STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care and Rehabilitation	**551 Kent Street , Andrews, North Carolina, 28901**

(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
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/27/26 through 4/30/26. Event ID# 22F571-H1. The following intakes were investigated 2677430, 2653536, 2636483, 2625592, 2621605, 2619314, 2610205,2609319, 2602252, 2574520. 5 of 33 complaint allegations resulted in deficiency.	F0000		
E0001 SS = F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards	E0001	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 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	05/25/2026

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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E0001 SS = F	Continued from page 1 approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to review and update the Emergency Preparedness (EP) Plan at least annually. Findings included: A review of the facility's EP Plan found it was dated 3/20/25. On 4/30/26 at 12:09 PM Administrator #2 was interviewed. She stated she was the interim Administrator for the facility while Administrator #1 was on leave, that included March 2026. Administrator #2 said she had not been aware the Emergency Preparedness plan's annual review was due to be reviewed and updated in March 2026. On 4/30/26 at 11:46 AM an interview with Administrator #1 stated the facility had not reviewed the Emergency Preparedness plan since 3/20/25. She stated it should be reviewed and updated at least annually. The Administrator Indicated she had been out on leave for multiple months and reviewing the EP Plan had been overlooked.	E0001	Continued from page 1 compliance with regulatory standards. The facility remains committed to continuous quality improvement and excellence in care delivery. E 0001 On 5/11/2026, the Executive Director completed a comprehensive review and update of the facility's Emergency Preparedness Plan to ensure it includes an all-hazards approach, current contact information, and facility-specific procedures. No residents were identified as having been negatively affected; however, all residents have the potential to be affected by deficient practice. To prevent recurrence, the following systemic changes have been implemented: On 4/30/2026, the Regional Vice President of Operations re-educated the Executive Director on: Emergency Preparedness Program regulatory requirements Annual review and update expectations A tracking mechanism has been implemented through the preventative maintenance tracking system (TELS) to ensure: Annual Emergency Preparedness Plan review is completed timely. Reminders are generated to prevent lapses. Any newly hired Executive Directors will be educated by the Regional Vice President of Operations during new hire orientation. To ensure continued compliance, the Executive Director/designee will: Perform quarterly audits of the Emergency Preparedness Program to verify:	05/25/2026

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E0001 SS = F		E0001	Continued from page 2 Plan is current and accessible. Required elements are present. Any changes have been updated timely. The Executive Director will present a quarterly review to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD- HOC QAPI Meeting on 5/11/2026. 5. Date of Compliance: 5/25/2026	05/25/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility	F0812	F812 On 4/27/2026, food items with signs of spoilage were discarded by the Dietary Manager, and the circulatory fan covers in walk in refrigerator were also cleaned by the Dietary Manager. No residents were identified as experiencing adverse effects; however, all residents have the potential to be affected by this deficient practice. On 4/28/2026, the Healthcare Services Group District Manager performed quality improvement monitoring of current food storage area and refrigerators to ensure no outdated items and areas were cleaned. No additional concerns were noted. Beginning 4/28/2026, Current dietary staff were educated by the Healthcare Services Group District Manager on the policy related to food storage and sanitation. This education will be provided to any newly hired dietary staff by the dietary manger during orientation process. To ensure the deficient practice will not recur, begin	05/25/2026

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F0812 SS = E	Continued from page 3 failed to clean the circulatory fan covers in the walk-in refrigerator and failed to dispose of food stored for use with signs of spoilage in the facility's walk-in refrigerator. This was for 1 of 3 refrigerators (walk-in) observed in the kitchen. The deficient practice had the potential to affect food served to residents. Findings Included: a. On 4/27/26 at 10:51 AM an observation in the walk-in refrigerator found the two circulatory fan covers with a buildup of greyish, clumpy and crumbly to touch substance. The substance was covering the 2 fan covers and would move when the fans were running. b. On 4/27/26 at 10:54 AM an observation in the walk-in refrigerator found a box of whole cucumbers located on the top shelf of a food storage rack. The cucumbers in the box were observed with a thick layer of white and fuzzy in appearance substance that covered about 50 percent of the cucumbers. The outside of the box had a received date of 3/23 written on it. On 4/27/26 at 11:00 AM the Dietary Manager observed the walk-in refrigerator with the surveyor. The Dietary Manager observed the circulatory fan covers and the box of cucumbers. On 4/27/26 at 11:02 AM the Dietary Manager was interviewed and stated she was not aware the fan covers had a substance on them. She said the fans were not on a routine cleaning list, and she did not know the last time they had been cleaned. The Dietary Manager further stated the box of cucumbers had been overlooked, and she had not yet checked the walk-in refrigerator for expired food. She stated the refrigerators were checked daily by her, and by the cook on the weekends. The Administrator was interviewed on 4/30/26 at 3:10 PM. She stated the food storage areas should be cleaned on a routine basis and expired or spoiled food should be disposed of.	F0812	Continued from page 3 4/27/2026 The Executive Director / designee will perform quality improvement monitoring on food storage and sanitation 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Executive Director/designee will present the review to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. 5. Date of Compliance: 5/25/2026	05/25/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living	F0584	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	05/25/2026

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F0584 SS = D	Continued from page 4 safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to maintain an intact headboard without rough edges (Resident #14) and maintain chair rail molding in good repair (Resident #14 and Resident #53). This deficiency occurred for 2 of 4 residents reviewed for safe, clean and homelike environment (Resident #14 and Resident #53) on 1 of 5 facility halls. The findings included:	F0584	Continued from page 4 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 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. F584 On 4/30/2026, The Maintenance Director replace the broken headboard and chair rail for resident #14. On 5/1/2026, The Maintenance Director removed broken chair rail for resident #53. On 5/1/2026, an environmental audit facility-wide was completed by the new Maintenance Director to identify repair concerns. Any immediate safety issues such as broken chair rail, damaged headboard, privacy curtain tracks etc were repaired or removed. The additional items identified will be placed on a schedule for repair and prioritized based on safety needs. Beginning 5/25/2026 the new director and assistant will create a work schedule to complete projects on an ongoing schedule.	05/25/2026

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F0584 SS = D	Continued from page 5 On 4/28/26 at 3:36 PM an observation was made of Resident #14's headboard. The upper right side of the headboard (as viewed from the foot of the bed) was visible eight inches above the mattress with the top edge angled downward. Observation looking down from the head of the bed revealed the left third of the headboard was missing. The remaining piece was connected to the right side of the bed frame, and the left side had a rough edge from top to bottom, resting on a screw sticking out of the left side of the bed frame. Close observation of the mounts on the headboard frame revealed a layer of wood-like splinters present on top of the metal mounts. An observation of the wall behind Resident #14's bed revealed a horizontal chair rail molding was mounted the length of the wall 18 inches above Resident #14's mattress, protruding 2 inches from the wall. The chair rail molding had six chipped areas with paint missing across the bottom edge with scattered wood-like splinters. Starting midway from the width of the bed, the chair rail molding was pulled away from the wall a quarter inch to where the privacy curtain met the wall where it was pulled away one inch from the wall. Review of Resident #14's quarterly Minimum Data Set (MDS) on 1/23/26 indicated she was cognitively intact and dependent for bed mobility. In an interview with Resident #14 on 4/28/26 at 3:37 PM she stated she wondered if the headboard got damaged when they changed out her air mattress a few weeks ago. Resident #14 explained she could not see the headboard because she had been unable to reposition herself to look at it. Resident #14 revealed one of the nurse aides told her it had a crack but could not recall exactly who it was or when she knew about the crack but that it was after getting her new mattress. The interview further revealed Resident #14 was able to see the end of the piece of chair rail molding pulled from the wall near the privacy curtain but could not see what it looked like behind the bed. Resident #14 stated this probably happened when the tall nurse aides put her bed up higher and her headboard pushed on the chair rail molding because the bed was too close to the wall but could not recall when this was. Nurse Aide (NA) #4 was interviewed on 4/30/26 at 9:06 AM and stated she had been caring for Resident #14 early in the morning on 4/27/26 when she noticed her headboard had a crack running	F0584	Continued from page 5 Beginning on 5/19/2026, All staff to include contract staff were educated by The Executive Director/Designee on the process of recording work orders and reporting maintenance concerns. This education will be provided to any newly hired staff to include contract staff by the Maintenance Director/Designee during the new hire orientation process. Beginning 5/19/2026, A task has been added to facility Mock Survey Rounds to check room for safe environment i.e., broken chair rail, broken headboard, broken privacy curtain tracks, and any other maintenance concerns. On 5/19/2026, the Regional Vice President of Operations educated the Executive Director on Mock Survey Rounds to include checking for a safe environment i.e., broken chair rails, broken headboard, broken privacy curtain tracks, and any other maintenance concerns. On 5/20/2026, The Executive Director educated the facility leadership team which includes Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Social Services, Medical Records Coordinator, Maintenance Director, Activities Director, Human Resource Coordinator, Business Office Manager and Minimum Data Set Nurse on Mock Survey Rounds to include checking for a safe environment i.e. broken chair rails, broken headboard, broken privacy curtain tracks and any other maintenance concerns. To ensure the deficient practice will not recur, beginning 5/21/2026 the Executive Director and/or Designee will perform quality improvement monitoring on Mock Survey Rounds 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. Results of Mock Survey Rounds to be brought to morning meeting Monday through Friday. The Maintenance Director will ensure that identified needs have been placed on work orders and on a schedule for repair. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. Date of Compliance: 5/25/2026	05/25/2026

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F0584 SS = D	Continued from page 6 down the middle. NA #4 stated it was the first time she had seen the crack but thought she heard another nurse aide say it had been cracked for a while but did not recall who. NA #4 explained she touched the headboard where the crack was to check it out and a broken piece fell to the ground. NA #4 explained when she looked more closely at the broken headboard she also noticed the chair rail molding above the bed had pulled away from the wall and thought it had been broken by the headboard. NA #4 revealed she put a sticky note with the room number on the broken piece and put it in a box outside the maintenance office door. She explained the process for reporting broken equipment was to fill out an electronic work order and she did an electronic work order to report the broken headboard when she noticed it but didn't specifically mention the chair rail molding being pulled from the wall. On 4/30/36 at 9:21 AM an interview was conducted with NA #2 who explained she had noticed a crack in Resident #14's headboard maybe a month ago. NA #2 stated she had told the hall nurse the day she noticed the crack but did not remember the exact day or which nurse it had been. She further explained she did not fill out a work order because she could not find any work order papers at the nurses' station or in the shelf cubbies in the lobby where they used to be. NA #2 revealed another coworker showed her the electronic workorder system, but she did not put in a work order for the cracked headboard because she got busy and forgot. On 4/30/26 at 10:59 AM an interview was conducted with NA #3 who stated she knew Resident #14's headboard had been broken, probably for several weeks. NA #3 stated she had forgotten there was an electronic work order system and thought she had left a note in a black work order folder at the nurses' station but could not remember for sure. At 4/30/26 at 9:57 AM the Maintenance Director was interviewed when he was observed walking down the hall with a headboard and stopped in front of Resident #14's room. The Maintenance Director explained he had started at the facility on 4/27/26 and staff had told him this morning that Resident #14's headboard was broken and he was there to replace it. He further explained no one had mentioned broken chair rail molding to him nor had he seen any work orders for Resident #14. During	F0584		05/25/2026

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F0584 SS = D	Continued from page 7 the interview the Maintenance Director stated the chair rail molding was there to stop damage on the wall from the headboards. He observed the damaged chair rail molding and headboard in Resident #14's room and stated it looked like the chair rail damage was caused by the bed. The Maintenance Director indicated because wood chip pieces were stuck to the headboard frame it looked like when the bed was raised the headboard got caught on the chair rail and probably pulled it from the wall. The Maintenance Director stated that when the Interim Maintenance Director had done training with him on 4/27/26 he received a paper list of needed repairs, but the broken headboard was not on the list. When asked if he had seen an electronic workorder for the broken headboard the Maintenance Director revealed he had received basic education on the workorder system but was still learning how to use it and had not seen all the electronic work orders yet. An interview was conducted with the Business Office manager on 4/30/26 at 10:00 AM with the Maintenance Director present. She explained she was assisting the new Maintenance Director with training on the electronic system used by the maintenance department, which included work orders as well as other facility processes. The Business Office Manager also stated she had been helping staff to put work orders into the system during the time the Interim Maintenance Director had been coming in the afternoons to help him keep up with things since he was at the facility part time. The Business Office Manager revealed she had not seen any paper or electronic work orders about a cracked or broken headboard and no one had mentioned it to her before today. A telephone interview was conducted with the Interim Maintenance Director on 4/30/26 at 11:28 AM. The interim Maintenance Director stated he was the full time Maintenance Director at a sister facility and been coming to this facility since mid-March to help in the afternoons after their prior Maintenance Director had left. He explained the Interim Administrator had given him a list of priority projects to complete. The Interim Maintenance Director explained he remembered being aware of a broken headboard when a work order came across his phone at some point but did not remember the date and could not check because he didn't have current access to the system. He stated he had several large projects going on at the time and tried to knock out the smaller things when he could but did not remember looking at the headboard. The Interim	F0584		05/25/2026

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F0584 SS = D	Continued from page 8 Maintenance Director further explained he had seen the piece of broken headboard in the maintenance door box within the last week but there was no sticky note on it and he had not asked anyone about it. An interview was conducted on 04/30/26 at 11:36 AM with the Interim Administrator who stated she had filled in for the Administrator from 1/8/26 until 4/6/26. She explained having asked the Interim Maintenance Director from a sister facility to come help and had given him a list with some priority repair projects and from there he worked from the electronic workorder system. The Interim Administrator stated she had not been aware of any broken headboards during her time at the facility. The Interim Administrator further explained if equipment was broken that staff had been trained to put a workorder in the electronic work order system. She revealed during the time the Interim Maintenance Director was coming to help that she had asked staff to also do a paper work order so she would know what was needed even during times when there was no maintenance person immediately on-site. During an interview with the Administrator on 4/30/26 at 12:28 PM she explained the facility had been using a paper work order system but now the process was to put work orders in electronically and the staff had training on how to do this when they implemented the system a few months ago. The Administrator revealed she had been unaware of any resident headboards being broken since her return from leave a few weeks ago. She further explained Resident #14's broken headboard could have potentially caused injury and that residents needed a headboard for positioning and safety. The Administrator stated she was sorry that Resident #14's headboard had not been replaced sooner. The interview further revealed she had been unaware of any broken pieces of chair rail molding in resident rooms until today. She revealed a broken piece of molding could potentially cause a skin tear or bruising and they would look at replacing or removing the chair rail molding in rooms with problems. 2. An observation was made on 4/28/26 at 9:40 AM of the wall next to Resident #53's bed. The left side of the bed was directly against the wall. There was horizontal chair rail molding 18 inches above the mattress, protruding 2 inches from the wall which	F0584		05/25/2026

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F0584 SS = D	Continued from page 9 ran from the back wall to mid-way in the room at the privacy curtain. The chair rail molding had 12 gouges in the wood without paint and ended in a 45-degree point partly visible behind the privacy curtain where it was pulled away from the wall half an inch. From the privacy curtain to the rest of the distance to the front wall, a strip the width of the chair rail molding painted a different color was visible and had six half inch holes evenly spaced in the wall. Review of Resident #53's quarterly MDS on 3/2/26 revealed he was cognitively intact. In an interview with Resident #53 on 4/28/26 at 3:12 PM he stated the chair rail molding on the wall had been like that as long as he could remember and he had not spoken with anyone about it. An interview was completed with NA #1 on 4/30/26 at 10:29 AM who stated she had noticed a piece of chair rail molding was missing in Resident #53's room a few weeks ago and told the nurse but could not recall which nurse, who thought there had been a workorder in for that. NA #1 stated she had not known the piece of chair rail molding over Resident #53's bed was broken off to a point. In an interview with NA #4 on 4/30/26 at 10:30 AM room she explained she took care of Resident #53 but did not know the chair rail molding over Resident #53's bed had a sharp point sticking out from the wall. In an interview and observation with the Maintenance Director on 4/30/26 at 9:57 AM he stated he started at the facility on 4/27/26 and had not yet been in Resident #53's rooms and had not been aware of the broken chair rail moldings. He further explained no one had mentioned broken chair rail molding to him nor had he seen any work orders for Resident #53's room. During the interview the Maintenance Director stated the chair rail molding was there to stop damage on the wall from the headboards. In a follow-up interview and observation with the Maintenance Director on 4/30/26 at 10:46 AM in Resident #53's room, he observed the chair rail molding on the wall over Resident #53's bed and	F0584		05/25/2026

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F0584 SS = D	Continued from page 10 explained it had at least 12 gouges in the wood with no paint and the end was at a 45 angle to a point at the height of the headboard where the privacy curtain met the wall and was pulled out from the wall half an inch. He explained the point was from where a now missing piece of molding had joined with this piece and could be a hazard if someone were to bump into it. The Maintenance Director stated he did not know why there was a missing piece of chair rail molding, but it may have been damaged from a headboard or just came loose over time and the holes in the wall were from where screws had been. During an interview with the Director of Nursing (DON) on 4/30/26 at 11:16 AM she stated during orientation that staff had training from maintenance that included how to put in electronic work orders. She explained that training had been done with current staff but maybe some staff had forgotten how. The DON revealed it was important for staff to put in work orders for broken equipment or furnishings to prevent injury. In an interview with the Administrator on 4/30/26 at 12:28 PM she stated she had been unaware of any broken pieces of chair rail molding in resident rooms until today. She revealed a broken piece of molding could potentially cause a skin tear or bruising and they would look at replacing or removing the chair rail molding in rooms with problems.	F0584		05/25/2026
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F0636	F636 On 4/30/2026, The Minimum Data Set Nurse was provided education by the Regional Minimum Data Set Nurse Coordinator regarding completion of CAAs (care area assessments). On 4/28/2026 - 4/30/2026, The Minimum Data Set Nurse reopened and corrected section V for resident # 4, #9, and #65. On 4/30/2026, The Minimum Data Set Nurse and the Regional Minimum Data Set Nurse Coordinator completed a 100% audit of all comprehensive assessments with an ARD in the last 30 days to ensure care area assessments are complete and contain required clinical narratives. All residents with comprehensive assessments due have the potential to be affected. Any additional identified residents were corrected at that time.	05/25/2026

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F0636 SS = D	Continued from page 11 (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F0636	Continued from page 11 On 4/30/2026, The Regional Minimum Data Set Nurse educated the Interdisciplinary Team regarding the care area assessment process. Any newly hired Interdisciplinary Team members will be educated on the Care Assessment process during the new hire orientation process by the Minimum Data Set Nurse or designee. Any newly hired Minimum Data Set Nurse will be educated by the Regional Minimum Data Set Nurse during the new hire orientation process. Beginning 4/30/2026, The facility has implemented a standardized care area assessment Clinical Analysis Template within the electronic health record (PCC) to prompt the interdisciplinary team to address the Why, How, and Risk rather than just repeating MDS data. As well as a new triple check meeting that will occur 48 hours prior to the completion- deadline for all comprehensive assessments. During this meeting, the Minimum Data Set Nurse and Interdisciplinary Team (IDT) will verify that all triggered care area assessments are signed, dated, and contain a clinical analysis. To ensure the deficient practice will not reoccur, begin 5/18/2026 The Regional Minimum Data Set Nurse/Travel Minimum Data Set Nurse or designee will audit 5 comprehensive assessments (or 100% if less than 5 per week) then 5 comprehensive assessments monthly for 2 months to ensure Care Area Assessments (CAAs) completion accuracy. The Minimum Data Set Nurse or Designee will provide the results to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. Date of Compliance: 5/25/2026	05/25/2026

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F0636 SS = D	Continued from page 12 (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive Care Area Assessment (CAA) to address the underlying causes and contributing factors of the triggered areas for 3 of 3 residents reviewed for comprehensive assessments (Resident #4, Resident #65 and Resident #9). The findings included: 1. Resident #4 was admitted to the facility on 2/17/26 with diagnoses that included myocardial infarction (heart attack), peripheral vascular disease, generalized anxiety disorder and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated 2/24/26 indicated Resident #4 was cognitively intact. A review of the Care Area Assessment summary of the admission MDS assessment dated 2/24/26 indicated a total of 6 care areas were triggered for Resident #4. The assessment did not include any information in the analysis of findings for 6 of the 6 triggered areas to describe the nature of Resident #4's problems, possible causes, contributing factions, risk factors related to the care area and reasons to proceed with care planning for the following triggered care areas: functional abilities, urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer/injury and psychotropic drug use. An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed that when she completed Resident #4's admission MDS, she did not know how to fill out and complete the CAA. The MDS Coordinator stated that after going through an online training on MDS a couple of weeks ago, she now had a better understanding about the CAA, and she learned that she had to explain the rationale behind care planning for the triggered care areas and if there were other issues that needed to be addressed. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed both of them received an education about the CAA today and understood that the CAA should have been completely filled out by the MDS Coordinator.	F0636		05/25/2026

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F0636 SS = D	Continued from page 13 2. Resident #65 was admitted to the facility on 3/21/26 with diagnoses that included chronic obstructive pulmonary disease, diabetes, schizoaffective disorder and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated 3/28/26 indicated Resident #65 was cognitively intact. A review of the Care Area Assessment summary of the admission MDS assessment dated 3/28/26 indicated a total of 7 care areas were triggered for Resident #65. The assessment did not include any information in the analysis of findings for 7 of the 7 triggered areas to describe the nature of Resident #65's problems, possible causes, contributing factions, risk factors related to the care area and reasons to proceed with care planning for the following triggered care areas: cognitive loss/dementia, functional abilities, urinary incontinence and indwelling catheter, behavioral symptoms, nutritional status, pressure ulcer/injury and psychotropic drug use. An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed that when she completed Resident #65's admission MDS, she did not know how to fill out and complete the CAA. The MDS Coordinator stated that after going through an online training on MDS a couple of weeks ago, she now had a better understanding about the CAA, and she learned that she had to explain the rationale behind care planning for the triggered care areas and if there were other issues that needed to be addressed. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed both of them received an education about the CAA today and understood that the CAA should have been completely filled out by the MDS Coordinator. 3. Resident #9 was admitted on 10/27/25 with diagnoses which included vascular dementia, psychotic disturbance and mood disturbance. Resident #9's physician orders included one dated 1/14/26 for quetiapine fumarate (an antipsychotic medication) 25 milligrams (mg) give 2 tablets at bedtime for paranoid delusion. Resident #9's Care Area Assessment (CAA)	F0636		05/25/2026

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F0636 SS = D	Continued from page 14 summary for the significant change in status Minimum Data Set (MDS) assessment dated 1/22/26 was reviewed. For the triggered area of Psychotropic Drug Use the CAA summary was checked for Care Planning Decision but was blank and without documentation supporting the reason for care planning. On 4/29/2026 at 2:48 PM the MDS Coordinator stated she began working as the MDS Coordinator on 12/25/25 and didn't know how to complete CAAs. She stated she completed Resident #9's MDS assessment dated 1/22/26 and did not complete Resident #9's CAA on the comprehensive assessment. The MDS Coordinator added, she had received education recently and now knows she should have completed it. During an interview on 4/30/26 at 3:10 PM the Administrator stated the MDS Coordinator had not received enough education on how to complete the CAAs and recently had been educated on completing them.	F0636		05/25/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F0641	F641 On 4/30/2026, The Minimum Data Set Nurse modified assessments for residents # 18, #4, and #9. On 4/30/2026, The Minimum Data Set Nurse and the Regional Minimum Data Set Nurse Coordinator completed a 100% audit of all comprehensive assessments with an Assessment Reference Date (ARD) in the last 30 days to ensure accuracy. All residents with comprehensive assessments due have the potential to be affected. Any additional identified residents were corrected at that time. On 4/30/2026 The Minimum Data Set Nurse was provided education by the Regional Minimum Data Set Nurse Coordinator regarding MDS Accuracy. Any newly hired Minimum Data Set Nurse will be educated by the Regional Minimum Data Set Nurse during the new hire orientation process. Beginning 4/30/26 the facility implemented a new process related to accuracy validation that will occur 48 hours prior to the completion- deadline for all assessments. During this time, the Minimum Data Set Nurse will review the assessment before closing for accuracy.	05/25/2026

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F0641 SS = D	Continued from page 15 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications (Resident #18 and Resident #4) and alarms (Resident #9) for 3 of 9 residents whose MDS were reviewed. The findings included: 1.Resident #18 was admitted to the facility on 3/19/14. A review of the physician's orders in Resident #18's medical record indicated no order for an anticoagulant. The quarterly MDS dated 1/30/26 indicated Resident #18 was taking an anticoagulant. An anticoagulant, also known as a blood thinner, is a medication that helps prevent blood clots from forming or growing larger. A review of the Medication Administration Record for Resident #18 for January 2026 indicated he did not receive an anticoagulant. An interview with the MDS Coordinator on 4/29/26 at 3:27 PM revealed she made an error with coding Resident #18 as receiving an anticoagulant on the quarterly MDS. The MDS Coordinator stated she made the error because Resident #18 received an antiplatelet medication which she confused with a similar sounding generic name for an anticoagulant. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed the MDS Coordinator should have coded Resident #18's quarterly MDS accurately. 2. Resident #4 was admitted to the facility on 2/17/26. A review of the physician's orders in Resident #4's	F0641	Continued from page 15 To ensure the deficient practice will not reoccur, begin 5/18/2026 The Regional Minimum Data Set Nurse/Travel Minimum Data Set Nurse or designee will audit 5 assessments (or 100% if less than 5 per week) then 5 assessments monthly for 2 months to ensure coding accuracy. The Minimum Data Set Nurse or Designee will provide the results to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. Date of Compliance: 5/25/2026	05/25/2026

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F0641 SS = D	Continued from page 16 medical record indicated no order for an anticoagulant. The annual MDS dated 2/24/26 indicated Resident #4 was taking an anticoagulant. An anticoagulant, also known as a blood thinner, is a medication that helps prevent blood clots from forming or growing larger. A review of the Medication Administration Record for Resident #4 for February 2026 indicated he did not receive an anticoagulant. An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed she made an error with coding Resident #4 as receiving an anticoagulant on the annual MDS. The MDS Coordinator stated that Resident #4 received an antiplatelet medication which she confused as an anticoagulant. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed the MDS Coordinator should have coded Resident #4's admission MDS accurately. 3. Resident #9 was admitted on 10/27/25 with diagnoses which included vascular dementia. Physician orders dated 1/4/26 included a wander alarm (a wearable electronic device that trigger door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #9's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. Resident #9's care plans included one dated 1/4/26 for elopement risk and wanderer related to dementia with attempts to leave the facility unattended. Interventions included the use of an electronic monitoring device. The care plan was written by the Activities Director. Resident #9's significant change in status MDS Assessment dated 1/22/26 did not indicate the use of a wander/elopement alarm. Resident #9's quarterly MDS dated 2/3/26 did not indicate the use of a wander/elopement alarm. On 4/29/26 at 2:48 PM the MDS Coordinator stated she was unaware Resident #9 had an order for a wander alarm and she had not correctly coded the MDS. She confirmed she had completed Resident #9's MDS assessments dated 1/22/26 and 2/3/26.	F0641		05/25/2026

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F0641 SS = D	Continued from page 17 The MDS Coordinator added that she began working as the MDS Coordinator on 12/25/25 and had missed the order for the wander alarm dated 1/4/26. On 4/30/26 at 3:10 PM the Administrator stated the wander alarm should have been captured on Resident #9's MDS assessments.	F0641		05/25/2026
F0914 SS = D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to repair a privacy curtain track which prevented the privacy curtain from extending around a resident's bed to provide total visual privacy. This deficient practice occurred for 1 of 19 residents reviewed for privacy (Resident #29). Findings included: Resident #29 was admitted on 9/17/25. A review of Resident #29's quarterly Minimum Data Set (MDS) dated 4/7/26 coded her with moderate cognitive impairment. On 4/28/26 at 9:30 AM an observation of Resident #29's room found the privacy curtain on the track was unable to fully close. On 4/28/26 at 9:40 AM Resident #29 was interviewed. She stated she had not paid any attention to the privacy curtain and did not know how long it had not fully closed. On 4/29/26 at 3:20 PM an observation of Resident #29's privacy curtain track remained unchanged. On 4/29/26 at 3:32 PM Nursing Aide (NA) #1 stated Resident #29's privacy curtain had not been closing all the way for a couple weeks. She stated she did not know if a work order had been put in to repair	F0914	F914 On 4/29/2026, The Maintenance Director repaired the affected Privacy Curtain Track for resident #29. On 4/29/2026, The Maintenance Director completed a 100% audit of privacy curtain tracks in the facility. No other rooms were found affected at this time. Beginning on 5/19/2026, All staff to include contract staff were educated by The Executive Director/Designee on the process of recording work orders and reporting maintenance concerns. This education will be provided to any newly hired staff to include contract staff by the Maintenance Director/Designee during the new hire orientation process. Beginning 5/19/2026, A task has been added to facility Mock Survey Rounds to check room for safe environment i.e., broken chair rail, broken headboard, broken privacy curtain tracks, and any other maintenance concerns. On 5/19/2026, the Regional Vice President of Operations educated the Executive Director on Mock Survey Rounds to include checking for a safe environment i.e., broken chair rails, broken headboard, broken privacy curtain tracks, and any other maintenance concerns. On 5/20/2026, The Executive Director educated the facility leadership team which includes Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Social Services, Medical Records Coordinator, Maintenance Director, Activities Director, Human Resource Coordinator, Business Office Manager and Minimum Data Set Nurse on Mock Survey Rounds to include checking for a safe environment i.e. broken chair rails, broken headboard, broken privacy curtain tracks and any other maintenance concerns. To ensure the deficient practice will not recur, beginning 5/21/2026 the Executive Director and/or Designee will perform quality improvement monitoring on Mock Survey Rounds 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. Results of Mock Survey	05/25/2026

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F0914 SS = D	Continued from page 18 the curtain track and she had not put in a work order for the curtain track. She stated multiple NAs and Nurses had provided care to the resident and she assumed one of them had put in a work order to repair the track. On 4/29/26 at 3:34 PM the Maintenance Manager stated he was new to the facility and was unaware Resident #29's privacy curtain track needed repair. He stated he was in the process of looking through work orders and did not know if a work order had been submitted. On 4/29/26 at 3:37 PM Nurse #1 stated she was unaware Resident #29's privacy curtain track could not fully close. She stated she would put in a work order. On 4/30/26 at 3:10 PM the Administrator stated in February 2026 a water line had burst in the ceiling that caused damage to some rooms. She stated Resident #29's privacy curtain track may have been damaged at that time. The Administrator indicated the facility had been using paper work orders at that time and had switched to electronic work orders since then. She did not know the privacy curtain track needed repair and was unaware if a work order had been submitted. The Administrator said the privacy curtain track should have been reported on a work order when it was discovered to be not working properly.	F0914	Continued from page 18 Rounds to be brought to morning meeting Monday through Friday. The Maintenance Director will ensure that identified needs have been placed on work orders and on a schedule for repair. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. Date of Compliance: 5/25/2026	05/25/2026
F0838 SS = C	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to:	F0838	F838 On 5/11/2026, The Executive Director reviewed and updated the facility assessment. This has the potential to affect all residents in the facility; however, no residents were affected at this time. On 4/30/2026 the Regional Vice President of Operations re-educated the Executive Director on the importance of reviewing and updating the facility assessment at a minimum of once per year and as needed. Any newly hired Executive Directors will be educated by the Regional Vice President of Operations during orientation. To ensure continued compliance, the Executive Director/designee will:	05/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345426	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care and Rehabilitation	**551 Kent Street , Andrews, North Carolina, 28901**

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F0838 SS = C	Continued from page 19 (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.	F0838	Continued from page 19 Perform quarterly audits of the Facility Assessment to verify: Required elements are present. Any changes have been updated timely. The Executive Director will present a quarterly review to the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee consists of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Services, and Minimum Data Set Nurse and a minimum of one direct care giver. This plan was approved by an AD HOC QAPI Meeting on 5/11/2026. Date of Compliance: 5/25/2026	05/25/2026

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F0838 SS = C	Continued from page 20 §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect	F0838		05/25/2026

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F0838 SS = C	Continued from page 21 resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to review and update the Facility Assessment annually. This had the potential to affect all residents residing in the facility. The findings included: Review of the Facility Assessment revealed it was dated 3/20/25 and there was no documentation to show the assessment had been reviewed and updated since that time or annually. On 4/30/26 at 11:48 AM an interview was held with the Administrator. She stated that she had been on medical leave from some time in November 2025 until April of this year. The Administrator stated that there was an Interim Administrator that covered her position for her when she was on medical leave. The interview further revealed the Administrator knew the facility assessment was due but did not pass this information on to the Interim Administrator. Her plan was to go over the Facility Assessment at next week's Quality Assurance & Performance Improvement (QAPI) meeting. On 4/30/26 at 12:02 PM an interview was conducted with the Interim Administrator. She stated that she was the Interim Administrator for the month of March 2026 and she had not been made aware that the Facility Assessment needed to be updated by 3/20/26.	F0838		05/25/2026