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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to provide a bed with enough length to prevent a resident's feet from pressing against the footboard for 1 of 1 resident reviewed for accommodation of needs (Resident #48).Findings included:Resident #48 was admitted to the facility 03/26/25 with diagnoses including incomplete quadriplegia C5-C7 (spinal cord injury between the 5th cervical vertebrae and the 7th cervical vertebrae resulting in loss of some motor functions but not all), and chronic pain due to trauma. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #48 was cognitively intact. Resident #48 was dependent on staff assistance with self-care tasks, bed mobility and transfers. It was noted Resident #48 had a height of 73 inches.During an observation and interview on 02/16/26 at 11:51 AM, Resident #48 was observed sitting up in bed watching television. The head of the bed was raised approximately 30 degrees. Resident #48's head was approximately two inches below the top of the bed, while his feet were pressed against the footboard of the bed. Resident #48's legs were in a straight position. Resident #48 stated his feet hurt when they were pressed against the footboard of the bed and he asked the Nursing Assistants (NAs) to elevate his feet on pillows to keep them from pressing against the footboard of the bed. He stated he had requested a longer bed multiple times, but he could not recall the dates he made the requests for a larger bed.Follow up observation and interview conducted with Resident #48 on 02/18/26 at 10:39 AM revealed Resident #48 sitting up in bed watching television with the head of the bed raised approximately 30 degrees. The top of Resident #48's head was approximately two inches below the top of the bed. Resident #48's legs were in a straight position, and his feet were pressed against the footboard of the bed. Resident #48 stated he had activated his call light to request his feet be elevated with a pillow, so they were not pressed against the footboard.An interview was conducted with NA #11 on 02/18/26 at 10:51 AM. She stated she had just completed care for Resident #48. NA #11 stated Resident #48 requested pillows be placed under his feet because it was uncomfortable when his feet were pressed against the footboard of the bed. She recalled Resident #48 had this concern on multiple occasions but could not provide an exact number of times. NA #11 indicated she used pillows to raise Resident #48's feet up and away from the foot board.An Interview was conducted with Medical Assistant (MA) #15 on 02/18/26 at 10:58 AM. MA #15 confirmed he provided care for Resident #48 and Resident #48 spent much of the day in bed watching television with the head of the bed raised. When the head of the bed was raised Resident #48's feet pressed against the foot board, which caused discomfort for Resident #48's feet. MA #15 stated Resident #48 requested his feet be raised on pillows, which kept his feet from pressing into the bed.An observation and interview were conducted with Resident #48 on 02/20/26 at 8:08 AM in conjunction with the Director of Nursing (DON). The DON stated Resident #48 was positioned correctly in bed and his feet were pressed against the footboard of the bed. The DON asked Resident #48 if he was comfortable and Resident #48 stated the bed was too small. The DON confirmed the bed appeared to be too (continued on next page)

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 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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	small for Resident #48 and he could be at risk for skin breakdown with his feet pressed against the footboard of the bed. An observation of Resident #48's feet revealed they were dry and intact with no rashes, bruising, or discoloration noted. The DON stated Resident #43 was in a longer bed before he transferred rooms on 01/29/25 but she could not explain why Resident #43 received a shorter bed after the transfer. An interview was conducted on 02/20/26 at 1:21 PM with the Maintenance Director. The Maintenance Director stated nursing staff assessed residents for proper bed size. Nursing staff would enter a work order in the TELS application (application on facility computers and facility cell phones used to manage work orders) if a resident needed a larger bed. He confirmed he received a work order for a longer bed for Resident #48 on 02/20/26. An interview was conducted with the Administrator on 02/20/26 at 1:21 PM. The Administrator confirmed nursing staff assessed residents for bed size when they were admitted to the facility. He stated the nursing assessment was a visual assessment and when a resident could express their needs nursing staff got verbal confirmation the resident was comfortable in the bed. He stated he expected residents to be in the proper sized bed.

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	345285	A. Building B. Wing	02/20/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 3 of 30 residents whose MDS assessments were reviewed (Residents #10, #47 and #108). Findings included:a. Resident #10 was admitted to the facility on [DATE].Review of Resident #10's electronic medical record revealed a quarterly Minimum Data Set (MDS) assessment with an ARD of 09/29/25 that was marked as completed on 10/22/25.b. Resident #47 was admitted to the facility on [DATE].Review of Resident #47's electronic medical record revealed a quarterly MDS assessment with an ARD of 11/15/25 that was marked as completed on 12/04/25.c. Resident #108 was admitted to the facility on [DATE].Review of Resident #108's electronic medical record revealed a quarterly MDS assessment with an ARD of 11/07/25 that was marked as completed on 12/02/25.During a joint interview on 02/19/26 at 1:42 PM, the MDS Registered Nurse (RN) and Regional MDS Consultant both verified Resident #10's quarterly MDS assessment dated [DATE], Resident #47's quarterly MDS assessment dated [DATE], and Resident #108's quarterly MDS assessment dated [DATE] were not completed within the regulatory time frame. The MDS RN explained the facility has had a lot of new admissions and they just got behind with the volume of MDS assessments to complete.During an interview on 02/20/26 at 2:57 PM with the Administrator present, the Regional Director of Clinical Operations (RDCO) revealed that while good-faith efforts had been made to address MDS issues, including completing assessments within regulatory timeframes, further improvement was still needed. The RDCO explained that a new rehabilitation company, who also had MDS resources that would provide the facility with additional MDS support, was starting at the facility on 03/01/26 which would help improve the MDS process and prevent further compliance issues.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the areas of hospice (specialized care focused on nearing the end of life) (Resident #29, Resident #62, and Resident #77) and preadmission screening and resident review (PASRR, a program ensuring residents with certain diagnoses received specialty services) (Resident #10) for 4 of 30 residents whose MDS assessments were reviewed. Findings included: 1. Resident #29 was admitted to the facility 10/20/23. Review of a hospice recertification note dated 12/15/25 revealed Resident #29 was initially admitted to hospice on 06/24/25 and was recertified to receive services from 12/21/25 through 02/18/26. Review of Resident #29's quarterly Minimum Data Set (MDS) assessment dated [DATE] did not indicate she was receiving hospice services. An interview with the Regional MDS Consultant on 02/19/26 at 1:42 PM revealed Resident #29's quarterly MDS assessment should have reflected that she was receiving hospice care, and it was an oversight. An interview with the Director of Nursing (DON) on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately. 2. Resident #62 was admitted to the facility 01/01/21. A hospice progress report dated 12/31/24 revealed Resident #62 was admitted to hospice on 09/10/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #62 was not coded as having a condition or chronic disease that may result in a life expectancy of less than 6 months or that she was receiving hospice care. A hospice progress report dated 01/21/26 revealed Resident #62 was recertified to receive services through 03/04/26. A joint interview was conducted with the MDS Coordinator and Regional MDS Consultant on 02/19/26 at 1:42 PM. The MDS Coordinator and Regional MDS Consultant both stated that Resident #62's quarterly MDS assessment should have reflected she had a life expectancy of less than 6 months and was receiving hospice care, and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to (continued on next page)

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	345285	A. Building B. Wing	02/20/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be coded accurately. 3. Resident #77 was admitted to the facility on [DATE]. A hospice agreement dated 01/28/26 revealed Resident #77 elected to receive hospice services effective 01/28/26. A significant change Minimum Data Set (MDS) assessment dated [DATE] did not indicate Resident #77 was receiving hospice care. A joint interview was conducted with the MDS Coordinator and Regional MDS Consultant on 02/19/26 at 1:42 PM. The MDS Registered Nurse (RN) confirmed the significant change MDS assessment was completed due to Resident #77 electing hospice services. The MDS RN stated the MDS assessment should have reflected that he was receiving hospice care and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately. 4. Resident #10 was admitted to the facility on [DATE]. A PASRR Level II determination notification letter dated 12/30/24 revealed Resident #10 had a Level II PASRR with no expiration date. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. An interview with the Regional MDS Consultant on 02/19/26 at 1:42 PM revealed Resident #10's annual MDS assessment dated [DATE] should have reflected she had a Level II PASRR and it was an oversight. An interview with the Director of Nursing on 02/20/26 at 2:39 PM revealed she expected MDS assessments to be coded accurately. An interview with the Administrator on 02/20/26 at 2:57 PM revealed he expected MDS assessments to be coded accurately.

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	345285	A. Building B. Wing	02/20/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) evaluation for a resident who was admitted to the facility with mental health disorders for 1 of 6 residents reviewed for PASRR (Resident #11).The findings included:A PASRR Determination Notification letter dated 02/03/16 revealed Resident #11 had a Level I PASRR with no expiration date. Resident #11 was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder, anxiety, depression, and bipolar disorder.Review of the admission minimum data set (MDS) dated [DATE] revealed that Resident #11 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #11's active psychiatric/mood disorder diagnosis included anxiety, depression, bipolar disorder, and schizophrenia. Resident #11 took antianxiety medications. Review of a Psychiatric Nurse Practitioner (NP) note dated 05/05/25 revealed Resident #11 was being seen for an initial psychiatric evaluation and medication review at the request of facility to evaluate Resident #11's mood. Resident #11 had a past medical history of obsessive compulsive disorder (OCD), schizophrenia, and bipolar disorder, seen for evaluation of anxiety, OCD, major depressive disorder, schizoaffective disorder, and insomnia. Review of a Psychiatric NP note dated 01/09/26 revealed Resident #11 was being treated for anxiety, depression, and bipolar disorder. Resident #11's symptoms were chronic and stable and well controlled on the current regimen.There was no documentation that a request was submitted for the resident to be evaluated for an updated PASRR. During an interview on 02/18/26 at 2:00 PM, the Social Worker (SW) stated she had been the SW since August 2025. She stated that she looked at the diagnosis and medications and submits to North Carolina Medicaid Uniform Screening Tool (NCMUST). She stated that she had a lot of Level II PASRR's at this facility, and she had a person she could call to help her with questions about PASRR in the PASRR office. She stated that when a resident came in she would review their diagnosis and if the resident had a mental health diagnosis she would resubmit for a re-evaluation. She further revealed that she had completed an audit when she started the job in August of 2025, and Resident #11 was overlooked. During an interview on 02/18/26 at 2:57 PM, the Administrator revealed that if there was a new admission with a Level I PASRR, the SW would be responsible for submitting for a re-evaluation for PASRR. He stated that his expectation was that all residents who were admitted with a Level I PASRR and who have a mental health diagnosis were reviewed by the SW and then submitted for re-evaluation for a Level II.

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	345285	A. Building B. Wing	02/20/2026

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) reevaluation after a significant change in physical or mental status was identified for residents previously determined to have a Level II PASRR. This deficient practice affected 2 of 5 sampled residents reviewed for PASRR (Residents #28 and #31).Findings included:a. Resident #28 was readmitted to the facility on [DATE]. Her cumulative diagnoses included schizoaffective disorder, bipolar type and anxiety disorder.A PASRR Level II determination notification letter dated 05/05/20 revealed Resident #28 had a Level II PASRR with no expiration date and nursing facility placement was appropriate.A significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #28's active psychiatric/mood disorder diagnoses included anxiety disorder and schizophrenia. She received antipsychotic and antidepressant medications during the MDS assessment period.The North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Social Worker on 02/20/26 at 2:00 PM revealed Resident #28 received a Level II PASRR effective 05/05/20 with no expiration date. There were no PASRR reevaluation requests submitted since the significant change MDS assessment dated [DATE].b. Resident #31 was admitted to the facility on [DATE]. His cumulative diagnoses included major depressive disorder and anxiety disorder.A PASRR Level II determination notification letter dated 08/19/21 revealed Resident #31 had a Level II PASRR with no expiration date and nursing facility placement was appropriate.A significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #31's active psychiatric/mood disorder diagnoses included anxiety disorder and depression (other than bipolar). He received antianxiety and antidepressant medications during the MDS assessment period.The North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Social Worker on 02/20/26 at 2:00 PM revealed Resident #31 received a Level II PASRR effective 08/19/21 with no expiration date. There were no PASRR reevaluation requests submitted since the significant change MDS assessment dated [DATE].During an interview on 02/18/26 at 2:00 PM, the Social Worker (SW) revealed she started her position in August 2025 and was still learning the PASRR process. The SW confirmed she was the person responsible for submitting requests for Level II PASRR reevaluations when needed. She explained when a resident admitted to the facility, she reviewed their diagnoses and if they had a mental health diagnosis she submitted a request for a reevaluation through NC MUST. The SW stated she was not aware a request for a Level II PASRR reevaluation needed to be submitted when a resident had a significant change in condition. During an interview on 02/18/26 at 2:55 PM, the Administrator revealed the SW was responsible for reviewing a resident's diagnoses and requesting Level II PASRR reevaluations as needed. The Administrator stated requests for Level II PASRR reevaluations should be made when a resident had a significant change in condition per the regulatory guidelines.

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	345285	A. Building B. Wing	02/20/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with the Medical Director, Registered Dietitian and staff, the facility failed to provide nutritional supplements according to the physician's diet order for 1 of 4 residents reviewed for weight loss (Resident #90).Findings included:Resident #90 was admitted to the facility 09/24/24 with diagnoses including vascular dementia and severe protein-calorie malnutrition.Resident #90 had an order dated 06/11/25 for fortified pudding after lunch for weight stability. Resident #90 had an order dated 12/02/25 for a frozen nutritional cup two times per day for weight stability. Resident #90's weight record revealed he weighed 154.4 pounds on 12/10/25.Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident #90 had severely impaired cognition, was independent for eating meals, had no swallowing disorders, weighed 154 pounds, and documented weight loss of five percent or more in the last month or loss of ten percent or more in the last six months while not on a prescribed weight loss regimen.Resident #90's weight record revealed he weighed 140.2 pounds on 12/24/25.The care plan for nutrition last revised 12/27/25 revealed a risk for potential nutritional problems. Interventions included providing Resident #90's diet as ordered.Resident #90's weight record revealed he weighed 136.2 pounds 01/05/26.A summary of the Registered Dietitian (RD) note dated 01/14/26 was as follows: Resident #90 showed a significant weight loss of 11.9%) over the last three months. Resident #90 usually consumed 51% to 75% of meals. Resident #90 received fortified pudding once daily, house supplement three times a day and a frozen nutritional cup two times a day as supplements. The RD note further stated a goal of no significant weight loss through the next assessment.A telephone interview with the RD on 02/19/26 at 3:20PM revealed she worked with Resident #90 due to weight loss. She stated in December 2025 she attempted to stabilize his weight loss by adding frozen nutritional cups to his dietary order in addition to the fortified pudding that was ordered in June of 2025. She confirmed she increased his house supplement in January 2026 as a further attempt at weight stabilization for Resident #90. The RD stated she expected Resident #90 to receive dietary supplements as ordered. Resident #90 had an order dated 1/15/26 for the house supplement (fortified shake) 120 milliliters by mouth four times a day for weight stability.Resident #90's weight record revealed he weighed 133.8 pounds on 02/06/26.Resident #90's diet orders included an order revised 2/16/26 for a regular diet, with mechanical soft/ground meat texture and nectar thick liquids.An observation of Resident #90's lunch meal ticket on 02/17/26 at 11:35 AM revealed he was to receive a regular mechanical altered /ground meal with nectar thick liquids. Fortified pudding and a frozen nutritional cup were not included on the ticket. An observation of Resident #90's meal tray at the same date and time revealed he received one serving of mechanically ground chicken, one serving of spinach, one serving of egg noodles and an apple crisp. Resident #90 had just received his meal tray at the time of the observation.An interview was conducted on 2/18/26 at 10:16 AM with Nurse Aide #11. She stated Resident #90 did not receive fortified pudding or a frozen nutritional cup on his lunch meal tray. She stated Resident #90 had consumed about seventy-five percent (75%) of his meals over the past 2 weeks when she had provided care. An observation of Resident #90's lunch meal tray on 2/18/26 at 11:26 AM revealed the meal tray did not contain fortified pudding or a frozen nutritional cup.An interview with the Dietary Manager on 02/19/26 at 8:12 AM revealed that Resident #90 had a physician order for fortified pudding and a frozen nutritional cup and that Resident #90 should have received those items on his meal tray. She stated nursing staff informed her of new dietary orders via the diet requisition form. Once she received the diet requisition form with the new diet orders from the nursing staff, she would make the changes in Meal Tracker (nutrition management system used to manage dining operations), which (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would add the changes to the meal ticket. She stated she had no recollection that she received a diet requisition form to add fortified pudding and a frozen nutritional cup to Resident #90's meal ticket. The Dietary Manager confirmed that the fortified pudding and frozen nutritional cup were not on the meal ticket for Resident #90.An interview was conducted with Unit Manager #1 on 02/19/26 at 08:23 AM. She stated nursing staff filled out a diet requisition form when a resident received a new diet order. Nursing staff would place the diet requisition form in the Dietary Manager's inbox. The Unit Manager could not recall if diet requisition forms were provided to the Dietary Manager for the fortified pudding and frozen nutritional cup for Resident #90.An observation of the nourishment room on 02/20/26 at 2:34 PM revealed the nourishment room did not contain fortified pudding or frozen nutritional cups.An interview with the Medical Director on 02/20/26 at 11:00 AM revealed he expected residents to receive nutritional supplements as ordered. He stated if residents did not receive nutritional supplements as ordered, they would be at risk for continued weight loss. During an interview on 02/20/26 at 12:25 PM, the Director of Nursing stated she expected the residents to receive nutritional supplements as ordered.An interview with the Administrator on 02/20/26 at 2:45 PM revealed he expected residents to receive dietary supplements as ordered.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident and staff interviews, the facility failed to complete bed rail assessments to determine the need for bed rail use and failed to obtain informed consent prior to installation for 2 of 2 sampled residents (Resident #47 and #53).Findings Included:a. Resident #47 was admitted to the facility on [DATE]. His cumulative diagnoses included chronic respiratory failure with hypoxia (low oxygen), muscle weakness, and chronic pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had intact cognition and range of motion impairment on both sides of the lower extremities. The MDS assessment noted Resident #47 required supervision or touching assistance with bed mobility, was independent with moving from a sitting-to-lying position and bed rails were not used as a physical restraint.During an observation on 02/16/26 at 2:30 PM, Resident #47 was lying in bed sleeping soundly. A bed grab bar was observed secured to the bedframe and in the upright position on the right side of Resident #47's bed.Review of Resident #47's electronic medical record on 02/16/26 revealed no evidence informed consent was obtained prior to the installation or use of the bed grab bar.Review of Resident #47's electronic medical record on 02/16/26 revealed the last completed bed rail assessment was dated 04/14/25. The bed rail assessment noted in part that Resident #47 nor his representative expressed a desire to have an assistive device to aid in mobility, safety and/or comfort, he needed assistance with rising independently from a supine (flat) position to a sitting/standing position, he had the ability to independently reposition himself in bed, and alternatives to bed rails had not been attempted due to a bed rail would promote mobility and transfers.During an observation and interview on 02/17/26 at 7:50 AM, Resident #47 was sitting up in bed eating breakfast with the head of the bed raised approximately 90 degrees. A bed grab bar was observed in the upright position on the right side of his bed. Resident #47 explained he used the bed grab bar to reposition himself when lying in bed or as an aid when pulling himself up to sit on the side of the bed.During an interview on 02/19/26 at 2:27 PM, Nurse Aide (NA) #1 revealed Resident #47 was able to use the bed grab bar to independently reposition himself in bed.During an interview on 02/19/26 at 2:38 PM, NA #2 revealed Resident #47 was able to use the bed grab bar independently for bed mobility.b. Resident #53 was admitted to the facility on [DATE]. His cumulative diagnoses included rheumatoid arthritis and intervertebral disc (cartilage between two vertebrae in the spinal column) degeneration of the lumbar region (lower back) with discogenic back pain and lower extremity pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had intact cognition and range of motion impairment on both sides of the upper and lower extremities. He was always incontinent of bladder and bowel and was dependent on staff assistance with toileting hygiene. The MDS assessment also noted Resident #53 required supervision or touching assistance with rolling left-to-right, required partial to moderate assistance with moving from a sitting-to-lying or lying-to-sitting position, and bed rails were not used a physical restraint. During an observation and interview on 02/17/26 at 3:30 PM, Resident #53 was sitting up in bed playing a game on his cellphone. Bilateral bed grab bars were observed in the upright position on each side of his bed. Resident #53 stated he used the bed grab bars only to hold onto to when staff rolled him onto his side to provide care.During an interview on 02/17/26 at 3:31 PM, Nurse Aide (NA) #11 revealed Resident #53 could hold onto the bed grab bars as staff provided care but he did not use them to independently reposition himself in bed.Review of Resident #53's electronic medical record on 02/17/26 revealed no evidence informed consent was obtained (continued on next page)

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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to the installation or use of the bed grab bars.Review of Resident #53's electronic medical record on 02/17/26 revealed the last completed bed rail assessment was dated 07/04/25. The bed rail assessment noted in part that Resident #53 nor his representative expressed a desire to have an assistive device to aid in mobility, safety and/or comfort, he was not able to rise independently from a supine (flat) position to a sitting/standing position, he did not have the ability to reposition himself in bed, he exhibited problems with balance and trunk control, and a physical therapy consult had been attempted as an alternative to bed rails.During an interview on 02/19/26 at 2:38 PM, NA #2 revealed Resident #53 would hold onto the bed grab bars to assist staff with turning during care, but he did not use them to independently reposition himself in bed.During an interview on 02/19/26 at 3:09 PM, the Director of Nursing (DON) revealed the only reason bed rails would be used for a resident was to promote independence with bed mobility. The DON explained hall nurses were responsible for completing the initial and quarterly bed rail assessments, Unit Managers were responsible for obtaining informed consent for the use of the bed rail and then maintenance was notified to install the bed rail. The DON stated she was not sure where the breakdown occurred.During an interview on 02/20/26 at 9:47 AM, the Unit Manager revealed nurses should be completing bed rail assessments upon a resident's admission, but she was not sure how often bed rail assessments should be completed thereafter. She stated nurses assessed the resident to determine the need for a bed rail, usually to promote independence with bed mobility, and then maintenance would be notified to install the bed rail. The Unit Manager was not aware that informed consent needed to be obtained from the resident or their representative prior to the installation of the bed rail.During an interview on 02/19/26 at 5:27 PM, the Administrator stated he expected nursing staff to obtain informed consent and complete bed rail assessments per the facility policy.