

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/10/2026
NAME OF PROVIDER OR SUPPLIER The Lodge at Rocky Mount Health and Rehabilitation			STREET ADDRESS, CITY, STATE, ZIP CODE 3322 Village Road , Rocky Mount, North Carolina, 27804	
(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 4/7/26 through 4/10/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22C655-H1.	E0000		04/10/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 4/7/26 through 4/10/26. Event ID # 22C655-H1. The following intakes were investigated: 878938 and 2682575. 10 of the 10 complaints allegations did not result in a deficiency.	F0000		04/10/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F0761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to date opened medications of Erythromycin Ophthalmic Ointment, Trilogy Ellipta inhaler, Nystatin Cream, Clotrimazole, Rhopressa, artificial tears, and PPD solution for 3 of 5 medication carts and 1 of 2 medication rooms reviewed for medication storage. The facility also failed to discard expired medications of multivitamin with iron, melatonin, glucose gel, Fluticasone nasal spray, one-a-day multivitamin for 3 of 5 medication carts and 1 of 2 medication rooms reviewed for medication storage. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents are at risk for deficient practice. On 4/10/26 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nurse Manager completed an audit of all medication carts, medication rooms, and central supply to ensure there were no other expired or opened and undated	04/11/2026

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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F0761 SS = E	<p>Continued from page 1 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review and staff interviews, the facility failed to date opened medications and discard expired medications for 3 of 5 medication carts (North Hall 3 medication cart, North Hall 1 medication cart and South Hall medication cart) and in 1 of 2 medication rooms (South Hall Medication Storage Room), reviewed for medication storage.</p> <p>The findings included:</p> <p>a. An observation conducted of the North Hall 3 medication cart with Nurse #6 on 4/10/26 at 2:09 PM revealed:</p> <ul style="list-style-type: none"> - one undated, opened and used bottle of Erythromycin Ophthalmic Ointment 0.5%. The manufacturer's instruction stated discard 28 days after opening. - one undated, opened and used Trilogy Elipta inhaler. The manufacturer's instruction on outside of box read to discard 6 weeks after opening. - one undated, opened and used Nystatin Cream tube. The manufacturer's instruction stated to discard 14 days after opening. - one undated, opened and used bottle of Clotrimazole Betamethasone Dipropionate. The manufacturer's instruction stated to discard 6 months after opening. - on undated, opened and used bottle of Rhopressa 2.5 milligram (mg) eye drops. The manufacturer's instruction on the bottle stated once open store at room temperature for up to 6 weeks. - one undated, opened and used bottle of artificial tears. The manufacturer's instruction stated to discard 30 days after opening. <p>An interview was conducted with Nurse #6 on 4/10/26 at 2:10 PM. Nurse #6 stated all medications in the medication cart were supposed to be dated when opened. Nurse #6 stated it was the nurse assigned to the medication cart's responsibility to check the cart.</p>	F0761	<p>Continued from page 1 medications. Any meds found to be opened and undated or expired were discarded.</p> <p>An ad hoc QAPI meeting was held on 4/10/26 to discuss the deficient practice and implement a plan of correction that included staff education and monitoring tools.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 4/10/26 DON and Staff Development Coordinator (SDC) provided education to all licensed nurses and medication aides to check the expiration date on the medication before pulling the medication to be given, as well as dating and labeling medications when opening. They were also educated to check their medication cart during each shift for expired or opened and undated/unlabeled medications.</p> <p>On 4/10/26 the DON provided education to the ADON to check each medication room weekly for expired or opened and undated/unlabeled medications.</p> <p>On 4/10/26 the DON was informed by the Administrator it is her responsibility to ensure all licensed nurses and medication aides receive the education before working their next shift. The DON will add the education to the new hire education for licensed nurses and medication aides and ensure it has been completed before being allowed to work their first shift.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>The Assistant Director of Nursing or Designee will audit each medication cart and both medication rooms weekly for 4 weeks, then three medication carts and both medication carts weekly for 4 weeks, then one medication cart and one medication room weekly for 4 weeks to ensure there are no expired medications or opened and undated/unlabeled medications. Any concerns will be addressed immediately. The Assistant Director of Nursing will present the findings of these audits monthly for 2 months to the Quality Assurance Performance Improvement committee for review.</p> <p>Date of compliance is 4/11/26</p>	04/11/2026

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<p>F0761 SS = E</p>	<p>Continued from page 2 b. An observation was conducted of the North Hall 1 medication cart with Certified Medication Aide (CMA) #1 on 4/10/26 at 2:10 PM revealed one opened and used bottle of multivitamin with iron with remaining pills and an expiration date of 3/2026. An interview was conducted with CMA #1 on 4/10/26 at 2:10 PM. CMA #1 stated she checks the medication cart for expired medications every day and just missed that bottle. c. An observation conducted of the South Hall medication cart for 100 and 200 halls with CMA #2 on 4/10/26 at 2:21 PM revealed: -one opened and used bottle of Melatonin 1 mg tablet with an expiration date of 2/2026, -one unopened box with 2 tubes of microdot glucose gel 37.5 grams (g) with an expiration date of 2/2025, -four undated opened and used bottles of Fluticasone Propionate nasal spray 50 microgram (mcg) spray. The manufacturer's instruction stated to discard 90 days after opening. -one undated opened and used Nystatin Cream tube. The manufacturer's instruction stated to discard 14 days after opening. An interview was conducted with CMA #2 on 4/10/26 at 2:27 PM. CMA #2 stated she checks the medication cart one to two times a week. CMA #2 stated she did not see the identified concerns. d. An observation conducted of the South Hall medication room with the South Unit Manager on 4/10/26 at 2:34 PM revealed: -two unopened bottles of one a day multivitamin with an expiration date of 2/2026. -one undated and accessed bottle of Tuberculin purified protein derivative (PPD) solution 5 tuberculin unit (TU)/0.1 milliliters (ml) in the refrigerator.</p>	<p>F0761</p>		<p>04/11/2026</p>

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F0761 SS = E	<p>Continued from page 3</p> <p>An interview was conducted with the South Unit Manager (UM) on 4/10/2026 at 2:40 PM. The South Unit Manager stated she was responsible for the medication room. She stated she tried to check the South Hall medication room once a week for expired medications or more often when cluttered. The South Unit Manager stated the medications rooms were to be checked weekly by the unit managers. She stated the Central Supply Clerk does come in to stock the over-the-counter medications and she checks the expiration dates as well. The South Unit Manager stated the PPD should have been dated when opened by the nurse. The South Unit Manager further stated the medication refrigerator was to be included when checking the medication room.</p> <p>An interview was conducted with the Director of Nursing (DON) on 4/10/2026 at 2:42 PM. The DON reported that Nursing Administration was responsible for checking the medication rooms and medication carts on the halls. The DON stated the assigned nurse should be checking the medication carts, dating opened medications and discarding expired medications. The DON further stated the medication carts and medication rooms had been checked on Wednesday by the Nursing Administration team, but she was unsure how the identified concerns were missed.</p> <p>An interview was conducted with the Administrator on 4/10/26 at 2:48 PM. The Administrator stated nurses should be checking medication carts each shift. The Administrator further stated the Nursing Administration team should be checking the medication carts and medication rooms weekly as part of their weekly tasks.</p>	F0761		04/11/2026
F0732 SS = C	<p>Posted Nurse Staffing Information</p> <p>CFR(s): §483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information.</p> <p>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name.</p> <p>(ii) The current date.</p>	F0732	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility failed to ensure accurate and updated information was provided on the daily nursing staff postings.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>On 4/10/26, the Administrator completed an audit of the last 30 days of the posted staffing to ensure it</p>	04/11/2026

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<p>F0732 SS = C</p>	<p>Continued from page 4 (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:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(g)(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.</p> <p>§483.35(g)(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.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to post accurate licensed and unlicensed nursing staffing data for 28 of 31 days reviewed for sufficient staffing (3/08/26, 3/09/26, 3/10/26, 3/11/26, 3/12/26, 3/14/26, 3/15/26, 3/16/26, 3/17/26, 3/18/26, 3/19/26, 3/20/26,</p>	<p>F0732</p>	<p>Continued from page 4 was accurate. Corrections were made for all inaccuracies.</p> <p>An ad hoc QAPI meeting was held on 4/10/26 to discuss the deficient practice and implement a plan of correction that included staff education and monitoring tools.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 4/10/26 the Director of Regulatory Compliance educated the Administrator on what the required information is for the daily nursing staff posting.</p> <p>On 4/10/26 the Administrator educated all receptionists on what the required information is for the daily nursing staff posting.</p> <p>The education provided was:</p> <p>The facility name.</p> <p>The current date.</p> <p>Use Daily Census Report to determine Total Census</p> <p>Use Daily Census Report to determine Total Census without ALF Residents</p> <p>The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed nurses, certified medication aides, and certified nursing assistants. All staff listed on assignment sheets count towards direct patient care unless they are listed as flexed.</p> <p>Each nurse will receive 8 hours per shift and count as 1 total number towards specified category. Unless this is a split shift and then each person working the shift will count as .5 total number and receive 4 hours towards specified category.</p> <p>Each CNA/CMA will receive 7.5 hours per shift and county as 1 total number. Unless this is a split shift</p>	<p>04/11/2026</p>

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F0732 SS = C	<p>Continued from page 5 3/21/26, 3/22/26, 3/23/26, 3/24/26, 3/25/26, 3/26/26, 3/27/26, 3/28/26, 3/30/26, 3/31/26, 4/01/26, 4/03/26, 4/04/26, 4/05/26, 4/06/26, and 4/07/26).</p> <p>The findings included:</p> <p>A review of the posted Report of Nursing Staff Directly Responsible, the daily staffing schedule, and the Salaried Employee Sheet from 03/08/26 through 04/07/26 revealed the following:</p> <p>a. A review of the daily nursing schedule form for the 7:00 am-3:00 pm shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:</p> <p>3/08/26-Report of Nursing Staff Directly Responsible for recorded 0 Registered Nurse (RN), 4 Licensed Practical Nurses (LPN), and 11 Nurse Aides (NA); the daily staffing schedule recorded one (1) RN, 3 LPN, and 10 NA.</p> <p>3/09/26- Report of Nursing Staff Directly Responsible for recorded 11 NA; the daily staffing schedule recorded 10 NA.</p> <p>3/14/26- Report of Nursing Staff Directly Responsible for recorded 12 NA; the daily staffing schedule recorded 10 NA.</p> <p>3/15/26- Report of Nursing Staff Directly Responsible for recorded 12 NA; the daily staffing schedule recorded 11 NA.</p> <p>3/16/26- Report of Nursing Staff Directly Responsible for recorded 6 LPN and 12 NA; the daily staffing schedule recorded 7 LPN and 10 NA.</p> <p>3/19/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded 2 RN. The Salaried Employee Sheet revealed one (1) of the 2 RNs scheduled was noted as off.</p> <p>3/20/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 4 LPN.</p> <p>3/25/26- Report of Nursing Staff Directly Responsible for recorded 6 LPN; the daily staffing schedule recorded 5 LPN.</p> <p>3/26/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded one (1) RN.</p>	F0732	<p>Continued from page 5 and then each person working the shift will receive 3.75 hours and count as .5 total number.</p> <p>Using the formula to deduct hours worked with ALF residents to obtain total hours worked per above category. CNAs: deduct 30 minutes per ALF resident on first and second shift and 15 minutes per ALF resident on third shift. LPNs: Deduct 1 hour per shift from LPN working on ALF hall.</p> <p>They were also instructed to ensure the nurse staffing is posted on a daily basis and is accurate at the beginning of the shift.</p> <p>On 4/10/26, the Administrator informed the Business Office Manager it was her responsibility to ensure all staff that post nurse staffing received the education before working their next shift and that any new employee with the nurse staff posting responsibility will be trained before working their first shift.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>The Administrator will audit the daily staffing posting 5 x weekly for 8 weeks to ensure that it is completed accurately. The Administrator will bring the results of these audits to the Quality Assurance Process Improvement (QAPI) committee for 2 months, and audits will continue at the discretion of the QAPI committee.</p> <p>Date of compliance is 4/11/26</p>	04/11/2026

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<p>F0732 SS = C</p>	<p>Continued from page 6</p> <p>3/27/26- Report of Nursing Staff Directly Responsible for recorded 2 RN; the daily staffing schedule recorded one (1) RN.</p> <p>4/03/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 4 LPN.</p> <p>4/05/26- Report of Nursing Staff Directly Responsible for recorded 0 RN, 4 LPN; the daily staffing schedule recorded one (1) RN and 3 LPN.</p> <p>4/07/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 6 LPN.</p> <p>b. A review of the daily nursing schedule form for the 3:00 pm-11:00 pm shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:</p> <p>3/08/26-Report of Nursing Staff Directly Responsible for recorded 11 Nurse Aides (NA); the daily staffing schedule recorded 10 NA.</p> <p>3/09/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 3 LPN.</p> <p>3/10/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.</p> <p>3/11/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN and 11 NA; the daily staffing schedule recorded 3 LPN and 10 NA.</p> <p>3/12/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.</p> <p>3/14/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 13 NA; the daily staffing schedule recorded 2 LPN and 11 NA.</p> <p>3/15/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN and 13 NA; the daily staffing schedule recorded 3 LPN and 11 NA.</p> <p>3/16/26- Report of Nursing Staff Directly Responsible for recorded 5 LPN; the daily staffing schedule recorded 3 LPN.</p> <p>3/17/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing</p>	<p>F0732</p>		<p>04/11/2026</p>

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<p>F0732 SS = C</p>	<p>Continued from page 8 schedule recorded 2 LPN.</p> <p>4/06/26- Report of Nursing Staff Directly Responsible for recorded 4 LPN; the daily staffing schedule recorded 3 LPN.</p> <p>c. A review of the daily nursing schedule form for the 11:00 pm-7:00 am shift revealed the licensed and unlicensed nursing staff was not recorded accurately for the following days:</p> <p>3/22/26-Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.</p> <p>3/24/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 8 NA; the daily staffing schedule recorded 2 LPN and 7 NA.</p> <p>3/25/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN; the daily staffing schedule recorded 2 LPN.</p> <p>4/03/26- Report of Nursing Staff Directly Responsible for recorded 3 LPN and 7 NA; the daily staffing schedule recorded 2 LPN and 8 NA.</p> <p>4/05/26- Report of Nursing Staff Directly Responsible for recorded 9 NA; the daily staffing schedule recorded 8 NA.</p> <p>During an interview on 4/08/26 at 11:02 am with the Staff Development Coordinator (SDC) she revealed she was responsible for the master schedule of the nursing department, but she did not complete the Report of Nursing Staff Directly Responsible that was posted in the lobby of the facility daily. The SDC reported that the Scheduler prepared the daily staffing schedule based off the master schedule and would then give the daily staffing schedule to the Receptionist to complete and post the Report of Nursing Staff Directly Responsible. The SDC stated that nursing staff work 8 and 12-hour shifts and were identified on the daily staffing schedule by a slash between the two staff names when staff were splitting an 8-hour shift.</p> <p>An interview was conducted on 4/09/26 at 9:50 am with Receptionist #1 who completed the Report of Nursing Staff Directly Responsible on 3/21/26 and 4/04/26. Receptionist #1 stated she received the daily staffing schedule from the Scheduler via email the night before and she used that information to complete the report. She stated she was trained to complete the form by the previous Business Office Manager, and she did not know when staff split a</p>	<p>F0732</p>		<p>04/11/2026</p>

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F0732 SS = C	<p>Continued from page 9</p> <p>shift that both staff members listed equaled only one person for the shift, so she just counted each name listed as one person. Receptionist #1 stated she did not update the Report of Nursing Staff Directly Responsible after she posted it first thing in the morning and she was not sure if anyone reviewed or updated the information posted throughout the day if changes were made to the staffing schedule.</p> <p>A telephone interview was conducted on 4/09/26 at 2:00 pm with Receptionist #2 who completed the Report of Nursing Staff Directly Responsible Monday through Friday. Receptionist #2 stated she was trained by Receptionist #3, Receptionist #4, and the previous Business Office Manager on how to complete the daily report. Receptionist #2 stated she was educated to count each person listed on the nursing schedule as one person for the shift staff totals. She stated she did not know that the facility had staff that worked 12-hour shift that required staff splitting shifts so she would not know how to count any staff member that split a shift. Receptionist #2 stated she completed and posted the form in the morning and did not adjust the numbers after she posted it because she would not know if changes were being made.</p> <p>Receptionist #3 was interviewed via telephone on 4/09/26 at 2:12 pm who revealed she completed the Report of Nursing Staff Directly Responsible every other weekend when she worked. She stated she was educated on how to complete the form by the previous Business Office Manager. Receptionist #3 stated she counted each person on the schedule as one person and did not know that some staff work half a shift. Receptionist #3 stated did not adjust or correct the form because she did not take call outs for nursing staff so she would not know if any corrections needed to be made to the form once it was completed.</p> <p>An attempt to conduct a telephone interview with Receptionist #4 on 4/09/26 at 2:11 pm was unsuccessful.</p> <p>The Scheduler was interviewed on 4/09/26 at 2:28 pm who revealed she prepared the daily staffing schedule based off the monthly master schedule from the SDC. She stated she did not complete the Report of Nursing Staff Directly Responsible and she did not take staff call outs to notify the receptionist of any changes in the daily staffing schedule.</p> <p>The previous Business Office Manager was interviewed on 4/10/26 at 9:42 am. She confirmed she had trained the reception staff on how to</p>	F0732		04/11/2026

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F0732 SS = C	<p>Continued from page 10 complete Report of Nursing Staff Directly Responsible based on the staffing schedule provided by nursing. The previous Business Office Manager stated she was not aware that if two people were listed for the same assignment for the shift that meant they were splitting a shift, so she had educated all staff to count each person listed to get the total number of staff per shift.</p> <p>An interview was conducted with the Business Office Manager on 4/10/26 at 12:22 pm who revealed she was gaining an understanding on the process and receiving training on completing the Report of Nursing Staff Directly Responsible.</p> <p>During an interview on 4/10/26 at 12:29 pm with the Administrator she revealed she should have been reviewing the Report of Nursing Staff Directly Responsible for accuracy prior to being posted. The Administrator stated she had just begun checking the form for accuracy the last several days but had not reviewed the form prior.</p>	F0732		04/11/2026
F0641 SS = B	<p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§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.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(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</p>	F0641	<p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The facility failed to accurately code the MDS assessment for use of a wander/elopement alarm for Resident #11 and the use of anticoagulant medication for Resident #10. The assessments were immediately amended and resubmitted.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All current residents have the potential to be affected by the deficient practice.</p> <p>An audit was completed on 4/10/26 by DON to ensure all residents with anticoagulant medications and wander guards were coded correctly on the MDS . No new concerns were found.</p> <p>An ad hoc QAPI was held on 4/10/26 to discuss the deficient practice and implement a plan of correction that included staff education and auditing tools.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p>	04/11/2026

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<p>F0641 SS = B</p>	<p>Continued from page 11 assessment; or</p> <p>(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.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of use of a wander/elopement alarm (Resident #11) and the use of anticoagulant medication (Resident #10) for 2 of 25 residents whose MDS assessments were reviewed.</p> <p>The findings included:</p> <p>1. Resident #10 was admitted to the facility on 5/16/24 with diagnoses which included hypertension.</p> <p>A physician order dated 2/20/26 for clopidogrel (an antiplatelet medication) 75 milligram (mg) give one tablet by mouth daily was observed in Resident #10's record. No anticoagulant medication had been ordered.</p> <p>Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #10 received clopidogrel 75 mg daily as ordered. No anticoagulant medication had been received.</p> <p>The admission Minimum Data Set (MDS) assessment dated 2/27/26 noted Resident #10 had been taking anticoagulant medication during the assessment period. The MDS did not include antiplatelet medication use during the assessment period.</p> <p>An interview was conducted with the MDS Nurse on 4/9/26 at 11:43 AM. The MDS Nurse stated that coding the anticoagulant medication was an error. The MDS nurse stated during the review of Resident #10's physician's orders, she saw an order to monitor signs and symptoms related to anticoagulant therapy. The MDS nurse confirmed the admission MDS assessment should have been coded</p>	<p>F0641</p>	<p>Continued from page 11</p> <p>MDS Coordinator #1 and #2 were educated on 4/10/26 by the Regional Clinical Reimbursement Consultant to ensure residents with anticoagulation medication and wander guards are accurately coded. The RAI manual was reviewed with the coordinators.</p> <p>The Administrator will be responsible for ensuring MDS Coordinators will not be allowed to work until the education is completed.</p> <p>The Regional Clinical Reimbursement Consultant will educate all new hires before they can begin work, the Administrator will ensure this is completed.</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained:</p> <p>The MDS Coordinator #1 or designee will complete audits of the facility MDS assessments to ensure MDS assessments including wander guards or anticoagulant medications continue to be coded accurately, 5 assessments weekly for 4 weeks, then 3 assessments weekly for 4 weeks, then 1 assessment weekly for 4 weeks. The Administrator or designee will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.</p> <p>The date of compliance is 4/11/26</p>	<p>04/11/2026</p>

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F0641 SS = B	<p>Continued from page 12 for the use of antiplatelet medication instead of anticoagulant medication.</p> <p>An interview was conducted with the Administrator on 4/10/26 at 2:15 PM. The Administrator stated she expected that the antiplatelet medication would have been coded correctly in Resident #10's MDS assessment.</p> <p>2. Resident #11 was originally admitted to the facility on 9/03/24 with diagnoses which included unspecified dementia severe without behavioral disturbance.</p> <p>The care plan revealed Resident #11 had a wander guard in place related to attempting to exit the facility without alerting staff and safety awareness which was implemented on 8/28/25. The care plan further noted the wander guard was on the right ankle.</p> <p>Resident #11 was discharged to the hospital on 12/18/25 and returned on 12/24/25.</p> <p>The elopement risk assessment completed on 12/24/25 revealed Resident #11 had a wander/elopement alarm bracelet placed.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated 3/05/26 revealed Resident #11 had severe cognitive impairment and was not coded for the use of a wander/elopement alarm.</p> <p>Review of the active physician orders was completed and revealed Resident #11 did not have a physician order for the wander/elopement alarm bracelet.</p> <p>An observation was conducted of Resident #11 on 4/08/26 at 3:30 pm. Resident #11 was noted to have a wander/elopement alarm bracelet on the right ankle.</p> <p>During an interview with the MDS Nurse on 4/10/26 at 11:13 am she stated that normally she would review physician orders, complete observations, and talk with staff to complete the MDS assessments for a resident. The MDS Nurse stated she knew Resident #11 had a wander/elopement alarm bracelet in place,</p>	F0641		04/11/2026

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F0641 SS = B	Continued from page 13 but she must not have coded it because there was not an order. The Administrator was interviewed on 4/10/26 at 12:33 pm who revealed the MDS Nurse should have done a physical observation and assessment or talk with nursing staff to determine if a wander/elopement alarm bracelet was in place for Resident #11 to ensure the assessment was coded accurately.	F0641		04/11/2026