STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345473	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilora Lake Healthcare	**6001 Wilora Lake Road , Charlotte, North Carolina, 28212**

(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 onsite recertification and complaint investigation survey was conducted from 4/19/2026 through 4/22/2026. Additional information was obtained offsite 4/23/2026 through 4/24/2026, therefore the exit date was changed to 4/24/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22E7BD-H1.	E0000		
F0000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted from 4/19/2026 through 4/22/2026. Additional information was obtained from 4/23/2026 through 4/24/2026, therefore the exit date was changed to 4/24/2026. Event ID# 22E7BD-H1. The following intakes were investigated 2987180, 2971400, 2967633, 2800174, 2798962, 2701920, 2691571, 2684135, 2668189, 2636647, 2598327, 2560995, 840188, 840187, and 840186. 5 of the 39 complaint allegations resulted in deficiency.	F0000		
F0602 SS = E	Free from Misappropriation/Exploitation CFR(s): 483.12 §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 not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident and staff interviews, the facility failed to protect a resident from misappropriation of personal funds when the former Business Office Manager used a resident's	F0602	The following Plan of Correction (POC) is submitted in response to the deficiencies cited during the recent survey conducted by the Agency. This POC is intended solely as a statement of the actions the facility has taken or will take to address the cited deficiencies and to achieve compliance with applicable federal and/or state regulations. This submission does not constitute an admission by	05/22/2026

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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F0602 SS = E	Continued from page 1 debit card to pay the former Business Office Manager's personal bills. This deficient practice affected 1 of 3 residents reviewed for prevent misappropriation of resident property (Resident #14). The findings included: Resident #14 was admitted to the facility on 7/4/2024. Resident #14 was her own Responsible Party. A quarterly Minimum Data Set assessment dated 11/4/2025 indicated that Resident #14 was cognitively intact. A review of the Initial Allegation Report dated 3/6/2026 indicated the facility became aware of the misappropriation of Resident #14's funds by the former Business Office Manager on 3/6/2026 when the Travel Business Office Manager assumed the former Business Office Manager's duties of assisting Resident #14 with an ongoing Medicaid application. The former Business Office Manager had resigned her position as of 2/20/2026. The Travel Business Office Manager noted charges listed on Resident #14's bank statements that were for personal expenses for the former Business Office Manager. The misappropriation occurred between 9/30/2025 and 12/22/2025 and the total amount stolen was $4,945.62. Resident's 14's debit card was immediately cancelled and a new one was ordered on 3/6/2026. The Travel Business Office Manager notified the former facility Administrator of the misappropriation. The Administrator notified and interviewed Resident #14 who confirmed the charges were not authorized. The former Administrator filed reports with local law enforcement, Adult Protective Services (APS) and the State Agency. Resident #14's family was notified and an investigation was initiated immediately. The Initial Report was signed by the former Administrator. A review of the 5-Day Investigation Report revealed the facility had contacted local law enforcement and was waiting for a detective to be assigned to the case. APS had been notified but screened out the report and forwarded the information to the State Agency. The facility attempted numerous times to reach the former Business Office Manager for a statement but the former Business Office Manager did not respond to any of the attempted contacts. The Administrator and Regional Business Office Manager contacted the current residents, the resident representatives and the discharged residents from 3/1/2025 to 3/1/2026 to inquire if any unauthorized charges had been noted in their	F0602	Continued from page 1 Facility that the deficiencies cited are accurate, nor does it imply agreement with the findings or conclusions of the survey. The facility reserves all rights to contest or appeal any findings through appropriate legal or administrative channels. The corrective actions described herein are implemented in good faith to ensure the health, safety, and well-being of our residents/patients, and to maintain compliance with regulatory standards. The facility remains committed to continuous quality improvement and excellence in care delivery. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. After misappropriated funds were discovered on 03/06/26, on 03/06/26 the Travel Business Office Manager called and got Resident #1 debit card cancelled and a new one was ordered. Travel Business Office Manager attempted to dispute charges, but the bank stated that charges were too old to dispute. On 03/06/26 Administrator interviewed Resident #1 and she agreed to speak with the police. On 3/06/26 Administrator filed a police report with Mecklenburg County police department report number #20260306185902. The report is still pending assignment of a detective. On 03/07/26, 03/08/26, 03/09/26, 3/10/26 Administrator and the Regional Director of Operations attempted to contact Employee #1, the alleged employee named in the allegation to gain a statement on the allegations. Employee #1 has not responded to any attempts for a statement. Employee #1 is no longer employed at that facility as of 02/20/26. On 3/09/26 Adult Protective Services were made aware of suspicion of Resident abuse/ neglect regarding misappropriation of resident's property/ funds. The Regional HR Director reviewed the background on 3/10/2026 for verification from Employee # 1 and the current receptionist as they handled money on the facility. The Executive Director requested a check on	05/22/2026

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F0602 SS = E	Continued from page 2 accounts. No concerns were noted. The former Business Office Manager was employed at the facility from 3/13/2025 to 2/20/2026. The facility held a Resident Council Meeting on 3/9/2026 to discuss misappropriation and that staff should not be using resident funds or receiving gifts. All staff members including contracted staff received education regarding abuse, neglect, and misappropriation on 3/9/2026. The facility requested a check from their corporate office in the amount of $4,945.62 to reimburse Resident #14. The 5-Day Investigation Report was signed by the former Administrator. A review of Resident #14's bank statements revealed that the former Business Office Manager had used Resident #14's debit card on 9/30/2025 for a credit card payment in the amount of $386.87; on 10/3/2025 for a credit card payment in the amount of $184.00; on 10/31/2025 for a natural gas payment in the amount of $567.88; on 11/5/2025 for a credit card payment in the amount of $544.04; on 11/25/2025 for a credit card payment in the amount of $334.71; on 11/25/2025 for a credit payment in the amount of $504.33; on 12/9/2025 for a credit card payment in the amount of $309.16; on 12/9/2025 for a credit card payment in the amount of $521.48; on 12/16/2025 for a credit card payment in the amount of $316.53; on 12/16/2025 for a credit card payment in the amount of $349.04; on 12/18/2025 for a credit card payment in the amount of $386.91; on 12/18/2025 for a credit card payment in the amount of $490.33 and on 12/22/2025 for an internet service fee in the amount of $50.34. A review of a report filed by local law enforcement on 3/6/2026 at 6:59 PM indicated that local law enforcement had been advised of credit card fraud as the suspected individual had used the victim's credit card to make unauthorized charges at multiple online locations. An interview was conducted with Resident #14 on 4/19/2026 at 3:13 PM. Resident #14 reported the former Business Office Manager used her debit card for the former Business Office Manager's own personal bills. Resident #14 stated she did not give the former Business Office Manager permission to use her card. Resident #14 went on to say she was disappointed in the former Business Office Manager as she had trusted her but that "these things happened." Resident #14 stated she would not have known any money was missing from her account if the Travel Business Office Manager had not been reviewing past bank statements for the Medicaid application. Resident #14 handled her own financial	F0602	Continued from page 2 03/16/2026 in the amount of 4,945.62 to reimburse resident #1. The check was received at the facility on 3/18/26. On 3/18/2026 The travel Business office manager spoke with resident to see which account she would like the check the was deposited into. Between 3/18 and 4/13 multiple attempts were made by the Travel Business Office Manager with the resident to determine which account she would like the funds deposited to. Each time the resident declined. On 4/13/2026 the resident agreed for the Travel Business office manager to deposit the check into her resident trust fund account. Funds posted and were made available on 4/14/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All current resident's funds were reviewed on 03/09/26 by Regional Business Office manager and Travel Business Office Manager to ensure policy was adhered to related to resident abuse/ neglect regarding misappropriation of resident property/funds. No other deficiencies were noted. The Administrator and Regional Business Office Manager spoke with all in-house residents, resident representatives, and discharged residents from 03/01/25-03/01/26. The interviews consisted of instructing families to review bank statements for any suspicious or unauthorized activity beginning 3/6/2026 to 3/10/2026. All residents with a BIMS of 11 or higher were interviewed by the Regional Business office Manager and Administrator on 3/6/2026 to 3/10/2026 related to: Have you reviewed your bank or credit card statements used to make payments to the facility between March 1, 2025 and March 1, 2026? During your review, did you identify any transactions you do not recognize or believe may be suspicious? If yes, please indicate the type of transaction(s) identified (check all that apply): ☐ Unrecognized charge ☐ Incorrect amount ☐ Duplicate charge ☐ Charge on an incorrect date ☐ Other (please describe below) Please provide details of any questionable	05/22/2026

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F0602 SS = E	Continued from page 3 affairs. Resident #14 indicated she initially was not going to press charges but decided that “theft was theft” and “that was wrong.” Resident #14 spoke with local law enforcement but had not heard anything further. Resident #14 thought the matter was in the “hands of the police now.” Resident #14 stated that the money taken had been reimbursed to her and had been put in her facility trust account per her preference. Resident #14 was satisfied with the resolution. An interview with the Director of Nursing (DON) was held on 4/22/2026 at 8:35 AM. The DON stated that once the misappropriation was identified that the former Business Office Manager had used the Resident 14’s funds for her own personal use, the State Agency, APS and local law enforcement were notified. Resident #14 was notified by the former Administrator that the misappropriation had occurred and an investigation began immediately. The DON stated the former Business Office Manager had already left the position when the misappropriation was discovered. The facility had attempted to contact the former Business Office Manager but had been unsuccessful. The DON reported that no other issues with misappropriation of resident funds were identified during the investigation. The DON stated Resident #14 had been reimbursed for the amount of money misappropriated. A telephone interview with the former Business Office Manager was attempted on 4/22/2026 at 10:36 AM. The former Business Office Manager endorsed that she had worked at the facility “a very short time” but she would have to call back as was in a meeting and could not talk at that time. The former Business Office Manager disconnected the call and did not respond to future attempts to contact her by text message on 4/22/2026 at 1:51 PM and voice mail on 4/23/2026 at 8:35 AM. A telephone interview with the former Administrator was conducted on 4/22/2026 at 10:45 AM. The former Administrator indicated she had been advised on 3/6/2026 by the Travel Business Office Manager that unauthorized charges had been made on Resident #14’s debit card by the former Business Office Manager for personal expenses. The Travel Business Office Manager had taken over assisting Resident #14 with her Medicaid application as the former Business Office Manager had resigned. When Resident #14’s bank statements were reviewed by the Travel Business Office Manager, the misappropriation of funds was discovered. The former Administrator stated she contacted the State Agency, APS, and local law enforcement. An	F0602	Continued from page 3 transaction(s) identified (date, amount, and description, if known): Have you already contacted your bank or credit card company regarding these transaction(s)? to discuss unauthorized activity and suspicious charges. There were 8 residents that were mailed the questionnaire and notification of the allegations with returned receipt. No negative finding noted. On 3/10/2026 the Regional HR Director audited 100% of the employee background checks to ensure they were on file and completed as required with no negative findings. Any resident can be affected by the deficient practice. A resident council was held 03/09/26 to discuss whether employees should receive gifts, ask them to borrow money, or use residents’ funds in any way and report any issues to the Administrator. The meeting was led the Activities Director with 13 residents in attendance. An ADHOC Quality Assurance Performance Improvement Committee was held on 03/09/2026 to formulate and approve a plan of correction and monitoring for deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Resident Abuse/ Neglect education regarding misappropriation of resident property/ funds was provided to all staff including contract staff 03/09/2026 by the Assistant Director of Nursing and all new employees will be educated upon hire in orientation by Assistant Director of Nursing. Beginning 3/10/2026 a new process was initiated for storage and secondary review of Background checks and reference checks for Business office staff was initiated. These records will be stored electronically and reviewed by the Regional Human Resources Director after the facility Human Resources Director or designee completes the background to ensure that there are no issues and have been completed as required. Beginning 3/10/2026 a new process was initiated for the review of Medicaid Pending cases that the facility is actively assisting the resident with for	05/22/2026

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F0602 SS = E	Continued from page 4 investigation began immediately. The former Administrator stated she was never able to contact the former Business Office Manager to obtain a statement. Resident accounts were reviewed and no other residents (both current and residents present (but now discharged) during the time the former Business Office Manager worked in the facility) were identified as having funds misused. The former Administrator stated she had no idea why Resident #14 was targeted. The former Administrator stated there had been no employment issues with the former Business Office Manager and she had worked a notice and resigned under good standing. The former Administrator stated she never had any idea that the former Business Office Manager would have misappropriated any resident's funds and thought she was a good employee. An interview was conducted with the Travel Business Office Manager on 4/22/2026 at 11:10 AM. The Travel Business Office Manager stated that she identified the misuse of Resident #14's funds while reviewing Resident #14's bank statements. The Travel Business Office Manager indicated she had taken over the former Business Office Manager's duties after she had left the position. The Travel Business Office Manager reported she was assisting Resident #14 with her ongoing Medicaid application. The Medicaid office had asked for the past 3 years of bank statements to confirm the pension amounts Resident #14 received on a monthly basis. Resident #14's bank records from 5/2023 to 12/2025 were received and when the Travel Business Office Manager began to review these on 3/6/2026, she stated she noted transactions made in the name of the former Business Office Manager beginning 9/30/2025 and ending 12/22/2025. The Travel Business Office Manager immediately reported the misappropriation to the former Administrator, the Business Office Supervisor at corporate and an investigation began immediately. The Travel Business Office Manager stated she had no idea why Resident #14 had been targeted. Reviews of all resident accounts during the time the former Business Office Manager worked in the facility were conducted and no other unauthorized transactions were identified. The Travel Business Office Manager stated it was a rare occasion when there was a resident filing a Medicaid application and needed the facility's assistance with the application process. The Travel Business Office Manager stated usually a resident's Responsible Party, Financial Power of Attorney or Guardian handled the application process. Resident #14 handled her own finances and did not have involved family to assist her with the Medicaid application process.	F0602	Continued from page 4 submission to Department of Social services. The Director of Medicaid Pending Services will review all current Medicaid pending cases weekly that the facility Business Office Manager is handling. The review will include review of any bank statements or other financial documents that have been submitted to the facility Business office manager to ensure that there are no questionable transactions. Beginning 4/24/2026, The Regional Vice President of Operation educated the administrator regarding the new process of securing any resident financial documents in which the facility is assisting the resident who has no family involvement with trying to get financial assistance. The documents must be locked up in a secured filling cabinet in the administrator's office requiring two signatures to sign in and out documents. Once placed back in the filling cabinet the administrator will review documents to ensure there are not questionable transactions. The Traveling Business office manager and Facility Business office manager was educated by administrator on April 24, 2026 regarding this process. On 3/18/2026 the Travel Business Office manager completed the monthly Resident Fund Management System reconciliation. This reconciliation includes: Petty Cash Box – counting and reconciliation to stated box amount Petty Cash Box reconciliation has been completed and there are no discrepancies between disbursement slips and cash in box Validation that disbursements and deposits have been keyed to the correct resident account and have the appropriate signatures and back up on forms Register Statement for Resident accounts are reconciled to bank statement to ensure that any pending deposits or pending withdrawals are identified and transactions match Expired and Discharged Resident accounts are reviewed to ensure they are closed timely and conveyed to appropriate party	05/22/2026

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F0602 SS = E	Continued from page 5 An interview with the Regional President of Operations was conducted on 4/22/2026 at 12:10 PM. The Regional President of Operations reported she was involved in the investigation and had contacted Resident 14's bank fraud unit. The Regional President of Operations was told the charges were over 90 days old so the bank fraud unit could not assist Resident #14 and this was a matter for local law enforcement. The Regional President of Operations stated the facility audited all resident accounts that were active when the former Business Office Manager was employed at the facility and no other issues were noted with those accounts. The Regional President of Operations did not know why Resident #14 was targeted for misappropriation by the former Business Office Manager. An interview with the Administrator was conducted on 4/22/2026 at 11:45 AM. The Administrator indicated the misappropriation had just been identified as she was taking over the position of facility Administrator. Reports to the State Agency, APS, and local law enforcement had been made. Resident #14 had received a letter from local law enforcement dated 3/31/2026 that the case had been assigned but law enforcement had not yet contacted the facility or Resident #14. The Administrator stated a reimbursement check for the total amount of the misappropriated funds had been deposited into Resident #14's facility trust account on 4/13/2026. On 4/23/2026 at 10:44 AM the assigned local law enforcement officer investigating the misappropriation responded via email. The Officer stated he was following up with the reporting person and the investigation was ongoing. The Officer stated he had advised his contact at the Medicaid Department of the Department of Justice regarding the status of the case. The facility provided a corrective action plan that was not accepted by the State Agency as it did not contain evidence that addressed prevention of misappropriation of resident funds.	F0602	Continued from page 5 Resident accounts with negative balances (if any) are reviewed for accuracy and any pending transactions Medicaid resident accounts are reviewed to ensure they are not over the state limit. The monthly Resident Fund Management System (RFMS) reconciliation is to be completed by the Business office manager, signed off by Administrator and then sent to be reviewed by the regional business office manager for validation. Beginning on 3/18/2026 a new process was initiated to include a monthly compliance audit by the Resident Trust Fund coordinator. To include the following areas: CASH RECEIPTS Is someone outside the Business Office going to the bank? Do they take both operating and trust? CREDIT CARD AUTHORIZATION Does the Center have any credit card authorizations? Did you check to make sure forms with credit card information (Recurring Charge Authorization Agreement and Credit Card Authorization) are kept in a locked drawer Audit a minimum of 25% of authorized recurrent payments and charges? Were all forms properly and completely filled out? Were all residents with recurrent payments current residents? If No, do we have written authorization to charge the card until balance paid in full? Were all charges authorized posted to the proper account? RESIDENT PAPERWORK Did you audit 100% of the in house Resident Trust	05/22/2026

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F0602 SS = E		F0602	Continued from page 6 Account Agreements and Center Forms and compare to Trial Balance Report? Did you validate that all forms have been received by National DataCare? Are both forms (Center and NDC) present and completed fully on sample audit? Beneficiary section to be filled out, if applicable Audit 10 Financial Packets uploaded to A/R system Check 25% of the in house residents to ensure all forms are present, completely filled out and signed. Are the Resident Trust Account Agreements completely filled out and executed? If someone other than the resident signed the agreement, do we have proof of his/her legal authority to execute the Agreement? (Sufficient legal authority includes a Rep Payee, Financial POA, Guardianship, or Conservator-ship) If a Resident Trust Account Agreement indicates wanting to open an account, is there an account open? If a Resident Trust Account Agreement indicates NOT wanting an account, have you confirmed there was not an account? Is the petty cash being maintained in a safe? Are the receipt books being maintained in a locked drawer, cabinet or safe? What is the approved amount of the cash box? Did you confirm that cash on hand, outstanding Withdrawals and outstanding checks equal approved amount for cash box? (Please attach cash count form to audit) Did you validate content of the safe as per policy? INCAPACITATED RESIDENTS Obtain a list of incapacitated residents from SS or ED? Incapacity comes either through a court determination or if the attending physician deems	05/22/2026

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F0602 SS = E		F0602	Continued from page 7 the resident incapacitated. Did you confirm that all residents listed have a POA, Rep Payee or legal guardian? Did you confirm that no incapacitated residents are signing to receive money unless there is an authorization on file from their legal guardian? WITHDRAWAL BOOKS Audit a 25% sample of the current withdrawal book Have you confirmed there are no missing withdrawal slips? Have you confirmed there are no missing withdrawal books? Is the proper documentation present for the withdrawal slips? (proper signatures, receipts for services rendered) Do receipts in receipt book match the charges posted to the RFMS acct? CASH DISBURSEMENT / REIMBURSEMENT Audit a minimum of 25% of the batches for each month audited for withdrawals and cash disbursements to residents and non-residents? Does Check Images Report from RFMS match copies of checks in Monthly RFMS Folder? Did you validate any disputable payee's names on Check Images Report and that payments are legitimate? Does the Center have proper receipts for Items/services? (A POA/Guardian Signature does not count as a receipt) Was the item/service requested or needed by the resident? RESIDENT SHOPPING /PURCHASE REIMBURSEMENT LIMITATIONS Did Center complete any resident shopping this Quarter?	05/22/2026

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F0602 SS = E		F0602	Continued from page 8 If No, then proceed to the discharged residents section. Check 25% of the Resident Shopping list to make sure those items are also listed on the Reimbursement Log? Confirm that none of the charges to the Resident Shopping list raise a red flag (like being unnecessary or excessive)? Are receipts attached to the list/log which document the purchases? Audit a 25% sample of residents listed on the Reimbursement Log to ensure money was appropriately posted to Resident Fund Management System (RFMS) DISCHARGED RESIDENTS Audit 100% of discharged residents accounts during audit period to ensure all balances were refunded? Confirm all residents listed on Trial Balance are current residents, then pull a Closed Account Summary Report to span the time frame audited. Were resident funds returned to the resident or appropriate individual within 30 days? Are all residents listed in RFMS currently in the census? UNCLAIMED PROPERTY Have Resident Trust stale checks been mailed to the Tax Director? STATEMENT RESIDENT TRUST FUND QUARTERLY Have the quarterly statements been mailed to all residents or their designated representative? When? Did you validate that in-house, competent residents signed their statement for the quarter?	05/22/2026

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F0602 SS = E		F0602	Continued from page 9 MISCELLANEOUS Is the center abiding by the policy not to accept cash (over $50 for RFMS)? Are the yearly Representative Payee forms being maintained in a binder? Have you confirmed that residents are not giving their ATM card and pin to any team member? Audit a 25% sample to ensure residents receive the proper personal needs amount? Did you ensure that residents receive their full personal needs regardless of care costs? Is the Surety Bond amount sufficient to cover all resident liability? Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 03/27/26 Medicaid pending residents whom the facility is completing the Medicaid application for; transactions will be reviewed monthly and ongoing by the Administrator and Travel Business Office Manager to ensure there are no suspicious transactions. The bank statements will be reviewed to verify balances, transactions, and countable assets. Any issues will be documented and followed up immediately to ensure no further concerns. Administrator/ Regional Director of Business/Travel Business Office manager will do random audits on 3 residents with a BIMS of 12 or higher 1x a week via questionnaire for any resident abuse/ neglect to include misappropriation of resident's property/ funds for 12 weeks. The Travel Business office manager will do audits for 3 residents 1 time a week of resident's funds in resident trust accounts to ensure that the policy is adhered to related to resident abuse/ neglect regarding misappropriation of resident's property/ funds for 12 weeks for residents with a BIMs of 11 or lower. The audit will also consist of resident representative interviews to ensure no finding of suspicious charges or unauthorized for the previous month. The Administrator will bring results to Quality Assurance and Performance meetings monthly for 3	05/22/2026

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F0602 SS = E		F0602	Continued from page 10 months. The results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process for 3 months or until substantial compliance is maintained. Date of compliance 05/22/26	05/22/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide toileting hygiene after a bowel movement and prior to placing a new and clean pull up on a resident dependent on staff for assistance with activities of daily living (ADL) for 1 of 4 residents (Resident #24). The findings included: Resident #24 was admitted to the facility on 02/24/26 with diagnoses which included type II diabetes mellitus, neurogenic bladder with suprapubic urinary catheter, muscles weakness and lymphedema. Resident #24's care plan dated 02/26/26 revealed a focus area for impaired physical mobility with goal for resident to be able to perform activity within physical limits. The interventions included: Consult physical therapy per order. Determine level of assistance needed based on activities of daily living (ADL) evaluation. Encourage resident to increase activity as indicated. Evaluate resident's ability to perform ADL. Monitor for environment barriers to mobility. Observe resident's posture and gait. Observe range of motion in all joints. Resident #24's admission Minimum Data Set (MDS) assessment dated 03/05/26 revealed she was cognitively intact and required substantial to	F0677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 4/20/26 the Director of Nursing ensured the resident was promptly cleansed, provided appropriate perineal care, and positioned comfortably with a clean brief. Resident #24 was assessed by the Assistant Director of Nursing for skin integrity on 4/20/26 and signs of discomfort or breakdown, with no adverse outcomes noted. The involved Nurse Aide (NA #1) received immediate re-education from the Assistant Director of Nursing on 4/20/26 regarding the requirement to cleanse residents after bowel movements and prior to application of clean briefs. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing (DON) or designee completed a review of residents who require assistance with toileting hygiene and incontinence care on 4/21/26. Unit observations were conducted on to ensure proper ADL care, including cleansing after bowel movements and before brief application on 4/21/26 No additional residents were identified as having been affected by similar deficient practices. Any resident can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee was held on 5/14/2026 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	05/22/2026

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F0677 SS = D	Continued from page 11 maximal assistance of one staff member with toileting hygiene, bed mobility and sitting to standing with her walker. The assessment also revealed the resident was occasionally incontinent of her bladder and frequently incontinent of her bowels. An observation on 04/20/26 at 2:29 PM of suprapubic catheter care revealed Nurse Aide (NA) #1 providing care and the Assistant Director of Nursing (ADON) observing care as well. NA #1 began by removing Resident #24's pull up which had visible brown substance on the pull up and an odor of stool. The NA removed the pull up from the resident and without cleaning the resident from the bowel movement began care of her suprapubic catheter. After completing the care of the catheter and without cleaning the resident he placed a new pull up on the resident and placed her covers over her in the bed. NA #1 gathered his supplies and trash and left the resident's room. An interview on 04/20/26 at 2:40 PM with Resident #24 revealed she was not aware earlier that day that she had a bowel movement because she could not always tell but said if she had a bowel movement she would have wanted to be cleaned prior to having another pull up placed on her. Resident #24 stated she was a large resident and knew that it was sometimes difficult to clean her up but said she preferred to be clean and not have the smell of stool. An interview on 04/20/26 at 2:46 PM with NA #1 revealed he was aware Resident #24's pull up had a brown liquid substance on it earlier that day and said he didn't know why he had not cleaned her but said he was nervous about being observed providing suprapubic catheter care and had just forgotten to clean her. NA #1 stated he had seen the brown liquid substance on Resident #24's pull up and had smelled it when he removed it and said he should have cleaned her up prior to proceeding with her suprapubic catheter care. NA #2 further stated he would go back and clean her and place a clean pull up on her. An interview on 04/20/26 at 2:51 PM with ADON, who is also the Staff Development Coordinator and Infection Preventionist, revealed she had not seen the pull up was soiled with a brown liquid substance but stated she had smelled it and did not know why NA #1 had not cleaned the resident before putting on a clean pull up. She stated she should have stopped him and made him clean her but was not positioned where she could see what was on the	F0677	Continued from page 11 On 4/21/26 The Director of Nursing Implemented the following systemic corrective actions: The ADON/Staff Development Coordinator completed all education and skills competencies listed below. All nursing assistants and licensed nursing staff received mandatory re-education on ADL care expectations, including (re-education completed by 5/15/26): Cleansing residents after bowel movements. Proper sequencing of care when residents require both toileting hygiene and catheter or other treatments. Respecting resident dignity, comfort, and hygiene during incontinence care The ADON/Staff Development Coordinator reinforced ADL care standards through skills review and competency validation for licensed nurses and nursing assistants completed by 5/15/26. Expectations for toileting hygiene and incontinence care were reinforced by the ADON/Staff Development Coordinator during shift huddles on 5/15/26. The above education for licensed nurses and nursing assistants will be incorporated into new-hire orientation to be provided by the ADON/Staff Development Coordinator or designee during the new hire orientation process. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and On 5/15/26 Supervisory nurses were instructed by the Director of nursing to provide real-time observation and coaching during ADL care on 5 residents per week for 4 weeks, then 5 residents monthly for 2 months. The audit results will be documented and reviewed with Nursing leadership and reported to the Quality Assurance and Performance Improvement (QAPI)	05/22/2026

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F0677 SS = D	Continued from page 12 pull up. The ADON stated she would have expected NA #1 to have cleaned the resident when he saw the brown liquid substance on her pull up. A telephone interview on 04/23/24 at 11:19 AM with the Director of Nursing (DON) revealed she expected the staff to clean all residents after a bowel movement before placing clean pull ups or briefs on them.	F0677	Continued from page 12 committee for 3 months. Any identified non-compliance will result in immediate re-education and disciplinary action per facility policy. Corrective action will be completed by 5/22/2026.	05/22/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F0880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Assistant Director of Nursing immediately addressed the identified infection control deficiencies involving hand hygiene and Enhanced Barrier Precautions (EBP) during care provided to Resident #24 on 4/20/26. The resident was assessed for signs and symptoms of infection on 4/20/26, and none were identified. Assistant Director of Nursing immediately intervened at the time of observation to correct the deficient practices. The involved Nurse Aides (NA #1 and NA #2) received immediate re-education on proper hand hygiene procedures, including required hand sanitization between glove changes, and correct use of gowns during all high-contact care activities for residents on Enhanced Barrier Precautions on 4/20/26 by The Infection Preventionist (IP). Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Observational rounds were conducted by The Infection Preventionist (IP) on 4/22/26 to assess staff compliance with hand hygiene and PPE use during resident care. No additional residents were identified as having been affected by similar deficient practices. The Infection Preventionist (IP) completed a facility-wide review of all residents currently on Enhanced Barrier Precautions to ensure appropriate signage, availability of PPE, and adherence to infection control protocols, completed on 5/14/26. Any resident can be affected by the deficient practice.	05/22/2026

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F0880 SS = D	Continued from page 13 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their Infection Control policies and procedures for Hand Hygiene when Nurse Aide (NA) #1 failed to sanitize his hands in between changing his gloves while providing suprapubic urinary catheter care to Resident #24. The facility also failed to follow their Enhanced Barrier Precautions (EPB) policy and procedure when NA #1 failed to wear a gown while providing incontinence care and while transferring Resident #24 and then NA #1 and NA #2 adjusted the same resident up in the bed after placing a turn sheet under her without wearing a gown. The deficient practice occurred for 2 of 8 staff observed for infection control practices (NA #1 and NA #2). The findings included:	F0880	Continued from page 13 An ADHOC Quality Assurance Performance Improvement Committee was held on 5/14/2026 to formulate and approve a plan of correction for the deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 4/20/26 The Director of Nursing implemented the following systemic corrective actions: Infection Preventionist (IP) completed all education below. All nursing staff, including nurse aides, received mandatory re-education on (re-education Completed by 5/15/26): Hand hygiene requirements, including sanitizing hands between glove changes Proper Hand Hygiene competencies for all direct staff. Proper donning and doffing of PPE competencies for all direct staff. Enhanced Barrier Precautions, with emphasis on gown use during all high-contact care activities, including incontinence care, transfers, and repositioning. Infection control policies and Enhanced Barrier Precautions requirements were reviewed during staff meetings by Infection Prevention (IP) nurse on 4/22/26. Visual reminders and signage were reinforced at resident room doors and PPE caddies to clearly communicate gown requirements for high-contact care on 4/20/26 by IP nurse. The above education will be added to the New hire orientation and annual competencies to include	05/22/2026

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F0880 SS = D	Continued from page 14 1. a. Review of the facility's Hand Hygiene policy and procedure which is part of the Infection Control policies and procedures last revised on 11/13/25 revealed the following: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 3. Alcohol-based hand rub (ABHR) with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Hand Hygiene Table: Alcohol based hand rub is preferred: After handling contaminated objects. Before applying and after removing personal protective equipment (PPE), including gloves. When during resident care, moving from a contaminated body site to a clean body site. When in doubt. An observation of suprapubic urinary catheter care on 04/20/26 at 2:29 PM with NA #1 on Resident #24 who was on Enhanced Barrier Precautions (EBP) with a sign on her door and a caddie of personal protective equipment attached to her door was completed. The observation revealed NA #1 washing his hands with soap and water and donning a gown, face shield and gloves. NA #1 proceeded to prepare 2 basins of water one with soap and water and one with just water. He placed the basins on the overbed table on top of a towel. NA #1 began by removing Resident #24's soiled brief and tossed it in the trash. NA #1 then removed his gloves and without sanitizing his hands, donned a clean pair of gloves and began cleaning the suprapubic catheter with soaped washcloths. After cleaning the catheter, he removed his gloves and without sanitizing his hands donned a clean pair of gloves and rinsed the	F0880	Continued from page 14 enhanced training on hand hygiene and enhanced barrier precautions. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Beginning On 4/20/26 the Director of Nursing or Designee will observe 5 residents on enhanced barrier precautions per week for 4 weeks, then 5 residents per month for 2 months to ensure that staff are compliant with: -Hand Hygiene compliance between glove changes -Proper use of gowns for residents on Enhanced Barrier Precautions -Compliance with infection control policies during high-contact resident care The Infection Preventionist or designee will provide the audit results to the Quality Assurance and Performance Improvement (QAPI) committee for 3 months. Any identified non-compliance will result in immediate re-education and disciplinary action per facility policy. The QAPI committee will evaluate audit trends to ensure sustained compliance. Corrective action will be completed by 5/22/2026.	05/22/2026

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F0880 SS = D	Continued from page 15 catheter with a wet washcloth and then proceeded to apply a new pull up on the resident. After applying the pull up, he emptied the basins and doffed his face shield, gown, and gloves, washed his hands with soap and water and removed the dirty linen and trash from the resident's room and left the room. An interview on 04/20/26 at 2:46 PM with NA #1 revealed he realized after providing care that he had not followed appropriate hand hygiene when he didn't sanitize his hands after removing his gloves and before applying clean gloves. He stated he was nervous about being watched and said he just forgot to sanitize his hands and said he even kept hand sanitizer in his pocket. An interview on 04/20/26 at 2:51 PM with the Assistant Director of Nursing (ADON), who was the Infection Preventionist (IP) revealed NA #1 should have sanitized his hands each time he removed his gloves before putting on clean gloves. The IP stated she had done education with all the staff about hand hygiene and doffing and donning personal protective equipment (PPE). A telephone interview with the Director of Nursing (DON) on 04/23/26 at 11:19 AM revealed she would have expected NA #1 to have sanitized his hands each time he removed his gloves and before putting on clean gloves. b. Review of the Enhanced Barrier Precautions policy and procedure which is part of the Infection Control policies and procedures last revised on 11/13/25 revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy Explanation and Compliance Guidelines: Implementation of Enhanced Barrier Precautions (EBP): a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.	F0880		05/22/2026

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F0880 SS = D	Continued from page 16 c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). High-contact resident care activities include: c. Transferring f. Changing briefs or assisting with toileting. An observation of incontinence care on 04/20/26 at 2:58 PM revealed a sign on the door indicating Resident #24 was on EBP with a caddie on her door containing PPE. The observation revealed NA #1 walking into Resident #24's room and donning gloves, obtaining a clean pull up and wipes and without donning a gown proceeding to remove the resident's pull up. NA #1 removed the pull up and began cleaning the resident in the front and then cleaned her behind. NA #1 was having difficulty getting the resident clean in bed and assisted her to stand with her walker so he could finish cleaning her behind and ensure her pull up was pulled up in the back. NA #1 then assisted the resident back on her bed, removed his gloves, sanitized his hands and left the room to get another staff member to assist in getting her pulled up and adjusted in the bed. NA #2 and NA #1 returned to Resident #24's room and donned clean gloves and without putting on a gown proceeded to assist the resident in moving side to side in the bed to place her turn sheet under her. After adjusting the turn sheet, NA #1 and NA #2 pulled the resident up in bed with the turn sheet and placed her covers over her. NA #1 and NA #2 removed their gloves; NA #1 removed the trash from the room and they both sanitized their hands after leaving the room. An interview with NA #1 and NA #2 on 04/20/26 at 3:04 PM revealed they were not aware they were supposed to wear a gown when providing incontinence care, transferring a resident, and adjusting a resident up in the bed. NA #1 and NA #2 stated they saw the sign and the caddie when going into the room but did not realize they had to wear PPE when adjusting a resident up in the bed. The EBP sign on the resident's door was reviewed with NA #1 and NA #2 and they both agreed they should have worn a gown while providing care to Resident #24. An interview on 04/20/26 at 3:15 PM with the IP revealed she would have expected NA #1 and NA #2 to have worn a gown while providing incontinence care, transferring the resident and adjusting the resident up in the bed.	F0880		05/22/2026

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F0880 SS = D	Continued from page 17 A telephone interview with the Director of Nursing (DON) on 04/23/26 at 11:19 AM revealed Resident #24 was on EBP due to her suprapubic urinary catheter and she would have expected NA #1 and NA #2 to have worn a gown during high-contact resident care activities.	F0880		05/22/2026
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 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.	F0628	mmediate action (s) taken for the resident(s) found to have been affected include: Resident # 83 was discharged without evidence of a documented transfer/ discharge notice being issued to the resident and Regional Ombudsman as required. Resident is no longer in the facility and contact information is no longer valid, a late notice cannot be delivered. During the annual survey the interim Social Services Director emailed March discharges to the regional ombudsman and on 5/1/26 the April discharges were emailed to the regional ombudsman. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who have been transferred or discharged have the potential to be affected. An audit was completed by the Social Worker on 5/15/2026 regarding residents who have been discharged in last 30 days to ensure they were provided notice as well as the regional ombudsman when required. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Administrator on 5/14/26 with social services staff to ensure they provide the required notices for residents upon transfer and discharge from the facility to the resident/responsible party and the regional ombudsman. Any newly hired Social services staff will be provided the above education by the Administrator during the new hire orientation process. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 5/23/26, For a period of four weeks, the social worker, or designee, will conduct a record audit of all residents who have been transferred or	05/22/2026

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F0628 SS = B	Continued from page 18 (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; (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	F0628	Continued from page 18 discharged from the facility to ensure the record includes a copy of the transfer/discharge notice. If the resident is still residing at the facility at the time of the record audit, the resident and their representative will be interviewed to ensure that they have received a transfer/discharge notice written in a language that they can understand. If the resident is no longer residing at the facility at the time of the audit, the resident and their representative will be contacted by phone to ensure they received the transfer/discharge notice. A transfer/discharge list will be sent to the State Ombudsman Office monthly via email to prove delivery. The audit will then be conducted on 5 discharges per month for 2 months to ensure appropriate notice has been provided to both resident/responsible party and ombudsman. The Administrator (or designee) will review audit results and report findings to the Quality Assurance and Performance Improvement committee monthly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance meeting for 3 months or until such time consistent substantial compliance has been met. Corrective action completion date: 5/22/26.	05/22/2026

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F0628 SS = B	Continued from page 19 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 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-	F0628		05/22/2026

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F0628 SS = B	Continued from page 20 (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 over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Regional Ombudsman and staff, the facility failed to provide a written discharge notice to the resident and send a copy of the notice to the Regional Ombudsman for a resident discharged home for 1 of 1 resident reviewed for discharge (Resident #83). The findings included:	F0628		05/22/2026

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F0628 SS = B	Continued from page 21 Resident #83 was admitted to the facility on 2/18/26. The admission Minimum Data Set (MDS) assessment dated 2/24/26 revealed she was cognitively intact. The resident's overall goal was for discharge to the community and active discharge planning was already occurring with referrals made to the local contact agency. A nursing note dated 3/31/26 at 7:21 PM stated Resident #83 was discharged home. She was alert and oriented and medication administration was explained and Resident #83 verbalized understanding by repeating the process. A review of Resident #83's electronic medical record (EMR) revealed no transfer or discharge notice was issued to Resident #83. A telephone interview with Resident #83 was attempted but was unsuccessful as the phone number had been disconnected. A telephone interview on 4/22/26 at 4:25 PM with the Regional Ombudsman revealed she had not received any notices of transfer or discharge, to include Resident #83's discharge, since December 2025 when the Former Social Worker left the facility. A telephone interview occurred with the Former Administrator on 4/22/26 at 4:12 PM. She stated she left the facility at the beginning of March 2026, did not recall Resident #83 and did not recall if a written transfer or discharge notice was given to Resident #83. She indicated the Former Social Worker (SW) would send transfer and discharge notices to the Regional Ombudsman. The Former Administrator stated when the Former SW left the facility in December 2025, the Former Medical Records Coordinator oversaw sending the notices to the Regional Ombudsman. The Former Administrator stated she did not personally send a transfer or discharge notice for Resident #83 to the Regional Ombudsman. An interview with the SW on 4/22/26 at 4:23 PM revealed she came to the facility at the beginning of April 2026 and was not familiar with Resident #83. She stated she had taken over the responsibility of sending the transfer and discharge notices to the Regional Ombudsman. A telephone interview with the Former Medical Records Coordinator occurred on 4/23/26 at 12:38 PM. She stated she was employed at the facility from November 2024 to the end of February 2026. The	F0628		05/22/2026

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F0628 SS = B	Continued from page 22 Former Medical Records Coordinator stated the Former Administrator had a background in social work and handled all the tasks of the SW's role after the Former SW left in December 2025. The Former Medical Records Coordinator stated she did not recall Resident #83 or if she had received a transfer or discharge notice from the facility. The Former Medical Records Coordinator indicated she did not have access to any transfer and discharge notices to send to the Regional Ombudsman. A telephone interview with the Administrator on 4/24/26 at 8:59 AM revealed she came to the facility in the middle of March 2026. She had the expectation that a designated staff member would have provided Resident #83's discharge notice and would have sent copies of all written transfer and discharge notices to the Regional Ombudsman.	F0628		05/22/2026