STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345410	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Continuing Care	**1287 Newsome Street , Mount Airy, North Carolina, 27030**

(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 09/07/25 through 09/11/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D594F-H1.	E0000		10/09/2025
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey were conducted from 09/07/2025 through 09/11/2025. Event ID# ID594F-H1. The following intakes were investigated: 2614437, 2596511, 2600490, 876074. 3 of the 8 complaint allegations resulted in deficiency.	F0000		10/09/2025
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to	F0577	The facility Administrator immediately moved the facility "Survey Results" binder from the current location of the bookshelf in the chapel/activities room to the end table in the chapel/activities room. The new location is more prominent and accessible to facility residents and resident representatives. The Facility currently has a framed sign located in the front lobby of the building that states, "State Survey Results are located in the chapel/activities room". The facility will add a section to its monthly newsletter stating that "State Survey Results are located in the chapel/activities room". All residents will be educated on the locations of "State Survey Results" in resident council. Upon admission all residents/resident representatives will be educated on where the facility "State Survey Results" are located. This will be completed by the Admissions Director with all new admissions. Current facility residents will continue to be educated on where the "State Survey Results" are located through monthly resident council meetings.	10/09/2025

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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F0577 SS = C	Continued from page 1 the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident and staff interviews, the facility failed to have the most recent survey results labeled and accessible to residents and the public in the location stated on the signage in the lobby. This deficient practice occurred 4 of 4 days of the survey. The findings included: During an initial tour of the facility on 9/8/2025 at 10:30 AM, a picture frame affixed to the wall in the main lobby contained the following information: “State Survey results are in the chapel/activities room.” Signage indicating the location of the survey results was not observed in any other area in the facility. An observation on 9/8/2025 at 12:30 PM of the chapel/activity room revealed the following: 2 bookcases observed filled with puzzles, 1 bookcase filled with reading books, the last bookcase had hymnals/ black binders/ 2 faded pink photo albums/ 1 purple/blue colored binder/ 1 red binder. No signage was located on the spines of the binders informing the residents or public of what was inside the binders. There was no other signage in the chapel/ activities room which stated where the survey results binder was located. An additional observation on 9/9/2025 at 9:00 AM revealed the survey results binder was not located in any other area of the facility. Further observation of the chapel/activity room continued to reveal no evidence of the survey results binder. A Resident Council group meeting was conducted on 9/10/2025 at 10:00 AM. During the meeting, the residents indicated they did not know where the survey results were located (Resident #76, Resident #13, Resident #16, Resident #23, Resident #38, Resident #39, Resident #54, Resident #55, Resident #56, Resident #60, Resident #61, Resident #63, Resident #2, Resident #82, and Resident #83). The Resident Council President	F0577	Continued from page 1 The facility Administrator will monitor weekly for 4 weeks and monthly for 3 months thereafter to ensure the "State Survey Results" are in the correct location in the chapel/activities room. This audit tool will be called "Survey Results Location". Results of facility audits will be reported to the Quality Assurance and Performance Committee by the Administrator. The Quality Assurance Committee will assess and modify as needed to ensure continued compliance.	

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F0577 SS = C	Continued from page 2 (Resident #76) shared she had been at the facility for several months and did not know the location of the survey results. An interview and observation were completed with the Activities Director (AD) on 9/10/2025 at 2:00 PM. The AD explained that the survey results binder was in the chapel/activity room. The AD stated the survey results binder was located on the “messy” bookshelf in the chapel/activity room and the binder was white. An observation with the AD revealed she retrieved the survey results binder in the chapel/activity room from the bookshelf with the hymnals, colored binders, and photo albums. The survey results binder was located on the top shelf of a 4-level bookshelf in the chapel/activity room and there was no label on the spine of the binder which was purple/blue in color. The survey results binder was not accessible to residents using wheelchairs. The AD further revealed the survey results binder had been in the chapel/activities room on the top shelf for as long as she has worked at the facility which was approximately 12 years. In an interview with the Administrator on 9/11/2025 at 9:52 AM, he explained the survey result binder was in the chapel/activities room. He stated there was a sign posted in the lobby identifying the location of the survey results. He further stated the chapel/activities room was unlocked 24 hours a day. The Administrator explained the survey results binder was in a white or a black binder and located on a shelf in the chapel/activity room at eye level for residents and the public's review.	F0577		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in	F0582	F582 The facility Admissions Coordinator and Social Worker initiated a (PIP) Performance Improvement Project on informing residents of their complete Medicare benefits. This will include, ensuring the ABN will be issued with the NOMNC for those residents who are electing to discharge home or being issued one for their last day of service. Upon admission all Medicare Residents and Resident Representatives are informed of the potential NOMNC or ABN during their stay. An audit will be completed by the Admissions Coordinator by reviewing the current Medicare census to ensure that all Residents have been provided with the	10/03/2025

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F0582 SS = D	Continued from page 3 §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Centers for Medicare and Medicaid Services (CMS)-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification review (Resident #71). The findings include: Resident #71 was admitted to the facility on 5/2/2025.	F0582	Continued from page 3 appropriate Medicaid/Medicare Coverage/Liability Notices. The facility will begin issuing NOMNCs and ABNs on all traditional Medicare Residents with planned discharges. All NOMNCs and ABNs will be issued by the facility Social Worker and/or her designee. The facility Social Worker and/or her designee will do weekly audits for 4 weeks and then monthly for 3 months to ensure all traditional Medicare Residents receive the proper notices (NOMNCs and ABNs) in a timely manner. This audit tool will be called "NOMNC/ABN Checks". Audits were initiated 10-6-25.	

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F0582 SS = D	Continued from page 4 A review of the medical record revealed a NOMNC was issued to Resident #71 which explained Medicare Part A coverage for skilled services would end on 7/25/2025. The form was reviewed by Resident #71's Responsible Party (RP) on 7/23/2025. Resident #71 remained in the facility after 7/25/25. A review of the medical record revealed a SNF-ABN was not provided to Resident #71 or their Responsible Party. Resident #71 had 15 Medicare part A days remaining. On 9/10/2025 at 8:47 AM an interview was completed with the Social Service Director confirmed the NOMNC was issued when Resident #71's Medicare Part A coverage for skilled services was ending. The Social Service Director confirmed that neither Resident #71 nor Resident #71's Responsible Party was issued a SNF-ABN prior to Medicare Part A services ending. The Social Service Director stated she was unaware a SNF ABN was supposed to be issued to Resident #71 or to the RP. An interview was completed with the Administrator on 9/11/2025 at 9:47 AM. He revealed when a resident was coming off Medicare Part A services and the resident had Medicare Part A days remaining, SNF-ABN should be issued. The Administrator further stated the process was overlooked.	F0582		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff and	F0600	F600 The facility Nurse Aides intervened immediately after witnessing the altercation/argument between Resident #50 and Family Member #1. Family Member #1 immediately left the facility. The Director of Nursing was immediately notified and initiated an investigation. The Assistant Director of Nursing completed a full skin sweep of Resident #50 to ensure no signs or symptoms of skin redness, discoloration, or areas of concern. There were no areas of concern noted. The Social Worker immediately interviewed Resident #50 to ensure there was no mental anguish and/or emotional change. There were no concerns noted by the Social Worker. The Director of Nursing called Family Member #1 to inform them at this time they could not visit any further until the investigation had been completed. Family Member #1 did not answer and there was no voicemail set up to leave a message. Staff were educated that if they see Family Member #1, they need	10/03/2025

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F0600 SS = D	Continued from page 5 resident interviews, the facility failed to protect a resident's right to be free from verbal and physical abuse when Family Member #1 pulled Resident #50 by her hair back into her room, which resulted in no physical harm to Resident #50. In addition, Family Member #1 raised her hand and stated to Resident #50 “I will slap you out of the chair”, this resulted in restricted visitation for the Family Member of Resident #50. This affected 1 of 3 residents reviewed for abuse (Resident #50). Findings included: Resident #50 was admitted to the facility on 8/16/22 with the diagnoses of chronic obstructive pulmonary disease (a lung disease that makes it hard to breathe), and Parkinson’s disease (a movement disorder that affects the nervous system and worsens over time). The quarterly Minimum Data Set (MDS) assessment dated 9/5/25 revealed Resident #50 was cognitively intact and had no behaviors or rejection of care. Review of the initial allegation report submitted to the State Agency (SA), on 9/10/2025 by the facility for abuse, indicated that Family Member #1 visited Resident #50. Resident #50 and Family Member #1 became verbally aggressive towards each other. Family Member #1 pulled Resident #50, who was sitting in a wheelchair, back into her room by grabbing Resident #50 by the hair. Resident #50 reported to the facility she and Family Member #1 had fought all their lives. The facility investigation report stated Resident #50 had no physical or mental harm. In addition, the facility reported the incident to local law enforcement. A review of Resident #50 skin assessment dated 9/10/25 revealed no new areas of concern. An interview was conducted with Nursing Assistant (NA) #1 on 09/11/25 at 3:25 PM. NA #1 stated on 9/10/25 Resident #50 was sitting in her wheelchair in her doorway, and Family Member #1 was in the room. NA #1 approached and asked Resident #50 if she wanted to take a shower. Resident #50 declined the shower. Family Member #1 said Resident #50 took a shower once a month, followed by profanity directed at Resident #50. NA #1 stated Resident #50 argued and used profanity toward her Family Member #1 then Family Member #1 grabbed and pulled Resident #50 by the hair, moving her in her wheelchair from the doorway back into her room. NA #1 did not state the distance Resident #50 was pulled. Resident #50 and Family Member #1 were separated by about 5 feet by NA #1. NA #1 stated Resident #50 and	F0600	Continued from page 5 to immediately ask them to leave until they speak with the Administrator or Director of Nursing. The facility contacted the local Law Enforcement Agency on 9-10-25, for the allegation pertaining to Resident #50. On that same day, Law Enforcement immediately came out to question and assess Resident #50 on the events that occurred. Questioning was completed and Resident #50 did not want to pursue any charges. The Surry County Adult Protective Services was contacted on 9-11-25 for the allegation that occurred with Resident #50. Surry County DSS completed the report and filed it on 9-11-25, no further investigation was initiated. The facility immediately initiated Resident interviews with all Residents who score a BIMS of 13 and higher to ensure there were no other areas of concern regarding Resident visitors. The Residents were interviewed on the following questions: - Do you have family, friends, or visitors come in to see you? - When visitors come in to visit, do the visits go well? - Have you ever had a bad visit where your family or friend has been ugly towards you? - Has a family or friend ever been physically abusive towards you while visiting? - Do you know who and how to report any issues you may have with your visitors? These interviews were completed on 9-10-25, by the Social Worker, Assistant Director of Nursing and MDS Nurses. There were no reported areas of concern. The facility immediately initiated staff education on abuse and resident rights on 9-10-25. The education was completed by the Staff Development Nurse and/or her designee on 9-10-25. Education and training on abuse and treating resident	

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F0600 SS = D	Continued from page 6 Family Member #1 had bickered in the facility in the past, but this was the first time she had witnessed it escalate into a physical altercation. NA #1 called NA #2 for assistance. NA #1 went to report the incident to the Director of Nursing (DON). An interview was conducted with NA #2 on 9/11/25 at 3:16PM. NA #2 stated when she arrived at the room, Resident #50 and Family Member #1 were about five feet apart and still engaged in an argument. NA #2 remained with Resident #50 and Family Member #1 while NA #1 went to report the incident to the DON. NA #2 revealed that Family Member #1 raised her hand and stated to Resident #50 “I will slap you out of the chair”. Resident #50 told Family Member #1 to leave, which Family Member #1 responded that she would never step foot in the building again and exited the facility. An interview and observation were conducted with Resident #50 on 9/11/25 at 4:09PM which revealed Resident #50 had grey, wavy hair with the top half of her hair pulled back into a ponytail. Resident #50's ponytail was approximately 3 to 5 inches in length. Resident #50 recalled Family Member #1 had yelled at her throughout their relationship. Family Member #1 was angry that the closet was not organized and had dirty clothes. Resident #50 listened from the doorway of her room while Family Member #1 yelled and everyone on the hall heard. NA #1 was talking to her and that was when Family Member #1 pulled her by her ponytail, moving her in her wheelchair from the doorway back into her room. Resident #50 denied any injury. Resident #50 stated it did not hurt having her ponytail pulled but rather made her angry towards Family Member #1. Resident #50 told Family Member #1 to leave, which she did. Resident #50 stated Family Member #1 left within 15 minutes of her arrival at the facility. Resident #50 stated she spoke with a Law Enforcement Officer and declined to press charges. On 9/11/25 at 5:04PM an attempt to interview Family Member #1 via telephone call was unsuccessful. There was no option for a voice mail. On 9/11/25 at 3:56PM an interview conducted with Assistant Director of Nursing (ADON) revealed after the incident a skin assessment was conducted of Resident #50's scalp. She stated Resident #50 denied injuries or pain. An interview on 09/11/2025 at 3:53PM with the Social Worker (SW) revealed Resident #50 informed the SW that Resident #50 declined to see the physician or mental health services for the incident and requested that	F0600	Continued from page 6 with dignity and respect will continue to be provided to all staff upon hire during the facility orientation. The Abuse and Neglect policy and procedure will continue to be given to new hire employees posted throughout the facility visible to employees, families, and residents, and issued to employees at general staff meetings. Information on abuse will be given to and taught on to all agency staff prior to working. On 9-10-25, the Staff Development Nurse and/or her designee immediately began educating all staff including full-time, part-time, and agency staff on Abuse Policy and Procedure with an emphasis on (Visitor to Resident abuse). Highlights of this education included. - What to do if you witness or suspect abuse - What you should do after you intervene with potential abuse. - How to report immediately and always stay with the victim until Administration arrives at the location. On 9-10-25, all staff were given the Abuse Reminders sheet, which includes definitions associated with abuse, ways to prevent abuse, monitoring residents for aggressive/inappropriate behavior, occurrences of such incidents being reported immediately, and remaining with the victimized resident/residents until the situation is completely resolved or the threat of harm is over. This is not an all-inclusive list of the Abuse Reminder sheet. The Director of Nursing and/or her designee will do random skin sweeps on 5 residents a week for 4 weeks and monthly for 3 months thereafter to ensure no areas of concerns are noted. The audit tool will be called "Resident Skin Sweeps". Theses audits were initiated 10-6-25. The Social Worker will interview 5 residents a week for 4 weeks and monthly for 3 months thereafter to ensure there are no issues or concerns with any resident visits. This audit tool will be called "Resident Visitation Interviews". These audits were initiated on 10-6-25.	

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F0600 SS = D	Continued from page 7 Family Member #1 not return for the time being. She did not want Family Member #1 banned from the facility. During an interview with the DON on 9/11/25 at 3:37PM, the DON revealed NA #1 reported the incident to her and went out on the hall and confirmed that Family Member #1 had left the facility. She interviewed Resident #50 who stated Family Member #1 had pulled her hair and that she was not injured. The DON revealed that Family Member #1 was allowed to return with supervised visits, but stated Family Member #1 had not answered her phone or responded to text messages since the incident. She indicated that law enforcement did not file a report. An attempt to telephone law enforcement on 9/11/25 at 5:16PM was unsuccessful.	F0600	Continued from page 7 The Director of Nursing and Social Worker will share the results of the skin sweeps and resident interviews at the quarterly Quality Assurance Performance Committee. They were reviewed and discussed at the QA meeting on 10-16-25. They will be reviewed and discussed again in the next quarterly QA meeting in January 2026.	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to implement a pressure-relieving chair cushion for 1 of 4 resident reviewed for pressure ulcers (Resident #30). This resulted in Resident #30 experiencing discomfort while up in her wheelchair and prevented her from remaining in her wheelchair for social activities. The findings included: Resident #30 was admitted on 7/9/2025 with diagnoses including pressure ulcers, diabetes, heart failure, and debility.	F0686	F686 The facility immediately provided Resident #30 with a gel cushion to alleviate pressure. The Director of Nursing immediately provided education to the treatment nurse to always ensure the gel cushion and all other accessories are in place prior to checking it off on the (TAR) Treatment Administration Record. The facility will review the (TAR) Treatment Administration Record and ensure that all devices are in place on all residents who have an order for a pressure relieving device. If there is an order for a pressure relieving device and it is not there, the Treatment nurse and/or her designee should retrieve the new device and ensure that it is in place before checking it off. All types of pressure relieving devices will be placed on the (TAR) Treatment Administration Record to check for placement at least once daily. The Treatment Nurse and/or her designee doing treatments is to verify and check off that the pressure relieving device is in place only after they have visualized the actual device. The Staff Development Coordinator and/or her designee will complete education with all facility nurses and CNAs on the importance of pressure relieving devices as well as replacing the pressure relieving device if it gets soiled, or to get a new one if they find the device is not in place.	10/03/2025

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F0686 SS = D	Continued from page 8 Review of the physician orders dated 7/9/2025 indicated a gel cushion to wheelchair for pressure reduction and to check placement daily. The Minimum Data Set (MDS) comprehensive assessment dated 7/15/2025, revealed Resident #30 was cognitively intact. The initial assessment indicated one Stage II pressure ulcer, one Stage III pressure ulcer, and one unstageable, deep tissue injury. Resident #30 was at risk for developing pressure ulcers and a pressure reducing device was provided in the chair. Record review of the initial care plan dated 7/28/2025 with a revision on 9/10/2025, revealed a current stage III pressure ulcer to the left buttock and the intervention to aid in healing was to provide a gel cushion to wheelchair for pressure reduction. Review of the Kardex (a resident care guide for the Nursing Assistants) indicated to provide a gel cushion to chair. Resident #30's Treatment Administration Record (TAR) for 9/2025 indicated gel cushion to wheelchair had been checked daily by the Wound Care Nurse on September 8th, 9th 10th. An interview and observation were conducted on 9/08/2025 at 11:28 AM with Resident #30 while she was sitting in a wheelchair in her room. She indicated there was a sore on her bottom and it hurt when sitting up for a while. She stated that her bottom was hurting because she had been up for an hour. Resident #30 stated she tried turning on her side in bed when uncomfortable but asked for pain medication when it gets bad. She further stated the cushion behind her legs on the wheelchair was comfortable. When asked if she had a pad or cushion for her wheelchair seat, she stated she thought she did but wasn't sure. No wheelchair cushion was observed in the chair or in the room. An interview and observation were conducted on 09/09/2025 at 9:24 AM with Resident #30 while she was lying in bed. Resident #30 stated she liked to get up for activities several days a week. She explained she can't walk and had been using a wheelchair for a long time. Resident #30 indicated it was painful to sit up	F0686	Continued from page 8 They will also be educated on ensuring the device is in place before checking it off on the TAR. This education was initiated on 10-2-25 and completed on 10-3-25. The Director of Nursing and/or her designee will complete audits weekly for the next four weeks on three random residents per day. The three random residents will be checked to ensure that pressure relieving devices are in place after they have been checked off. This audit tool will be called "Treatment/Pressure Device Checks". Audits were initiated on 10-6-25 and completed on 10-31-25. The Director of Nursing will share the results of the treatment/pressure device audits at the quarterly Quality Assurance Performance Committee and review and discuss on 10-16-25. They will be reviewed and discussed again in the next quarterly QA meeting in January 2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345410	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Continuing Care	**1287 Newsome Street , Mount Airy, North Carolina, 27030**

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F0686 SS = D	Continued from page 9 too long in chair. No cushion was observed in the wheelchair or anywhere in the room. An observation on 09/09/2025 at 10:49 AM revealed Resident #30 sitting up in wheelchair in activities room attending church service. No cushion was observed in the wheelchair. A follow up observation and interview was done on 09/09/2025 at 11:47 AM. Resident #30 was observed back in bed. She stated she had wanted to stay up longer but her bottom hurt too much and replied that her pain level was 5 out of 10 (5 is moderate pain on a scale of 1 being minimal pain to 10 being great pain). No cushion was observed in the wheelchair. An observation of the activity calendar on the wall in the hall revealed bingo was scheduled as the activity at 2:00PM on 09/09/2025. During an interview on 09/09/2025 at 4:28 PM Resident #30 stated she didn't stay up after bingo this afternoon because her bottom was hurting from sitting in the wheelchair. Resident #30 stated she doesn't remember if she had a wheelchair cushion and didn't think to ask for one. No cushion was observed in the wheelchair. An observation and interview were conducted on 09/10/2025 at 10:09 AM with the Wound Care Nurse (WCN) during which she looked at Resident #30's wheelchair and stated the cushion was not in the chair. She indicated she had signed off on the TAR that the cushion was in the chair on September 8th, 9th and 10th. She explained that the person who signed off on the TAR that the cushion was in the chair was validating it was present, and she must not have checked to confirm if the cushion was present. She further stated that she didn't specifically remember seeing the cushion recently in the chair. She explained that when checking the chair, if the cushion wasn't there, she would replace it. An interview with Nurse Aide (NA) #4 on 09/10/2025 at 10:20 AM revealed she remembered Resident #30 having a cushion in the wheelchair but didn't recall when she had last seen it. She further explained that cushions were normally left in the chair. The cushions were	F0686		

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F0686 SS = D	Continued from page 10 replaced when a soiled cushion was sent to laundry. The Kardex provided information that there was a cushion in Resident #30's wheelchair. During an interview on 09/10/2025 at 11:17 with NA #11, she stated she did remember seeing a wide black cushion in Resident #30's wheelchair recently but wasn't sure the exact day. She revealed Resident #30's Kardex had the wheelchair cushion listed. If the cushion wasn't in the chair she would check with the nurse and retrieve one from the supply room. During an interview with on 09/11/2025 at 11:19 AM, the Director of Nursing (DON) stated that it was standard practice that everyone with a wheelchair got a cushion and that this was part of the admission. Three types of cushions were available from the supply room, and it was nursing judgement as to which type was used. The DON remarked that staff have been in-serviced to document on the TAR after it was validated that treatment interventions were present. She also explained that when an NA recognized a cushion was missing, they should let the nurse know and replace it.	F0686		