STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345356	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET , RICH SQUARE, North Carolina, 27869

(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
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 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:	E0001	E0001 How corrective action will be accomplished for resident(s) found to have been affected. No residents were affected by the deficient practice. How corrective action will be accomplished for resident(s) found to have been affected. All residents have the potential to be affected by the deficient practice What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/18/25 the administrator updated the Emergency Preparedness Plan to address the types of service the facility provides. The administrator updated the names and contact information for administrative staff on 07/08/25. The Emergency Preparedness Plan will include the means for providing the facility's occupancy, needs and its ability to provide assistance to the authority having jurisdiction. The Administrator included the documentation of staff education in the Preparedness Plan book. On 07/18/25 the Administrator conducted a full-scale facility elopement exercise in compliance with the emergency plan requirements. On 07/08/25 the administrator initiated annual education on Emergency Preparedness Plan to staff that included activation of the Emergency Preparedness Plan. On 07/08/25 the Regional Director of Clinical Services reviewed the facility policy and re-educated the administrator on requirements on maintaining a	07/21/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345356	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

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E0001 SS = F	Continued from page 1 This CONDITION is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to address the types of services the facility had the ability to provide in an emergency including delegations of authority, failed to have names and contact information for staff and resident physician, failed to have a method for sharing information on occupancy and needs, failed to provide annual education for the emergency prep training program, and failed to conduct emergency prep testing as required. The findings included: A review of the facility's Emergency Preparedness (EP) plan was conducted on 7/02/25 and was noted as updated on 1/20/25. The EP plan revealed the following: a. The EP plan did not address the types of services the facility had the ability to provide in an emergency, and continuity of operations which included delegation of authority and succession plans. b. The EP plan did not include updated names and contact information for administrative staff which included the Administrator, Director of Nursing, Social Services, Admissions Director, Business Office Manager, Minimum Data Set Nurse, Housekeeping Director, and Medical Director. c. The EP plan did not include a include a means for providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. d. The EP plan revealed no documentation regarding annual training to staff or contracted providers. e. The EP plan did not include facility participation in a full-scale exercise that was community based or facility based within the last 12 months. An interview was conducted with the Administrator on	E0001	Continued from page 1 comprehensive Emergency preparedness Plan. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator will monitor to ensure that through observation and review that the Emergency preparedness Plan is maintained. This monitoring process will take place weekly for 4 weeks and then monthly thereafter. The administrator will report findings of the monitoring process monthly to the QAPI Committee and Regional Director.	

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E0001 SS = F	Continued from page 2 07/02/25 at 12:03 PM. The Administrator stated she briefly reviewed the EP plan when she began working at the facility in March 2025, but she did not fully review the information to make sure everything was updated and in place. The Administrator stated she and the Maintenance Director would be responsible to ensure the EP plan was current and complete. The Administrator stated she was unable to provide any documentation that the EP plan education was completed within the last year. The Administrator reported the facility had not participated in any community-based or facility-based full-scale exercises that she was aware of and she had no documentation regarding any exercises. The Administrator stated she would check to see if she could find any information. The Administrator was unable to provide any further documentation at the time of survey exit regarding the EP plan.	E0001		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/30/2025 through 07/02/2025. Event ID # EP6811. The following intake was investigated: NC 00230771. 2 of 2 complaint allegations did not in a deficiency.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or	F0578	F-578 Advance Directives How corrective action will be accomplished for resident(s) found to have been affected. Resident 1 was identified as being affected by the deficient practice for not having documented advance directives education noted in chart. On 07/17/25 the Administrator educated resident and daughter on resident's rights to form advance directives and documented their decision for resident to remain a full code. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed All residents of the facility have the potential to be affected by this practice.	07/21/2025

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F0578 SS = D	Continued from page 3 surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff and Nurse Practitioner interviews, the facility failed to provide written information to the resident and/or resident representative pertaining to their right to accept or refuse medical/surgical treatment and the opportunity to formulate an Advance Directive for 1 of 7 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 2/8/2008 with diagnoses that included high blood pressure and a history of a stroke. A quarterly Minimum Data Set assessment dated 4/16/2025 revealed Resident #1 was cognitively intact. Review of Resident #1's electronic medical record revealed a full code Physician order dated 4/22/2025. There was no documentation in the record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered to the resident or resident representative.	F0578	Continued from page 3 On 7/11/25 an advance directives audit was initiated by Social Services on all current residents for compliance with facility policy and no further deficiencies were noted. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/08/25 the Administrator and Regional Director reviewed the facility policy and provided education to the Admissions Director and Director of Nursing on advance directives in accordance with facility policy. Beginning 07/08/25 all residents/representatives will receive advance directives education, and their decision documented upon admission by the Admission Director or Admissions Nurse per facility policy. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Admissions Director will review all admissions monthly for advance directives documentation and report findings to QAPI Committee. Results will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F0578 SS = D	Continued from page 4 An interview was completed on 7/1/2025 at 10:35 am with Resident #1. The Resident was unable to recall if she received education regarding the right to formulate an advance directive. An interview was completed on 7/2/2025 at 11:42 am with the Administrator. The Administrator revealed approximately 2 months ago the facility's Nurse Practitioner (NP) provided education regarding advance directives and treatment via phone call to Resident #1's Representative. The Administrator stated the NP revealed she had forgotten to document the conversation in Resident #1's medical record. The Administrator stated it was her expectation facility residents or resident representatives were educated on advance directives and those conversations documented in their medical record. An interview was completed on 7/2/2025 at 11:48 am with the facility's NP. The NP stated in May 2025 she had a telephone conversation with Resident #1's Representative and provided education on advance directives and treatment due to Resident #1's gradual decline in health. The NP stated she had forgotten to document the conversation in Resident #1's medical record. Attempts to contact Resident #1's Representative were unsuccessful.	F0578		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F0582	F-582 Advance Beneficiary Notice How corrective action will be accomplished for resident(s) found to have been affected. Residents 19 and 108 were found to be affected by the deficient practice. On 07/02/25 resident 19 was informed of payment status and failure to provide the ABN timely as of the resident's last covered day on 03/05/25. Resident 108 has been discharged. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed:	07/21/2025

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F0582 SS = D	Continued from page 5 changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary notification (Resident #19 and Resident #108). The findings included:	F0582	Continued from page 5 All residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. An audit was conducted by Social Services and the Business Office Manager on current residents who were admitted in the past six months and met criteria to receive an ABN to ensure compliance. Corrective actions were completed on 07/18/25. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/02/25 the Administrator and the Regional Director reviewed the facility policy and educated the Business Office Manager and Social Services Director on the facility’s Advance Beneficiary Notices policy. All newly hired Social Service Directors and Business Office Managers will receive training upon hire by the Administrator on the Advance Beneficiary Notice policy. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator or designee will audit all residents that meet criteria for an ABN weekly x 4 weeks, then monthly to verify that notices were issued timely and appropriately. Audits will be reviewed by the QAPI committee monthly and changes implemented as needed to maintain compliance.	

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F0582 SS = D	Continued from page 6 1. Resident #108 was admitted to the facility on 111/7/24. Medicare Part A services began on 11/7/24. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #108 on 1/28/25, which indicated Resident #108's Medicare Part A coverage for skilled services would end on 1/25/25. Resident #108 remained in the facility. Review of Resident #108's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #108. An interview was conducted with the Business Office Manager 7/01/25 at 1:32 PM. He revealed that when Resident #108 was admitted from the hospital on 11/7/24, she was billed for the month of October 2024 and the first week of November 2024. However, the previous facility billing was not finalized yet, so they billed Resident #108 based on her recollection of admission history. The last day of coverage for Medicare Part A was 8/30/24, which needed a 60-day reset. Based on that history, she had cleared 60 days of reset for all 100 days to be available when she was admitted to the nursing facility. At the time, that was what the Business Office Manager thought was accurate. All services were provided and billed accordingly, and the last covered day was initially 1/25/25. When the claims for January and February were paid in March 2025, the Business Office Manager found out on 3/19/25 that she already had passed the 100 days 5 days earlier than they thought. The services from 9/1/24 through 9/6/24 were not included. Therefore, the last covered day had changed. The Business Office Manager stated that he then billed Medicare Part B instead of Medicare Part A. During a follow-up interview with the Business Office Manager on 7/01/25 at 11:00 AM, he stated the Social Worker (SW) was responsible for issuing the SNF ABN, and this was something the previous SW used to take care of it. The SW was interviewed on 7/01/25 at 11:02 AM. She stated that she was only responsible for the NOMNC document, and the Business Office Manager was responsible for issuing the SNF ABN.	F0582		

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F0582 SS = D	Continued from page 7 An interview was conducted with the Administrator on 7/01/25 at 11:06 AM. She stated that she began at the facility in March 2025, but it was her understanding that the SW was responsible for issuing all the Beneficiary Notices. During a follow-up interview with the Administrator on 7/02/25 at 10:04 AM, she revealed that she forgot to instruct the current SW to also provide the SNF ABN with the NOMNC when a resident remained in the facility. The previous SW must have included the SNF ABN in her workload, but that was not communicated to the current SW. 2. Resident #19 was admitted to the facility on 1/27/25. Medicare Part A services began on 1/27/25. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #19 on 3/3/25, which indicated Resident #19's Medicare Part A coverage for skilled services would end on 3/5/25. Resident #19 remained in the facility. Review of Resident #19's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #19. An interview was conducted with the Business Office Manager on 7/01/25 at 11:00 AM, He stated the Social Worker (SW) was responsible for issuing the SNF ABN, and this was something the previous SW used to take care of it. The SW was interviewed on 7/01/25 at 11:02 AM. She stated that she was only responsible for the NOMNC document, and the Business Office Manager was responsible for issuing the SNF ABN. An interview was conducted with the Administrator on 7/01/25 at 11:06 AM. She stated that she began at the facility in March 2025, but it was her understanding that the SW was responsible for issuing all the Beneficiary Notices. During a follow-up interview with the Administrator on	F0582		

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F0582 SS = D	Continued from page 8 7/02/25 at 10:04 AM, she revealed that she forgot to instruct the current SW to also provide the SNF ABN with the NOMNC when a resident remained in the facility. The previous SW must have included the SNF ABN in her workload, but that was not communicated to the current SW.	F0582		
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	F0628	F-628 Discharge Notification to Ombudsman How corrective action will be accomplished for resident(s) found to have been affected. Residents 25 and 57 were found to be affected by the deficient practice. Both residents had been discharged to the hospital without notifying the Ombudsman in a timely manner. On 07/02/25 the Ombudsman was notified of discharges. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: All residents that discharge from the facility have the potential to be affected by the deficient practice. On 7/11/25 an audit for all discharges in past 3 months was completed by the Administrator and any discharges to be submitted to Ombudsman were completed. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 7/02/25 the Administrator and Regional Director reviewed the facility policy for compliance and provided education to the Social Service Director on notifying the Ombudsman of resident discharges according to facility policy. The Social Service Director will include Administrator in monthly transmission to Ombudsman beginning 07/11/25. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator will monitor monthly transmission to Ombudsman for compliance. Results will be reported to	07/21/2025

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F0628 SS = B	Continued from page 9 of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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;	F0628	Continued from page 9 the QAPI committee monthly. Any changes will be implemented as needed to remain in compliance.	

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RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET , RICH SQUARE, North Carolina, 27869

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F0628 SS = B	Continued from page 10 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as 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	F0628		

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F0628 SS = B	Continued from page 11 facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to notify the Ombudsman in writing of a	F0628		

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F0628 SS = B	Continued from page 12 resident transfer to the hospital for 2 of 2 residents reviewed for hospitalization (Resident #25 and Resident #57). The findings included: 1.a. Resident #25 was admitted to the facility on 7/01/24. The nursing progress note dated 8/19/24 revealed Resident #25 was transferred to the hospital for further evaluation of chest pain and difficulty breathing. The medical record indicated Resident #25 was discharged from the facility on 8/19/24 and returned to the facility on 9/06/24. The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. b. The nursing progress note dated 9/13/24 revealed Resident #25 was transferred to the hospital for further evaluation of altered mental status and low blood pressure. The medical record indicated Resident #25 was discharged from the facility on 9/13/24 and returned to the facility on 9/18/24. The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. c. The nursing progress note dated 11/22/24 revealed Resident #25 was transferred to the hospital for further evaluation of shortness of breath. The medical record indicated Resident #25 was discharged from the facility on 11/22/24 and returned to the facility on 11/26/24.	F0628		

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F0628 SS = B	Continued from page 13 The facility was unable to provide documentation regarding notification to the Ombudsman of Resident #25's transfer to the hospital. Attempts to conduct a telephone interview with the previous Social Worker on 7/01/25 at 12:25 pm and 7/02/25 at 11:34 am were unsuccessful. An attempt to conduct a telephone interview with the Ombudsman on 7/01/25 at 1:10 pm was unsuccessful. An interview was conducted with the Administrator on 7/01/25 at 11:40 am who revealed she was unable to locate the previous Social Worker's documentation regarding notification to the Ombudsman for Resident #25's hospitalizations because she believed the previous Social Worker took items when she left the facility. 2. Resident #57 was admitted to the facility on 5/15/25. The nursing progress note dated 5/21/25 revealed Resident #57 was transferred to the hospital for further evaluation of abnormal laboratory results. The medical record indicated Resident #57 was discharged from the facility on 5/21/25 and returned to the facility on 6/02/25. An interview was conducted with the Social Worker on 7/01/25 at 1:00 pm who revealed she was unable to locate the Ombudsman notification for Resident #57's transfer to the hospital on 5/21/25. The Social Worker stated she normally emailed the list to the Ombudsman but she was unable to find any record that information was sent to the Ombudsman for the May 2025 discharges and transfers. The Social Worker stated she must have just let it slip by without sending it to the Ombudsman. An attempt to conduct a telephone interview with the Ombudsman on 7/01/25 at 1:10 pm was unsuccessful. During an interview with the Administrator on 7/01/25	F0628		

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F0628 SS = B	Continued from page 14 at 11:40 am she stated the facility was unable to locate any documentation that the Social Worker notified the Ombudsman of Resident #57's transfer to the hospital. The Administrator stated the Social Worker was responsible to submit the information to the Ombudsman as required.	F0628		
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 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 observations, record review, and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas	F0641	F-641 Accuracy of Assessments How corrective action will be accomplished for resident(s) found to have been affected. Residents 45,6, and 25 were affected by the deficient practice. A modification of MDS dated 04/19/25 for resident 45 was completed on 07/16/25 to reflect anticonvulsant medication usage. A modification of MDS dated 05/27/25 for resident 6 was completed on 07/18/25 to reflect the removal of mechanically altered diet. A modification of MDS dated 06/27/25 for resident 25 was completed on 07/07/25 to reflect use of hearing aide. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: All residents have the potential to be affected by the deficient practice. An audit was completed on 07/18/25 by the Reimbursement Nurse to ensure that all current residents receiving anticonvulsant medications were accurately coded on the last MDS assessment. Any additional inaccuracies identified were corrected. An audit was completed on 07/18/25 by the Reimbursement Nurse to ensure that all current residents' diets were accurately coded on the last MDS assessment. Any additional inaccuracies identified were corrected. An audit was completed on 07/18/25 by the Reimbursement Nurse to ensure that all current residents that used hearing aids during their interview for section B were accurately coded on the last MDS assessment. Any additional inaccuracies were corrected. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?	07/21/2025

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F0641 SS = D	Continued from page 15 of use of anticonvulsant medication (Resident #45), resident prescribed diet (Resident #6), and use of a hearing aid (Resident #25) for 3 of 21 residents whose MDS assessments were reviewed. The findings included: 1. Resident #45 was admitted to the facility on 1/10/24 with diagnoses which included Alzheimer's Disease and cerebrovascular disease. Resident #45 had a physician order dated 2/01/24 for gabapentin (an anticonvulsant medication also used to treat pain) capsule 300 milligrams (mg) give one capsule by mouth at bedtime for pain. Resident #45 had an active physician order dated 2/29/24 for divalproex sodium tablet delayed release (an anticonvulsant medication) 250 mg; give 2 tablets once time a day for mood disorder related to dementia. The Minimum Data Set (MDS) quarterly assessment dated 4/19/25 revealed Resident #45 had severe cognitive impairment and was not coded for the use of anticonvulsant medication. Review of the April 2025 Medication Administration Record (MAR) revealed Resident #45 was administered the gabapentin and divalproex sodium medications as ordered. An interview was conducted on 7/02/25 at 10:44 am with the MDS Nurse who confirmed Resident #45 was administered the anticonvulsant medication during the look back period of the MDS assessment. The MDS Nurse stated she must have just missed the anticonvulsant medication when she completed Resident #45 medication section of the MDS assessment. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #45's medications were coded accurately. 2. Resident #6 was admitted to the facility on	F0641	Continued from page 15 On 07/08/25 the Regional Nurse Consultant reviewed the facility policy and re-educated the MDS nurse and dietary manager regarding the need for accurate coding on the MDS to reflect anticonvulsant usage, correct diet, and use of hearing aids during section B interviews. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Regional Nurse will audit MDS assessments weekly for 4 weeks and then monthly thereafter to ensure anticonvulsant usage, diets, and hearing aid use are accurately coded. Any inaccuracies will be corrected immediately. The audit results will be reported to the QAPI committee monthly. The QAPI committee review and make changes as needed to ensure the facility remains in compliance.	

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F0641 SS = D	Continued from page 16 11/21/14. Resident #6 had an active physician order dated 4/28/25 for a regular diet, regular texture, thin (regular) liquid consistency. The Minimum Data Set (MDS) quarterly assessment dated 5/27/25 revealed Resident #6 was cognitively intact, had no swallowing issues, and was coded for a mechanically altered diet. During an observation of the lunch meal on 7/01/25 Resident #6 was observed to have a regular texture diet with thin liquids which was confirmed by the meal ticket. An interview was conducted with the MDS Nurse on 7/02/25 at 10:44 am who revealed the Dietary Manager completed the section regarding diet for Resident #6. The MDS Nurse stated she was not responsible for coding Resident #6's diet and she was not responsible for reviewing the section since it was completed by the Dietary Manager. During an interview on 7/02/25 at 11:22 am the Dietary Manager confirmed Resident #6 did not have a mechanically altered diet but was ordered a regular diet. The Dietary Manager stated she coded Resident #6's diet in error when she completed the MDS assessment. The Administrator was interviewed on 7/02/25 at 11:55 am and revealed the Dietary Manager was responsible to ensure Resident #6's diet was coded accurately on the MDS assessment. 3. Resident #25 was admitted to the facility on 7/01/24 with diagnoses which included cognitive communication deficit. Review of the Minimum Data Set (MDS) annual assessment dated 6/02/25 revealed Resident #25 was cognitively intact and was not coded for use of a hearing aid. An observation and interview with Resident #25 was	F0641		

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F0641 SS = D	Continued from page 17 conducted on 6/30/25 at 10:48 am. Resident #25 was observed sitting in a wheelchair near the television with a hearing aid in the left ear and a hearing aid noted outside the right ear and attached to a clip. Resident #25 stated he normally took out the hearing aids when sleeping or he didn't want to hear all the noise, but he did use them throughout the day. An observation was conducted on 7/01/25 at 1:58 pm of Resident #25. Resident #25 was noted to be sleeping with his hearing aids in the charging station on the bedside table. An interview was conducted with the MDS Nurse on 7/02/25 at 10:35 am who revealed she did not recall Resident #25 with hearing aids when she completed the hearing section of the MDS assessment. The MDS Nurse stated she was not aware Resident #25 used hearing aids. An interview was conducted on 7/02/25 at 11:05 am with Nurse Aide (NA) #1 who revealed he was assigned to Resident #25 on the days he worked and knew the resident well. NA #1 stated Resident #25 had hearing aids that he used and was able to put them in and take them out as he liked. NA #1 stated Resident #25 was hard of hearing, and he had the hearing aids for as long as he could remember. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #25's assessment was coded accurately.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656	F-656 Comprehensive Care Plan How corrective action will be accomplished for resident(s) found to have been affected. Resident 45 was identified as being affected by the deficient practice for inaccuracies in his care plan. On 07/02/25 the MDS coordinator updated the care plan for Resident 45. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed	07/21/2025

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F0656 SS = D	Continued from page 18 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to develop a person-centered care plan in the areas of use of side rails for positioning (Resident #45), and hearing loss with use of a hearing aid (Resident #25) for 2 of 21 residents whose care plans were reviewed. The findings included: 1. Resident #45 was admitted to the facility on 1/10/24	F0656	Continued from page 18 All residents of the facility have the potential to be affected by this practice. On 7/10/25 comprehensive care plan audit was initiated by the MDS Nurse and Regional Nurse on all current residents for compliance with care plan policy and all discrepancies were corrected. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/02/25 the Administrator and Regional Director reviewed the facility policy and provided education to the MDS Nurse on Comprehensive Care Plan compliance in accordance with facility policy. The Director of Nursing and MDS Nurse will review care plan items during the daily clinical meeting and update as needed per policy beginning 07/18/25 and continuing as part of the routine meeting moving forward. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Regional Nurse will review a random sample of care plans weekly x 4 weeks, then monthly to assure compliance. Results will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F0656 SS = D	Continued from page 19 with diagnoses which included Alzheimer's Disease. The Side Rail Use Assessment dated 1/10/24 revealed Resident #45 requested side rails related to weakness to assist with turning, repositioning, and transfers. Resident #45 was noted to have 1/4 side rails to the upper bed bilaterally (both sides) while in bed. Review of Resident #45's care plan reviewed and updated on 5/08/25 revealed no care plan for the use of side rails for positioning. Observations were conducted on 6/30/25 at 10:50 am, 7/01/25 at 12:35 pm, and 7/02/25 at 9:03 am and Resident #45 was observed to be in bed with side rails to the upper portion of the bed bilaterally. An interview was conducted with the MDS Nurse on 7/02/25 at 10:44 am who revealed she was responsible for the development of resident care plans. The MDS Nurse stated she was new to the facility and did not recall if she was notified of Resident #45's use of side rails. The MDS Nurse stated Resident #45's use of side rails should have had a care plan in place but she did not recall if there was a care plan in place in the past. During an interview on 7/02/25 at 11:13 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible for resident care plans. The DON stated resident care plans were reviewed during care plan meetings and Resident 45 should have had a care plan in place for the use of side rails. An interview was conducted with the Administrator on 7/02/25 at 11:55 am. The Administrator revealed the MDS Nurse was responsible to review and develop resident comprehensive care plans. The Administrator stated the MDS Nurse was responsible to develop Resident #45's care plan for the use of side rails. 2. Resident #25 was admitted to the facility on 7/01/24 with diagnoses which included dementia with other behavioral disturbances. The Minimum Data Set (MDS) annual assessment dated	F0656		

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(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
F0656 SS = D	Continued from page 20 6/02/25 revealed Resident #25 was cognitively intact, was coded for adequate hearing without the use of a hearing aid. Resident #25's care plan last reviewed on 6/22/25 revealed no care plan for hearing loss or use of hearing aids. An observation and interview with Resident #25 was conducted on 6/30/25 at 10:48 am. Resident #25 was observed sitting in a wheelchair near the television with a hearing aid in the left ear and a hearing aid noted outside the right ear and attached to a clip. Resident #25 stated he normally took out the hearing aids when sleeping or he didn't want to hear all the noise, but he did use them throughout the day. An observation was conducted on 7/01/25 at 1:58 pm of Resident #25. Resident #25 was noted to be sleeping with his hearing aids in the charging station on the bedside table. An observation was conducted on 7/02/25 at 11:30 am of Resident #25 who was observed sitting in his room with both hearing aids in place watching television. An interview was conducted with the MDS Nurse on 7/02/25 at 10:35 am who revealed she did not recall Resident #25 with hearing aids when she completed the hearing section of the MDS assessment. The MDS Nurse stated she was not aware Resident #25 used hearing aids and she did not develop a care plan for the use of hearing aids or hearing impairment. An interview was conducted with the Director of Nursing (DON) on 7/02/25 at 11:13 am with the Director of Nursing (DON) who revealed the MDS Nurse was responsible to ensure Resident #25's care plan was developed for hearing loss and use of hearing aids. During an interview on 7/02/25 at 11:55 am with the Administrator she revealed the MDS Nurse was responsible to ensure Resident #25 had a care plan in place for the use of hearing aids.	F0656		
F0657 SS = D	Care Plan Timing and Revision	F0657	F-657 Care Plan Timing and Revision	07/21/2025

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F0657 SS = D	Continued from page 21 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: 2. Resident #45 was admitted to the facility on 1/10/24 with diagnoses which included Alzheimer's disease. Resident #45 had a physician order dated 3/05/24 for wander guard, check daily and ensure functioning properly every day, every shift for wandering. The wander guard order was discontinued on 4/16/25. The Minimum Data Set (MDS) quarterly assessment dated 4/19/25 completed by the MDS Nurse revealed Resident #45 had severe cognitive impairment and was not coded for the use of a wander/elopement alarm.	F0657	Continued from page 21 How corrective action will be accomplished for resident(s) found to have been affected. Resident 45 and 18 were identified as being affected by the deficient practice for not having updated care plans when a change in care/condition was noted. On 07/02/25 the MDS coordinator updated the care plan for Resident 45 and 18. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed All residents of the facility have the potential to be affected by this practice. On 7/10/25 comprehensive care plan audit was initiated by the MDS Nurse and Regional Nurse on all current residents for compliance with care plan policy and all discrepancies were corrected. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/02/25 the Administrator and Regional Director reviewed the facility policy and provided education to the MDS Nurse on Care Plan timing and revision compliance in accordance with facility policy. The Director of Nursing and MDS Nurse will review care plans during the daily clinical meeting and update as needed per policy beginning 07/18/25. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Regional Nurse will review a random sample of care plans weekly x 4 weeks, then monthly moving forward to assure compliance. Results will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F0657 SS = D	Continued from page 22 The care plan last reviewed on 5/08/25 revealed Resident #45 was an elopement risk/wanderer related to exit seeking behavior with an intervention which included a wander guard to the left ankle. An observation of Resident #45 was conducted on 6/30/25 at 2:28 pm and no wander guard alarm was observed on Resident #45's ankles or wrists. An interview was conducted on 7/02/25 at 10:44 am with the MDS Nurse who revealed she completed the MDS assessment section related to the wander/elopement alarm and that Resident #45 did not have a wander guard in place when she completed the MDS assessment. The MDS Nurse stated she did review and revise Resident #45's care plan quarterly but she must have missed the care plan for the wander guard when the review was completed. The MDS Nurse stated she should have revised Resident #45's care plan to reflect the wander guard was no longer in use. During an interview on 7/02/25 at 11:13 am with the Director of Nursing (DON) she revealed Resident #45 no longer required a wander guard and the MDS Nurse was responsible to review and revise Resident #45's care plan to accurately reflect his care needs. An interview was conducted with the Administrator on 7/02/25 at 11:55 am who revealed the MDS Nurse should have revised Resident #45's care plan when last reviewed and the wander guard was no longer ordered. Based on observations, record review, and staff interviews, the facility failed to revise the care plan in the areas of pain management, hypertension management, and anticoagulant (blood thinner) medication use (Resident # 18) and the use of a wander/elopement alarm (Resident #45) for 2 of 21 residents whose care plans were reviewed. The findings include: 1. Resident #18 was readmitted to the facility on 9/10/24 with diagnoses which included end stage renal disease (ESRD) with dependence on hemodialysis (HD), hypertension (HTN), and diabetes.	F0657		

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F0657 SS = D	Continued from page 23 Resident #18's physician orders revealed the following: - 9/10/24 Roxicodone oral tablet 5 milligrams (mg), give 1 tablet by mouth every 4 hours as needed for pain - 1/10/25 Amlodipine Besylate tablet 10 mg, give 1 tablet by mouth at bedtime for HTN - 6/6/25 Eliquis oral tablet 2.5 mg, give 1 tablet by mouth two times a day for Pulmonary Embolism (blockage of a lung artery) Review of Resident #18's care plan reviewed and updated on 5/8/25 revealed no care plan for the use of pain, hypertensive, and anticoagulant medications. An interview was conducted with the Minimum Data Set (MDS) Nurse on 7/01/25 at 1:40 PM. She revealed that she began working at the facility in April 2025. She explained she was responsible for updating the nursing sections of resident care plans and gave examples of problems that would be added to the revised care plan: wounds, new pain, falls, HTN medication, anticoagulant medication, etc. The MDS Nurse stated that she received information for care plan updates from the daily clinical meetings. She confirmed that Resident #18's care plan was missing the topics for pain, HTN, and anticoagulant medications. These medications for Resident #18 should have been discussed in the daily clinical meeting. The pain and HTN medications were ordered prior to her start date in April of this year, so she was not involved when those medications were initiated. However, the anticoagulant medication was added on 6/6/25, but she could not recall if the new medication was discussed in the daily clinical meeting. During an interview with the Director of Nursing (DON) on 7/02/25 at 9:44 AM, she revealed that the MDS Nurse was responsible for updating the nursing section of the care plan, and updates were discussed in the daily morning meeting. She stated that the anticoagulant medication should have been entered into the care plan when it was ordered on 6/6/25. However, the HTN and pain medications should have been added when Resident #18 was readmitted.	F0657		

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F0657 SS = D	Continued from page 24 The Administrator was interviewed on 7/02/25 at 10:00 AM. She revealed that the care plan for Resident #18 should have included the pain, HTN, and anticoagulant medications ordered by the physician. She indicated that all new initiated medications were discussed in the daily clinical meeting. The Administrator stated that she could not speak to why the pain and HTN medications were an issue because she started with the company on 3/27/25. However, the MDS Nurse told her that she missed the anticoagulant medication ordered for Resident #18 on 6/6/25 by mistake. The Administrator stated that the staff turnover in the nursing department could have also influenced communication.	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, Pharmacy Consultant and Nurse Practitioner (NP) interviews, the facility failed to clarify the physician orders for lidocaine 4% external pain patches that resulted in the pain patches remaining on the resident's skin over the manufacturer's recommended duration of 12 hours. This deficient practice was for 1 of 3 residents observed for medication administration (Resident #15). The findings included: Resident #15 was admitted to the facility on 10/12/15 with diagnoses which included pain unspecified and diabetes with neuropathy (nerve pain). Review of physician orders revealed an active physician order dated 2/18/24 for lidocaine 4% external pain patch. Apply to the left side topically one time a day for pain at 9:00 am; apply in the am and remove at bedtime and per schedule. The order noted the removal time as 8:59 am.	F0658	F-658 Professional Standards How corrective action will be accomplished for resident(s) found to have been affected. Resident 15 was identified as being affected by the deficient practice with the potential of being at increased risk for skin irritation/rash. On 7/01/25 Nurse 1 was re-educated by the Director of Nursing on lidocaine patch placement and removal in accordance with professional standards and manufactured recommendations. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: All residents have the potential to be affected by the deficient practice. On 07/01/25 the Regional Director reviewed the facility policy with the Director of Nursing to ensure compliance with recommended practices and found the policy to be accurate. On 07/01/25 the Director of Nursing reviewed all resident orders for Lidocaine patches to ensure each order had an application and removal time in compliance with professional standards. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/08/25 the Director of Nursing educated all	07/21/2025

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F0658 SS = D	Continued from page 25 In addition, there was an active physician order dated 4/30/25 for lidocaine external patch 4%. Apply to the right side topically one time a day for right side pain. The order did not specify a removal time. The manufacturer's instructions written on the Lidocaine 4% external pain patch package stated to use one patch for up to 12 hours and discard patch after single use. During a continuous medication administration observation on 7/01/25 at 8:14 am through 8:37 am, Nurse #1 was observed to prepare and date a lidocaine 4% external pain patch to apply to Resident #15's left side. Nurse #1 was then noted to remove a lidocaine external pain patch from Resident #15's left side dated 6/30/25 and throw the used patch in the trash can. Nurse #1 applied the new lidocaine 4% external pain patch to the same area of Resident #15's left side. Next, Nurse #1 was observed to prepare and date another lidocaine 4% external pain patch to apply to Resident #15's right side. Nurse #1 was then noted to remove a lidocaine external pain patch from Resident #15's right side dated 6/30/25 and throw the used patch in the trash can. Nurse #1 applied the new lidocaine 4% external pain patch to the same area of Resident #15's right side. Resident #15's skin was observed to be intact without redness or irritation. An immediate interview was conducted with Nurse #1 on 7/01/25 at 8:37 am who revealed she normally removed Resident #15's lidocaine 4% external pain patches from the previous day just before she applied the new one. She stated the time of removal for the left pain patch was listed for 8:59 am and the new patch was ordered to be administered at 9:00 am. Nurse #1 stated the right lidocaine external patch was not ordered to be removed at any certain time, so she removed it before she applied the new one. Nurse #1 stated she thought the lidocaine external patch was only supposed to be used for 12 hours but she did not clarify the orders with a physician to see if a removal time was needed. A telephone interview was conducted with the Pharmacy Consultant on 7/02/25 at 2:52 pm who revealed Resident #15's lidocaine 4% external pain patch was to be removed after 12 hours, and the next patch should not be placed for another 12 hours: 12 hours on 12 hours off. The Pharmacy Consultant stated that when a lidocaine 4% external pain patch remained in place continuously without the 12-hour time frame to remove the patch, the resident was at risk for skin rash or	F0658	Continued from page 25 licensed nurses and medication aides on lidocaine patch placement and removal in accordance with professional standards and manufactured recommendations. All Licensed Nurses and medication aides will receive professional standards and proper medication management upon hire and annually. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing or designee will audit all Lidocaine patch orders weekly x 4 weeks to ensure compliance with standards. All new orders will be audited thereafter as part of daily clinical meeting. The Director of Nursing will report the audit results to the QAPI committee monthly. The QAPI committee will review and make changes as needed to ensure the facility remains in compliance.	

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F0658 SS = D	Continued from page 26 irritation at the site where the patch was applied. An interview was conducted with the Nurse Practitioner (NP) on 7/02/25 at 9:27 am who revealed Resident #15's lidocaine 4% external pain patch order should have included a removal time of 12 hours after application. The NP stated she did not realize the order did not have a removal time so that Resident #15 would have 12 hours with the lidocaine 4% external pain patch off the skin. During an interview on 7/01/25 at 3:15 pm with the Director of Nursing (DON) she revealed the orders for Resident #15's lidocaine 4% external pain patches to the left and right side were not accurate and should have included to remove the patches after 12 hours. She stated the order should have specified to apply the patch at 9:00 am and remove at 9:00 pm. The DON stated physician orders were reviewed during the clinical meetings but she did not recall seeing that Resident #15's orders for the lidocaine 4% external pain patches did not include to remove after 12 hours of use.	F0658		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F0692	F-692 Nutrition and Hydration Status Maintenance How corrective action will be accomplished for resident(s) found to have been affected. Resident 45 was identified as being affected by the deficient practice for not receiving dietary supplements as ordered on meal tray. On 07/1/25 when the missing supplements were reported to the dietary manager, she corrected the issue immediately and provided the supplements to the resident. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed All residents of the facility have the potential to be affected by this practice. On 7/01/25 all other resident trays were observed for accuracy in accordance with physician orders and no further deficiencies were noted. What measures will be put in place or systemic changes	07/21/2025

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F0692 SS = D	Continued from page 27 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff, Nurse Practitioner and Registered Dietitian (RD) interviews, the facility failed to provide nutritional supplements to prevent further weight loss as recommended by the RD and prescribed by physician (Resident #45) for 1 of 3 residents reviewed for nutrition. The findings included: Resident #45 was admitted to the facility on 1/10/24 with diagnoses which included Alzheimer's disease and diabetes. An active physician order dated 6/22/24 to add ice cream to lunch tray every day to aid with prevention of further significant weight loss per RD recommendation. An active physician order dated 11/03/24 to add nutritional shake supplement to lunch tray daily to aid in the prevention of further weight loss per RD recommendation. An active physician order dated 4/28/25 for a consistent carbohydrate (CCD), no added salt (NAS) diet. Regular texture, thin (regular) liquid consistency. Review of Resident #45's electronic health record revealed the following weights were recorded: 6/20/25 185.6 pounds 5/10/25 186.4 pounds 4/13/25 185 pounds 3/20/25 188.8 pounds 2/13/25 190.2 pounds	F0692	Continued from page 27 made to ensure that the identified issue does not occur in the future? On 07/01/25 the Administrator and Regional Director reviewed the facility policy and provided education to the Dietary Manager on Nutrition and Hydration Maintenance in accordance with facility policy. On 07/08/25 all dietary staff were educated by the Dietary Manager on Nutrition and Hydration Maintenance and tray accuracy in accordance with facility policy. All dietary employees will receive education on on Nutrition and Hydration Maintenance and tray accuracy up hire and annually via SNF Clinic. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Dietary Manager will audit meal trays daily x 2 weeks, then monthly for accuracy and report findings to QAPI Committee. Results will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F0692 SS = D	Continued from page 28 1/17/25 189 pounds 12/16/24 192.6 pounds 11/11/24 207.4 pounds 10/12/24 212 pounds The RD visit note dated 3/25/25 revealed Resident #45's current base weight was 188.8 pounds and Resident #45 had a 10.9% weight loss for the last 159 days. Resident #45 was noted to have a CCD, NAS regular texture diet with ice cream and nutritional shake once daily. The RD visit note further recorded that Resident #45's diet order with additional supplements met requirements and the RD would continue to monitor Resident #45 per protocol. The Minimum Data Set (MDS) quarterly assessment dated 4/19/25 revealed Resident #45 had severe cognitive impairment. Resident #45 was coded for a therapeutic diet, was not coded for any signs and symptoms of a swallowing disorder, was independent for eating. Resident #45 was coded for weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, not on physician-prescribed weight-loss regimen. The care plan was last reviewed and updated on 5/08/25. Resident #45 had a nutritional problem related to diet restrictions with a goal to maintain adequate nutritional status. The interventions included explaining and reinforcing the importance of maintaining the diet ordered and encouraging compliance. An observation was conducted on 6/30/25 at 12:49 pm of Resident #45 during the lunch meal. The meal ticket on the lunch tray revealed Resident #45 was to receive ice cream and nutritional shake. No ice cream or nutritional shake were noted on the lunch tray. An attempt to conduct a telephone interview on 7/02/25 at 9:59 am with Dietary Aide #1 who worked on 6/30/25 during the lunch meal tray line was unsuccessful.	F0692		

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F0692 SS = D	Continued from page 29 An observation of Resident #45's lunch meal was conducted on 7/01/25 at 12:33 pm. No ice cream or nutritional shake were noted on the lunch tray. An interview was conducted on 7/02/25 at 11:07 am with Dietary Aide #2 who worked on 7/01/25 during the lunch meal tray line revealed the ice cream was normally added to Resident #45's lunch tray just before the meal tray cart goes to the unit and the nutritional shake would be put on the tray during the meal tray line. Dietary Aide #2 stated she must have forgotten to put the ice cream and nutritional shake on Resident #45's lunch tray. An interview was conducted on 7/01/25 at 2:51 pm with the Dietary Supervisor who revealed when a resident had supplements ordered on the diet ticket the dietary department was responsible to supply the supplements. The Dietary Supervisor stated when the meal tray line was in progress the Dietary Aides were responsible to review the meal tickets and ensure all supplements listed on the meal ticket were added to the meal tray. An interview was conducted on 7/01/25 at 12:38 pm with the Dietary Manager who revealed the Dietary Aides were responsible to place the ice cream and nutritional shake on Resident #45's lunch tray as ordered and noted on the meal ticket. A telephone interview with the facility's Registered Dietitian (RD) was conducted on 7/01/25 at 3:32 pm. The RD revealed she recommended the ice cream and nutritional shakes to be added to Resident #45's meal tray due to a recent significant weight loss. The RD stated Resident #45 was at risk for additional weight loss by not receiving the nutritional supplements as recommended and ordered. An interview was conducted on 7/02/25 at 9:05 am with the Nurse Practitioner (NP) who revealed Resident #45 was ordered the nutritional supplements due to weight loss and the supplements should have been provided as ordered. During an interview with the Administrator on 7/02/25 at 11:57 am she revealed the Dietary Department was responsible for ensuring that Resident #45 received the	F0692		

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F0692 SS = D	Continued from page 30 dietary supplements as ordered by the physician.	F0692		
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following:	F0838	F-838 Corrective action for resident(s) affected by the alleged deficient practice: No residents were affected by the deficient practice. How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by the deficient practice. As a result of this deficient practice systemic changes have been put into place to prevent any risk to our residents. On 7/08/25 the Administrator revised the facility assessment to include input from direct care staff and residents and noted contracts in place related to medical supplies and dialysis. The revision also addressed staffing needs for each shift and weekends, competencies and skills needed to care for residents and any staffing needs due to changes to the resident population as required. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 7/08/25 the Regional Director of Clinical Services reviewed the facility policy for compliance and re-educated the Administrator on the facility assessment requirements including the involvement of direct care staffing and residents and specific staffing needs for each shift and each unit. Staff will receive skills and competency education upon hire and annually through the facility SNF Clinic program per facility policy. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The facility assessment plan will be reviewed during the QAPI meeting monthly for 3 months, then quarterly thereafter for compliance. Any necessary changes will be discussed with the IDT and made at that time.	07/21/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET , RICH SQUARE, North Carolina, 27869

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F0838 SS = F	Continued from page 31 (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. §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:	F0838		

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F0838 SS = F	Continued from page 32 §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and review of the Facility Assessment the facility failed to ensure the required parties were involved in the development the Facility Assessment, failed to: have an accurate facility assessment that recorded the current administrative staff and Medical Director, ensure the staffing plan considered specific staffing needs for each unit and shift as required, provide information regarding the skills and competencies that were required for licensed nursing staff and Certified Nurse Aides (CNAs), and have an accurate staff type and position list. This deficient practice had the potential to affect 54 of 54 residents. The findings included: The Facility Assessment was reviewed and was noted to have been updated and reviewed with the facility's Quality Assurance Performance and Improvement (QAPI)	F0838		

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F0838 SS = F	Continued from page 33 committee on 1/28/25. The persons involved in completing the assessment were listed as the Administrator, the Director of Nursing (DON), the Medical Director, Social Service Director, Dietary Manager, Therapy Director, and a Governing Board Member. There was no indication that direct care staff were involved in completing the assessment or that the facility solicited and considered input from residents, resident representatives and family members. The Facility Assessment was noted to have the former Administrator, the former Medical Director, and the former Social Worker listed under the administrative personnel. Further review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse), and CNAs noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. The staff type and position list recorded the facility had provided 1 FTE for a Staff Development Coordinator (SDC). The Facility Assessment did not provide information regarding the skills and competencies that were required for licensed nursing staff and CNAs. An interview was conducted with the Administrator on 7/02/25 at 11:59 am who revealed she was not employed by the facility when the current Facility Assessment was reviewed and updated. The Administrator confirmed the facility did not have an SDC and that the staff position list was inaccurate. The Administrator stated she had not yet reviewed or updated any information in the Facility Assessment since she started at the facility in March 2025. The Administrator was unable to provide any further documentation at the time of survey exit regarding the Facility Assessment.	F0838		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	F-880 Infection Prevention & Control How corrective action will be accomplished for	07/21/2025

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F0880 SS = D	Continued from page 34 §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; (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	F0880	Continued from page 34 resident(s) found to have been affected. Resident 260 was identified as being affected by the deficient practice with the potential of being at increased risk for infection. No infection resulted from the practice. On 7/01/25 Nurse 2 was re-educated by the Director of Nursing on hand hygiene prior to and immediately after donning gloves during medication administration in accordance with facility policy. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: All residents have the potential to be affected by the deficient practice. On 07/01/25 the Regional Director reviewed the facility policy with the Director of Nursing to ensure compliance with recommended practices and found the policy to be accurate. What measures will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 07/07/25 the Director of Nursing educated all licensed nurses on hand hygiene prior to and immediately after donning gloves during medication administration in accordance with facility policy. All nursing staff will receive Infection Control education upon hire and annually. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing or designee will audit licensed nurses for proper use of hand hygiene prior to and immediately after donning gloves during medication administration daily x 1 week, then weekly x 4 weeks, and then monthly thereafter. The Director of Nursing will report the audit results to the QAPI committee monthly. The QAPI committee will review and make changes as needed to ensure the facility remains in compliance.	

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F0880 SS = D	Continued from page 35 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 review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse #2 failed to perform hand hygiene between glove changes during the observation of medication administration for 1 of 4 staff observed for infection control practices (Nurse #2). The findings included: The facility's Infection Prevention and Control Program (IPCP) policy implemented 10/04/23 and reviewed annually indicated in part that the facility established and maintained an (IPCP) to prevent the development and transmission of communicable diseases and infections. The policy further noted that hand hygiene shall be performed in accordance with the facility's established hand hygiene procedures. Review of the facility's Hand Hygiene Policy, no date, indicated that all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further noted that the use of gloves did not replace hand hygiene and that staff were to perform hand hygiene prior to donning gloves, and immediately after	F0880		

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F0880 SS = D	Continued from page 36 removing gloves. A continuous observation was conducted on 7/01/25 from 8:54 am through 8:58 am of medication administration for Resident #260. At 8:54 am Nurse #2 donned clean gloves without performing hand hygiene and was observed to use her gloved hands to spread open Resident #260's eye lids to administer eye drops to both eyes. Nurse #2 then removed the gloves, donned clean gloves without performing hand hygiene, removed Resident #260's oxygen tubing from the nose and administered nasal spray to both nostrils. Nurse #2 removed the gloves and did not perform hand hygiene. Nurse #2 then adjusted Resident #260's oxygen tubing with her ungloved hands and handed the resident a medicine cup with pills. Nurse #2 donned clean gloves without performing hand hygiene and placed a pain patch on Resident #260's right shoulder. Nurse #2 removed the gloves and performed hand hygiene when she exited Resident #260's room. An immediate interview was conducted with Nurse #2 on 7/01/25 at 8:58 am who revealed she should have used hand sanitizer between the glove changes during the medication administration but she just forgot. During an interview with the Director of Nursing (DON) on 7/01/25 at 3:13 pm she revealed she was also the facility's Infection Preventionist and was responsible for the IPCP. The DON stated Nurse #2 should have performed hand hygiene before she put on clean gloves and immediately after she took the gloves off.	F0880		