STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matthews Health & Rehab Center	**600 Fullwood Lane , Matthews, North Carolina, 28105**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/13/26 through 4/16/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22DCE9-H1.	E0000		04/30/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/13/26 through 4/16/26. Event ID #22DCE9-H1. The following intakes were investigated: 2985587, 2807414, 2798186, 2737980, 2724229, 2696695, 2687711, 2661786, 2631311, 2628790, 2619681, 848130, 848131, 848122, 848132, and 848126. 5 of the 50 allegations resulted in deficiency.	F0000		04/30/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F0578	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 3/15/226, resident #106 was found unresponsive by nurse. Resident #106 was immediately assessed during the event on 3/15/26. CPR was initiated per protocol due to inability to verify code status in the EMR banner. A second nurse verified the physician's order identifying a DNR status, and CPR was discontinued. The Director of Nursing was notified on 3/15/26 and initiated immediate education for licensed staff. On 3/16/26, the Interdisciplinary Team and Regional Director of Clinical Services reviewed the incident and implemented corrective actions, including process revision and staff re-education. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents were determined to have the potential to be affected. On 3/16/26, the Director of Social Services (DSS) completed a 100% audit of all current residents. No	04/17/2026

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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F0578 SS = D	Continued from page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with the Power of Attorney (POA), Medical Director, and staff, the facility failed to ensure a resident's advance directive information was entered throughout the medical record for 1 of 3 residents reviewed for advance directives (Resident #106). The findings included: Resident #160 was admitted to the facility on 03/03/2026. Resident #160 Medical Orders for Scope of Treatment (MOST) form dated 03/03/2026 revealed resident was a Do Not Resuscitate (DNR). A physician's order dated 03/03/2026 indicated Resident #106's advance directive was DNR, meaning no cardiopulmonary resuscitation (CPR) would be initiated in the event of cardiac or respiratory arrest. Review of Resident #160's Electronic Health Record (EHR) revealed the resident face sheet banner, located at the top of the electronic record and used to display key resident information, did not display a code status of either Full Code or DNR. Review of the Advance Directive dated 03/06/2026 indicated Resident #106's code status was DNR. Review of Resident #160's care plan dated	F0578	Continued from page 1 additional concerns identified. This audit included verification of code status in the EMR banner, physician orders, care plan, and MOST forms. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/16/26, the Director of Social Services (DSS) completed a 100% audit of all current residents. This audit included verification of code status in the EMR banner, physician orders, care plan, and MOST forms. The facility identified the root cause as lack of a standardized process and need for staff education. The following systemic changes were implemented: Effective 3/16/26, a standardized code status verification process was implemented for all admissions, readmissions, room changes, change in condition, and return from hospital: The admitting/primary nurse is responsible for verifying code status using physician orders. Social Services will concurrently verify advance directives and ensure alignment of the EMR banner, physician orders, care plan, and MOST form, and report discrepancies to the DON in real time. Nursing supervisors will complete an admission/readmission checklist within 24 hours of admission. Code status will be reviewed daily during the clinical morning meeting for new or re-admissions or residents with change in condition. Weekend admissions will be reviewed by the weekend manager, with final verification by the DON/designee on the next business day. Effective 3/15/26, the emergency code status verification process was reinforced: The primary nurse will remain with the resident and initiate appropriate interventions.	04/17/2026

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F0578 SS = D	Continued from page 2 03/08/2026 revealed no Advance Directive was documented. Resident #160 5-day Minimum Data Set (MDS) assessment dated 03/09/2026 Revealed resident #160 had severe cognitive impairment. Review of Nurse #1's progress note dated 03/10/2026 revealed that at 10:00 AM, Resident #160 was found unresponsive during a medication pass. The code status was not available in the electronic Medication Administration Record (eMAR), which is the electronic system staff use to document medications and review resident treatment information, and CPR was initiated. Th MOST form, a physician-signed medical order that outlines a resident's wishes for life-sustaining treatment, was later found indicating a DNR status, and CPR was stopped and the Power of Attorney (POA) and physician were notified. A phone interview was conducted on 04/14/2026 at 11:28 AM with Resident #109's POA. The POA stated he received a call from the facility on 03/10/2026 and spoke with Nurse #1 that morning, who informed him that Resident #109 was found unresponsive and Emergency Medical Services (EMS) were contacted. The POA reported he received a second call but could not recall the time he was notified that Resident #109 had expired. The POA stated he was not informed that CPR was initiated. The POA further stated he was not concerned that CPR was provided; however, Resident #109's wishes were for a DNR status in the event of a life-threatening incident. A phone interview with Nurse #1 on 04/14/2026 at 12:00PM revealed on 03/10/2026 at around 10:00 AM, Resident #109 was found unresponsive during a medication pass. The code status was not available in the banner at the time of the incident. Nurse #1 stated she initiated CPR and called for assistance from Nurse #2. Nurse #1 reported she was unable to locate the code status in the banner, and Nurse #2 went to the nurse's station to locate the code status binder. Nurse #2 identified that Resident #109 had a DNR order, and Nurse #1 immediately discontinued CPR. Nurse #1 stated CPR was performed for less than one minute, with approximately 25 chest compressions, and the resident did not respond. Nurse #1 reported that EMS were contacted and later canceled once the DNR status was confirmed; however, she was unsure who canceled the call. Nurse #1 stated she notified Resident #109's POA on 03/10/2026 but could not recall the exact times of the notifications or whether she informed the POA	F0578	Continued from page 2 A second licensed nurse will immediately verify code status using physician orders (primary), MOST form, and EMR banner (secondary). If CPR is initiated and a valid DNR is confirmed, CPR will be stopped immediately in accordance with facility policy. Education: 100% of licensed nurses and social services staff were educated on 3/15/26–3/16/26 by the DON/designee. All agency staff were educated by 3/16/26. All new hires and agency staff will receive education during orientation prior to assignment. Policy Revision: The code status policy was revised on 3/16/26 to clearly define roles, responsibilities, and required verification processes. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Monitoring will be conducted as follows An Ad Hoc QAPI meeting was conducted on 3/17/26 with the Administrator, DON, Social Services, Unit Managers, and Department Heads to review the deficient practice and implement oversight measures. The Medical Director reviewed and validated the process on 3/17/26. Beginning 3/18/26, the Director of Social Services, or designee will audit 10 residents weekly for 8 weeks to ensure:	04/17/2026

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F0578 SS = D	Continued from page 3 that CPR had been initiated. Nurse #1 further stated she notified the Director of Nursing (DON), who provided education to refer to physician orders to verify code status in the event a resident is found unresponsive. A phone interview was attempted with Nurse #2 on 04/14/2026 at 12:50 PM; however, no response was received. An interview was conducted with Social Worker #1 on 04/14/2026 at 1:00 PM. Social Worker #1 stated Resident #109 was a short-term resident admitted to the facility on 03/03/2026 and that Social Worker #1 was responsible for updating care plan meetings and addressing advance directives for short-term residents. An interview with Unit Manager #1 on 04/15/2026 at 10:47 AM, who was responsible for overseeing short-term residents, revealed that she was responsible for ensuring code statuses were updated for short-term residents upon admission and during their stay. She stated that at admission, orders were entered by nursing staff, and the banner should have been updated to reflect a Full Code or DNR status. Unit Manager #1 reported that a former Assistant Director of Nursing (ADON), who was no longer employed at the facility, had worked with the family at the time of admission and may have missed updating Resident #109's banner to reflect DNR status. Unit Manager #1 stated that when a social worker completed advance directive audits, she was responsible for following up on any code status discrepancies for short-term residents. A phone interview was attempted with the former ADON on 04/14/2026 at 12:55 PM; however, no response was received. An interview with the facility's physician on 04/15/2026 at 11:35 AM revealed that he did not recall the incident and stated that Resident #109 had a DNR order upon admission to the facility on 03/03/2026, initiated by another provider, per Resident #109's POA. An interview with the DON on 04/15/2026 at 11:35 AM revealed that upon admission, each resident would have had an advance directive status ordered by the facility physician. She stated that afterward, each resident's banner should have reflected either Full Code or DNR status. The DON further stated that although the former ADON had not entered the code status in the banner for Resident #109, all nursing staff were responsible for updating and	F0578	Continued from page 3 EMR banner accuracy Physician order consistency MOST form present and accuracy Care plan alignment Audit results will be reviewed monthly by the QAPI Committee. Additional audits or corrective actions will be implemented based on findings as determined by the QAPI Committee. The Administrator is responsible for overall compliance 5. Include dates when corrective action will be complete: All corrective actions, including staff education, policy revision, and implementation of the standardized code status verification process, were completed by 3/17/26. Ongoing monitoring began on 3/18/26 and will continue per the outlined QAPI plan.	04/17/2026

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F0578 SS = D	Continued from page 4 entering code status in the banner. An interview with the Administrator on 04/15/2026 at 11:57 AM revealed that each resident's banner should have reflected either Full Code or DNR status upon admission. The facility provided a Plan of Correction (POC); however, it was not accepted.	F0578		04/17/2026
F0584 SS = A	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels.	F0584		04/30/2026

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F0584 SS = A	Continued from page 5 Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure the insulated outer covering of the call light wires was intact and secured in its housing for 2 of 12 rooms on 2 of 5 halls observed for a safe, clean, and homelike environment (Resident #26 and Resident #131). The findings included: 1. On 4/13/26 at 11:48 AM an observation was conducted of Resident #26's room. The box that held the call light wires at the head of the resident's bed was observed pulled from the metal housing in the wall and hung in the space beside the left side of the bed. Two large blue and one large white insulated wire were attached to the back of the bed control box. The blue wire closest to Resident #26 had a break in the insulation and one small orange, one small white, and one small black wire were exposed. An observation and interview were conducted with the Maintenance Director of the call light wires in Resident #26's room on 4/13/26 at 2:01 PM. The Maintenance Director stated the call light box "popping out of the wall" in Resident #26's and other rooms had been an ongoing issue. He indicated residents and staff had been educated not to wrap the call light cord around the bed rail because of the risk of pulling the call light box from the wall whenever a bed was raised or lowered. The Maintenance Director explained the exposed wires were low voltage and had a low likelihood of causing injury. However, he stated he did use electrical tape to cover any wires that were exposed if they were damaged. According to the Maintenance Director, he had requested past administrations consider replacing the call light system to reduce the occurrences, but to his knowledge the request had not been acted upon. The Administrator was interviewed on 4/16/26 at 1:18 PM and stated he expected Resident #26's, and all other call lights, to be in working order and in good repair. The Administrator stated the call light box should not hang out of the wall, but he understood if the call light cord was wrapped around	F0584		04/30/2026

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F0584 SS = A	Continued from page 6 the bedrail, then it had the potential to pull the box out of the wall. 2. On 04/13/2026 at 8:37 AM, an observation of Resident #131's room revealed the call light system was not properly secured. The box housing the call light wires at the head of the resident's bed was observed pulled from the metal wall housing and hanging in the space beside the left side of the bed. Two large blue wires and one large white insulated wire were observed attached to the back of the bed control box. On the exterior of the box, two white cords were plugged in and exposed. An observation and interview were conducted with the Maintenance Director of the call light wires in Resident #131's room on 4/13/26 at 2:01 PM. The Maintenance Director stated the call light box "popping out of the wall" in Resident #131's and other rooms had been an ongoing issue. He indicated residents and staff had been educated not to wrap the call light cord around the bed rail because of the risk of pulling the call light box from the wall whenever a bed was raised or lowered. The Maintenance Director explained the exposed wires were low voltage and had a low likelihood of causing injury. However, he stated he did use electrical tape to cover any wires that were exposed if they were damaged. According to the Maintenance Director, he had requested past administrations consider replacing the call light system to reduce the occurrences, but to his knowledge the request had not been acted upon. An interview with the Administrator on 04/16/2026 at 2:00 PM revealed he was unaware of the unsecured call light wiring observed in Resident #131's room. The Administrator stated he expected all call light systems throughout the facility to be in working order and maintained in good repair.	F0584		04/30/2026
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F0640		04/30/2026

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F0640 SS = A	Continued from page 7 (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the	F0640		04/30/2026

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F0640 SS = A	Continued from page 8 facility failed to complete discharge Minimum Data Set (MDS) assessments (Resident #4 and Resident #53) and a death in facility tracker (Resident #91) for 3 of 3 residents who MDS assessments were reviewed due to no MDS assessment completed in the last 120 days (Resident #4, #53, and #91). The findings included: 1a. Resident #4 was admitted to the facility on 11/18/25. A review of nursing documentation dated 12/12/25 revealed Resident #4 was transferred to the hospital from dialysis. Review of orders revealed all active orders were discontinued by the Director of Nursing on 12/23/25 at 11:35 AM. Review of the Electronic Medical Record (EMR) revealed Resident #4 was discharged from the facility census on 12/12/25 at 1:09 PM. A review of Resident #4's EMR revealed no discharge MDS assessment had been completed within 14 days of discharge. b. Resident #53 was admitted to the facility on 11/15/25. A review of nursing documentation dated 11/23/25 revealed Resident #53 was discharged home with home care services. A review of Resident #53's EMR revealed a discharge MDS assessment dated 11/23/25 was partially completed and was not signed as completed by the nurse. c. Resident #91 was admitted to the facility on 11/12/25. A review of nursing documentation dated 12/26/25 revealed Resident #91 expired at the facility. A review of Resident #91's EMR revealed a death in facility tracker was not completed. An interview was conducted with MDS Nurse #1 on 4/14/26 at 3:30 PM. MDS Nurse #1 acknowledged that MDS assessments were required at discharge and had to be completed within 14 days. MDS Nurse #1 reported she was responsible for the MDS assessments when assigned to her by the MDS Nurse #3, the MDS Coordinator. She reported she	F0640		04/30/2026

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F0640 SS = A	Continued from page 9 was not assigned the final MDS assessments for Resident #4, Resident #53, and Resident #91. An interview was conducted with MDS Nurse #2 on 4/14/26 at 3:45 PM. MDS Nurse #2 reported that the facility had employed MDS Nurse #3 as the MDS Coordinator, and MDS Nurse #3 completed all levels of MDS assessments during November and December 2025 and assigned MDS assessments to MDS Nurses #1 and #2 for completion. MDS Nurse #2 reviewed Resident #4, Resident #53, and Resident #91's MDS assessments and stated she was unaware that these MDS assessments had not been completed, as MDS Nurse #3 had not assigned those assessments to her. She reported that MDS Nurse #3 had been responsible for assigning assessments during November and December 2025. She explained that when MDS Nurse #3 left employment on 2/1/26, no overdue or outstanding MDS assessments had been reported to her during their final MDS nurse meeting. During an interview with the Administrator on 4/16/26 at 2:30 PM he indicated that residents' discharge MDS and the death in facility tracker should have been completed within the required timeframe.	F0640		04/30/2026
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	F0842		04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matthews Health & Rehab Center	**600 Fullwood Lane , Matthews, North Carolina, 28105**

(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 10 (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; (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	F0842		04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0842 SS = A	Continued from page 11 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, observations, and staff interviews, the facility failed to complete an accurate admission skin assessment and accurate documentation of skin integrity for 1 of 3 residents reviewed for pressure ulcers (Resident #166). Findings included: Review of the hospital discharge summary dated 11/21/25 at 12:47 PM revealed Resident #166 had major surgery on 10/25/25 and had surgical incisions to his chest and abdomen, a pressure ulcer on his sacrum, and an arteriovenous (AV) fistula in his right arm. An AV fistula is an artificial blood vessel connection between an artery and a vein. They are used to facilitate kidney dialysis - a treatment that uses a special machine to remove waste materials from the body. Resident #166 was admitted to the facility on 11/21/25 with diagnoses that included a pressure ulcer to his sacrum, aftercare following major surgery, dependent on renal dialysis, and the presence of an AV fistula. Review of the Electronic Medical Record (EMR) revealed Resident #166 was admitted on Friday, 11/21/25, at 2:28 PM. Review of the Admission Observation completed by Nurse #1 dated 11/21/25 at 9:40 PM revealed no skin alterations were documented by Nurse #1 for Resident #166 in the admission observation. The observation did not include Resident 166 had an AV fistula, had surgical wounds to his chest and abdomen, or a pressure ulcer to his sacrum. A review of Nurse #1’s progress note dated 11/21/25 at 11:34 PM. Nurse #1 wrote Resident #166 had warm, dry skin with a Stage 2 pressure ulcer on his sacrum and there were [adhesive would closure strips] on his left kidney area, lung sounds were clear on the right and left sides, and his abdomen was soft and flat with normal active bowel sounds across all four quadrants. A Stage 2 pressure ulcer is a shallow open wound where the top layer of skin	F0842		04/30/2026

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F0842 SS = A	Continued from page 12 is gone, and the second layer may be partially damaged. Nurse #1 did not document surgical incision down the center of his chest or the AV fistula. Nurse #1 was unavailable for an interview during the survey. An interview with the Director of Nursing (DON) was conducted on 4/15/26 at 3:09 PM. The DON stated it was her expectation that admission assessments be completed in full by the admitting nurse. She stated there were no circumstances in which any portion should be skipped over. She was not aware that the admitting nurse had not documented in the admission assessment template Resident #166 had a surgical incision on his chest and abdomen, AV fistula for dialysis, and a pressure ulcer on his sacrum. She stated it was her expectation when the nurse assessed and observed the resident, they should accurately document it in the medical record. An interview was conducted with the Administrator on 4/15/26 at 3:38 PM. The Administrator stated that during rare after-hours admissions, the nurse on duty was responsible for completing the admission assessment. He reported that the Wound Nurse completed an assessment for all new admissions as part of the checks-and-balances process to ensure all existing wounds and issues were identified. He stated it was the expectation that nurses complete a full assessment on every new admission, which included a head-to-toe skin assessment.	F0842		04/30/2026