STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Valley Health and Rehabilitation	**200 Heritage Circle , Hendersonville, North Carolina, 28791**

(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 02/16/26 through 02/20/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E3F98-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/16/26 through 02/20/26. Event ID: 1E3F98-H1. The following intakes were investigated: 2648249, 2654999, 2662495, 2667363, 2677267, 2717210, 2730564, 2735389, 2742685, and 2744334. 3 of the 35 complaint allegations resulted in deficiency.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide a bed with enough length to prevent a resident's feet from pressing against the footboard for 1 of 1 resident reviewed for accommodation of needs (Resident #48). Findings included: Resident #48 was admitted to the facility 03/26/25 with diagnoses including incomplete quadriplegia C5-C7 (spinal cord injury between the 5th cervical vertebrae and the 7th cervical vertebrae resulting in loss of some motor functions but not all), and chronic pain due to trauma. The quarterly Minimum Data Set assessment dated	F0558	Based on observations, record review, and resident and staff interviews, the facility failed to provide a bed with enough length to prevent a Resident's feet from pressing against the foot board for 1 of 1 Residents reviewed for accommodation of needs (Resident #48). The resident was immediately assessed, and interim measures were put in place to prevent discomfort and risk for injury/skin issues on 2/20/26 by the Director of Nursing (DON). A longer bed was obtained and placed in the resident's room on 2/20/26 by the maintenance director. The DON confirmed the resident is now able to rest in bed with proper support and alignment. The resident was interviewed and verified satisfaction with the correction. Current facility residents are at risk of being affected by the deficient practice. A 100% audit of current facility residents was completed on 2/20/26 by the DON/Unit Manager (UM) to ensure residents have appropriate accommodations related to bed sizing/fit (including height/positioning needs). Any issues identified during the audit were corrected immediately. No other residents were found to be affected. To ensure the deficient practice does not recur, the facility updated the process for identifying and providing resident accommodations by implementing a visual assessment of bed fit upon	03/16/2026

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

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

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F0558 SS = D	Continued from page 1 12/02/25 revealed Resident #48 was cognitively intact. Resident #48 was dependent on staff assistance with self-care tasks, bed mobility and transfers. It was noted Resident #48 had a height of 73 inches. During an observation and interview on 02/16/26 at 11:51 AM, Resident #48 was observed sitting up in bed watching television. The head of the bed was raised approximately 30 degrees. Resident #48's head was approximately two inches below the top of the bed, while his feet were pressed against the footboard of the bed. Resident #48's legs were in a straight position. Resident #48 stated his feet hurt when they were pressed against the footboard of the bed and he asked the Nursing Assistants (NAs) to elevate his feet on pillows to keep them from pressing against the footboard of the bed. He stated he had requested a longer bed multiple times, but he could not recall the dates he made the requests for a larger bed. Follow up observation and interview conducted with Resident #48 on 02/18/26 at 10:39 AM revealed Resident #48 sitting up in bed watching television with the head of the bed raised approximately 30 degrees. The top of Resident #48's head was approximately two inches below the top of the bed. Resident #48's legs were in a straight position, and his feet were pressed against the footboard of the bed. Resident #48 stated he had activated his call light to request his feet be elevated with a pillow, so they were not pressed against the footboard. An interview was conducted with NA #11 on 02/18/26 at 10:51 AM. She stated she had just completed care for Resident #48. NA #11 stated Resident #48 requested pillows be placed under his feet because it was uncomfortable when his feet were pressed against the footboard of the bed. She recalled Resident #48 had this concern on multiple occasions but could not provide an exact number of times. NA #11 indicated she used pillows to raise Resident #48's feet up and away from the foot board. An Interview was conducted with Medical Assistant (MA) #15 on 02/18/26 at 10:58 AM. MA #15 confirmed he provided care for Resident #48 and Resident #48 spent much of the day in bed watching television with the head of the bed raised. When the head of the bed was raised Resident #48's feet pressed against the foot board, which caused discomfort for Resident #48's feet. MA #15 stated Resident #48 requested his feet be raised on pillows, which kept his feet from pressing into the bed.	F0558	Continued from page 1 admission/readmission. This will be a resident specific assessment and focus on resident preference and comfort. Facility and agency licensed nurse and certified nursing assistants were re-educated on identifying issues, how to communicate the issue, and how to assess bed sizing and accommodating residents needs and ensuring they have a bed that is of an appropriate size; education completed by 3/15/26 by the DON/UM. Newly hired staff and staff not educated by 3/15/26 will be educated upon hire or prior to working their next scheduled shift. The facility will monitor compliance as follows: the DON/Designee will complete audits on 5 residents to ensure resident accommodation needs are met related to bed sizing/fit: twice weekly x 4 weeks, then weekly x 4 weeks, and monthly x 1 month. Audit results will be brought by the DON / designee and reviewed in Quality Assurance Performance Improvement (QAPI) monthly to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring plan of correction is completed. Completion Date: 3/16/2026	

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F0558 SS = D	Continued from page 2 An observation and interview were conducted with Resident #48 on 02/20/26 at 8:08 AM in conjunction with the Director of Nursing (DON). The DON stated Resident #48 was positioned correctly in bed and his feet were pressed against the footboard of the bed. The DON asked Resident #48 if he was comfortable and Resident #48 stated the bed was too small. The DON confirmed the bed appeared to be too small for Resident #48 and he could be at risk for skin breakdown with his feet pressed against the footboard of the bed. An observation of Resident #48's feet revealed they were dry and intact with no rashes, bruising, or discoloration noted. The DON stated Resident #43 was in a longer bed before he transferred rooms on 01/29/25 but she could not explain why Resident #43 received a shorter bed after the transfer. An interview was conducted on 02/20/26 at 1:21 PM with the Maintenance Director. The Maintenance Director stated nursing staff assessed residents for proper bed size. Nursing staff would enter a work order in the TELS application (application on facility computers and facility cell phones used to manage work orders) if a resident needed a larger bed. He confirmed he received a work order for a longer bed for Resident #48 on 02/20/26. An interview was conducted with the Administrator on 02/20/26 at 1:21 PM. The Administrator confirmed nursing staff assessed residents for bed size when they were admitted to the facility. He stated the nursing assessment was a visual assessment and when a resident could express their needs nursing staff got verbal confirmation the resident was comfortable in the bed. He stated he expected residents to be in the proper sized bed.	F0558		
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 3 of 30 residents whose MDS	F0638	Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 3 of 30 residents whose MDS assessments were reviewed. (Residents #10, #47 and #108). Assessments identified had already been completed and submitted at time of survey. An audit of current facility residents with scheduled quarterly MDS assessments in the past 30 days was conducted on 3/12/26 by the Regional Director of Clinical Reimbursement (RDCR) and MDS coordinator to ensure assessments were completed within the required regulatory timeframe. All assessments had been submitted within the regulatory timeframe except for one, which was submitted past the 14-day timeframe. Any	03/16/2026

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F0638 SS = D	Continued from page 3 assessments were reviewed (Residents #10, #47 and #108). Findings included: a. Resident #10 was admitted to the facility on 05/14/24. Review of Resident #10's electronic medical record revealed a quarterly Minimum Data Set (MDS) assessment with an ARD of 09/29/25 that was marked as completed on 10/22/25. b. Resident #47 was admitted to the facility on 06/06/24. Review of Resident #47's electronic medical record revealed a quarterly MDS assessment with an ARD of 11/15/25 that was marked as completed on 12/04/25. c. Resident #108 was admitted to the facility on 07/08/25. Review of Resident #108's electronic medical record revealed a quarterly MDS assessment with an ARD of 11/07/25 that was marked as completed on 12/02/25. During a joint interview on 02/19/26 at 1:42 PM, the MDS Registered Nurse (RN) and Regional MDS Consultant both verified Resident #10's quarterly MDS assessment dated 09/29/25, Resident #47's quarterly MDS assessment dated 11/15/25, and Resident #108's quarterly MDS assessment dated 11/07/25 were not completed within the regulatory time frame. The MDS RN explained the facility has had a lot of new admissions and they just got behind with the volume of MDS assessments to complete. During an interview on 02/20/26 at 2:57 PM with the Administrator present, the Regional Director of Clinical Operations (RDCO) revealed that while good-faith efforts had been made to address MDS issues, including completing assessments within regulatory timeframes, further improvement was still needed. The RDCO explained that a new rehabilitation company, who also had MDS resources that would provide the facility with additional MDS support, was starting at the facility on 03/01/26 which would help improve the MDS process and prevent further compliance issues.	F0638	Continued from page 3 assessments identified as incomplete were prioritized and completed to ensure compliance. Assessment identified during audit had been completed prior to audit. To ensure the deficient practice does not recur the RDCR provided education to the MDS Coordinator on 3/12/2026 regarding regulatory timeframes for completion of quarterly MDS assessments and the importance of maintaining compliance with the 14-day completion requirement following the ARD. To improve compliance moving forward, the facility implemented the following process changes: 1) The MDS Coordinator will maintain and review a weekly MDS tracking calendar to ensure assessments are completed within the required timeframe, 2) the Director of Nursing (DON) will review the MDS schedule weekly with the MDS Coordinator to monitor upcoming and pending assessments, and 3) additional MDS support resources will be utilized as needed to assist with timely completion of assessments during periods of increased admissions or census changes. Newly hired MDS coordinators or MDS coordinators not educated by 3/15/2026 will be educated upon hire or prior to working their next scheduled shift. To maintain compliance the DON or designee will audit 3 completed MDS assessments twice weekly for 4 weeks, 1x/weekly for 4 weeks, and 1x/monthly for 3 months to verify completion within the required regulatory timeframe. Results of the audits will be brought by the DON and reviewed in Quality Assessment Performance Improvement (QAPI) monthly for at least 3 months to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring the plan of correction is completed. Completion date: 3/16/2026	
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F0641	F641 Based on record review and staff interviews, the facility failed to accurately code the Minimum Date Set	03/16/2026

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F0641 SS = E	Continued from page 4 §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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the areas of hospice (specialized care focused on nearing the end of life) (Resident #29, Resident #62, and Resident #77) and preadmission screening and resident review (PASRR, a program ensuring residents with certain diagnoses received specialty services) (Resident #10) for 4 of 30 residents whose MDS assessments were reviewed. Findings included: 1. Resident #29 was admitted to the facility 10/20/23.	F0641	Continued from page 4 (MDS) assessment for the areas of hospice (specialized care focused on nearing the end of life) (Resident #29, Resident #62, and Resident #77) and preadmission screening and resident review (PASRR, a program ensuring residents with certain diagnoses received speciality services) (Resident #10) for 4 out of 30 residents whose MDS assessments were reviewed. Inaccurately coded MDS assessments had a modification completed and submitted by 3/11/26. Current facility Residents are at risk of being affected by the deficient practice. A 100% audit of assessments completed in the past 30 days was completed on 3/4/26 by Regional Director of Clinical Reimbursement (RDCR) to ensure that MDS assessments accurately coded hospice and PASRR determinations. 1 additional Resident MDS assessment was modified for accurate coding of PASRR, and no additional Residents required a modification to the MDS assessment for hospice coding. The RDCR provided education to the MDS Coordinator regarding accurate MDS coding requirements related to Hospice services, PASRR Level II determinations, and verification of supporting documentation prior to completing the MDS on 3/13/2026. To prevent recurrence, the facility implemented the following process changes: 1) Hospice status and PASRR Level II determinations will be verified during the MDS completion process using the Resident's Medical Record and supporting documentation, and 2) the facility Quality Assurance Clipboard will be updated as needed for an additional resource. Newly hired MDS staff and staff not educated by 3/15/2026 will be educated upon hire or prior to working their next scheduled shift. The RDCR or Director of Nursing (DON) will audit 2 completed MDS assessments to ensure coding accuracy for hospice services and PASRR determinations 3x/wk for 4 weeks, weekly for 4 weeks, then monthly for 3 months. The DON will bring data from audits and they will be reviewed in Quality Assurance Performance Improvement (QAPI) monthly to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring the plan of correction is completed. Completion Date: 3/16/2026	

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F0641 SS = E	Continued from page 5 Review of a hospice recertification note dated 12/15/25 revealed Resident #29 was initially admitted to hospice on 06/24/25 and was recertified to receive services from 12/21/25 through 02/18/26. Review of Resident #29's quarterly Minimum Data Set (MDS) assessment dated 01/29/26 did not indicate she was receiving hospice services. An interview with the Regional MDS Consultant on 02/19/26 at 1:42 PM revealed Resident #29's quarterly MDS assessment should have reflected that she was receiving hospice care, and it was an oversight. An interview with the Director of Nursing (DON) on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately. 2. Resident #62 was admitted to the facility 01/01/21. A hospice progress report dated 12/31/24 revealed Resident #62 was admitted to hospice on 09/10/24. A quarterly Minimum Data Set (MDS) assessment dated 11/27/25 revealed Resident #62 was not coded as having a condition or chronic disease that may result in a life expectancy of less than 6 months or that she was receiving hospice care. A hospice progress report dated 01/21/26 revealed Resident #62 was recertified to receive services through 03/04/26. A joint interview was conducted with the MDS Coordinator and Regional MDS Consultant on 02/19/26 at 1:42 PM. The MDS Coordinator and Regional MDS Consultant both stated that Resident #62's quarterly MDS assessment should have reflected she had a life expectancy of less than 6 months and was receiving hospice care, and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately.	F0641		

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F0641 SS = E	Continued from page 6 3. Resident #77 was admitted to the facility on 02/15/23. A hospice agreement dated 01/28/26 revealed Resident #77 elected to receive hospice services effective 01/28/26. A significant change Minimum Data Set (MDS) assessment dated 01/31/26 did not indicate Resident #77 was receiving hospice care. A joint interview was conducted with the MDS Coordinator and Regional MDS Consultant on 02/19/26 at 1:42 PM. The MDS Registered Nurse (RN) confirmed the significant change MDS assessment was completed due to Resident #77 electing hospice services. The MDS RN stated the MDS assessment should have reflected that he was receiving hospice care and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately. 4. Resident #10 was admitted to the facility on 05/14/24. A PASRR Level II determination notification letter dated 12/30/24 revealed Resident #10 had a Level II PASRR with no expiration date. The annual Minimum Data Set (MDS) assessment dated 05/06/25 revealed Resident #10 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. An interview with the Regional MDS Consultant on 02/19/26 at 1:42 PM revealed Resident #10's annual MDS assessment dated 05/06/25 should have reflected she had a Level II PASRR and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments	F0644	Based on record review and staff interviews, the	03/16/2026

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F0644 SS = D	Continued from page 7 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with mental health disorders for 1 of 6 residents reviewed for PASRR (Resident #11). The findings included: A PASRR Determination Notification letter dated 02/03/16 revealed Resident #11 had a Level I PASRR with no expiration date. Resident #11 was admitted to the facility on 2/6/25 with diagnosis that included schizoaffective disorder, anxiety, depression, and bipolar disorder. Review of the admission minimum data set (MDS) dated 2/9/25 revealed that Resident #11 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #11's active psychiatric/mood disorder diagnosis included anxiety, depression, bipolar disorder, and schizophrenia. Resident #11 took antianxiety medications. Review of a Psychiatric Nurse Practitioner (NP) note dated 05/05/25 revealed Resident #11 was being seen for	F0644	Continued from page 7 facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with mental health disorders for 1 of 6 residents reviewed for PASRR (Resident #11). Upon identification of defeicent practice the Social Services Director (SSD) initiated a PASRR Level 2 screening for Resident #11 on 2/16/26. Current facility residents with mental disrders are at risk of being affected by the deficient practice. A 100% audit was completed on 3/10/26 by the SSD of current facility residents with a mental disorder to ensure a PASRR review was initiated when indicated. Any issues identified during the audit were corrected immediately by initiating PASRR referrals and documenting follow-up. No other Residents were found to be affected. To ensure the deficient practice does not recur the Minimum Data Set (MDS) Coordinator, SSD, Admissions Coordinator, and Director of Nursing (DON) were educated on PASRR requirements, triggers, and documentation by the Administrator on 3/12/26. Newly hired staff or staff not educated by 3/15/26 will be educated upon hire or prior to working their next scheduled shift by the DON or designee. The DON or designee will notify the SSD of newly admitted residents with a mental disorder or a current resident with a new diagnosis of mental disorders so the SSD can initiate a PASRR screening as indicated. The facility will monitor the compliance by the Administrator or Designee completing audits to ensure PASRR referrals are initiated timely when there are newly admitted residents with a mental disorder or a current resident receives a new diagnosis of mental disorders weekly x 4 weeks, then monthly x 2 months. The Administrator will bring data from audits and audit results will be reviewed in Quality Assusrance Performance Improvement (QAPI) meeting monthly to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring plan of correction is completed. Completion Date: 3/16/2026	

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F0644 SS = D	Continued from page 8 an initial psychiatric evaluation and medication review at the request of facility to evaluate Resident #11's mood. Resident #11 had a past medical history of obsessive compulsive disorder (OCD), schizophrenia, and bipolar disorder, seen for evaluation of anxiety, OCD, major depressive disorder, schizoaffective disorder, and insomnia. Review of a Psychiatric NP note dated 01/09/26 revealed Resident #11 was being treated for anxiety, depression, and bipolar disorder. Resident #11's symptoms were chronic and stable and well controlled on the current regimen. There was no documentation that a request was submitted for the resident to be evaluated for an updated PASRR. During an interview on 02/18/26 at 2:00 PM, the Social Worker (SW) stated she had been the SW since August 2025. She stated that she looked at the diagnosis and medications and submits to North Carolina Medicaid Uniform Screening Tool (NCMUST). She stated that she had a lot of Level II PASRR's at this facility, and she had a person she could call to help her with questions about PASRR in the PASRR office. She stated that when a resident came in she would review their diagnosis and if the resident had a mental health diagnosis she would resubmit for a re-evaluation. She further revealed that she had completed an audit when she started the job in August of 2025, and Resident #11 was overlooked. During an interview on 02/18/26 at 2:57 PM, the Administrator revealed that if there was a new admission with a Level I PASRR, the SW would be responsible for submitting for a re-evaluation for PASRR. He stated that his expectation was that all residents who were admitted with a Level I PASRR and who have a mental health diagnosis were reviewed by the SW and then submitted for re-evaluation for a Level II.	F0644		
F0646 SS = D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the	F0646	Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) reevaluation after a significant change in physical or mental status was identified for Residents previously determined to have a Level II PASRR. This deficient practice affected 2 of 5 sampled Residents reviewed for PASRR. (Residents #28 and #31). Significant change PASRR screens was submitted on 2/19/26 for Residents #28 and #31. Current facility residents with a Level 2 PASRR are at risk of being affected by the deficient practice. A 100% audit was completed on 3/5/2026 by the Vice	03/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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F0646 SS = D	Continued from page 9 facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) reevaluation after a significant change in physical or mental status was identified for residents previously determined to have a Level II PASRR. This deficient practice affected 2 of 5 sampled residents reviewed for PASRR (Residents #28 and #31). Findings included: a. Resident #28 was readmitted to the facility on 04/28/15. Her cumulative diagnoses included schizoaffective disorder, bipolar type and anxiety disorder. A PASRR Level II determination notification letter dated 05/05/20 revealed Resident #28 had a Level II PASRR with no expiration date and nursing facility placement was appropriate. A significant change in status Minimum Data Set (MDS) assessment dated 05/29/25 revealed Resident #28 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #28's active psychiatric/mood disorder diagnoses included anxiety disorder and schizophrenia. She received antipsychotic and antidepressant medications during the MDS assessment period. The North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Social Worker on 02/20/26 at 2:00 PM revealed Resident #28 received a Level II PASRR effective 05/05/20 with no expiration date. There were no PASRR reevaluation requests submitted since the significant change MDS assessment dated 05/29/25. b. Resident #31 was admitted to the facility on 07/10/25. His cumulative diagnoses included major depressive disorder and anxiety disorder. A PASRR Level II determination notification letter dated 08/19/21 revealed Resident #31 had a Level II PASRR with no expiration date and nursing facility placement was appropriate. A significant change in status Minimum Data Set (MDS) assessment dated 01/30/26 revealed Resident #31 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #31's active psychiatric/mood disorder diagnoses included anxiety	F0646	Continued from page 9 President of Clinical Operations (VPCO) of all residents with a Significant Change Minimum Data Set (MDS) in the last 3 months to ensure a PASRR review was initiated when indicated. Issues identified during the audit were corrected immediately by initiating PASRR referrals and documenting follow-up. 4 additional residents were identified and PASRR reviews. The PASRR screens were initiated on 3/6/26 by the SSD. On 3/12/26 the Administrator provided education to the interdisciplinary team including the Social Worker, Director of Nursing (DON), unit managers, activities director, business office manager, and MDS coordinator regarding PASRR requirements, including the need to submit a Level II PASRR reevaluation request following a significant change in condition. The prevent recurrence, the facility implemented the following process changes: 1) Residents with Level II PASRR determinations will be identified and maintained on a PASRR tracking log by the Social Worker, 2) the Social Worker will review Residents with Level II PASRR determinations during significant change assessments to determine if a PASRR reevaluation request is required, and 3) significant change MDS assessment will be communicated to the Social Worker to ensure appropriate PASRR review and follow-up when applicable. Newly hired staff or staff not educated by 3/15/2026 will be educated upon hire or prior to working their next scheduled shift. The Administrator or DON will audit 5 Residents with Level II PASRR determinations 2x/wk for 4 weeks, 1x/wk for 4 weeks, then monthly for 3 months to ensure appropriate PASRR reevaluation requests are submitted when significant changes in condition occur. The DON will bring data from audits and the results will be reviewed in QAPI monthly to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring the plan of correction is completed. Completion Date: 3/16/26	

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F0646 SS = D	Continued from page 10 disorder and depression (other than bipolar). He received antianxiety and antidepressant medications during the MDS assessment period. The North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Social Worker on 02/20/26 at 2:00 PM revealed Resident #31 received a Level II PASRR effective 08/19/21 with no expiration date. There were no PASRR reevaluation requests submitted since the significant change MDS assessment dated 01/30/26. During an interview on 02/18/26 at 2:00 PM, the Social Worker (SW) revealed she started her position in August 2025 and was still learning the PASRR process. The SW confirmed she was the person responsible for submitting requests for Level II PASRR reevaluations when needed. She explained when a resident admitted to the facility, she reviewed their diagnoses and if they had a mental health diagnosis she submitted a request for a reevaluation through NC MUST. The SW stated she was not aware a request for a Level II PASRR reevaluation needed to be submitted when a resident had a significant change in condition. During an interview on 02/18/26 at 2:55 PM, the Administrator revealed the SW was responsible for reviewing a resident's diagnoses and requesting Level II PASRR reevaluations as needed. The Administrator stated requests for Level II PASRR reevaluations should be made when a resident had a significant change in condition per the regulatory guidelines.	F0646		
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;	F0692	The facility failed to provide nutritional supplements according to the physician's diet order for 1 of 4 residents reviewed for weight loss (Resident #90). Immediate correction was completed on 2/19/26 by the Dietary Manager and Director of Nursing (DON): Dietary initiated same-day delivery of the fortified pudding and frozen nutritional cups per the current order, and Nursing verified receipt and documented intake. The Registered Dietitian (RD) and attending provider were notified of missed supplements on 2/16/2026 through 2/19/2026 for reassessment and further interventions as indicated. The resident representative was notified and verified understanding of the correction. No further interventions or orders were put in place by RD or medical provider. Current facility residents with orders for dietary supplements are at risk of being affected by the deficient practice. A 100% audit of current facility resident supplement orders was completed on 2/19/2026 by the Dietary Manager in collaboration with the	03/16/2026

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F0692 SS = D	Continued from page 11 §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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with the Medical Director, Registered Dietitian and staff, the facility failed to provide nutritional supplements according to the physician's diet order for 1 of 4 residents reviewed for weight loss (Resident #90). Findings included: Resident #90 was admitted to the facility 09/24/24 with diagnoses including vascular dementia and severe protein-calorie malnutrition. Resident #90 had an order dated 06/11/25 for fortified pudding after lunch for weight stability. Resident #90 had an order dated 12/02/25 for a frozen nutritional cup two times per day for weight stability. Resident #90's weight record revealed he weighed 154.4 pounds on 12/10/25. Review of the quarterly Minimum Data Set assessment dated 12/10/25 revealed Resident #90 had severely impaired cognition, was independent for eating meals, had no swallowing disorders, weighed 154 pounds, and documented weight loss of five percent or more in the last month or loss of ten percent or more in the last six months while not on a prescribed weight loss regimen. Resident #90's weight record revealed he weighed 140.2 pounds on 12/24/25. The care plan for nutrition last revised 12/27/25 revealed a risk for potential nutritional problems. Interventions included providing Resident #90's diet as ordered. Resident #90's weight record revealed he weighed 136.2 pounds 01/05/26. A summary of the Registered Dietitian (RD) note dated 01/14/26 was as follows: Resident #90 showed a	F0692	Continued from page 11 Director of Nurisng (DON) or designee using the facility's supplement order listing report to cross-check all active supplement orders against the dietary supplement production list and delivery process. Any discrepancies identified would be corrected immediately by adding the supplement to the dietary production list and confirming delivery/receipt. No other discrepancies were found. To ensure the deficient practice does not recur, the facility put the following into place. On 3/12/26 the Dietary Manager and Nursing leadership (DON/Unit Managers) were reeducated by the Administrator on the process for new or changed supplement orders, including: (a) verification that all supplement orders are entered correctly, (b) same-day communication to Dietary using the communication form, (c) Dietary addition to the production list, and (d) Nursing confirmation of delivery. All current facility and agency nursing and dietary staff were educated by 3/15/26 by the Administrator/DON/Dietary Manager on the process and how to report concerns. All newly hired staff or staff not educated by 3/15/2026 will be educated upon hire or prior to working their next scheduled shift. The DON or Designee will monitor compliance by auditing 5 residents with orders for supplements, 3 times a week for 4 weeks; then 2 times a week for 4 weeks; and weekly for four weeks to verify: (a) supplement order present, (b) supplement appears on Dietary production list, (c) supplement delivered as ordered, and (d) intake documentation completed. Data from audits will be brought by the DON and reviewed in the Quality Assurance Performance Improvement (QAPI) meeting monthly for 3 months and ongoing as indicated. The administrator is responsible for ensuring the plan of correction is completed. Completion Date: 3/16/2026	

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F0692 SS = D	Continued from page 12 significant weight loss of 11.9%) over the last three months. Resident #90 usually consumed 51% to 75% of meals. Resident #90 received fortified pudding once daily, house supplement three times a day and a frozen nutritional cup two times a day as supplements. The RD note further stated a goal of no significant weight loss through the next assessment. A telephone interview with the RD on 02/19/26 at 3:20PM revealed she worked with Resident #90 due to weight loss. She stated in December 2025 she attempted to stabilize his weight loss by adding frozen nutritional cups to his dietary order in addition to the fortified pudding that was ordered in June of 2025. She confirmed she increased his house supplement in January 2026 as a further attempt at weight stabilization for Resident #90. The RD stated she expected Resident #90 to receive dietary supplements as ordered. Resident #90 had an order dated 1/15/26 for the house supplement (fortified shake) 120 milliliters by mouth four times a day for weight stability. Resident #90's weight record revealed he weighed 133.8 pounds on 02/06/26. Resident #90’s diet orders included an order revised 2/16/26 for a regular diet, with mechanical soft/ground meat texture and nectar thick liquids. An observation of Resident #90’s lunch meal ticket on 02/17/26 at 11:35 AM revealed he was to receive a regular mechanical altered /ground meal with nectar thick liquids. Fortified pudding and a frozen nutritional cup were not included on the ticket. An observation of Resident #90’s meal tray at the same date and time revealed he received one serving of mechanically ground chicken, one serving of spinach, one serving of egg noodles and an apple crisp. Resident #90 had just received his meal tray at the time of the observation. An interview was conducted on 2/18/26 at 10:16 AM with Nurse Aide #11. She stated Resident #90 did not receive fortified pudding or a frozen nutritional cup on his lunch meal tray. She stated Resident #90 had consumed about seventy-five percent (75%) of his meals over the past 2 weeks when she had provided care. An observation of Resident #90’s lunch meal tray on 2/18/26 at 11:26 AM revealed the meal tray did not contain fortified pudding or a frozen nutritional cup. An interview with the Dietary Manager on 02/19/26 at	F0692		

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F0692 SS = D	Continued from page 13 8:12 AM revealed that Resident #90 had a physician order for fortified pudding and a frozen nutritional cup and that Resident #90 should have received those items on his meal tray. She stated nursing staff informed her of new dietary orders via the diet requisition form. Once she received the diet requisition form with the new diet orders from the nursing staff, she would make the changes in Meal Tracker (nutrition management system used to manage dining operations), which would add the changes to the meal ticket. She stated she had no recollection that she received a diet requisition form to add fortified pudding and a frozen nutritional cup to Resident #90's meal ticket. The Dietary Manager confirmed that the fortified pudding and frozen nutritional cup were not on the meal ticket for Resident #90. An interview was conducted with Unit Manager #1 on 02/19/26 at 08:23 AM. She stated nursing staff filled out a diet requisition form when a resident received a new diet order. Nursing staff would place the diet requisition form in the Dietary Manager's inbox. The Unit Manager could not recall if diet requisition forms were provided to the Dietary Manager for the fortified pudding and frozen nutritional cup for Resident #90. An observation of the nourishment room on 02/20/26 at 2:34 PM revealed the nourishment room did not contain fortified pudding or frozen nutritional cups. An interview with the Medical Director on 02/20/26 at 11:00 AM revealed he expected residents to receive nutritional supplements as ordered. He stated if residents did not receive nutritional supplements as ordered, they would be at risk for continued weight loss. During an interview on 02/20/26 at 12:25 PM, the Director of Nursing stated she expected the residents to receive nutritional supplements as ordered. An interview with the Administrator on 02/20/26 at 2:45 PM revealed he expected residents to receive dietary supplements as ordered.	F0692		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F0700	The facility failed to complete bed rail assessments to determine the need for bed rail use and failed to obtain informed consent prior to installation for 2 of 2 sampled residents (Resident #47 and #53). The side rail assessments and informed consent for the identified residents were completed on 3/11/26 by the Director of Nursing (DON) or Unit Manager. The DON confirmed the residents' side rails are now in place based on current assessment and documented need.	03/16/2026

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F0700 SS = D	Continued from page 14 correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to complete bed rail assessments to determine the need for bed rail use and failed to obtain informed consent prior to installation for 2 of 2 sampled residents (Resident #47 and #53). Findings Included: a. Resident #47 was admitted to the facility on 06/06/24. His cumulative diagnoses included chronic respiratory failure with hypoxia (low oxygen), muscle weakness, and chronic pain. The quarterly Minimum Data Set (MDS) assessment dated 11/15/25 revealed Resident #47 had intact cognition and range of motion impairment on both sides of the lower extremities. The MDS assessment noted Resident #47 required supervision or touching assistance with bed mobility, was independent with moving from a sitting-to-lying position and bed rails were not used as a physical restraint. During an observation on 02/16/26 at 2:30 PM, Resident #47 was lying in bed sleeping soundly. A bed grab bar was observed secured to the bedframe and in the upright position on the right side of Resident #47's bed. Review of Resident #47's electronic medical record on 02/16/26 revealed no evidence informed consent was	F0700	Continued from page 14 Current facility residents that utilize side rails are at risk of being affected by the deficient practice. A 100% audit was completed on 3/10/26 by the Administrator and Designee of all residents with side rails to ensure side rail assessments and informed consent are completed and up to date. Any issues identified during the audit were corrected immediately by completing the required assessments and updating care plans as indicated. 37 additional residents were identified and corrected on 3/12/26 To ensure the deficient practice does not recur the facility implemented a process to ensure side rail assessments and informed consents are completed on admission, quarterly, annually, and with any significant change in condition on 3/10/26. Facility and agency licensed nurses and unit managers were re-educated on side rail assessment and informed consent requirements, documentation, and care planning by 3/15/26 by the DON/Administrator. The process will be upon identification of a side rail being needed the information will be communicated to the DON or administrator and a side rail assessment will be completed and informed consent will be obtained if a side rail is indicated prior to the side rail being installed. Newly hired licensed nurses and unit managers or staff not educated by 3/15/2026 will be educated upon hire or prior to working their next scheduled shift. The facility will monitor the corrective action by the DON/Designee will complete audits of 5 residents with side rails to ensure assessments and informed consents remain current weekly x 4 weeks, then 3 residents weekly for 4 weeks and then 1 resident weekly for 4 weeks. The DON will bring audit results and review in Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months to ensure sustained compliance. Any concerns identified will be corrected immediately. The administrator is responsible for ensuring the plan of correction is completed. Completion Date: 3/16/2026	

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F0700 SS = D	Continued from page 15 obtained prior to the installation or use of the bed grab bar. Review of Resident #47's electronic medical record on 02/16/26 revealed the last completed bed rail assessment was dated 04/14/25. The bed rail assessment noted in part that Resident #47 nor his representative expressed a desire to have an assistive device to aid in mobility, safety and/or comfort, he needed assistance with rising independently from a supine (flat) position to a sitting/standing position, he had the ability to independently reposition himself in bed, and alternatives to bed rails had not been attempted due to a bed rail would promote mobility and transfers. During an observation and interview on 02/17/26 at 7:50 AM, Resident #47 was sitting up in bed eating breakfast with the head of the bed raised approximately 90 degrees. A bed grab bar was observed in the upright position on the right side of his bed. Resident #47 explained he used the bed grab bar to reposition himself when lying in bed or as an aid when pulling himself up to sit on the side of the bed. During an interview on 02/19/26 at 2:27 PM, Nurse Aide (NA) #1 revealed Resident #47 was able to use the bed grab bar to independently reposition himself in bed. During an interview on 02/19/26 at 2:38 PM, NA #2 revealed Resident #47 was able to use the bed grab bar independently for bed mobility. b. Resident #53 was admitted to the facility on 04/03/25. His cumulative diagnoses included rheumatoid arthritis and intervertebral disc (cartilage between two vertebrae in the spinal column) degeneration of the lumbar region (lower back) with discogenic back pain and lower extremity pain. The quarterly Minimum Data Set (MDS) assessment dated 12/03/25 revealed Resident #53 had intact cognition and range of motion impairment on both sides of the upper and lower extremities. He was always incontinent of bladder and bowel and was dependent on staff assistance with toileting hygiene. The MDS assessment also noted Resident #53 required supervision or touching assistance with rolling left-to-right, required partial to moderate assistance with moving from a sitting-to-lying or lying-to-sitting position, and bed rails were not used a physical restraint. During an observation and interview on 02/17/26 at 3:30 PM, Resident #53 was sitting up in bed playing a game on his cellphone. Bilateral bed grab bars were observed	F0700		

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F0700 SS = D	Continued from page 16 in the upright position on each side of his bed. Resident #53 stated he used the bed grab bars only to hold onto to when staff rolled him onto his side to provide care. During an interview on 02/17/26 at 3:31 PM, Nurse Aide (NA) #11 revealed Resident #53 could hold onto the bed grab bars as staff provided care but he did not use them to independently reposition himself in bed. Review of Resident #53's electronic medical record on 02/17/26 revealed no evidence informed consent was obtained prior to the installation or use of the bed grab bars. Review of Resident #53's electronic medical record on 02/17/26 revealed the last completed bed rail assessment was dated 07/04/25. The bed rail assessment noted in part that Resident #53 nor his representative expressed a desire to have an assistive device to aid in mobility, safety and/or comfort, he was not able to rise independently from a supine (flat) position to a sitting/standing position, he did not have the ability to reposition himself in bed, he exhibited problems with balance and trunk control, and a physical therapy consult had been attempted as an alternative to bed rails. During an interview on 02/19/26 at 2:38 PM, NA #2 revealed Resident #53 would hold onto the bed grab bars to assist staff with turning during care, but he did not use them to independently reposition himself in bed. During an interview on 02/19/26 at 3:09 PM, the Director of Nursing (DON) revealed the only reason bed rails would be used for a resident was to promote independence with bed mobility. The DON explained hall nurses were responsible for completing the initial and quarterly bed rail assessments, Unit Managers were responsible for obtaining informed consent for the use of the bed rail and then maintenance was notified to install the bed rail. The DON stated she was not sure where the breakdown occurred. During an interview on 02/20/26 at 9:47 AM, the Unit Manager revealed nurses should be completing bed rail assessments upon a resident's admission, but she was not sure how often bed rail assessments should be completed thereafter. She stated nurses assessed the resident to determine the need for a bed rail, usually to promote independence with bed mobility, and then maintenance would be notified to install the bed rail. The Unit Manager was not aware that informed consent	F0700		

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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
F0700 SS = D	Continued from page 17 needed to be obtained from the resident or their representative prior to the installation of the bed rail. During an interview on 02/19/26 at 5:27 PM, the Administrator stated he expected nursing staff to obtain informed consent and complete bed rail assessments per the facility policy.	F0700		
F0842 SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F0842		03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/20/2026

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Orchard Valley Health and Rehabilitation	**200 Heritage Circle , Hendersonville, North Carolina, 28791**

(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
F0842 SS = A	Continued from page 18 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain accurate records related to the administration of nutritional supplements for 1 of 4 residents reviewed for accurate medical records (Resident #90).	F0842		

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F0842 SS = A	Continued from page 19 The findings included: Review of Resident #90's February 2026 Medication Administration Record (MAR) revealed a physician's order dated 6/11/25 for fortified pudding supplement given after lunch, one time a day for weight stability. Further review noted the order was initialed on the MAR as administered by Nurse #14 on 02/17/26 at 12:00 PM and Nurse #13 on 2/16/26 at 12:00 PM. Review of Resident #90's February 2026 MAR revealed a physician's order dated 12/02/25 for a frozen nutritional cup supplement given two times a day for weight stability. Further review noted the order was initialed on the MAR as administered by Nurse #14 on 02/17/26 at 11:00 AM and Nurse #13 on 2/16/26 at 11:00 AM. An observation of Resident #90's lunch meal and meal ticket on 02/17/26 at 11:35AM revealed fortified pudding and a frozen nutritional cup were not included on the ticket and not included on the meal tray. During a phone interview with Nurse #14 on 02/20/26 at 9:11 AM, she revealed she was assigned to Resident #90 on 2/17/26 during 1st shift (7:00 AM to 3:00 PM). She stated the fortified pudding and the frozen nutritional cup were provided by the dietary department and included on Resident #90's meal trays. She confirmed if she had signed it off on the MAR as completed it meant she had witnessed Resident # 90 had received the fortified pudding and frozen nutritional cup on his meal tray. During a phone interview with Nurse # 13 on 02/20/26 at 9:42 AM, she revealed she was assigned to Resident #90 on 2/16/26 during 1st shift. She stated the fortified pudding and frozen nutritional cup were provided by the dietary department and included on Resident #90's meal trays. She confirmed if she had signed it off on the MAR as completed it meant she had confirmed with the Nurse Aide (NA) that Resident # 90 had received the fortified pudding and frozen nutritional cup on his meal tray. An interview with the Dietary Manager on 02/19/26 at 8:12 AM revealed that she reviewed Resident #90's dietary orders on 02/19/26 and confirmed that Resident #90 had an order for fortified pudding and a frozen nutritional cup. She stated that the fortified pudding and frozen nutritional cup were not in Meal Tracker (nutrition management system used to manage dining operations), which resulted in the fortified pudding and frozen nutritional cup not appearing on Resident	F0842		

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F0842 SS = A	Continued from page 20 #90's meal ticket. She confirmed Resident #90 had not received fortified pudding or a frozen nutritional cup from the dietary department prior to 02/19/26. During an interview on 02/20/26 at 12:25 PM, the Director of Nursing (DON) revealed when a nurse had signed off on the MAR that a nutritional supplement was completed, the nurse should have visualized and confirmed the resident had received the supplement. During an interview on 02/20/26 at 02:45 PM, the Administrator revealed he expected the medical record documentation to be complete and accurate.	F0842		