STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Rehabilitation Center	**616 Wade Avenue , Raleigh, North Carolina, 27605**

(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 3/23/26 through 3/26/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F4CBC-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 3/23/26 through 3/26/26. Event ID #1F4CBC-H1. The following intakes were investigated #2807631, #2794400, #2735754, #2747301, #2728738, #2723581, #2704090, #2696843, #2688150, #2664923, #2652217, #2647867, #2639613, #2630949, #2624219, #2607584, #2599244, #2594085, #811297, #811292, #811293, #811291, #811289 and #811287. 3 of 94 complaint allegations resulted in a deficiency. The Statement of Deficiencies was amended on 4/23/26 at tag F842 to correct a typo.	F0000		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F0585	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #136 responsible party will be provided with a written summary for grievances dated 2/3/25, 7/22/25, 2/12/26 and 3/9/26 by the facility administrator. Completed 4/10/26. Address how the facility will identify other residents	04/23/2026

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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F0585 SS = D	Continued from page 1 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F0585	Continued from page 1 having the potential to be affected by the same deficient practice: An audit of all grievances from the previous 30 days will be conducted to ensure the resident/responsible party was provided for each written summary of the grievance by the facility administrator. Any concerns will be corrected. Completed on 3/31/2026. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to the facility Administrator on 4/10/2026 regarding facility grievance policy to include Providing written summary to the resident and/or responsibility party by the vice president of operation on 4/10/2026. The facility administrator will provide education to interdisciplinary team (including Director of Nursing, Social Services, Dietary/ housekeeping manager and activity director) regarding the facility grievance process, including written notification to resident and/or responsible party on 3/31/26. IDT members identified as not receiving the education will be scheduled to receive the education prior to working the next shift. Newly hired Interdisciplinary team members will receive the education during orientation. Indicate how the facility plans to monitor its performance to make sure that the solutions are sustained: The administrator or designee will audit 5 grievances per week for 12 weeks to ensure that a written summary was provided to the resident and/or responsible party. The Administrator will bring the audits to QAPI. Data obtained during the audit process will be analyzed for patterns and trends by the Quality Assurance Committee monthly for 3 months. The committee will review to determine if further action is needed.	04/23/2026

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F0585 SS = D	Continued from page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Responsible Party (RP) and staff interviews, the facility failed to provide written grievance summaries for 4 grievances filed by Resident #136's responsible party. The deficient practice occurred for 1 of 1 resident reviewed for grievances (Resident #136). Findings included: Review of facility policy dated 08/2023 titled "Resident Rights/Grievances" read in part: The Administrator is responsible for overseeing the grievance process. The process includes receiving and tracking grievances, leading investigations while maintaining the confidentially of all information associated with grievance, reaching conclusion, and taking appropriate actions…The resident, or anyone acting on their behalf filing the grievance, will be communicated with regarding the conclusion of the investigation and the corrective actions that will be taken. The resident or anyone acting on their behalf has the right to obtain a copy of the written conclusion. The Administrator will validate the completion of the process in a timely manner upon receipt of the completed Grievance Report." Resident 136 was admitted to the facility on 02/16/24 and was readmitted on 03/02/26.	F0585		04/23/2026

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F0585 SS = D	Continued from page 3 Resident #136's Minimum Data Set (MDS) assessment dated 02/18/26 indicated that the resident was severely cognitively impaired. A review of the facility's grievance log from January 2025 through March 2026 revealed four grievances from Resident #136's RP that revealed: A grievance dated 02/03/25 read in part, issues with activities of daily living (ADL) care, with Resident #136 found wet and soiled. Date the written decision was issued section, was left blank. Identify the method(s) used to notify the resident and/or anyone acting on their behalf section, was left blank. Delivery method of conclusion section was left blank. Was the grievance conclusion accepted or declined section, was left bank. Resident/Responsible Party offered conclusion section, was left blank. Date notification offered section, was left blank. Summary of pertinent findings of conclusions regarding the resident's concerns section, was left blank. Resident/Responsible Party signature section was left blank. A grievance dated 07/22/25 read in part, issues with missing washable pads and a listening ear microphone. Date the written decision was issued section, was left blank. Identify the method(s) used to notify the resident and/or anyone acting on their behalf section, was left blank. Delivery method of conclusion section was left blank. Was the grievance conclusion accepted or declined section, was left bank. Resident/Responsible Party offered conclusion section, was left blank. Date notification offered section, was left blank. Summary of pertinent findings of conclusions regarding the resident's concerns section, was left blank. Resident/Responsible Party signature section was left blank. A grievance dated 02/12/26 read in part, RP expressed concern with Resident #136's hair appearance. Identify the method(s) used to notify the resident and/or anyone acting on their behalf section, was left blank. Resident/Responsible Party offered conclusion section, was left blank. Date notification offered section, was left blank. Summary of pertinent findings of conclusions regarding the resident's concerns section, was not completed. Corrective actions taken or to be taken by the	F0585		04/23/2026

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F0585 SS = D	Continued from page 4 facility as a result of the grievance (be specific), was left blank. Summary statement of the grievance was left blank. Completed by (signature and title), was left bank. Resident/Responsible Party signature section was left blank. A grievance dated 03/09/26 read in part, issue with discoloration on Resident #136's right and left hand from a lab draw. Identify the method(s) used to notify the resident and/or anyone acting on their behalf section, was left blank. Resident/Responsible Party offered conclusion section, was left blank. Date notification offered section, was left blank. Resident/Responsible Party signature section was left blank. An interview was conducted on 03/25/26 at 3:02 PM with Resident #136's RP. She reported submitting multiple verbal grievances to the facility's administrative staff, including the Administrator. She stated that she was not asked whether she wanted a written grievance summary, did not receive any written summaries or follow-up communication, and was not provided with any verbal or written updates or follow-up interviews regarding her grievances. An interview was conducted on 03/23/26 at 3:21 PM with the Administrator. The Administrator confirmed that Resident #136's RP did not receive written grievance summaries for any grievances filed. She acknowledged she was not fully aware that complainants or those filing a grievance on the resident's behalf must receive written summaries of grievance findings, even when issues were resolved verbally. The Administrator stated that Resident #136's RP also did not receive written grievance summaries because the administrative staff did not believe formal written documentation was required for the representative's four verbal grievances, which concerned activities of daily living (ADL) care, missing pads and a microphone, hair grooming, and right/left hand discoloration. The Administrator reported that she learned only today (03/23/26) that the facility was required to offer or provide written grievance summaries to complainants or those filing a grievance on the resident's behalf. Prior to this, staff communicated resolutions solely through phone calls or in-person conversations, with no written documentation provided. The Administrator indicated that all four of Resident #136's grievances were resolved. The interview further revealed the Administrator investigated and resolved grievances and was responsible for overseeing the grievance	F0585		04/23/2026

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F0585 SS = D	Continued from page 5 process. On 03/26/26 at 8:05 AM, an interview was conducted with the Vice President of Operations. He stated that staff were expected to follow the facility's grievance policy, ensuring that individuals who filed a grievance were informed of the grievance summary and its conclusion. An interview was conducted on 03/26/26 at 9:08 AM with the Director of Clinical Services. She confirmed that Resident #136's RP did not receive a verbal or written grievance summary or any follow-up notifications from the grievances she filed. She stated that, moving forward, all individuals submitting a grievance would receive a written grievance summary and decision.	F0585		04/23/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F0641	F641 Accuracy of Assessment Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #128 Minimum Data Set (MDS) dated 1/9/26 was reviewed and modified to reflect the use of anticonvulsant medication during the 7 day look back by the Resident Care Specialist on 3/27/26. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Audit will be completed of residents receiving anticonvulsant medication to ensure that most current Minimum Data Set (MDS) accurately reflects the use of the medication during the 7 days look back period by the Resident Care Specialist /designee on 3/28/26. No other assessments were noted to be coded incorrectly. 3. Address what measures will be put into place or	04/23/2026

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F0641 SS = D	Continued from page 6 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 area of use of anticonvulsant medication for 1 of 39 residents whose MDS assessments were reviewed (Resident #128). The findings included: Resident #128 was admitted to the facility on 5/16/24 with diagnoses which included bipolar disorder, dementia with other behavioral disturbances, and anxiety disorder. Resident #128 had a physician order dated 6/03/25 for lamotrigine (an anticonvulsant medication) 25 milligram (mg) oral tablet; give one tablet by mouth two times a day for bipolar disorder. Review of the Medication Administration Record (MAR) for January 2026 revealed Resident #128 was administered the lamotrigine medication as ordered. The Minimum Data Set (MDS) quarterly assessment dated 1/09/26 and completed by MDS Nurse #2, revealed Resident #128 had severely impaired cognition. Resident #128 was not coded for anticonvulsant medication use during the 7-day lookback period. The Regional MDS Nurse was interviewed on 3/25/26 at 3:15 pm and revealed MDS Nurse #2 was a per diem staff member that assisted the facility with resident assessments when needed. The Regional MDS Nurse reviewed Resident #128's physician order and MAR and confirmed the quarterly MDS assessment should have been coded for the use of the anticonvulsant medication. A telephone interview was conducted with MDS Nurse #2 on 3/26/26 at 10:44 am. MDS Nurse #2	F0641	Continued from page 6 systemic changes made to ensure that the deficient practice will not recur: The Resident Care Specialist will be provided education regarding accurate coding of Section N of use of anticonvulsant medication during the 7-day look back period by the regional resident care specialist. Completed on 3/30/26. All newly hired Resident Care Specialists will be educated during department orientation in regards to ensuring accurate coding of Section N use of anticonvulsant medication during the 7-day look back period. This education will be completed by the Director of Nursing/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing or Designee will complete an audit of 4 residents to ensure that Section N coded correctly for residents identified receiving anticonvulsant medication weekly x 12 weeks. The Director of Nursing will bring the results of the audit to QAPI. Data obtained during the audit process will be analyzed for patterns and trends by the Quality Assurance Committee monthly for 3 months. The committee will review to determine if further action is needed.	04/23/2026

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F0641 SS = D	Continued from page 7 stated that not coding the anticonvulsant medication was an oversight when she completed Resident #128's MDS assessment. During an interview with the Administrator on 3/26/26 at 11:35 am she revealed MDS Nurse #2 should have coded Resident #128's MDS assessment correctly based on the documentation in the medical record within the look back period.	F0641		04/23/2026
F0842 SS = D	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	F0842	F842 Resident Records - Identifiable Information Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or because it is required by the provisions of federal and state law. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of the lidocaine patch medication omissions for resident #139 on 3-26-26 and there were no new orders. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 30-day lookback of current resident medication administration records was completed for omissions by the Director of Nursing/designee. Any identified medication omissions were communicated to the resident primary physician for any new orders or need for updated assessments. Completed on 4/16/2026. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Licensed Nurses were educated by the Director of Nursing/Designee on ensuring that medication is recorded into Resident's electronic medical record accurately. Education completed by 4/13/2026. All newly hired licensed nurses will be educated	04/23/2026

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F0842 SS = D	Continued from page 8 45 CFR 164.506; (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 record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 39 residents reviewed for accurate medical records (Resident #139). The findings included:	F0842	Continued from page 8 during department orientation in regards to ensuring medications are recorded into the resident's electronic medical record accurately. This education will be completed by the Director of Nursing/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing/Designee will complete an audit of the electronic medication administration record for medication omissions will be completed 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks to maintain compliance during the morning clinical meeting. The Director of Nursing will bring the results of the audit to QAPI. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	04/23/2026

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F0842 SS = D	Continued from page 9 Resident #139 was admitted into the facility on 4/9/25. Resident #139 had a physician's order dated 4/9/25 for Lidocaine External Patch (topical anesthetic) 4% apply to bilateral shoulders topically in the morning for pain. Resident #139's September 2025 Medication Administration Record (MAR) indicated that the Lidocaine patches were not documented as administered on 9/1/25 and 9/9/25 by Nurse #1. Resident #139's October 2025 MAR indicated that the Lidocaine patches were not documented as administered on 10/6/25 and 10/20/25 by Nurse #1. An interview with the Unit Manager on 3/25/26 at 7:55 AM revealed that all nurses should ensure medications were documented at the end of their shift. A telephone interview on 3/25/26 at 4:00 PM with Nurse #1 revealed that she could not remember if she applied the Resident #139's Lidocaine patches or not. She further revealed that she could not remember why the Lidocaine patches were not documented as administered on 9/1/25, 9/9/25, 10/6/25, or 10/20/25. A telephone interview on 3/26/25 at 8:34 AM with the Director of Nursing indicated that the nursing staff should ensure all medication was documented accordingly at the end of their shift. A telephone interview on 3/26/25 at11:32 AM with the Administrator revealed that she expected the nursing staff to document medication administration when the medication was given.	F0842		04/23/2026
F0628 SS = A	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	F0628		04/23/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Raleigh Rehabilitation Center	**616 Wade Avenue , Raleigh, North Carolina, 27605**

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F0628 SS = A	Continued from page 10 must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (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;	F0628		04/23/2026

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F0628 SS = A	Continued from page 11 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an 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	F0628		04/23/2026

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F0628 SS = A	Continued from page 12 Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (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.	F0628		04/23/2026

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F0628 SS = A	Continued from page 13 §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 and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of resident transfer to the hospital for 2 of 8 residents reviewed for hospitalization (Resident #141 and Resident #151). The findings included: 1. Resident # 141 was admitted to the facility on 11/05/25. The Situation, Background, Assessment, Recommendation (SBAR) summary for provider dated 1/02/26 at 12:02 am revealed Resident #141 was transferred to the hospital for further evaluation. The facility was unable to provide documentation that the Ombudsman was notified of Resident #141's transfer to the hospital on 1/02/26. A telephone interview was conducted with the Ombudsman on 3/26/26 at 11:43 am who revealed she did not receive notification of Resident #141's transfer to the hospital on 1/02/26 from the facility. The Social Service Assistant was interviewed on 3/26/26 at 12:01 pm and stated she would review	F0628		04/23/2026

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F0628 SS = A	Continued from page 14 the facility census in the morning, each day she worked, to see if a resident was sent to the hospital and then she would send the resident notification of transfer to the Ombudsman via facsimile. The Social Service Assistant stated she must have just missed sending Resident #141's notification to the Ombudsman for the 1/02/26 transfer. During an interview with the Social Service Manager on 3/26/26 at 12:05 pm she revealed that she or the Social Service Assistant were responsible for the Ombudsman notification when a resident was transferred to the hospital. She stated she was not in the facility at the time Resident #141 was transferred to the hospital so the information should have been sent by the Social Service Assistant. The Social Service Manager stated she was not able to confirm that Resident #141's transfer to the hospital was reported to the Ombudsman. An interview was conducted on 3/26/26 at 12:09 pm with the Administrator who revealed the Ombudsman was to be notified of any unplanned transfer to the hospital by the Social Service Assistant or Social Service Manager. The Administrator stated the Social Service staff should have confirmed Resident #141's transfer to the hospital was submitted to the Ombudsman as required. 2. Resident #151 was admitted to the facility on 1/22/26. A nursing progress note dated 2/19/26 revealed Resident #151 was transferred to the hospital for further evaluation. A telephone interview was conducted with the Ombudsman on 3/26/26 at 11:43 am who revealed the facility did not send notification regarding Resident #151's transfer to the hospital on 2/19/26. The Social Service Assistant was interviewed on 3/26/26 at 12:01 pm and stated the normal process for notification of the Ombudsman was to review the facility census in the morning, each day she worked, to see if a resident was sent to the hospital and then send the information to the Ombudsman via facsimile. The Social Service Assistant was unable to state how Resident #151's notification to the Ombudsman was not sent when he was transferred	F0628		04/23/2026

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F0628 SS = A	Continued from page 15 to the hospital. During an interview with the Social Service Manager on 3/26/26 at 12:05 pm she revealed that she or the Social Service Assistant were responsible for the Ombudsman notification when a resident was transferred to the hospital. The Social Service Manager stated she was not able to confirm Resident #151's transfer to the hospital was reported to the Ombudsman. The Social Service Manager stated it was possible that the information regarding Resident #151's transfer to the hospital was just overlooked at the time of transmission to the Ombudsman. An interview was conducted on 3/26/26 at 12:09 pm with the Administrator who revealed that the Ombudsman was to be notified of any unplanned transfer to the hospital by the Social Service Assistant or Social Service Manager. The Administrator stated the Social Service staff should have confirmed Resident #151's transfer to the hospital was submitted to the Ombudsman as required.	F0628		04/23/2026