STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345138	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTH AND REHABILITATION CENTER	322 NUWAY CIRCLE , LENOIR, North Carolina, 28645

(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
F0000	INITIAL COMMENTS An unannounced on-site complaint investigation survey was conducted on 07/07/2025 through 07/08/2025. Event ID: HPC011. The following incidents and complaints were investigated: 872869, 872870, 872871, 872872, 872884, 872879, 872880, 872873, 872874, 872875, 872876, 872877, and 872878. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G) 6 of the 43 complaint allegations resulted in deficiency.	F0000		07/16/2025
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Nurse Practitioner, and staff interviews, the facility failed to provide supervision to prevent accidents when a resident (Resident #1) with left sided weakness, muscle wasting, vascular dementia and at risk for falls fell from the bed in low position on 5/25/2025 and the facility failed to implement a new intervention for fall prevention. The resident had another fall from bed that was not in the low position on 6/1/2025 and was found face down on the floor. Resident #1 was transferred to	F0689	"Past Noncompliance - no plan of correction required"	07/16/2025

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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F0689 SS = G	Continued from page 1 the hospital for emergency medical treatment where it was discovered Resident #1 had sustained a large scalp laceration with significant bleeding that was cleaned and repaired with staples and a cervical spine (one of the vertebrae of the neck) fracture that required wearing a cervical collar at all times. This deficient practice occurred for 1 of 3 residents reviewed for falls (Resident #1).	F0689		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff, pharmacist and Nurse Practitioner interviews, the facility failed to prevent a significant medication error when an ordered medication was not available to be administered and when Medication Aide (MA) #1 pulled an incorrect dose of a potassium supplement and crushed and administered the potassium supplement that was labelled as a do not crush medication for 1 of 3 residents reviewed for medication errors (Resident #4). The findings included: Resident #4 was admitted to the facility on 6/4/2025 with diagnosis that included end stage renal disease on hemodialysis, other specified disorders of the brain, secondary hyperparathyroidism of renal origin, and dysphagia oral phase. Review of Resident #4's hospital records prior to admission revealed the following lab results: On 6/4/2025 a Potassium level of 3.8 (Normal range 3.5-5.2) On 5/30/2025 a Potassium level of 3.9, a Calcium level of 9.6 (normal range 8.5-10.2), Phosphorus 2.7 (Normal range 2.5-4.5) Review of Resident #4's care plan 6/6/2025 revealed resident was care planned at risk for cardiac complications secondary to chronic kidney disease with interventions that included administer medication as	F0760	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F760 The facility to prevent a significant medication error when Medication Aide (MA) #1 pulled an incorrect dose of potassium chloride and then crushed the medication despite the medication being labeled as do not crush MA #1 was educated on the seven rights of medication administrator on 7/17/2025. Current residents are at risk of this error. The Director of Nursing (DON) or designee will educate current licensed nurses and current Medication aides on the 7 rights of medication administration including how the medications have special directions such as do not crush. Education will be completed by 07/28/2025. Any nurse or medication aide that has not received education will be educated prior to the start of their shift. This includes agency staff. Education will be provided by the Director of nursing or designee. New nurses and medication aides will receive education during the orientation process by the Director of Nursing or designee. The Director of Nursing or designee will perform a medication administration observation on current licensed nurses and current medication aides. This will be completed by 7/28/2025.	07/29/2025

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F0760 SS = D	Continued from page 2 ordered. Review of Resident #4's admission Minimum Data Set (MDS) assessment dated 6/10/2025 revealed Resident #4 was cognitively intact and indicated Resident #4 received hemodialysis. A. Review of a Physician's order dated 6/4/2025 stated Cinacalcet HCL (cinacalcet mimics the action of calcium in the body and is used to treat hyperparathyroidism with chronic kidney disease and also helps regulate calcium and phosphorus levels which reduce the risk of bone disease and cardiovascular issues) 60 milligrams (mg) tablet take one tablet by mouth once daily with food. Review of the Medication Administration Record (MAR) for June 2025 revealed cinacalcet HCL 60mg daily was coded as not available to be administered to Resident #4 as scheduled on 6/19/2025 and 6/23/2025. Review of the MAR for July 2025 revealed cinacalcet HCL 60mg daily was coded as not available to be administered to Resident #4 as scheduled on 7/3/2025 and 7/7/2025. On 7/7/2025 at 9:06 AM Medication Aide (MA) #1 was observed as she prepared Resident #4's medications. MA #1 noted that Resident's cinacalcet 60mg was not available and MA #1 was observed as she reported the unavailable medication to Nurse #3. MA #1 was asked prior to administering the medications if she had completed pulling Resident #4's medication. MA #1 confirmed she had all of Resident #4's medication and was ready to administer them. During an interview on 7/7/2025 at 9:15 AM MA #1 stated Resident #4's cinacalcet 60mg had been unavailable on other days as well and she had asked the nurses to reorder it. During an interview on 7/8/2025 at 11:54 AM Nurse #3 stated MA #1 had reported that Resident #4 did not have any cinacalcet available. Nurse #3 stated she called and reported the unavailable medication to the dialysis center. During an interview on 7/8/2025 at 9:03 AM the Pharmacist stated that seven tablets of cinacalcet 60 mg had been sent to the facility from the pharmacy on 6/5/2025, 6/11/2025 and 6/23/2025. The Pharmacist stated that medication (cinacalcet) was supposed to be supplied from the dialysis center, but they had sent a week supply when the facility requested to try to help	F0760	Continued from page 2 Any nurse or medication aide not receiving a medication administration observation will be completed during their first available shift by the Director of Nursing or designee. Any new nurse or medication aide will receive the medication administration observation during the orientation process by the director of nursing or designee. The DON or designee will perform 5 medication pass observations on licensed nurses or medication aides weekly x 4 weeks, then 3 weekly x 4 weeks, then 1 weekly x 1 week. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of Completion 7/29/2025	

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F0760 SS = D	Continued from page 3 the facility have a supply until it was received from dialysis center. The Pharmacist stated missing doses of cinacalcet may cause a difference in residents serum lab values. During an interview on 7/8/2025 at 10:24 AM the Dialysis Charge Nurse stated the facility had called the week prior for a refill of Resident #4's cinacalcet and it had been processed for refill. The Dialysis Charge Nurse stated the facility would receive the medication by mail and it was likely in transit. B. Review of a Physician's order dated 6/5/2025 stated "Potassium Chloride Crys" ER (extended release) (extended-release potassium chloride is used to treat or prevent low potassium levels. It is crucial for proper functioning of the heart, muscles, kidneys and nervous and digestive systems) 20 milliequivalents (MEQ) tablet extended release take two tablets by mouth once daily for supplement. On 7/7/25 at 9:06 AM MA #1 was observed as she pulled one tab of potassium chloride 20 MEQ and placed it in a medication cup for Resident #4. MA #1 completed preparing Resident #4's medications and put several medications in a plastic sleeve to crush them. MA #1 was asked prior to crushing the medications if she had completed pulling Resident #4's medication. MA #1 confirmed she had all of Resident #4's medication and was ready to administer them. The MA #1 and surveyor reviewed Resident #4's order for potassium chloride and verified the order read to administer two tablets of potassium chloride 20 MEQ. MA 1 stated she had missed that and only pulled one tablet and verified she would have administered an incorrect dose. MA#1 pulled a second potassium chloride 20 MEQ tablet, placed it into a plastic sleeve and crushed the two potassium tablets along with several other medications and administered Resident #4 the medications that had been prepared. During an interview on 7/7/2025 at 9:15 AM MA #1 verified she had prepared an incorrect dose of potassium chloride for Resident #4. During a follow up interview on 7/8/2025 at 9:45 AM MA #1 verified she had crushed the potassium chloride tablets and administered them to Resident #4. MA #1 verified that the card that contained Resident #4's potassium chloride had a sticker that read "DO NOT CRUSH" and she stated she should not have crushed the potassium chloride tablets. Review of Resident # 4's physicians orders revealed there was not instructions that read "DO NOT CRUSH" in the medication profile in the electronic record.	F0760		

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F0760 SS = D	Continued from page 4 During an interview on 7/7/2025 at 4:50 PM the Clinical Nurse Consultant stated medications that were not supposed to be crushed would have “DO NOT CRUSH” prepopulated into the medication instructions through the computer system. The Clinical Nurse Consultant stated, “potassium can’t be crushed so it will automatically show on the MAR”. The Pharmacist stated only certain formulations of Potassium could be crushed. The Pharmacist stated the formulation used by Resident #4 was not supposed to be crushed. The Pharmacist stated they do not prepopulate “DO NOT CRUSH” instructions into medication instructions in the electronic medication profile but the cards of medications would have a sticker that read “DO NOT CRUSH” for any medication that was not supposed to be crushed. The Pharmacist stated receiving a lower dose of potassium chloride had the potential to cause a change in serum blood levels. During an interview on 7/8/2025 at 11:00 AM the Nurse Practitioner (NP) stated it was significant for a dialysis resident to miss doses of cinacalcet and to receive an incorrect dose of potassium chloride. The NP stated that medications were ordered for a reason and should be administered as ordered. The NP stated cinacalcet was prescribed to help control calcium levels and missing doses could affect those levels. The NP stated if a resident received an incorrect dosage of potassium, it could alter the levels in the blood, and it should not be crushed because it affected the absorption rate. During an interview on 7/8/2025 at 11:45 the Unit Manager #1 stated she was not aware Resident #4 did not have her cinacalcet available to administer. The unit manager stated she knew it was provided by the dialysis center. The Unit Manager #1 stated medication instructions could be entered into the medication profile under instructions. The Unit Manager #1 verified medications that were not supposed to be crushed would have a sticker on the packaging that read “DO NOT CRUSH”. During an interview on 7/8/2025 at 12:40 PM Director of Nursing (DON) stated she expected that a pill labeled “DO NOT CRUSH” would not be crushed, and that if a resident was unable to swallow a pill that could not be crushed a different form of the medication should be ordered. The DON stated she expected residents to receive medications as ordered and if two tablets were ordered, two tablets should be administered. The DON stated she expected medication ordered for the resident to be available to be administered as ordered.	F0760		

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F0760 SS = D	Continued from page 5 During a joint interview on 7/8/2025 at 12:45 PM the Clinical Nurse Consultant and Administrator stated they expected the correct dosage of medication to be administered as ordered and that medications that were not supposed to be crushed would not be administered crushed. The Administrator and Clinical Nurse Consultant stated they expected medications ordered for the resident to be available to be administered to the resident but knew there was some adjustment since some medications were now being provided by the dialysis center and not the facility pharmacy.	F0760		
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident, staff, and pest control contractor supervisor interviews, the facility failed to maintain an environment free from of flies in 2 of 2 resident rooms (Resident #2 and #3) on 1 of 4 halls and the kitchen. In addition, the facility failed to notify the pest control contractor of the increased fly activity. Findings included: a. Resident #3 was admitted to the facility on 6/25/25. Review of Resident #3's Minimum Data Set (MDS) admission assessment dated7/01/25 indicated he had moderately impaired cognition. An observation on 7/07/25 at 10:20 AM in Resident #3's room noted 6 flies at the same time on the bed and privacy curtain. Resident #3 stated he could not sleep due to flies crawling on him and thought it was an awful environment. He also stated he had reported his concerns about the flies to multiple staff members. b. Resident #2 was admitted to the facility on 1/30/25. Review of Resident #2's Minimum Data Set (MDS) quarterly assessment dated 5/09/25 indicated he had moderately impaired cognition. An observation on 7/07/25 at 11:50 AM in Room #2's room noted 3 flies at the same time on the bed and bedside	F0925	F925 The rooms and kitchen area in which flies were found were immediately cleaned and inspected by housekeeping and maintenance. Fly bait was distributed by the maintenance director on July 8, 2025, in the following areas: dumpster, dock, and patio. Bug Out conducted fly treatment on July 8, 2025 All residents have the potential to be affected by this finding. The facility maintenance director will complete weekly rounds in areas identified, including all residents' rooms. The facility contacted Bug Out and revised contract effective July 16, 2025, to increase scheduled visits to twice a week and as needed. The insect light traps that were reported to be replaced were replaced on July 15, 2025, by Bug Out and new light trap added to the kitchen. Facility received 2 Air Curtain/Fly Fan to be installed over the automatic doors by Connelly Springs on 07/19/2025. The Maintenance Director received in-service from the Administrator on July 9, 2025, which included a review of the facility's policy related to pest control. Any new maintenance director will received education during the orientation process by the administrator. The Maintenance Director will conduct in-service with all staff including agency of the facility's policy related to pest control. All staff will be educated by the maintenance director on the process of entering work orders related to pest control in the TELS system. Education will be completed by July 18, 2025.	07/29/2025

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F0925 SS = E	Continued from page 6 table. Resident #2 stated he had trouble eating since he did not like eating food after he saw flies crawling on his food. c. An observation on 7/07/25 at 12:15 PM in the kitchen revealed 1 fly on a metal cart and 3 flies on the temperature logbook lying on the counter by the food preparation area where food was being plated for the lunch meal. The Dietary Manager stated the pest control service technician had been there recently to treat. She also stated they cleaned between meals and stored the food between meals. An interview on 7/07/25 at 7:33 PM with Nursing Assistant (NA) #1 revealed she had not reported seeing flies in the facility electronic software maintenance system. She stated the Administrator was already aware since it had been mentioned in the facility group chat text messaging. An interview on 7/07/25 at 8:36 PM with NA #2 revealed he knew there was a book at the nurses' station to write maintenance concerns. He had not reported the flies in the facility as it was a "known issue." An interview on 7/07/2 at 2:22 PM with the Maintenance Director revealed they had a pest control service company who serviced the facility monthly and as needed for pest control. He also revealed they currently had a fly pest problem which had gotten worse in the last couple of weeks. He stated his first reported fly concern was on 6/20/25. He also stated he had not asked the pest control service technician about other treatment options available to treat the flies. He stated he had not notified his Regional Maintenance Director of the increased number of flies. The Maintenance Director stated he believed the increased presence of flies was a result of the new automatic doors which were installed to allow easier access to the outside courtyard and smoking area. He stated he had recently had them adjusted to close faster. He stated about a year ago, the facility started utilizing an electronic software program where staff reported maintenance concerns. He stated based on this electronic software program, the first reported flies were reported on 6/20/25, but the report did not provide any further details. An observation was conducted on 7/07/25 at 9:30 AM of the automatic doors exiting the facility into the smoking area and courtyard. The automated doors opened with a hand wave sensor. No air curtain was observed to engage when the door was opened.	F0925	Continued from page 6 Any employee not receiving education will receive education prior to the beginning of their shift. New employees will receive education during the orientation process by the maintenance director. The administrator and maintenance director will complete facility rounds to determine progress of fly prevention. This will be done weekly x 12 weeks. The maintenance director will audit work orders and report to the interdisciplinary team 5x weekly in morning meeting x 12 weeks. Audit results will be reviewed during the QAPI meetings to assess compliance and determine if further action or resolution is necessary. Date of completion 07/29/2025	

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F0925 SS = E	Continued from page 7 Observations conducted on 7/08/25 at 5:55 AM and at 6:15 AM both revealed the left side of the automatic door was not fully closed and there was an open area of approximately 3 inches between the door and the door frame. Review of the pest control summary sheets on 7/07/25 at 2:25 PM, was conducted in conjunction and in the presence of the Maintenance Director. The review of the summary sheets revealed the pest control service had been to the facility and provided pest control services most recently on 6/23/25, 6/20/25, 5/27/25, and 4/24/25. The pest control summary sheets all noted flies in multiple locations and had recommendations which read in part the insect light traps in multiple locations were not working properly and needed to be replaced. The Maintenance Director stated he thought the insect light traps were working properly. He also stated insect light traps had been ordered for the kitchen. An observation on 7/7/25 at 2:30 PM with the Maintenance Director of the 5 insect light traps. Each resident hall had an insect light trap mounted on the wall and 1 insect light trap was located at the nurses' station. Dead bugs were observed on the sticky trap sheets inside the machines. All the light traps had stickers which read the bulbs were replaced on the date of 3/25/24. An interview on 7/08/25 at 9:23 AM with the Pest Control Contractor Supervisor revealed he had not received any reports of increased fly activity from the facility. He stated this facility was noted to have fly activity on a regular basis. He also stated there were additional treatments which could have been done if they had been aware of the increased fly activity at the facility. An interview on 7/08/25 at 10:42 AM with the Administrator revealed she was aware of the fly problem and had requested the pest control service technician to come to the facility last week for fly treatment but did not know if he had come or not. She also revealed the facility had ordered an air curtain to be placed at the automatic door to help prevent pests from entering the facility through that door. She stated there should not be fly problems when residents were trying to sleep or eat.	F0925		