STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345426	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care and Rehabilitation	551 Kent Street Andrews, NC 28901

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to clean the circulatory fan covers in the walk-in refrigerator and failed to dispose of food stored for use with signs of spoilage in the facility's walk-in refrigerator. This was for 1 of 3 refrigerators (walk-in) observed in the kitchen. The deficient practice had the potential to affect food served to residents. Findings Included:a. On 4/27/26 at 10:51 AM an observation in the walk-in refrigerator found the two circulatory fan covers with a buildup of greyish, clumpy and crumbly to touch substance. The substance was covering the 2 fan covers and would move when the fans were running.b. On 4/27/26 at 10:54 AM an observation in the walk-in refrigerator found a box of whole cucumbers located on the top shelf of a food storage rack. The cucumbers in the box were observed with a thick layer of white and fuzzy in appearance substance that covered about 50 percent of the cucumbers. The outside of the box had a received date of 3/23 written on it. On 4/27/26 at 11:00 AM the Dietary Manager observed the walk-in refrigerator with the surveyor. The Dietary Manager observed the circulatory fan covers and the box of cucumbers. On 4/27/26 at 11:02 AM the Dietary Manager was interviewed and stated she was not aware the fan covers had a substance on them. She said the fans were not on a routine cleaning list, and she did not know the last time they had been cleaned. The Dietary Manager further stated the box of cucumbers had been overlooked, and she had not yet checked the walk-in refrigerator for expired food. She stated the refrigerators were checked daily by her, and by the cook on the weekends. The Administrator was interviewed on 4/30/26 at 3:10 PM. She stated the food storage areas should be cleaned on a routine basis and expired or spoiled food should be disposed of.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, record reviews, and resident and staff interviews, the facility failed to maintain an intact headboard without rough edges (Resident #14) and maintain chair rail molding in good repair (Resident #14 and Resident #53). This deficiency occurred for 2 of 4 residents reviewed for safe, clean and homelike environment (Resident #14 and Resident #53) on 1 of 5 facility halls.The findings included:On 4/28/26 at 3:36 PM an observation was made of Resident #14's headboard. The upper right side of the headboard (as viewed from the foot of the bed) was visible eight inches above the mattress with the top edge angled downward. Observation looking down from the head of the bed revealed the left third of the headboard was missing. The remaining piece was connected to the right side of the bed frame, and the left side had a rough edge from top to bottom, resting on a screw sticking out of the left side of the bed frame. Close observation of the mounts on the headboard frame revealed a layer of wood-like splinters present on top of the metal mounts. An observation of the wall behind Resident #14's bed revealed a horizontal chair rail molding was mounted the length of the wall 18 inches above Resident #14's mattress, protruding 2 inches from the wall. The chair rail molding had six chipped areas with paint missing across the bottom edge with scattered wood-like splinters. Starting midway from the width of the bed, the chair rail molding was pulled away from the wall a quarter inch to where the privacy curtain met the wall where it was pulled away one inch from the wall. Review of Resident #14's quarterly Minimum Data Set (MDS) on 1/23/26 indicated she was cognitively intact and dependent for bed mobility. In an interview with Resident #14 on 4/28/26 at 3:37 PM she stated she wondered if the headboard got damaged when they changed out her air mattress a few weeks ago. Resident #14 explained she could not see the headboard because she had been unable to reposition herself to look at it. Resident #14 revealed one of the nurse aides told her it had a crack but could not recall exactly who it was or when she knew about the crack but that it was after getting her new mattress. The interview further revealed Resident #14 was able to see the end of the piece of chair rail molding pulled from the wall near the privacy curtain but could not see what it looked like behind the bed. Resident #14 stated this probably happened when the tall nurse aides put her bed up higher and her headboard pushed on the chair rail molding because the bed was too close to the wall but could not recall when this was. Nurse Aide (NA) #4 was interviewed on 4/30/26 at 9:06 AM and stated she had been caring for Resident #14 early in the morning on 4/27/26 when she noticed her headboard had a crack running down the middle. NA #4 stated it was the first time she had seen the crack but thought she heard another nurse aide say it had been cracked for a while but did not recall who. NA #4 explained she touched the headboard where the crack was to check it out and a broken piece fell to the ground. NA #4 explained when she looked more closely at the broken headboard she also noticed the chair rail molding above the bed had pulled away from the wall and thought it had been broken by the headboard. NA #4 revealed she put a sticky note with the room number on the broken piece and put it in a box outside the maintenance office door. She explained the process for reporting broken equipment was to fill out an electronic work order and she did an electronic work order to report the broken headboard when she noticed it but didn't specifically mention the chair rail molding being pulled from the wall. On 4/30/36 at 9:21 AM an interview was conducted with NA #2 who explained she had noticed a crack in Resident #14's headboard maybe a month ago. NA #2 stated she had told the hall nurse the day she noticed the crack but did not remember the exact day or which nurse it had been. She further explained she did not fill out a work order because she could not find any work order papers at the nurses' station or in the shelf cubbies in the lobby where they used to be. NA #2 revealed another coworker showed her the electronic workorder system, but she did not put in a work order for the cracked headboard because she got busy and forgot. On 4/30/26 at 10:59 AM an interview was conducted with NA #3 who stated she knew Resident #14's headboard had been broken, probably for several weeks. NA #3 stated she had (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forgotten there was an electronic work order system and thought she had left a note in a black work order folder at the nurses' station but could not remember for sure. At 4/30/26 at 9:57 AM the Maintenance Director was interviewed when he was observed walking down the hall with a headboard and stopped in front of Resident #14's room. The Maintenance Director explained he had started at the facility on 4/27/26 and staff had told him this morning that Resident #14's headboard was broken and he was there to replace it. He further explained no one had mentioned broken chair rail molding to him nor had he seen any work orders for Resident #14. During the interview the Maintenance Director stated the chair rail molding was there to stop damage on the wall from the headboards. He observed the damaged chair rail molding and headboard in Resident #14's room and stated it looked like the chair rail damage was caused by the bed. The Maintenance Director indicated because wood chip pieces were stuck to the headboard frame it looked like when the bed was raised the headboard got caught on the chair rail and probably pulled it from the wall. The Maintenance Director stated that when the Interim Maintenance Director had done training with him on 4/27/26 he received a paper list of needed repairs, but the broken headboard was not on the list. When asked if he had seen an electronic workorder for the broken headboard the Maintenance Director revealed he had received basic education on the workorder system but was still learning how to use it and had not seen all the electronic work orders yet. An interview was conducted with the Business Office manager on 4/30/26 at 10:00 AM with the Maintenance Director present. She explained she was assisting the new Maintenance Director with training on the electronic system used by the maintenance department, which included work orders as well as other facility processes. The Business Office Manager also stated she had been helping staff to put work orders into the system during the time the Interim Maintenance Director had been coming in the afternoons to help him keep up with things since he was at the facility part time. The Business Office Manager revealed she had not seen any paper or electronic work orders about a cracked or broken headboard and no one had mentioned it to her before today. A telephone interview was conducted with the Interim Maintenance Director on 4/30/26 at 11:28 AM. The interim Maintenance Director stated he was the full time Maintenance Director at a sister facility and been coming to this facility since mid-March to help in the afternoons after their prior Maintenance Director had left. He explained the Interim Administrator had given him a list of priority projects to complete. The Interim Maintenance Director explained he remembered being aware of a broken headboard when a work order came across his phone at some point but did not remember the date and could not check because he didn't have current access to the system. He stated he had several large projects going on at the time and tried to knock out the smaller things when he could but did not remember looking at the headboard. The Interim Maintenance Director further explained he had seen the piece of broken headboard in the maintenance door box within the last week but there was no sticky note on it and he had not asked anyone about it. An interview was conducted on 04/30/26 at 11:36 AM with the Interim Administrator who stated she had filled in for the Administrator from 1/8/26 until 4/6/26. She explained having asked the Interim Maintenance Director from a sister facility to come help and had given him a list with some priority repair projects and from there he worked from the electronic workorder system. The Interim Administrator stated she had not been aware of any broken headboards during her time at the facility. The Interim Administrator further explained if equipment was broken that staff had been trained to put a workorder in the electronic work order system. She revealed during the time the Interim Maintenance Director was coming to help that she had asked staff to also do a paper work order so she would know what was needed even during times when there was no maintenance person immediately on-site. During an interview with the Administrator on 4/30/26 at 12:28 PM she explained the facility had been using a paper work order system but now the process was to put work orders in electronically and the staff had training on how to do this when they implemented the system a few months ago. The Administrator revealed she had been unaware of any resident headboards being broken since her return from leave a few weeks ago. She further explained Resident #14's broken headboard could have potentially caused (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury and that residents needed a headboard for positioning and safety. The Administrator stated she was sorry that Resident #14's headboard had not been replaced sooner. The interview further revealed she had been unaware of any broken pieces of chair rail molding in resident rooms until today. She revealed a broken piece of molding could potentially cause a skin tear or bruising and they would look at replacing or removing the chair rail molding in rooms with problems. 2. An observation was made on 4/28/26 at 9:40 AM of the wall next to Resident #53's bed. The left side of the bed was directly against the wall. There was horizontal chair rail molding 18 inches above the mattress, protruding 2 inches from the wall which ran from the back wall to mid-way in the room at the privacy curtain. The chair rail molding had 12 gouges in the wood without paint and ended in a 45-degree point partly visible behind the privacy curtain where it was pulled away from the wall half an inch. From the privacy curtain to the rest of the distance to the front wall, a strip the width of the chair rail molding painted a different color was visible and had six half inch holes evenly spaced in the wall. Review of Resident #53's quarterly MDS on 3/2/26 revealed he was cognitively intact. In an interview with Resident #53 on 4/28/26 at 3:12 PM he stated the chair rail molding on the wall had been like that as long as he could remember and he had not spoken with anyone about it. An interview was completed with NA #1 on 4/30/26 at 10:29 AM who stated she had noticed a piece of chair rail molding was missing in Resident #53's room a few weeks ago and told the nurse but could not recall which nurse, who thought there had been a workorder in for that. NA #1 stated she had not known the piece of chair rail molding over Resident #53's bed was broken off to a point. In an interview with NA #4 on 4/30/26 at 10:30 AM room she explained she took care of Resident #53 but did not know the chair rail molding over Resident #53's bed had a sharp point sticking out from the wall. In an interview and observation with the Maintenance Director on 4/30/26 at 9:57 AM he stated he started at the facility on 4/27/26 and had not yet been in Resident #53's rooms and had not been aware of the broken chair rail moldings. He further explained no one had mentioned broken chair rail molding to him nor had he seen any work orders for Resident #53's room. During the interview the Maintenance Director stated the chair rail molding was there to stop damage on the wall from the headboards. In a follow-up interview and observation with the Maintenance Director on 4/30/26 at 10:46 AM in Resident #53's room, he observed the chair rail molding on the wall over Resident #53's bed and explained it had at least 12 gouges in the wood with no paint and the end was at a 45 angle to a point at the height of the headboard where the privacy curtain met the wall and was pulled out from the wall half an inch. He explained the point was from where a now missing piece of molding had joined with this piece and could be a hazard if someone were to bump into it. The Maintenance Director stated he did not know why there was a missing piece of chair rail molding, but it may have been damaged from a headboard or just came loose over time and the holes in the wall were from where screws had been. During an interview with the Director of Nursing (DON) on 4/30/26 at 11:16 AM she stated during orientation that staff had training from maintenance that included how to put in electronic work orders. She explained that training had been done with current staff but maybe some staff had forgotten how. The DON revealed it was important for staff to put in work orders for broken equipment or furnishings to prevent injury. In an interview with the Administrator on 4/30/26 at 12:28 PM she stated she had been unaware of any broken pieces of chair rail molding in resident rooms until today. She revealed a broken piece of molding could potentially cause a skin tear or bruising and they would look at replacing or removing the chair rail molding in rooms with problems.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a comprehensive Care Area Assessment (CAA) to address the underlying causes and contributing factors of the triggered areas for 3 of 3 residents reviewed for comprehensive assessments (Resident #4, Resident #65 and Resident #9).The findings included: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included myocardial infarction (heart attack), peripheral vascular disease, generalized anxiety disorder and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was cognitively intact. A review of the Care Area Assessment summary of the admission MDS assessment dated [DATE] indicated a total of 6 care areas were triggered for Resident #4. The assessment did not include any information in the analysis of findings for 6 of the 6 triggered areas to describe the nature of Resident #4's problems, possible causes, contributing factions, risk factors related to the care area and reasons to proceed with care planning for the following triggered care areas: functional abilities, urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer/injury and psychotropic drug use. An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed that when she completed Resident #4's admission MDS, she did not know how to fill out and complete the CAA. The MDS Coordinator stated that after going through an online training on MDS a couple of weeks ago, she now had a better understanding about the CAA, and she learned that she had to explain the rationale behind care planning for the triggered care areas and if there were other issues that needed to be addressed. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed both of them received an education about the CAA today and understood that the CAA should have been completely filled out by the MDS Coordinator. 2. Resident #65 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, diabetes, schizoaffective disorder and cognitive communication deficit. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #65 was cognitively intact. A review of the Care Area Assessment summary of the admission MDS assessment dated [DATE] indicated a total of 7 care areas were triggered for Resident #65. The assessment did not include any information in the analysis of findings for 7 of the 7 triggered areas to describe the nature of Resident #65's problems, possible causes, contributing factions, risk factors related to the care area and reasons to proceed with care planning for the following triggered care areas: cognitive loss/dementia, functional abilities, urinary incontinence and indwelling catheter, behavioral symptoms, nutritional status, pressure ulcer/injury and psychotropic drug use. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed that when she completed Resident #65's admission MDS, she did not know how to fill out and complete the CAA. The MDS Coordinator stated that after going through an online training on MDS a couple of weeks ago, she now had a better understanding about the CAA, and she learned that she had to explain the rationale behind care planning for the triggered care areas and if there were other issues that needed to be addressed. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed both of them received an education about the CAA today and understood that the CAA should have been completely filled out by the MDS Coordinator. 3. Resident #9 was admitted on [DATE] with diagnoses which included vascular dementia, psychotic disturbance and mood disturbance. Resident #9's physician orders included one dated 1/14/26 for quetiapine fumarate (an antipsychotic medication) 25 milligrams (mg) give 2 tablets at bedtime for paranoid delusion. Resident #9's Care Area Assessment (CAA) summary for the significant change in status Minimum Data Set (MDS) assessment dated [DATE] was reviewed. For the triggered area of Psychotropic Drug Use the CAA summary was checked for Care Planning Decision but was blank and without documentation supporting the reason for care planning. On 4/29/2026 at 2:48 PM the MDS Coordinator stated she began working as the MDS Coordinator on 12/25/25 and didn't know how to complete CAAs. She stated she completed Resident #9's MDS assessment dated [DATE] and did not complete Resident #9's CAA on the comprehensive assessment. The MDS Coordinator added, she had received education recently and now knows she should have completed it. During an interview on 4/30/26 at 3:10 PM the Administrator stated the MDS Coordinator had not received enough education on how to complete the CAAs and recently had been educated on completing them.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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) assessments in the areas of medications (Resident #18 and Resident #4) and alarms (Resident #9) for 3 of 9 residents whose MDS were reviewed.The findings included: 1.Resident #18 was admitted to the facility on [DATE]. A review of the physician's orders in Resident #18's medical record indicated no order for an anticoagulant. The quarterly MDS dated [DATE] indicated Resident #18 was taking an anticoagulant. An anticoagulant, also known as a blood thinner, is a medication that helps prevent blood clots from forming or growing larger. A review of the Medication Administration Record for Resident #18 for January 2026 indicated he did not receive an anticoagulant. An interview with the MDS Coordinator on 4/29/26 at 3:27 PM revealed she made an error with coding Resident #18 as receiving an anticoagulant on the quarterly MDS. The MDS Coordinator stated she made the error because Resident #18 received an antiplatelet medication which she confused with a similar sounding generic name for an anticoagulant. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed the MDS Coordinator should have coded Resident #18's quarterly MDS accurately. 2. Resident #4 was admitted to the facility on [DATE]. A review of the physician's orders in Resident #4's medical record indicated no order for an anticoagulant. The annual MDS dated [DATE] indicated Resident #4 was taking an anticoagulant. An anticoagulant, also known as a blood thinner, is a medication that helps prevent blood clots from forming or growing larger. A review of the Medication Administration Record for Resident #4 for February 2026 indicated he did not receive an anticoagulant. An interview with the MDS Coordinator on 4/29/26 at 2:49 PM revealed she made an error with coding Resident #4 as receiving an anticoagulant on the annual MDS. The MDS Coordinator stated that Resident #4 received an antiplatelet medication which she confused as an anticoagulant. An interview with the Director of Nursing and the Administrator on 4/30/26 at 3:08 PM revealed the MDS Coordinator should have coded Resident #4's admission MDS accurately. 3. Resident #9 was admitted on [DATE] with diagnoses which included vascular dementia. Physician orders dated 1/4/26 included a wander alarm (a wearable electronic device that trigger (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door locks or alarms when a resident approaches an exit, allowing for freedom of movement within safe, monitored boundaries) to be placed on Resident #9's left lower leg and to monitor the wander alarm placement on the left lower leg every shift. Resident #9's care plans included one dated 1/4/26 for elopement risk and wanderer related to dementia with attempts to leave the facility unattended. Interventions included the use of an electronic monitoring device. The care plan was written by the Activities Director. Resident #9's significant change in status MDS assessment dated [DATE] did not indicate the use of a wander/elopement alarm. Resident #9's quarterly MDS dated [DATE] did not indicate the use of a wander/elopement alarm. On 4/29/26 at 2:48 PM the MDS Coordinator stated she was unaware Resident #9 had an order for a wander alarm and she had not correctly coded the MDS. She confirmed she had completed Resident #9's MDS assessments dated 1/22/26 and 2/3/26. The MDS Coordinator added that she began working as the MDS Coordinator on 12/25/25 and had missed the order for the wander alarm dated 1/4/26. On 4/30/26 at 3:10 PM the Administrator stated the wander alarm should have been captured on Resident #9's MDS assessments.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to repair a privacy curtain track which prevented the privacy curtain from extending around a resident's bed to provide total visual privacy. This deficient practice occurred for 1 of 19 residents reviewed for privacy (Resident #29). Findings included:Resident #29 was admitted on [DATE]. A review of Resident #29's quarterly Minimum Data Set (MDS) dated [DATE] coded her with moderate cognitive impairment.On 4/28/26 at 9:30 AM an observation of Resident #29's room found the privacy curtain on the track was unable to fully close.On 4/28/26 at 9:40 AM Resident #29 was interviewed. She stated she had not paid any attention to the privacy curtain and did not know how long it had not fully closed. On 4/29/26 at 3:20 PM an observation of Resident #29's privacy curtain track remained unchanged. On 4/29/26 at 3:32 PM Nursing Aide (NA) #1 stated Resident #29's privacy curtain had not been closing all the way for a couple weeks. She stated she did not know if a work order had been put in to repair the curtain track and she had not put in a work order for the curtain track. She stated multiple NAs and Nurses had provided care to the resident and she assumed one of them had put in a work order to repair the track. On 4/29/26 at 3:34 PM the Maintenance Manager stated he was new to the facility and was unaware Resident #29's privacy curtain track needed repair. He stated he was in the process of looking through work orders and did not know if a work order had been submitted. On 4/29/26 at 3:37 PM Nurse #1 stated she was unaware Resident #29's privacy curtain track could not fully close. She stated she would put in a work order. On 4/30/26 at 3:10 PM the Administrator stated in February 2026 a water line had burst in the ceiling that caused damage to some rooms. She stated Resident #29's privacy curtain track may have been damaged at that time. The Administrator indicated the facility had been using paper work orders at that time and had switched to electronic work orders since then. She did not know the privacy curtain track needed repair and was unaware if a work order had been submitted. The Administrator said the privacy curtain track should have been reported on a work order when it was discovered to be not working properly.

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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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interviews, the facility failed to review and update the Facility Assessment annually. This had the potential to affect all residents residing in the facility.The findings included:Review of the Facility Assessment revealed it was dated 3/20/25 and there was no documentation to show the assessment had been reviewed and updated since that time or annually.On 4/30/26 at 11:48 AM an interview was held with the Administrator. She stated that she had been on medical leave from some time in November 2025 until April of this year. The Administrator stated that there was an Interim Administrator that covered her position for her when she was on medical leave. The interview further revealed the Administrator knew the facility assessment was due but did not pass this information on to the Interim Administrator. Her plan was to go over the Facility Assessment at next week's Quality Assurance & Performance Improvement (QAPI) meeting.On 4/30/26 at 12:02 PM an interview was conducted with the Interim Administrator. She stated that she was the Interim Administrator for the month of March 2026 and she had not been made aware that the Facility Assessment needed to be updated by 3/20/26.