STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345089	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Cove Health and Rehabilitation Center	**511 Windmill Street , Walnut Cove, North Carolina, 27052**

(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 8/18/25 through 8/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D3B7F-H1.	E0000		09/15/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/18/25 through 8/21/25. Event ID# 1D3B7F-H1. The following intakes were investigated 2574239, 753420, 753421, 753422, 753423, 753432, 753435, 753436. 1 of the 14 complaint allegations resulted in deficiency.	F0000		09/15/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and staff, resident and resident RP (Responsible Party) interviews, the facility failed to protect a resident's right to be free from misappropriation of property leading to a monetary loss of $1309.99 for 1 of 3 residents reviewed for misappropriation of resident property (Resident #23). The findings included: Resident #23 was admitted to the facility on 4/24/25 with diagnoses that included cerebral infarction. Resident #23's Admission Minimum Data Set (MDS)	F0602	1) On 6/25/25, Nurse #1 was informed by Resident #23 of an authorized transaction on her bank statement. Resident # 23 stated that her Responsible Party, who has been handling Resident's funds, called her and notified her of a transaction in the amount of $1309.99 paid to APF Triad Properties on 6/20/25. Resident #23 stated that her Responsible Party had reached out to APF Triad Properties on 6/25/25 and spoke with the property manager regarding the transaction. The property manager indicated that a payment in the amount of 1309.99 was received from Resident #23 debit card on 6/20/25 as rental payment for a tenant with the same name as NA #5. Nurse #1 immediately contacted the Director of Clinical Services, who notified the Executive Director. The Director of Clinical Services arrived at the facility shortly after and completed the interview with Resident #23. During the interview with Resident #23, she offered the same details she had offered Nurse #1, verbalizing concern over an unauthorized transaction on her bank statement on 6/20/2025. Resident #23 called her Responsible Party on 6/20/2025 and conducted an interview so that she could provide more specific details surrounding the transaction. Resident # 23's Responsible party confirmed the transaction details as stated above by Resident #23. Resident #23's Responsible Party stated that after noticing the transaction, she contacted APF Triad Properties to inquire about the transaction. Resident #23's Responsible Party stated the property manager informed her that Resident #23's debit card had	09/18/2025

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

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

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F0602 SS = D	Continued from page 1 assessment revealed she was cognitively intact. The facility 24 Hour Initial Allegation Report completed by the Administrator dated 6/25/25 revealed the Director of Nursing was notified of an allegation that Resident #23 reported a missing debit card on 6/25/25 at 5:56 PM. The Administrator was notified on 6/25/25 by the Director of Nursing about the allegation. The report noted Resident #23's RP (Responsible Party) informed her there were potentially unauthorized charges on her debit card. Resident #23's RP informed her she had called the company that processed the charge and was informed the charge was related to a monthly rent payment. There was no physical injury or harm. There was no mental anguish. No alleged perpetrator was identified in the initial report, and the local police were notified. The facility 5 Day Investigation Report completed by the Director of Nursing and dated 7/1/25 documented the following: - Resident #23 reported her RP had informed her about the transaction on her debit card. She reported that her RP had contacted the company that made the charge for the funds to clarify the purpose of the charges. The manager of the company reviewed the charge and indicated it was related to a rent payment for a tenant of the apartment community. The manager disclosed the tenants' name to the RP. Resident #23 asked the facility to call her RP for more details. Resident #23's RP confirmed there was a charge made to the apartment community for a tenant that was an employee (Nursing Assistant #5) of the facility. - Resident #23 and her RP were informed by the facility that Nursing Assistant (NA) #5 would be suspended pending investigation. NA #5 was called and suspended pending the results of the investigation. - On 6/25/25 the local Sheriff's Department was notified and a deputy came to the facility and interviewed Resident #23. The facility followed up with the deputy and was informed that the case had been turned over to the criminal investigative unit and a detective would be available to answer any additional questions. -On 6/26/25 the Director of Nursing notified Adult Protective Services (APS) of the incident. An addendum to the facility investigation dated 7/16/25 written by the Director of Nursing noted the detective had notified the facility that a warrant had been	F0602	Continued from page 1 been used to make a rental payment in the amount of 1309.99 by a tenant who shared the same name as NA #5. After contacting APF Triad Properties, Resident #1's Responsible Party contacted the resident to see if she was familiar with the tenant who had been identified by the property manager. Resident #23 stated she recognized the name as NA #5 who had worked with her frequently. It was at that time Resident #23 alerted Nurse #1 of her concern on 6/25/2025. On 6/20/25, the Director of Clinical Services contacted local law enforcement, who were provided with all details received from Resident #23 and her sister. An initial allegation was filed with the State agency on 6/26/25 by the Director of Nursing Services. Resident #23 denied any emotional distress at the time of the initial interview. Resident #23 has been followed by facility Psychiatric provider since admission and was seen on 6/30/25. Resident #23 verbalized no distress to provider and reported mood as stable. There have been no changes to Resident #23's daily activities, as she continues to participate in group activities and enjoys socializing with other residents/staff. On 6/25/25, NA #5 was immediately suspended pending investigation. Director of Clinical Services contacted law enforcement officer on 6/27/25 to follow up. The law enforcement officer stated the investigation had been turned over to the Criminal Investigation Unit, and a Detective would reach out with any further questions. NA #5 contacted the Director of Clinical Services on July 3rd ,2025, to notify that she was resigning from her position at Walnut Cove Health and Rehabilitation APS notified of incident by Director of Clinical Services on 6/26/2025. Resident #23 Notified the Director of Clinical Services on 7/7/2025, that the full amount of misappropriated funds, ($1309.99) were fully reimbursed by her bank's fraud department. 2) On 6/26/25, the Executive Director held an ADHOC	

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F0602 SS = D	Continued from page 2 issued for the arrest of NA #5 who used Resident #23's debit card. The detective indicated enough evidence had been collected to charge NA #5 with three separate felony charges related to the unauthorized use of Resident #23's debit card. An attempt to contact the law enforcement officer on 8/19/25 at 3:38 PM was unsuccessful. An attempt to contact the alleged perpetrator (NA #5) on 8/19/25 at 3:42 PM was unsuccessful. During an interview with Resident #23 on 8/20/25 at 9:45 AM she stated she had called to check her account balance the morning of 6/25/25 because she was expecting a deposit. Resident #23 reported her account balance was at $51.00 and a charge of $1309.99 had been charged to her card. Resident #23 stated she called her RP to have her find out information about the charge. Resident #23 stated she kept her debit card in her purse in the top drawer of the dresser. Resident #23 stated she never missed her debit card. Resident #23 denied that she used the funds to pay for any part of her stay at the facility. Resident #23 stated she was surprised that someone used her debit card without her consent. Resident #23 stated she did not feel afraid or that she could not trust staff that worked with her. Resident #23 stated the bank reimbursed her the money back in July. An interview with Resident #23's RP on 8/19/25 at 3:21 PM revealed she was notified by Resident #23 the morning of 6/25/25 to review her debit card account because she was missing some money. The RP stated she noticed a charge for $1309.99 was charged to Resident #23's account and neither the RP nor resident recognized the charge. The RP stated she called the number attached to the transaction and learned that the payment was to a rental agency for NA #5. The RP stated she explained to Resident #23 that she needed to report the charge to the facility. The RP stated she had not had any interaction with NA #5. The RP stated the facility notified both Resident #23 and her that the local law enforcement would be notified. During an interview with Nurse #4 on 8/19/25 at 4:53 PM she stated she was informed by another NA on the unit on 6/25/25 that Resident #23 had made a complaint about missing money from her debit card. She was unable to recall which NA informed her of this. Nurse #4 stated she went to speak with Resident #23, and she reported that someone had made an unauthorized charge to her debit card. Nurse #4 stated she immediately reported	F0602	Continued from page 2 Quality Assurance Performance Improvement meeting. The Executive Director presented the deficient practice of misappropriation of resident property. Staff interviews were completed by unit managers on 6/25/25-6/26/25, with 100% compliance on 6/26/25.Interviews were completed with 100% of facility and contract staff, with questions directly related to misappropriation. There were no reports of any type of misappropriation during these staff interviews. Social Worker interviewed all alert and oriented residents on 6/26/25 to ensure no employee had asked any resident for money, or use of their Bank card, Credit Card, Electronic Benefit Transfer Card, or United Healthcare Ucard. There were no further allegations or concerns verbalized by the residents who were interviewed. On 9/15/2025, the facility-initiated calls to Responsible Parties of all cognitively impaired residents to determine if there were any issues related to misappropriation of resident's funds to be completed by 9/16/25. 3) Director of Clinical Services initiated re-education of all facility and contract staff with written validation of understanding of abuse policy on 6/25/25-6/26/25 with 100% compliance. Special emphasis on misappropriation of resident property, unauthorized use of a resident's Bank card, Credit Card, Electronic Benefit Transfer Card, or United Healthcare Ucard for personal use or gain was included in re-education. Residents are made aware upon admission and throughout their stay of having the option of having a personal lockbox. A key is provided to the resident, and a spare key in a locked box/drawer in the Maintenance Director's office. All residents/responsible parties are offered a Resident Fund Management System account upon admission by the Business Office Manager and are allowed to make changes at any time during their stay. 4) An action plan was initiated to include quality improvement monitoring and the frequency of monitoring.	

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F0602 SS = D	Continued from page 3 the information to the Director of Nursing via phone. Nurse #4 stated the Director of Nursing came in and went to interview Resident #23. During an interview with the Director of Nursing on 8/19/25 at 3:45 PM she stated she learned about the unauthorized charge when Resident #23 came to her and stated she had received a call from her RP the morning of 6/25/25. The Director of Nursing stated she asked Resident #23 if she had loaned her card out or given it to any of the staff. Resident #23 denied she had given the debit card to anyone else, and Resident #23 stated she always kept the card in her purse located in the top dresser drawer located at the bedside. The Director of Nursing revealed the facility had never seen Resident #23's debit card. The Director of Nursing stated that the facility offered all residents a place to keep their valuables upon admission and Resident #23 declined. During an interview with the Administrator on 8/20/25 he stated that he became aware of the unauthorized charges to Resident #23's debit card on 6/25/25 by the Director of Nursing. The Administrator stated Resident #23 reported she had unauthorized charges on her debit card. The Administrator indicated he notified local law enforcement on 6/25/25. The facility provided a plan of correction that was not acceptable to the State Agency. When identifying other residents who had the potential to be affected by the same deficient practice the facility interviewed cognitively intact residents, but they did not comprehensively assess if any non-interviewable residents were affected. The interventions used to identify if non-interviewable residents were affected were skin assessments and the fact that no new allegations of misappropriation were made by family members during the 5-day investigation period. Additionally, the facility's monitoring procedures only addressed interviewable residents.	F0602	Continued from page 3 The Executive Director and/or Director of Clinical Services complete quality monitoring on five random residents with BIMS >13, weekly for a period of twelve weeks to ensure residents are protected from misappropriation of personal property. The Executive Director and/or Director of Clinical Services complete quality monitoring with the Responsible Parties of five random residents with BIMS <13, weekly for a period of twelve weeks to ensure residents are protected from misappropriation of personal property. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for a period of three months. Quality Improvement monitoring schedule will be modified based on the findings of monitoring. Corrective action will be completed by 9/18/25.	
F0640 SS = B	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	F0640	1) On 8/21/2025, the MDS Coordinator immediately completed Minimum Data Set (MDS) Discharge Assessments for resident #55, resident #81, and resident #85 2) All residents are at risk of being affected by the deficient practice. The MDS Coordinator was re-educated by the Regional Director of Clinical Services on 8/21/25 to ensure all	09/18/2025

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F0640 SS = B	Continued from page 4 in the facility: (i) Admission assessment. (ii) Annual assessment updates. (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	F0640	Continued from page 4 Minimum Data Sets (MDS) are accurate and all discharges are completed. An ADHOC Quality Assurance Performance Improvement Committee was held on 8/21/2025 to formulate and approve a plan of correction for the deficient practice. 3) Weekly Audits will be completed for all discharged residents by the MDS Coordinator to ensure Minimum Data Set (MDS) Discharge Assessments are completed within 14 days of every resident discharge for 12 weeks. 4) Beginning 8/24/2025, the MDS Coordinator will perform a weekly audit of discharging residents to ensure that the discharge assessment is completed within 14 days of the resident discharge. This weekly audit will continue for a period of 12 weeks. The Facility will review the Performance Improvement Plan monthly during the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for a period of 3 months. Findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) monthly, and Quality monitoring audits will be updated as indicated. Corrective action will be completed by 9/18/25.	

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F0640 SS = B	Continued from page 5 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 facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 3 of 3 residents reviewed for resident assessment (Resident #55, Resident #81, Resident #85). The findings included: a.Resident #55 was admitted to the facility on 3/10/25. Review of Resident #55's medical record revealed he was discharged to another facility on 4/11/25. Review of Resident #55's medical record revealed the last completed MDS assessment was a comprehensive assessment dated 3/21/25. There was no discharge assessment completed or transmitted. b. Resident #81 was admitted to the facility 3/27/25. Review of Resident #81's medical record revealed he was discharged home on 4/12/25. Review of Resident #81's medical record revealed the last completed MDS assessment was a comprehensive assessment dated 4/4/25. There was no discharge assessment completed or transmitted. c. Resident #85 was admitted to the facility on 3/25/25. Review of Resident #85's medical record revealed she was discharged home on 4/10/25. Review of Resident #55's medical record revealed the last completed MDS assessment was a comprehensive assessment dated 4/2/25. There was no discharge assessment completed or transmitted. During an interview with the MDS Coordinator on 08/21/25 at 10:53 AM while viewing the medical records she stated all three residents had missing discharge MDS assessments. The MDS Coordinator stated when she knew a person was discharged, she completed a discharge MDS assessment that indicated whether the person was coded as "discharge return not anticipated," or "discharge return anticipated." The MDS Coordinator indicated the discharge MDS assessment had to be	F0640		

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F0640 SS = B	Continued from page 6 completed 14 days after discharge. The MDS Coordinator stated she was not sure how she had missed completing the discharge MDS assessments for the three residents. She further stated the assessments did not trigger on her MDS progress list. During an interview with the Administrator on 08/21/25 at 3:16 PM, he stated he expected that the discharge MDS assessment would be completed and transmitted according to guidelines.	F0640		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641		09/18/2025

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F0641 SS = A	Continued from page 7 Based on record review and staff interviews, the facility failed to accurately code an admission Minimum Data Set (MDS) assessment in the area of tobacco use for 1 of 3 residents reviewed for smoking (Resident #23). The findings included: Resident #23 was admitted to the facility on 4/24/25. Review of the medical record revealed an Admission Assessment completed by Unit Manager #1 and dated 4/25/25 which indicated Resident #23 did not smoke. Review of the medical record revealed a smoking assessment dated 4/25/25 which indicated the resident was a safe smoker and she required assistance to get outside to go smoke. Review of the admission MDS assessment with an Assessment Reference Date (ARD) dated 5/1/25 revealed Resident #23 was cognitively intact and coded as no tobacco use. On 08/20/25 at 9:30 AM an observation was conducted of Resident #23 smoking in the courtyard with staff present. During an interview with Resident #23 on 8/20/25 at 10:08 AM the resident stated she had been a smoker since she was admitted to the facility back in April of 2025. During an interview and observation of Resident #23's medical record with the MDS Nurse on 08/21/2025 at 10:53 AM she stated that she got her information from the initial admission assessment and the white board from the morning clinical meeting. Review of an admission assessment dated 4/25/25 revealed Resident #23 was coded as a nonsmoker by Unit Manager #1 that completed the assessment. Further review of the medical record revealed a smoking assessment that was conducted on 4/25/25 by the nurse that was caring for Resident #23. The MDS Nurse confirmed she had completed Resident #23's 5/1/25 MDS Assessment. The MDS Nurse stated she was aware Resident #23 smoked and did not realize her admission MDS assessment did not reflect the same. The MDS Nurse further stated she was not aware of the smoking assessment completed by the nurse. Multiple attempts to reach Unit Manager #1 via phone were unsuccessful.	F0641		

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F0641 SS = A	Continued from page 8 During an interview with the Director of Nursing on 8/21/25 at 3:00 PM she stated she recalled a conversation with Resident #23 when she first came to the facility, and she stated she wanted to quit smoking and was not going to smoke. During an interview with the Administrator on 08/21/2025 at 3:16 PM he stated he expected that MDS assessment would reflect the current status of the resident.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was	F0656	1)On 8/21/2025, the MDS Coordinator was made aware that a person-centered care plan had not been developed for resident #13 in the area of diabetes management. The MDS Coordinator immediately implemented a person-centered care plan to reflect diabetes management for resident #13 on 8/21/25. On 8/21/2025, the MDS Coordinator was made aware that a person-centered care plan had not been implemented for resident #23, who currently smokes. The MDS Coordinator immediately reviewed resident #23's chart and developed a person-centered care plan to reflect the resident's current smoking status on 8/21/25. 2)All residents are at risk of being affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee was held on 8/21/2025 to formulate and approve a plan of correction for the deficient practice. On 8/21/2025, the Unit Managers performed an audit of all diabetic residents in the facility to ensure there was a person-centered care plan in place, reflecting diabetes management for each resident with a diagnosis of diabetes. No other deficient practices were found. On 8/21/25 all current residents who smoke were audited by the MDS Coordinator to ensure they were accurately care planned and coded for safe smoking or unsafe smoking. No other deficiencies were found. 3)On 8/21/2025, the MDS Coordinator was re-educated by the Regional Director of Clinical Services regarding the development and implementation of person-centered care plans for each resident. Beginning 8/24/2025, The MDS Coordinator will perform a weekly audit of (5) residents to ensure person-centered care plans are in place, reflecting the current status of each resident. This weekly audit will continue for a	09/18/2025

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Walnut Cove Health and Rehabilitation Center	**511 Windmill Street , Walnut Cove, North Carolina, 27052**

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F0656 SS = D	Continued from page 9 assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to develop a person-centered care plan in the areas of diabetes management (Resident #13) and smoking status (Resident #23). This deficient practice was for 2 of 29 residents whose care plans were reviewed. The findings included: 1. Resident #13 was admitted to the facility on 11/07/24 with diagnoses which included diabetes. An active physician order included insulin glargine (long-acting insulin) inject 15 units subcutaneously in the morning related to diabetes. An active physician order included insulin glargine inject 20 units subcutaneously at bedtime for diabetes. An active physician order included metformin (medication used to treat diabetes) 500 milligram tablet; give one tablet twice a day for diabetes. Resident #13's care plan which was last reviewed on 7/08/25 revealed no care plan for the management of diabetes. The Minimum Data Set (MDS) quarterly assessment dated 7/14/25 revealed Resident #13 had moderate cognitive impairment. Resident #13 was coded for diabetes diagnosis and the use of hypoglycemic (which included insulin) medication. An interview was conducted with the MDS Nurse on 8/21/25 at 9:37 am who revealed she was responsible for Resident #13's care plan. The MDS Nurse reviewed Resident #13's care plan in the presence of the surveyor and reported that she did not see that a care	F0656	Continued from page 9 period of 12 weeks. 4)Beginning 8/24/2025, the MDS Coordinator will perform a weekly audit of (5) current residents to ensure all person-centered care plans reflect the current status of each resident. This weekly audit will continue for a period of 12 weeks. Beginning 8/24/2025, the MDS Coordinator will begin a weekly audit of current residents who smoke and all new admissions, ensuring a person-centered care plan is in place reflecting the current smoking status of each resident. These audits will continue for a period of 12 weeks. The Facility will review the Performance Improvement Plan monthly during the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for a period of 3 months. Findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) monthly, and Quality monitoring audits will be updated as indicated. Corrective action will be completed by 9/18/25.	

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F0656 SS = D	Continued from page 10 plan for diabetes had ever been implemented. The MDS Nurse stated she should have caught the missing care plan when she completed the comprehensive review, but she just missed it. An interview was conducted with the Director of Nursing (DON) on 8/21/25 at 12:35 pm who revealed the MDS Nurse was responsible to ensure that Resident #13's care plan for medical diagnoses were in place when she completed the review. 2. Resident #23 was admitted to the facility on 4/24/25. Review of the admission MDS assessment with an Assessment Reference Date (ARD) dated 5/1/25 revealed Resident #23 was cognitively intact. Review of the medical record revealed a smoking assessment dated 4/25/25 which indicated the resident was a safe smoker and she required assistance to get outside to go smoke. Resident #23's care plan last revised on 8/12/25 revealed no care plan for smoking. During an interview and observation of Resident #23's medical record with the MDS Nurse on 08/21/2025 at 10:53 AM she stated she was responsible for completing the care plan. Review of Resident #23's care plan by the MDS Nurse revealed she did not see a smoking care plan for Resident #23 had been implemented. During an interview with the Director of Nursing on 8/21/25 at 3:00 PM, she stated the MDS Nurse was responsible for making sure Resident #23's care plan reflected her smoking status. During an interview with the Administrator on 08/21/2025 at 3:16 PM, he stated the MDS nurse was responsible for care plans.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F0657	On 8/21/25, the MDS Coordinator corrected the care plan in the area of wander/ elopement alarm for resident #13 and smoking status for Resident #39. On 8/21/2025 the MDS Coordinator performed an audit on all current residents who were coded to be an elopement risk or an unsafe smoker to ensure they have an accurate, up to date care plan. No other deficient practice was noted.	09/18/2025

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F0657 SS = D	Continued from page 11 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to revise the care plan in the areas of use of a wander/elopement alarm (Resident #13) and smoking status (Resident #39) for 2 of 29 residents whose care plans were reviewed. The findings included: 1. Resident #13 was admitted to the facility on 11/07/24 with diagnoses which included Alzheimer's Disease. The Elopement Risk Evaluation assessment completed on 6/24/25 revealed Resident #13 was not determined to be at risk for elopement. The care plan which was last reviewed on 7/08/25 revealed Resident #13 had a care plan in place for elopement risk with an intervention for the use of a wander/elopement alarm. The Minimum Data Set (MDS) quarterly assessment dated 7/14/25 revealed Resident #13 had moderate cognitive impairment and was not coded for the use of the wander/elopement alarm.	F0657	Continued from page 11 An ADHOC Quality Assurance Performance Improvement Committee was held on 9/05/25 to formulate and approve a plan of correction for the deficient practice. The MDS Coordinator was re-educated by the Regional Director of Clinical Services on 8/21/25 to ensure any resident who is an elopement risk or unsafe smoker have an up-to-date care plan that is accurate and patient centered. The Director of Nursing will do audits on (3) current residents who are coded as elopement risks and have an elopement care plan in place for accuracy, weekly, for a period of (12) weeks starting 9/05/25. The Director of Nursing will do audits weekly on (3) current residents who smoke, to ensure each care plan reflects the smoking interventions in place for each resident. This audit will be ongoing for a period of (12) weeks starting 9/05/25. The Facility will review the Performance Improvement Plan monthly during the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for a period of 3 months. Findings will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) monthly, and Quality monitoring audits will be updated as indicated. Corrective action will be completed by 9/18/25.	

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F0657 SS = D	Continued from page 12 Review of Resident #13's active physician orders revealed no physician order for the use of a wander/elopement alarm. An observation on 8/18/25 at 12:47 of Resident #13 revealed no wander/elopement alarm was in place. An interview was conducted with the MDS Nurse on 8/21/25 at 9:37 am who confirmed Resident #13 did not have a wander/elopement alarm in use. The MDS Nurse stated she did not see the wander/elopement alarm was still listed as an intervention for Resident #13 when she completed her care plan review and it was just missed. An interview was conducted with the Director of Nursing (DON) on 8/21/25 at 12:35 pm who revealed Resident #13 had a wander/elopement alarm in the past but no longer had the wander/elopement alarm. The DON stated the MDS Nurse was responsible to ensure that Resident #13's care plan was accurate when she completed the review. 2. Resident #39 was admitted to the facility on 2/22/24 with diagnoses which included major depressive disorder and nicotine dependence. The Minimum Data Set (MDS) quarterly assessment dated 5/08/25 revealed Resident #39 was cognitively intact. The quarterly smoking evaluation dated 8/02/25 revealed Resident #39 was determined to be an unsafe smoker. The care plan last reviewed on 8/14/25 revealed Resident #39 was a safe smoker with a goal that Resident #39 would not participate in unsafe smoking practices. The care plan had interventions which included educating the resident on the smoking policy, smoking locations and times. During an interview on 8/18/25 at 3:55 pm Resident #39 stated he smoked cigarettes daily and the facility had him on the unsafe smoking list, so he was not allowed to go out by himself to smoke. An observation was conducted on 8/20/25 at 2:10 pm of Resident #39 smoking with staff present with no identified concerns. An interview was conducted with Nurse Aide (NA) #1 who revealed Resident #39 had previously been a safe smoker and was allowed to go out by himself to smoke. NA #1stated Resident #39 was recently changed to an unsafe smoker and he now needed to be supervised when smoking.	F0657		

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F0657 SS = D	Continued from page 13 During an interview with the MDS Nurse on 8/21/25 at 9:46 am she revealed she was aware that Resident #39 was determined to be an unsafe smoker, but she had not updated Resident #39's care plan yet. The MDS Nurse stated she should have updated Resident #39's care plan to reflect the unsafe smoker status when she completed the review. The Director of Nursing (DON) was interviewed on 8/21/25 at 12:38 pm who revealed Resident #39 was determined to be an unsafe smoker and the MDS Nurse was notified of the change. The DON stated the MDS Nurse should have updated Resident #39's smoking care plan to reflect the current smoking status.	F0657		