide #2 noticed them. The nurse also stated she had not seen any changes in Resident #31 and Resident #74 during that shift. An interview with Med Aide #2 was conducted on 07/09/2025 at 1:24 PM. She stated she worked the 7:00 PM to 7:00 AM shift on 05/23/2025 and after she received the cart from Nurse #6 and was about to pass medications, she noticed the melatonin in the top drawer of the cart. She went to get Nurse #1 because the bottles of melatonin did not have a resident's name, and they don't have stock bottles of melatonin in the cart. Nurse #1 told her to take the medication out	F0605		

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F0605 SS = D	Continued from page 7 of the drawer, and she put it in the nourishment room. Med Aide #2 indicated she had never seen or heard of anyone giving medication to residents without an order prior to this incident and she never gave any medications to residents that did not have a physician's order. The Med Aide also stated there were no changes on her shift in the Residents after they were given the melatonin. An interview with the Director of Nursing (DON) was conducted on 07/09/2025 at 2:02 PM. The DON stated she was made aware by Nurse #1 that bottles of melatonin were found on the SPARK units medication cart on 05/23/2025. The medication came from a popular budget store and all bottles had the same white tablets and the store name across it and some of the bottles were still sealed. The DON asked the Nurse #1 how the medication got there but she did not know. Nurse #1was told to remove them from the cart. All the nursing staff were asked if they brought the medication in and all the nurses stated, "No". She continued to call and leave messages for Med Aid #1 because Med Aide #1 was not on the schedule that week. She finally called her back on 05/29/2025 and stated, "Yes" to bringing in and administering the melatonin to Resident #16, Resident #31 and Resident #74 and forgot to take them with her at the end of her shift on 05/23/2025. The DON also stated she asked Med Aide #1, why did she give the medication, and Med Aide #1 replied, "She wanted a peaceful night". Med Aide #1 was told she was not supposed to give residents unprescribed medication. Med Aide #1 stated she gave 5 mg of melatonin to the 3 residents and no one else. The Med Aide was made aware that she was going to be suspended and the investigation was conducted. The DON indicated the Residents Med Aide #1 administered the melatonin to were assessed, no issues were found, she notified the state agencies and police, but the police did not file a report because it was not a narcotic. The DON noted Med Aide #1 was fired. The staff were educated to have a physician order before administering medications and the DON helped with education. The DON stated she expected the nursing staff to administer medications as ordered and if there is a change in behaviors, then the physician should be notified. The officer that came to the facility did not file a police report because it was not a criminal matter or a narcotic. An interview with the Administrator was conducted on 07/09/2025 at 3:21 PM. The Administrator stated she was made aware by the DON on 05/23/2025 that several bottles of melatonin were found in the med cart on the SPARK unit on 05/23/2025, and it was not from their pharmacy. All nurses and med aides were notified and	F0605		

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F0605 SS = D	Continued from page 8 questioned about the medications and Med Aide #1 finally got back to the DON on 5/29/2025 and admitted to having the melatonin and administering it to Resident #16, Resident #31 and Resident #74. Med Aide #1 was suspended and then fired. The responsible parties (RP) and physician were made aware of no new orders were given. The Residents involved were assessed with no negative findings. They reported to police, and state agencies and completed the plan of correction (POC). An interview with Nurse #1 was attempted but not successful. An interview with the Physician was not conducted because he was out of the country. An interview with Med Aide #1 was attempted but not successful. The facility provided the following corrective action plan with a compliance date of 5/31/25. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Problem: Med Aide administered melatonin medication to 3 residents with insomnia without a physician's order. On 5/23/2025, the medications were removed from the medication cart and locked in the nourishment room cabinet. All nursing staff were interviewed concerning the found medications. On 5/23/2025 the incident was reported to the physician and no new orders were given. The Residents where the medications were found were assessed by Nurse #1 and there were no changes found in the residents. On 05/29/2025 The DON spoke with Medication Aide #1 upon interview, Medication Aide #1 stated she purchased the medication from a brand-name retail store and where she placed it on the cart. The Medication Aide #1 did not notify anyone that the medications were brought into the facility. Medication Aide #1 stated she administered a single 5mg dose of the over-the-counter melatonin, to Resident #16, Resident #31, and Resident #74, in effort to ensure she "Had a peaceful night". On 5/29/25, following this admission, Medication Aide #1 was immediately suspended. Resident #16, Resident #31 and Resident #74 were reassessed by the Unit Managers with no negative findings. The nurse notified	F0605		

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F0605 SS = D	Continued from page 9 the physician and resident representatives of all three identified residents of the incident. There were no new orders from the physician. On 5/29/25, The Administrator and DON immediately initiated an investigation. The Administrator notified the Health Care Personnel Registry (HCPR), local law enforcement, and Adult Protective Services (APS) of the incident. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/29/25 the Social Worker interviewed all alert and oriented residents regarding: Have you been given any medications not prescribed? There were no identified areas of concern voiced during the interviews. On 5/29/25, the Unit Managers initiated an assessment of all residents regarding changes in condition. The purpose of the audit was to identify any residents with a change in condition and ensure the change is not related to the administration of unprescribed medications. There were no identified areas of concern during the audit. The audit was completed on 5/30/25. On 5/29/25, the Director of Nursing (DON) audited all medication carts to ensure there was no over-the-counter melatonin present on the carts. There were no other over the counter melatonin medication bottles identified. On 5/29/25, interviews were initiated by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and Treatment nurses with nurses and medication aids regarding: To your knowledge, have you ever given a medication that did not have a prescribed order or know of a staff member who has given medication without a prescribed order. On 5/30/25, the interviews were amended to include 1. To your knowledge, have you ever administered a medication that did not have a prescribed order (nurses and med aides only) 2. Do you know of, or have you heard of any staff member administering medications to a resident without a prescribed order (all staff)? An investigation will be initiated by the Administrator into any identified areas of concern during the interviews. The interviews will be completed on 5/30/25 for all staff that have worked. The Administrator, Director of Nursing, or Staff Development Coordinator (SDC) will monitor the staff's completion. After 5/30/25, any staff who have not received the interview	F0605		

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F0605 SS = D	Continued from page 10 will complete upon their next scheduled work shift. On 5/29/25, the DON and Nursing Consultants initiated medication pass observations with all nurses and medication aides utilizing the Medication Pass Audit Tool. This observation is to ensure all medications are administered according to the physician's orders. All nurses and medication aids will be retrained during the observation for all identified areas of concern. The observations will be completed by 05/30/25 for all nurses and medication aids that worked. The Administrator, Director of Nursing, or Staff Development Coordinator (SDC) will monitor staff completion. After 05/30/25, any nurse or medication aid who has not worked and completed the audit will complete it on their next scheduled work shift. All newly hired nurses and medication aides, including the agency, will complete a medication pass audit during orientation to ensure medications are administered by physician's order. On 05/30/25, the assisting sister facility nurses initiated an audit of all current resident's Medication Administration Record in comparison to medications stored in the medication cart to ensure no unprescribed medications were present in the cart. The assisting sister facility nurses addressed all concerns identified during the audit to include removal of any medications found on the cart not currently prescribed. The audit was completed by 05/30/25. On 05/30/25, the Administrator initiated an audit of all incident reports for the past 30 days to identify trends, and identify any incidents related to medication administration to ensure appropriate interventions were initiated, physician notified, and resident assessed as indicated. There were no identified areas of concern during the audit. The audit was completed by 05/30/25. On 5/30/25, the Director of Nursing reviewed progress notes from 5/16/25-5/30/25 to identify all residents with a change in condition. A comprehensive review was initiated by all residents identified with changes in condition to ensure the change was not related to the administration of unprescribed medications. There were no changes in the condition identified that were related to medication administration. On 5/30/25, the Social Worker completed education with all alert and oriented residents regarding medications administration. The education included immediately reporting concerns with medication administration prior to it being administered and reporting to the DON or	F0605		

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F0605 SS = D	Continued from page 11 Administrator if you feel the concern was not resolved. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. On 05/29/25, the SDC initiated an in-service of all nurses and medication aides regarding Rights of Medication Administration with emphasis on (1) administering the right medication, right dose, to the right resident per physician order (2) not administering medications without a physician's order, notifying the DON immediately if you are aware of medications being administered without a physician's order. The in-services will be completed on 05/30/25. After 05/30/25, all nurses and medication aides that have not received the in-services will receive their next scheduled shift. All newly hired nurses and medication aides, including agencies, receive education during orientation by the SDC. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 5/29/25, the decision was made to monitor the plan for administration of unprescribed medication and presented to the QAPI Committee by the Administrator on 5/29/25. On 5/29/25, the decision was made by the Administrator, for the Unit Managers, MDS, and SDC to complete 5 medication pass audits weekly x 4 weeks then monthly x 1 month to include all shifts to ensure medications are being administered per physician order using the rights of medication administration and that medications were not administered without a physician order. The DON will address all concerns identified during the audit to include but not limited to assessment of the residents, notification of the physician for further recommendations, and retraining of staff. The DON will review the medication pass audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Unit Managers, MDS, and SDC will complete an audit all current resident's Medication Administration Record in comparison to medications stored in the medication cart to ensure no unprescribed medications are present in the cart weekly x 4 weeks then monthly x 1 month. An investigation will be initiated by the Director of Nursing or Administrator of all identified areas of concern.	F0605		

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F0605 SS = D	Continued from page 12 The Unit Managers, MDS, and SDC were notified of this responsibility on 5/30/25 by the Administrator. The Administrator or DON will present the findings of the Med Pass and Mar/Cart audit tools to the QAPI committee monthly for 1 month for review and to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date corrective actions completed: 05/31/2025 Onsite validation of the corrective action plan was completed on 07/10/2025. Interviews with the nursing staff in the facility confirmed they received in-service training on Rights of Medication Administration with emphasis on (1) administering the right medication, right dose, to the right resident per physician order (2) not administering medications without a physician's order. A review of the audit tools was conducted including a review of the resident questionnaires for all alert and oriented residents completed on 05/29/2025. The compliance date was 05/31/2025. The Plan of Correction was verified on 07/10/2025.	F0605		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §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 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	F0628	Resident #21's Responsible Party was sent a copy of the notice containing the reason for transfer for hospital discharge on 9/2/24 and 3/23/25. On 7/31/25, the Social Worker initiated an audit of residents who were transferred and/or discharged from the facility from June 1st through July 31, 2025, to ensure a Notice of Transfer and Discharge was provided to the resident and/or Resident Representative. The purpose of the audit is to ensure the notice included Residents Appeal Rights; the Regional Ombudsman contact information, and written notification of transfer/discharge was provided to the Resident's Representative and Regional Ombudsman. This audit will be completed by 08/5/2025. The Social Worker will address any identified concerns regarding communication of Discharges in the audit. On 7/9/2025 the Staff Development Coordinator initiated an Inservice with the Nursing Home Administrator, Minimum Data Set Coordinator, Director of Nursing, Unit Managers, and licensed nurses regarding Transfer and Discharge Notices with emphasis on notifying the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The transfer or discharge notification will be noted in	08/06/2025

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F0628 SS = B	Continued from page 13 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- (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;	F0628	Continued from page 13 the resident's medical record. After 08/6/25, any newly hired nurses and/or agency staff will receive education during orientation. The Administrator or Director of Nursing will audit 5 residents who are transferred and/or discharged from the facility using the Transfer/Discharge Audit Tool, weekly x 4weeks, then monthly x 2 months to ensure the resident discharge information was provided to the Responsible Party and/or Resident. The Administrator will forward the results of the Transfer/Discharge Audit Tool to the QA Committee monthly x 2 months for review and determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F0628 SS = B	Continued from page 14 (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 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	F0628		

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F0628 SS = B	Continued from page 15 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- (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:	F0628		

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F0628 SS = B	Continued from page 16 (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 over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews the facility failed to notify the Resident Representative in writing of the reason for the unplanned transfer/discharge to the hospital for 1 of 1 resident (Resident #21) reviewed for hospitalizations. The findings included: Resident #21 was admitted into the facility on 10/28/20. A review of Resident #21's nursing progress notes indicated that she was transferred to the hospital on 9/2/24 and returned to the facility on 9/5/24. Resident #21 was also transferred to the hospital on 3/23/25 and returned to the facility on 3/28/25. A review of Resident #21's quarterly Minimum Data Set assessment dated 6/30/25 indicated she was severely cognitively impaired. A review of Resident #21's medical record indicated no documentation of the reason for the transfers was sent to the Resident Representative. A telephone interview was attempted with Resident #21's representative but they were unavailable. An interview with the Administrator on 7/9/25 at 10:00 AM indicated that she was aware of the need for	F0628		

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F0628 SS = B	Continued from page 17 documentation to be sent to the Resident Representative and she was the one who had done that during the time the Social Worker was on leave. However, the Administrator reported she stopped sending out the notice when the Social Worker returned from leave and had not informed the Social Worker that she would be responsible for the notices. The Administrator further indicated she had spoken to the Social Worker and confirmed that Resident #21's representative had not been notified of the reason for transfer by mail for either discharge.	F0628		