STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345313	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER: **Northampton Nursing and Rehabilitation Center**		STREET ADDRESS, CITY, STATE, ZIP CODE: **HWY 305 North , Jackson, North Carolina, 27845**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/19/26 through 4/22/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22E6D7-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/19/26 through 4/22/26. Event ID# 22E6D7-H1. The following intakes were investigated: 2716478, 2714766, 2620037, 848219, 848222, 848214 and 848210. 26 of the 26 complaint allegations did not result in deficiency.	F0000		
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-	F0641	F641 Accuracy of Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/22/26 the Minimum Data Set (MDS) Nurse completed a modification of assessment dated 2/24/26 MDS quarterly assessment for Resident #39 to reflect accurate coding for the use of supplemental oxygen and dialysis while at the facility. On 4/22/26 the Minimum Data Set (MDS) Nurse completed a modification of assessment dated 1/29/26 MDS quarterly assessment for Resident #9 to reflect accurate coding for insulin use. On 4/22/26 the Minimum Data Set (MDS) Nurse completed a modification of assessment dated 3/6/26 MDS admission assessment for Resident #29 to reflect accurate coding for receiving hospice care while at the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/7/26, the MDS Consultant initiated an audit of	05/19/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345313**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/22/2026**
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F0641 SS = D	Continued from page 1 (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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of the use of supplemental oxygen and dialysis (Resident #39), the use of hypoglycemic medication (Resident #9), and hospice services (Resident #29). The deficient practice was for 3 of 26 residents whose MDS assessments were reviewed. The findings included: 1. Resident #39 was admitted to the facility on 11/20/25 with diagnoses which included end stage renal disease with dependence on dialysis and chronic obstructive pulmonary disease (COPD). Resident #39 had the following physician orders: 11/20/25 oxygen flow at 3 liters per minute (LPM) via nasal cannula (NC) to keep oxygen saturation greater than 90% every shift for hypoxia. 11/21/25 for dialysis on Monday, Wednesday, and Friday. The Minimum Data Set (MDS) quarterly assessment dated 2/24/26 revealed Resident #39 had severe cognitive impairment and was not coded for the use of supplemental oxygen and dialysis while a resident at the facility. The MDS Nurse was interviewed on 4/22/26 at 9:36 am and revealed she completed the MDS assessments by reviewing physician orders,	F0641	Continued from page 1 the most recent comprehensive, significant change assessments and/or quarterly MDS assessment section for all residents to include residents #39, #9, and #29 to ensure all MDS's assessments completed are coded accurately for supplemental oxygen, dialysis, hypoglycemic medications and hospice services. There were no additional concerns identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 5/11/26, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for supplemental oxygen, dialysis, hypoglycemic medications and hospice services. All newly hired MDS Coordinator or MDS nurses will be in-serviced regarding MDS Assessments and Coding during orientation. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 10 audits of newly completed MDS assessments to include assessments for resident residents #39, #9, and #29 utilizing the MDS Accuracy Audit Tool will be reviewed by the Director of Nursing (DON) weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment to include coding for supplemental oxygen, dialysis, hypoglycemic medications, and hospice services utilizing a MDS Audit Tool. All identified areas of concern will be addressed immediately by the Director of Nursing (DON) through retraining the MDS nurse and completing necessary modification to the MDS assessment. The Administrator will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concern have been addressed. The Administrator will forward the results of MDS Accuracy Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	05/19/2026

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F0641 SS = D	Continued from page 2 observations, and a review of nursing progress notes. The MDS Nurse stated she was aware of Resident #39’s use of supplemental oxygen and dialysis but she just miscoded the assessment. During an interview with the Administrator on 4/22/26 at 2:51 pm she reported that the MDS Nurse was responsible for coding Resident #39’s assessment correctly to be an accurate reflection of the care the resident received. 2. Resident #9 was admitted to the facility on 4/24/22 with diagnoses which included diabetes and long-term use of insulin. Resident #9 had a physician order dated 10/28/25 for insulin glargine (long-acting insulin) to inject 80 units subcutaneously (under the skin) at bedtime for diabetes. Review of the Medication Administration Record (MAR) for January 2026 revealed Resident #9 received the insulin glargine as ordered. The Minimum Data Set (MDS) quarterly assessment dated 1/29/26 revealed Resident #9 was not coded for the use of a hypoglycemic medication which included insulin. An interview was conducted on 4/22/26 at 9:41 am with the MDS Nurse who revealed she would review physician orders and the MAR to complete the medication portion of the MDS assessment. The MDS Nurse stated she just miscoded Resident #9’s quarterly assessment for insulin use. The Administrator was interviewed on 4/22/26 at 2:51 pm. The Administrator stated the MDS Nurse was responsible for coding Resident #9’s assessment correctly to be an accurate reflection of the care the resident received. 3. Resident #29 was admitted to the facility on 03/03/26 with diagnoses that included Alzheimer's disease, heart disease, and diabetes. A Physician’s order dated 03/03/26 stated to continue hospice services in the long-term care	F0641		05/19/2026

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F0641 SS = D	Continued from page 3 facility. A hospice care plan was initiated on 03/03/26 and included the following interventions spiritual care consult, notify Physician of significant changes, and provide medication per Physician orders. An admission Minimum Data Set (MDS) assessment dated 03/06/26 revealed Resident #29 was coded as not receiving hospice care while a Resident at the facility. An interview was completed on 04/22/26 at 12:34pm with the MDS Nurse. The MDS Nurse stated she mistakenly coded Resident #29 as not receiving hospice care while a resident on the 03/06/26 MDS assessment. The MDS Nurse verified Resident #29 should have been coded as receiving hospice care while a resident. An interview was completed on 04/22/26 at 3:03pm with the facility's Administrator. The Administrator stated the Resident's MDS should be an accurate reflection of the Resident when the assessment was completed.	F0641		05/19/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F0880	F880 Infection Prevention & Control 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/23/26, Nursing assistant (NA) #3 was immediately educated by the Director of Nursing on the facility Infection prevention program policy and procedure of utilizing Personal Protective Equipment (PPE) for patients identified with Enhanced Barrier Precautions (EBP) to include but not limited to applying PPE when activities of daily living care are performed. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 5/08/2026, the DON or ADON initiated 15 random resident care observations with all nursing staff on all shifts to include NA #3. This audit is to ensure staff are utilizing appropriate use of PPE while in rooms designated as requiring isolation precautions/EBP, to include but not limited when activities of daily living care are performed. The nurse supervisors and/or the DON will address all concerns identified during the audit to include education of staff. The observations will be completed by the DON or ADON by 5/14/2026.	05/19/2026

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F0880 SS = D	Continued from page 4 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 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 observation, record review, and staff interviews, the facility failed to implement their	F0880	Continued from page 4 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/30/26, the ADON/SDC initiated in-servicing with all nursing staff on infection prevention program policy and procedure regarding EBP proper utilization of PPE to include but not limited to applying PPE when activities of daily living care are performed. The in-service will be completed by 5/18/26. After 5/18/26 any nursing staff who have not completed the in-service will complete it upon next scheduled work shift. All newly hired staff will be in-serviced by the ADON/SDC during orientation regarding infection prevention program policy and procedure on EBP proper utilization of PPE to include but not limited to applying PPE when activities of daily living care are performed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The ADON/SDC will complete 5 Resident Care Audits to include NA #3 utilizing the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 months. This audit is to ensure staff is implementing the facility Infection prevention program policy and procedure of utilizing PPE for patients identified with EBP to include but not limited to applying PPE when activities of daily living care are performed. The ADON/SDC will address all areas of concern identified during the audit to include re-education of staff. The DON will review the Resident Care Audit Tool weekly x 4 weeks then monthly x 1 month. The DON will present the findings of the Resident Care Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine any trends or the need for further frequency of monitor.	05/19/2026

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F0880 SS = D	Continued from page 5 infection prevention program policies and procedures when Nurse Aide (NA) #3 failed to apply personal protective equipment (PPE) when activities of daily living (ADL) care was performed for a resident on Enhanced Barrier Precautions (EBP). This deficient practice was for 1 of 3 staff members observed for infection control practices (NA #3). The findings included: The facility's Infection Prevention and Control Program (IPCP) last revised April 2023 stated that the IPCP was designated to establish and maintain an effective program that provided a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The facility's Enhanced Barrier Precautions (EBP) policy last revised 4/01/23 read in part that EBP was utilized in conjunction with standard precautions when performing high-contact resident care activities and included the use of both gowns and gloves. The policy noted in part that EBP applied to all residents with an indwelling medical device, such as an indwelling catheter. The policy further noted that resident care activities that were considered high-contact included dressing and transferring. An observation on 4/21/26 at 10:04 am revealed Resident #2 had signage posted at the entrance of the room that alerted staff that the resident was on enhanced barrier precautions. The signage noted that providers and staff must wear gloves and a gown for the following high-contact resident care activities which included dressing. A supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves. A continuous observation of resident care for Resident #2 was conducted on 4/21/26 at 10:05 am through 10:12 am with NA #3. NA #3 was observed to have gloves on and put Resident #2's shirt and pants on while the resident was on the bed. NA #3 then assisted Resident #2 to turn onto the left side and she pulled the shirt down to cover the resident's back and pulled the resident's pants up. The NA then assisted the resident to turn onto the right side and completed dressing Resident #2. NA #3 then had Resident #2 turn onto his back and then straightened the shirt and pants and moved the indwelling urinary catheter bag onto the bed in between the resident's legs without a disposable gown in place. NA #3 was then observed to remove the disposable gloves and perform hand hygiene	F0880		05/19/2026

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F0880 SS = D	Continued from page 6 with hand sanitizer. NA #3 failed to wear a gown during the resident care observation. An immediate interview was conducted with NA #3 on 4/21/26 at 10:12 am. NA #3 stated she was not aware she needed to wear a gown when she provided the care to Resident #2. NA #3 confirmed the signage and PPE supplies were present at the entrance of Resident #2's room but she stated she had not read the sign before she provided the care. The Infection Preventionist (IP) was interviewed on 4/22/26 at 1:29 pm. The IP stated that NA #3 was required to wear a gown and gloves when she provided care to Resident #2 related to the indwelling urinary catheter. The IP stated that all staff had received education regarding EBP and the use of PPE when providing specific care duties. The IP further stated that each resident who was on EBP had the signage and PPE supplies on the door that provided information about the requirement for gown and glove use when providing specific resident care. An interview was conducted on Director of Nursing (DON) on 4/22/26 at 2:43 pm. The DON stated that all staff had been educated regarding EBP and the use of PPE when resident care was provided. The DON stated NA #3 should have worn a gown when she provided care to Resident #2. During an interview with the Administrator on 4/22/26 at 2:52 pm she revealed EBP education was provided to all staff and the EBP signage was posted for Resident #2. The Administrator stated NA #3 should have worn the required PPE when she provided care to Resident #2.	F0880		05/19/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed	F0732	F732 Posted Nurse Staffing Information Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/19/26, the scheduler immediately posted an updated Daily Nursing Staff Sheet for residents and visitors with complete staffing information and resident census next to the main entrance of the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	05/19/2026

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F0732 SS = C	Continued from page 7 nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to post an updated daily nurse staffing sheet for residents and visitors for 1 of 4 days during the survey period (4/19/26). The findings included: On 4/19/26 (Sunday), during the initial tour of the	F0732	Continued from page 7 On 5/12/26, the Director of Nursing (DON) initiated an audit of Daily Nursing Staff Sheets for the past 30 days to ensure all sheets were completed accurately to include resident census, Registered Nurse (RN) hours, license practical nurse (LPN) hours, nursing assistant (NA) hours, resident census, and that the current day was posted per facility protocol and in a location easily assessable to residents and visitors. The DON will update staffing sheet for all concerns identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/30/2026, the Staff Development Coordinator initiated an in-serviced with the scheduler and all nurses regarding Posting of Daily Nurse Staffing Sheet with emphasis on completing Daily Nursing Staff Sheets with complete and accurate information to include the census at the beginning of each shift, RN/LPN hours, NA hours and posting staffing sheet posted per facility protocol and in a location easily assessable to residents and visitors. In-service will be completed by 5/18/26. After 5/18/26, any scheduler or nurse who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired scheduler and nurses will be in-serviced by the Staff Development Coordinator during orientation regarding Posting of Daily Nurse Staffing Sheet. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON will audit the Daily Nurse Staffing Sheets to include weekends weekly 3 times a week x 4 weeks then weekly x 4 weeks to ensure staff sheets includes complete and accurate information prior to the beginning of each shift to include RN hours utilizing the Daily Staffing Audit Tool. Retraining will be immediately conducted by the DON for any identified areas of concern. The Administrator will review and initial the Daily Staffing Audit Tool weekly x eight weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the Daily Nurse Staffing Audit Tool to the Quality	05/19/2026

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F0732 SS = C	Continued from page 8 facility at 9:40 AM the daily nurse staffing sheet posted near the facility entrance was dated 4/16/26 (Thursday). The daily nurse staffing sheet was not updated to reflect the current date, census, and staffing information. During an interview on 4/19/26 at 10:15 AM, Nurse #1 stated the Scheduler prepared the daily nurse staffing sheets and placed them in a binder on Fridays at the nurses’ station for nurses to update and post on the weekends. Nurse #1 indicated she worked on 4/18/26 (Saturday) and the day of the interview (4/19/26) and had not noticed the daily nurse staffing sheet posted near the facility entrance had not been updated since 4/16/26. During an interview with the Scheduler on 4/19/26 at 2:01 PM, the Scheduler confirmed she completed and posted the daily nurse staffing sheets. The Scheduler explained she had last worked on Thursday (4/16/26) and had given the completed daily nurse staffing sheets for 4/17/26, 4/18/26, and 4/19/26 to the Assistant Director of Nursing before leaving work. The Scheduler further stated the facility nurses usually ensured the daily nurse staffing sheet was current and updated to reflect the actual staff working in the facility. During an interview with the Assistant Director of Nursing (ADON) on 4/19/26 at 2:33 PM. The ADON stated the Scheduler had given her the daily nurse staffing sheets for 4/17/26, 4/18/26, and 4/19/26 on 4/16/26. The ADON stated that she placed the daily nursing staffing sheets in the green staffing binder that was kept at the nurse’s station. The ADON stated the nurses usually ensured the daily nurse staffing was current and updated. She did not know what happened to the documents that she had placed in the binder. During an interview with the Director of Nursing (DON) on 4/19/26 at 11:24 AM, the DON stated facility charge nurse was responsible for ensuring that the daily nurse staffing sheets were posted. The DON verified that Nurse #1 was the charge nurse that weekend and would have been responsible for updating and posting the staffing sheets. During an interview on 4/19/25 at 3:37 PM, the Administrator stated that it was the Scheduler’s responsibility to complete the daily nurse staffing sheet Monday through Friday. The Administrator stated nurses were responsible for posting the daily nurse staffing sheets on weekends. The Administrator stated the charge nurse should have updated the daily nurse staffing sheet to reflect the	F0732	Continued from page 8 Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	05/19/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Nursing and Rehabilitation Center	**HWY 305 North , Jackson, North Carolina, 27845**

(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
F0732 SS = C	Continued from page 9 current date, current census and staffing information and posted the document so it clearly visible to residents and visitors.	F0732		05/19/2026