STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345291**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/21/2025**
NAME OF PROVIDER OR SUPPLIER **Oxford Health and Rehabilitation Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **500 Prospect Avenue , Oxford, North Carolina, 27565**	

(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 from 11/17/25 through 11/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DB680-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/17/25 through 11/20/25. Event ID #1DB680-H1. The following intakes were investigated: 2673639, 2672449, 2651052, 2667088, 2629782, 2610928, 2594572, 2581456, 829447, 829445, 829440, 829438, 829450, 829441, 829442, 829453, 829439, 829234, 829437, 829434, 829431, 829430, 829428, 829427, 829426, 829455, 829424, 829423, 829422, 829420, and 829419. 8 of the 104 complaint allegations resulted in deficiency.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due	F0580		

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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F0580 SS = D	Continued from page 1 to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to immediately notify the Responsible Party (RP) of Resident #125 being sent to the hospital following a change of condition. This was for 1 of 3 residents reviewed for notification of change (Resident #125). The findings included: Resident #125 was admitted to the facility on 01/29/15 with diagnoses that included nontraumatic intracerebral and intracranial hemorrhage, type 2 diabetic mellitus,	F0580		

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F0580 SS = D	Continued from page 2 dysphagia, dementia, and hemiplegia and hemiparesis. Resident #125’s quarterly Minimum Date Set (MDS) assessment dated 11/12/25 indicated her cognition was severely impaired. The responsible party was unable to be reached for an interview. Change of condition note dated 04/26/25 revealed Resident 125 was sent to the hospital at approximately 10:30 AM related to altered level of consciousness (difficult to arouse). Resident #125 had very little reaction to sternal rub, non-verbal, and overall decreased reaction to stimuli. New order received to send Resident #125 to the hospital for evaluation. Progress note dated 04/26/25 written by Nurse #8 indicated physician was notified regarding altered mental status (AMS) and lack of responsiveness. Order provided to send out. Ems called. Resident sent to ER. Responsible party (RP) notified by House Supervisor. An interview was conducted on 11/19/25 at 1:21 PM with Nurse #8. She stated she did send resident to the hospital on 04/26/25. She explained she had been off for a couple of days and when she returned she noticed Resident #125 had a change in mental status and lack of responsiveness. She stated she called the physician and received an order to send resident to the hospital for evaluation. She explained that the House Nursing Supervisor assisted with sending Resident #125 to the hospital and she told Nurse #8 she would call the Responsible Party (RP) to notify her of the transfer. An interview was conducted on 11/19/2025 at 1:33 PM with the House Nursing Supervisor. She stated she remembered assisting Nurse #8 with sending Resident #125 to the hospital for evaluation on 04/26/25. She explained she did attempt to call Resident #125's Responsible Party (RP) to notify them of the transfer. She further explained no one answered when she attempted to call the RP and she did not remember if she left a voicemail. She continued by saying she got busy with another emergency in the building and could not try to call the RP back. The next morning, she attempted to call the RP back and the RP stated the hospital had notified her the evening prior to making her aware of the transfer. An interview was conducted on 11/19/2025 at 1:45 PM with the Director of Nursing (DON). She stated Resident #125’s RP should have been notified on 04/26/25 of the transfer to the hospital for change of mental status.	F0580		

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F0580 SS = D 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 §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.	F0580 F0582		

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F0582 SS = D	Continued from page 4 (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 review, and staff and Durable Power of Attorney interviews, the facility failed to convey (transfer) funds within 30 days of discharge from the facility to the Durable Power of Attorney for 1 of 3 residents reviewed for refund of deposit (Resident #165). Findings included: Resident #165 was admitted to the facility on 3/14/25. The resident had a planned discharge to another skilled nursing facility on 4/11/25. A review of the discharge tracking MDS dated 4/11/25 revealed Resident #165 had a planned discharge to another facility on 4/11/25. On 11/18/25 at 1:03 PM an interview via telephone with Resident #165's Durable Power of Attorney (DPOA) occurred. The DPOA explained the resident initially paid privately for care at the facility. Resident #165 was discharged to another skilled nursing facility on 4/11/25 and was owed a refund of approximately $1700. The DPOA revealed she had been in contact with the facility's Business Office Manager (BOM) the week of 4/11/25 and was told she would receive a refund but still had not received the refund as of 11/18/25. The DPOA expressed she was mad she had to wait so long for the reimbursement. The DPOA voiced, "they [the facility] were giving her the run around". The BOM was interviewed on 11/19/25 at 11:04 AM. The BOM indicated the DPOA had not yet received a refund of $1730 for two reasons. First, at the time of discharge Resident #165 had outstanding insurance claims pending and it was the facility's policy to collect all outstanding insurance payments before a refund could be issued. The pending insurance claims were completed during the week of 6/27/25 and a refund check was issued on 7/9/25. Second, the refund check was returned to the facility during the week of 8/11/25 due to an error in the mailing address. The BOM indicated she had not yet requested a new refund to be sent with the corrected address due to an oversight and she should have notified the corporate office of the mailing	F0582		

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F0582 SS = D	Continued from page 5 address error and requested another refund. On 11/19/25 at 11:27 AM a telephone interview occurred with the Director of Billing Office Services. The Director of Billing Services indicated that it was the facility policy for refunds to be provided by the 30th day of discharge and when all insurance payments had been received. The Director of Billing Services confirmed the last insurance payment was received by the facility on 6/27/25 and the BOM notified the corporate office on 7/9/25 of the refund request. The Director of Billing Services further revealed that he did not become aware that the initial refund check had been returned due to an error in the mailing address until sometime this month and had not yet received additional mailing address information from the BOM and therefore had not mailed a second refund check. An interview was conducted with the Administrator on 11/20/25 at 2:23 PM. The Administrator indicated that the resident/resident representative should have received a refund per the regulation.	F0582		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of a controlled substance medication (oxycodone) prescribed to treat pain. This occurred for 2 of 2 residents (Resident #177 and Resident #131) reviewed for the misappropriation of property. The findings included: a. Resident #177 was admitted to the facility on 9/18/25 from a hospital. His cumulative diagnosis included chronic hip pain, heart failure and non-Alzheimer's dementia.	F0602	"Past Noncompliance - no plan of correction required"	

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F0602 SS = D	Continued from page 6	F0602		

A review of Resident 177's electronic medical record (EMR) revealed his physician's orders included the following pain medications:

--On 9/30/25, a physician's order was received for 500 milligrams (mg) of acetaminophen (an over-the-counter pain medication) to be administered as two tablets by mouth every 8 hours for pain.

--On 10/7/25, a physician's order was written for 10 mg oxycodone to be administered as one tablet by mouth every 6 hours as needed for chronic hip pain for 14 days.

A Packing Slip Proof of Delivery from the facility's contracted pharmacy was provided for review. This form was signed by Nurse #5 and confirmed 40 tablets of 10 mg oxycodone were delivered to the facility on 10/17/25 at 2:49 AM.

Documentation on Resident #177's October 2025 Medication Administration Record (MAR) indicated the resident received one dose of 10 mg oxycodone on each of the following dates/times:

--10/17/25 at 2:59 AM;

--10/17/25 at 4:57 PM;

--10/17/25 at 11:51 PM;

--10/18/25 at 8:54 PM (documented as administered by Nurse #3).

This documentation indicated that as of 10/19/25, there should have been 36 tablets of 10 mg oxycodone remaining in the bubble pack card for Resident #177.

The controlled drug record for Resident #177 (a declining inventory sheet which documented when each tablet of oxycodone was withdrawn from the medication cart) was not available for review.

b. Resident #131 was admitted to the facility on 2/18/25 with re-entry on 10/10/25 from a hospital. Her cumulative diagnosis included osteoarthritis, chronic pain, diabetes, and chronic kidney disease.

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F0602 SS = D	Continued from page 7 A review of Resident 131's physician's orders and Medication Administration Records from July 2025 through October 2025 revealed the resident had orders to receive 5 mg oxycodone on an as needed basis throughout her stay at the facility. Two Packing Slip Proof of Delivery forms sent from the facility's contracted pharmacy were provided for review. One form was signed by Nurse #11 and confirmed 40 tablets of 5 mg oxycodone were delivered to the facility on 9/19/25 at 8:47 PM. A second Packing Slip Proof of Delivery form sent from the facility's contracted pharmacy was also provided for review. This form was signed by Nurse #7 and confirmed 15 tablets of 5 mg oxycodone were delivered to the facility on 10/10/25 at 11:14 PM. Resident #131's physician's orders indicated her most recent order for oxycodone was written on 10/11/25. This order indicated 5 mg oxycodone was to be administered by mouth every 6 hours as needed for pain. The resident's controlled drug record (dated 7/18/25) revealed oxycodone tablets dispensed for Resident #131 on 7/18/25 was still in use with 5 tablets remaining in that bubble pack card as of 10/19/25. On 10/19/25 at 7:36 PM, Nurse #7 signed this controlled drug record to indicate one tablet of 5 mg oxycodone was withdrawn from the medication cart to be administered to Resident #131, leaving 4 tablets of oxycodone remaining in the bubble pack card. The controlled drug records for the 9/19/25 and 10/10/25 oxycodone deliveries were not available for review. An Initial Allegation Report dated 10/22/25 and signed by the facility's Administrator revealed the facility became aware of an allegation related to the diversion of resident drugs belonging to Resident #177 and Resident #131 on 10/21/25 at 6:10 PM. The accused employee was identified as Nurse #7. An Investigation Report was submitted to the State Agency on 10/27/25. A summary of the facility's investigation reported that Nurse #3 contacted Unit Manager #1 by telephone on 10/19/25. Nurse #3 explained to the Unit Manager that she was assigned to Resident #177's medication cart on the first shift of 10/18/25. She recalled Resident	F0602		

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F0602 SS = D	Continued from page 8 #177’s bubble pack card of oxycodone was on the cart during that shift and remembered that she even administered one dose of oxycodone as ordered / requested by the resident during her shift. When she came back in to work for first shift on 10/19/25, the count of controlled drug records kept on the medication cart was correct during the change of shift. However, she discovered both Resident #177’s bubble pack card of oxycodone and it’s corresponding controlled drug record were missing from the medication cart when she went to administer the medication to Resident #177 on this date (10/19/25). Unit Manager #1 notified the facility’s Director of Nursing (DON). The facility was unable to locate Resident #177’s missing medication. Nurse #7 was suspended on 10/21/25 pending investigation. The facility’s Investigation Report read in part, “100% audit done 10/21/25, 2 residents [Resident #177 and Resident #131] were found to be missing narcotics. However, no residents have missed their meds [medications] to date…Total of 90 oxycodone between two residents could not be accounted for signed by this nurse [referring to Nurse #7].” Nurse #7 was identified by the facility as the alleged perpetrator for the diversion of the oxycodone discovered to be missing for both Resident #177 and Resident #131. The nurse was reported to the local law enforcement, the State Board of Nursing, County Department of Social Services, and Drug Enforcement Agency. A telephone interview could not be conducted with Nurse #7. No current contact information was available. Nurse #7 was identified as the accused employee. She worked on Resident #177’s hall on 10/18/25 during both 2nd (3:00 PM – 11:00 PM) and 3rd shifts (11:00 PM – 7:00 AM). She also worked on Resident #131’s hall on 10/19/25 for 2nd shift. An interview was conducted on 11/19/25 at 3:00 PM with Nurse #3. During the interview, Nurse #3 reported that she was routinely assigned to work on Resident #177’s hall. She recalled working on Resident #177’s hall on 1st shift the morning of 10/18/25. The resident’s bubble pack card containing oxycodone tablets was available on the medication cart at that time, which allowed her to administer a dose of oxycodone upon the resident’s request that morning. However, when she returned to work the next morning on 10/19/25, both the bubble pack card containing the oxycodone and it’s corresponding controlled drug record were missing. Nurse #3 stated she reported the missing medication by telephone to Unit Manager #1 on 10/19/25, which prompted an investigation. The nurse stated that she	F0602		

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F0602 SS = D	Continued from page 9 was able to find an invoice from the pharmacy which documented a bubble pack card containing 40 tablets of 10 mg oxycodone that was delivered from the pharmacy for Resident #177 on 10/17/25 at 2:49 AM. The resident's October 2025 Medication Administration Record (MAR) indicated 4 tablets of the oxycodone had been administered, leaving a total of 36 missing tablets. As the interview with Nurse #3 continued on 11/19/25 at 3:00 PM, the nurse was asked if Resident #177 expressed having pain or exhibited signs of pain when his PRN oxycodone was not available. She stated he did not. The nurse reported the resident continued to receive his acetaminophen as scheduled for pain management. Nurse #3 stated that in addition to working on 10/18/25 and 10/19/25, she worked on Resident #177's hall on 1st and 2nd shifts of 10/20/25. She reiterated that the resident did not express having pain nor did he exhibit signs of pain when she worked with him. An interview was conducted on 11/18/25 at 3;15 PM with Unit Manager #1. During the interview, the Unit Manager discussed the missing oxycodone. She reported that Resident #177's oxycodone was the first medication discovered to be missing. A comprehensive search for his missing medication was conducted, but the oxycodone tablets were not found. When Resident #177's EMR was checked, it was discovered that Nurse #7 discontinued the resident's order for the oxycodone on 10/19/25. Unit Manager #1 reported she contacted the facility's Nurse Practitioner on 10/20/25 to make her aware of the missing medication and a new order was received to replace the oxycodone. When asked if Resident #177 expressed or exhibited signs of pain, the Unit Manager reported he had scheduled acetaminophen, his pain level was fine, and he "was okay," Upon further inquiry about the facility's investigation, the Unit Manager reported audits were conducted on all six of the facility's medication carts. The audits identified one other resident (Resident #131) had a discrepancy in her controlled substance medication count of oxycodone. An interview was conducted on 11/18/25 at 3:45 PM with the facility's Administrator in the presence of the Regional Consultant. During the interview, the Administrator was asked to discuss the situation encountered with Resident #177's and Resident #131's missing oxycodone. The Administrator reported that the facility initiated a search for Resident #177's oxycodone when it was discovered to be missing. When	F0602		

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F0602 SS = D	Continued from page 10	F0602		

the investigation was expanded, the card count sheet for Resident #131's hall "didn't look right" because something had been "written over." When nursing checked further, it was discovered some of Resident #131's oxycodone were also missing. She noted, however, that Resident #131 did have a few tablets of oxycodone remaining in one card that was still available for her until the missing oxycodone tablets were replaced. The Administrator stated she was brought into the investigation on 10/20/25 when the missing medications weren't found and the pharmacy confirmed they were not returned. Upon inquiry, the Administrator reported that Nurse #7 never returned to the facility after she was suspended and her contact phone number was no longer working.

A follow-up interview was conducted on 11/19/25 at 4:44 PM with the Administrator in the presence of the facility's Director of Nursing (DON). When the Administrator and DON were asked how many tablets of oxycodone were determined to have gone missing, they reported Resident #177 had 36 missing tablets of 10 mg oxycodone while Resident #131 had 55 tablets of 5 mg oxycodone missing (1-bubble pack card containing 15 tablets and 1-bubble pack card containing 40 tablets) for a total of 91 missing tablets of oxycodone.

The facility provided the following corrective action plan with a completion date of 10/25/25:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 10/19/25 the 500-hall Unit Manager received a phone call from the 7:00 AM-3:00 PM nurse assigned to Resident #177 that he was missing his oxycodone bubble pack and the controlled drug receipt/record/disposition form for said medication. The Unit Manager questioned the nurse on the correct narcotic count sheet at shift and the nurse stated the count was correct, however she noticed the bubble pack of oxycodone was missing when she went to administer the medication to the resident. This nurse indicated she was the nurse assigned to this same medication cart on 10/18/25 and the bubble pack was present during that shift. The Unit Manager on the 500 hall called the Medical Records Director to confirm if she had collected any controlled drug receipt/record/disposition forms from the 500 hall and she stated the last time she collected any of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345291	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

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F0602 SS = D	Continued from page 11 identified forms was on Thursday, 10/16/25. At this time, the Unit Manager notified the Director of Nursing and was instructed to look for the medication in all medication carts/units to see if it was delivered to another location and to write a statement of findings. On 10/20/25 at 9:00 AM the Director of Nursing instructed the 7:00 AM-3:00 PM Unit Manager to complete a second audit of the 500-hall medication cart and the medication room and was unable to locate the missing medication. The Unit Manager interviewed the 500-hall nurse assigned and she stated, “the medication in question was present in the medication cart on Saturday during first shift as she had administered the medication as ordered/requested by the resident.” She also stated that “the medication was delivered on 10/17/25 and was administered on 10/18/25 on 3rd shift”. At this time, the Unit Manager notified the Staff Development Coordinator, at which time they both reported the concern to the Administrator on 10/21/25 that all carts had been audited, pharmacy records were reviewed, delivery confirmation had been requested from pharmacy and/or destruction of medications. Upon audit of all medication carts/units, it was discovered that Resident #131 was missing 2 cards of oxycodone 5mg, one card of 40 tablets and one card of 15 tablets. No other residents had discrepancies noted per the completed audit findings. The two identified residents were interviewed and stated they had not missed any medications, specifically the medication in question. The medication in question for both identified residents was “as needed” and had not been requested prior to identifying the discrepancy. Both residents identified were not affected by the missing narcotics as Resident #177 had a replacement card delivered the same day at no charge to the resident and Resident #131 had one card remaining on hand. Neither resident was charged for the replacement of missing medications. On 10/21/25, the Staffing Agency was made aware by the Administrator of the allegations pending pharmacy confirmation for Nurse #7. Per Staffing Agency Director, Nurse #7 was advised to come in to give a formal statement and to complete a drug test. She stated she would come in on 10/22/25, however never reported to the facility. Communication was sent by the agency to Nurse #7 that she would be suspended pending investigation. An employer complaint was initiated by the Administrator to the North Carolina Board of Nursing on 10/22/25 against Nurse #7. A 24- hour report was sent in to Department of Health and Human Services	F0602		

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F0602 SS = D	Continued from page 12 on 10/22/25 by the Administrator for misappropriation of resident's property on Resident #177 and Resident #131. The local Police were notified by the Administrator on 10/22/25 to which an officer came out take a written report and information to try to reach out to Nurse #7. The Pharmacy was notified on 10/19/25, again on 10/20/25 and a third follow-up call on 10/22/25 by the Staff Development Coordinator. The pharmacy was to send the form to the Administrator for notifying the Drug Enforcement Administration once all information was finalized/obtained from the police investigation. Adult Protective Services and Ombudsman were notified by the Administrator on 10/24/25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/21/25-10/22/25 the Unit Managers, Assistant Director of Nursing and Director of Nursing In-Training completed a 100% audit to include the narcotic count sheet and medication on each medication cart. There are 6 medication carts in total. During this audit, no additional residents were identified to have been affected by the deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Staff Development Coordinator initiated education on 10/22/25 for all licensed nursing staff and medication aides to include the following but not limited to narcotic count sheets, sign in/out sheet, shift to shift narcotic count, receiving and returning narcotics to/from pharmacy, reconciliation of medications prior to delivery driver leaving, misappropriation of property/drug diversion and self-reporting of legal issues per North Carolina Board of Nursing requirements. This education was completed on 10/24/25. Any licensed nurse and/or medication aide that has not received the education by 10/24/25 will be educated prior to the start of his/her next scheduled shift. The Director of Nursing, Unit Managers, Nurse Supervisors and/or Staff Development Coordinator will monitor the schedules daily to ensure all staff have completed the training prior to the start of his/her shift. All new hires will be educated during orientation by SDC or designee.	F0602		

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F0602 SS = D	Continued from page 13 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Monitoring began on 10/22/25 by the Unit Manager's, Director of Nursing and/or designee. The initial results of these audits were reviewed during an impromptu Quality Assurance and Improvement Committee meeting held during daily stand-up on 10/23/25. Medication carts and count sheets will be monitored by the Unit Manager's during the week and by the Registered Nurse supervisors on the weekends daily for 4 weeks, then three times a week for 4 weeks and then weekly for 4 weeks or until substantial compliance is achieved. The continued audits will be reviewed at the Quarterly Quality Assurance Meeting x 3 months for further problem resolution if needed. The Administrator and/or the Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Date of Compliance: 10/25/2025 Validation of the corrective action plan was completed on 11/20/25: The validation included staff interviews and a review of the in-service education provided to the licensed nurses on the subject of "Handling Narcotic Misappropriation" with education on the follow-up of incidents. The in-service records confirmed that all nurses scheduled to work during the 4-day survey had completed this education. An observation was also conducted of the process employed by nursing staff to verify the narcotic count during shift change. A review of the facility's monitoring tool revealed audits were initiated on 10/20/25 and continued in accordance with the corrective action plan. The facility's completion date of 10/25/25 was validated on 11/20/25.	F0602		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a	F0656		

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F0656 SS = D	Continued from page 14 comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to implement care planned interventions for fall safety for 1 of 4	F0656		

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F0656 SS = D	Continued from page 15 residents reviewed for accidents (Resident #105). The findings included: Resident #105 was admitted to the facility on 4/1/25 with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following stroke affecting the dominant right side. The admission Minimum Data Set (MDS) assessment dated 4/7/25 indicated Resident #105 was severely cognitively impaired and required total assistance from staff for activities of daily living (ADL). She was assessed as having no falls since admission. A review of Resident #105's active care plan initiated on 4/17/25 revealed there was a problem area for being at risk for falls related to muscle weakness, reduced physical mobility, requiring assistive devices to walk or transfer with an intervention of a fall mat to bilateral sides of bed. On 11/17/25 at 2:51 PM an observation revealed Resident #105 lying on her bed with no fall mats present on either side of her bed. On 11/19/25 at 12:40 PM an observation revealed Resident #105 lying on her bed with no fall mats present on either side of her bed. On 11/19/25 at 12:42 PM an interview was conducted with Nursing Assistant # 5, who was assigned to Resident #105 on 11/19/25 from 7:00 AM- 3:00 PM. She indicated Resident #105 was alert but required staff to assist with all ADL needs. Nursing Assistant #5 indicated she was not aware that Resident #105 required bilateral floor mats for fall injury prevention. On 11/19/25 12:43pm an interview was conducted with Nurse # 9, who was assigned to Resident #105 on 11/19/25 from 7:00 AM-3:00 PM. She indicated she was not aware Resident #105 had been care-planned to require bilateral floor mats while in bed for fall injury prevention. An interview was conducted with the MDS Coordinator on 11/20/25 at 12:44 PM. She indicated Resident #105 was actively care-planned for the use of bilateral floor mats at the bedside for fall injury prevention and the nursing staff should have provided the floor mats for fall injury prevention. On 11/19/25 12:47 PM an interview was conducted with	F0656		

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F0656 SS = D	Continued from page 16 the Director of Nursing. She indicated nursing staff should have followed Resident #105's care plan and provided the bilateral floor mats for fall injury prevention. On 11/20/25 2:23 PM an interview was conducted with the Administrator. She indicated nursing staff should follow a resident's care plan and staff should have provided Resident #105 with bilateral floor mats at bedside as indicated in her care plan.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and physician and staff interviews, the facility failed to have effective systems in place for entering medication orders into the electronic medical record and administering medications per the physician orders for a new admission for 1 of 6 residents whose medications were reviewed (Resident #174). The findings included: Resident #174 was admitted to the facility on 12/10/24 at approximately 4:45 PM with diagnoses that included Type 2 diabetes mellitus with chronic foot ulcer, hypertension, atrial fibrillation, and congestive heart failure. A review of Resident #174's physician orders dated 12/10/24 included the following: Coreg Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth at bedtime for hypertension at 8:00 PM, start date 12/11/25. Hold for systolic blood pressure (SBP) below 95 and HR below 60. Gabapentin Capsule 100 MG Give 1 capsule by mouth two times a day for neuropathy at 9:00 AM & 9:00 PM, start date 12/11/25.Flomax Capsule 0.4 MG (Tamsulosin HCl) Give 1 capsule by mouth at bedtime for benign prostatic hyperplasia at 9:00 PM, start date 12/11/25. Atorvastatin Calcium Oral Tablet 10 MG Give 1 tablet by mouth at bedtime for hyperlipidemia at 9:00 PM, start date 12/11/25. Torsemide Oral Tablet 20 MG (Torsemide) Give 1 tablet by mouth every 12 hours for	F0658		

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F0658 SS = D	Continued from page 17 congestive heart failure (CHF) at 9:00 AM & 9:00 PM, start date 12/11/25. Resident #174's admission Minimum Date Set (MDS) assessment dated 12/16/24 indicated he was cognitively intact. A review of Resident #174's December Medication Administration Record (MAR) revealed all the medication orders were entered into the electronic medical record (EMR) on 12/10/24 and were scheduled to start on 12/11/24. There was no entry on the MAR for the administration of Coreg, Gabapentin, Torsemide, Flomax, or Atorvastatin at 9:00 PM for 12/10/24. Resident #174 started receiving his scheduled medications on 12/11/24 per orders. Record reviews revealed Resident #174's blood pressure on 12/11/24 was 119/50 (normal range is less than 120/80). No concerns were documented related to blood pressure on 12/11/24. An interview was conducted on 11/19/2025 at 12:30 PM with Nurse #6. She verified she worked on 12/10/25 from 7:00 AM-7:00 PM. She stated she was not the floor nurse on 12/10/24 but she did assist with Resident #174's admission. She explained that the steps she normally would take when an admission comes in was, she would call the on-call provider to clarify the medication orders and then looked to see what medications were available in the Pyxis system. Nurse #6 indicated she then sends the medication list to the pharmacy and if it was past the pharmacy cut off time for submitting orders, she would call the pharmacy to make them aware of the medications needed. However, for Resident #174's admission she only called the on-call provider to clarify the medication orders, she entered the medications into Resident #174's EMR and then sent the orders to the pharmacy. She did not check to verify if any medications were due on the evening of 12/10/24. She indicated that when she entered Resident 174's medications into the EMR the start date and time automatically scheduled the medications to start on 12/11/24 at 8:00 AM. Nurse #6 confirmed that she did not check the Pyxis system for the Coreg, Gabapentin, Torsemide, Flomax, or Atorvastatin at 9:00 PM for 12/10/24.because she did not think about the 9:00 PM medications that needed to be administered on 12/10/24, she was only trying to get the medications into the EMR. Nurse #6 continued by confirming that she did not administer Resident #174 any medications on 12/10/24. An interview was conducted on 11/19/25 at 12:59 PM with Nurse #3. She stated she was the direct care nurse for Resident #174 on 12/10/24. Nurse #3 explained that since the medications were entered to start 12/11/24	F0658		

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F0658 SS = D	Continued from page 18 she was unaware Resident #174 had scheduled medications that should have been administered on 12/10/24 at 8:00 PM/9:00 PM. Nurse #3 continued by confirming that she did not administer Resident #174 any medications on 12/10/24. An interview was conducted on 11/19/24 at 12:12 PM with the Director of Nursing (DON). She indicated she was unaware Resident #174 did not receive his 8:00 PM/9:00 PM medications on 12/10/24. She explained the transcribing nurse should have reviewed Resident #174's medications to determine if he had any upcoming medications due. An interview was conducted on 11/19/2025 at 11:26 AM with Physician #1. He stated he did not recall Resident #174 however he wound expect medications to be administered on date of admission if they were ordered. Physician #1 explained although there was the potential for negative outcomes to occur, none resulted due to Resident #174's medications not being administered at 9:00 PM on 12/10/24.	F0658		
F0689 SS = D	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 observations, record review and staff interviews, the facility failed to ensure smoking assessments were accurate and completed quarterly for 1 of 8 residents reviewed for smoking (Resident #50). The findings included: Resident #50 was admitted to the facility on 3/3/2025 with diagnoses including Parkinson's disease and chronic obstructive pulmonary disease. Review of the comprehensive Minimum Data Set (MDS) assessment dated 3/17/2025 revealed Resident #50 was	F0689		

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F0689 SS = D	Continued from page 19 not using tobacco at the time of admission and was severely cognitively impaired. Resident #50's smoking assessment dated 6/10/2025 completed by Nurse #4 recorded Resident #50 had cognitive loss and indicated Resident #50 needed supervision when smoking. The smoking assessment specified Resident #50 had a cognitive loss, required an occupational therapy evaluation as needed, and needed supervision when smoking. An interview was conducted on 11/20/2025 at 1:37 PM with Nurse #4, Unit Manager. Nurse #4 revealed she completed the smoking assessment for Resident #50 on 6/10/2025. She stated the process for the smoking assessments was that they are to be completed quarterly on all residents who smoke. Nurse #4 explained a smoking assessment, consisted of observing residents smoking, and speaking with the nurses and nurse aides. Nurse #4 stated she spoke with staff prior to completing any smoking assessment and did this for Resident #50's June 2025 assessment. She stated she had just started working and knew she had missed a few residents' smoking assessments and she was "catching up" on the smoking assessments. Nurses #4 stated she had observed Resident #50 smoke independently on 6/10/25 and verified he was a safe smoker and able to smoke independently. She further stated she thought she may have completed Resident #50's June 2025 smoking assessment inaccurately. The significant change Minimum Data Set (MDS) assessment dated 9/14/2025 indicated Resident #50 was moderately cognitively impaired and required partial to moderate assistance with upper and lower dressing. The MDS revealed Resident #50 was a current tobacco user. Resident #50's care plan included a focus for smoking dated 6/10/2025, and interventions included may smoke independently and perform smoking assessments as needed. On 11/17/2025, a list of smokers was provided by the facility and Resident #50 was not listed on the facility's smoking list as an independent unsupervised or supervised smoker. Review of smoking assessment dated 11/17/2025 for Resident #50 revealed he required supervision with smoking. This assessment was struck through, and another smoking assessment was completed on 11/18/2025 indicating Resident #50 was independent with smoking. Review of the smoking assessments dated 1/17/2025 and 11/18/2025 revealed both were completed by Nurse #4.	F0689		

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F0689 SS = D	Continued from page 20 An interview was conducted on 11/20/2025 at 1:37 PM with Nurse #4, Unit Manager. Nurse #4 stated she completed and removed the smoking assessment for Resident #50 on 11/17/2025 due to the assessment not being accurate. She stated she had coded Resident #50 as needing supervision, but that was a “mistake,” and she did another assessment on 11/18/2025. Nurse #4 indicated Resident #50 was independent with smoking based on her observations, interviews with staff, and her assessment based on the assessment completed on 11/18/2025. On 11/18/2025 at 11:28 AM, Resident #50 was observed smoking in the designated smoking area accompanied by other residents. Resident #50 was observed holding his cigarette in the left hand with controlled movements to and from the lips while smoking. Resident #50 was observed positioned approximately two feet from the self-closing metal container in a wheelchair and dropping ashes onto the concrete. There were no staff members observed in the smoking area. An interview was conducted on 11/19/2025 at 12:52 PM with Resident #50. He indicated he started smoking about 2 years ago out of boredom. But he was not smoking when he was first admitted to the facility. Resident #50 stated he recently started smoking out of boredom. Resident #50 stated he was aware of the designated smoking area and was able to identify the location. He further stated he would never smoke in his room and he kept his smoking materials in fear they would go missing. An interview was conducted on 11/18/2025 at 12:36 PM with Nurse #1. Nurse #1 stated she kept Resident #50’s smoking materials in the nurse’s medication cart and they were labeled with his name. She stated Resident #50’s family members also brought him smoking material and sometimes he will have them in his possession. She further revealed Resident #50 does not need supervision when smoking. On 11/19/2025 at 12:57 PM in an interview with the Director of Nursing (DON), she explained smoking assessments were completed on admission, quarterly, and for a change in condition. She stated nurses were responsible for conducting smoking assessments, and Resident #50 should have had a smoking assessment conducted in September 2025. The DON stated interventions for a smoker were based on the assessment performed whether they are independent or supervised. If a resident needed a smoking apron, a staff member for supervision, were some of the interventions the DON	F0689		

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F0689 SS = D	Continued from page 21 was referencing. She stated the facility had staff to assist with supervised smokers and ensure interventions were followed. The DON confirmed independent residents who smoke may go out to the smoking area at their leisure. The DON could not explain why the assessment for Resident #50 was inaccurate or not completed quarterly. The DON stated the nurses were notified when a smoking assessment was due for a resident in the electronic medical record. An interview was conducted on 11/19/2025 at 10:01 AM with the Administrator. She stated the window in her office that views the smoking area and she could view all the residents who are smoking in the smoking area. She stated she had viewed Resident #50 smoking from her office and believed the smoking assessment dated 6/10/2025 was not completed accurately for Resident #50. The Administrator stated Resident #50 was a safe smoker and she had observed him many times but had not completed a formal smoking assessment. She further stated Nurse #4 informed her she was confused with the verbiage of the smoking assessment and the smoking assessment for Resident #50 was inaccurate. The Administrator stated residents who were assessed as safe independent smokers were allowed to possess their own smoking materials. She further explained residents who required supervision with smoking, their smoking materials were kept with the nurse on their unit. The Administrator confirmed smoking assessments were completed for residents upon admission, quarterly and as needed for the purpose of a safe smoking evaluation. She further revealed the nurses were responsible for completing the assessment based on an alert in the electronic medical record for the resident.	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 record review and physician and staff interviews, the facility failed to prevent significant medication errors when Nurse #6 did not schedule a new residents' (Resident #174) medication to start on the afternoon of admission. The medications were available in the Pyxis system (an automated, secure, and centralized system used in healthcare to manage the storage, dispensing, and tracking of medications).	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345291**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/21/2025**

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F0760 SS = D	Continued from page 22 Resident #174 was admitted on 12/10/24 at approximately 4:45 PM, his medications were scheduled to start on 12/11/24 at 8:00 and 9:00 AM. This was for 1 of 6 residents whose medications were reviewed. The findings included: Based on record review and physician and staff interviews, the facility failed to have effective systems in place for obtaining and administering medications to a new admission which resulted in a significant medication error for 1 of 6 residents whose medications were reviewed (Resident #174). The findings included: Resident #174 was admitted to the facility on 12/10/24 with diagnoses that included type 2 diabetes mellitus (DM) with chronic foot ulcer and atrial fibrillation. Nursing progress notes revealed Resident #174 was admitted to the facility on 12/10/24 at approximately 4:45 PM. A review of Resident #174's physician orders dated 12/10/24 included the following medications: - Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 24 unit subcutaneously every 12 hours for DM at 8:00 AM & 8:00 PM, start date 12/11/24. - Apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day for atrial fibrillation at 9:00 AM & 9:00 PM, start date 12/11/24. A review of Resident #174's December Medication Administration Record (MAR) revealed all medications orders were entered into the electronic medical record (EMR) on 12/10/24 and were scheduled to start on 12/11/24. There were no orders entered on the MAR to administer the Lantus insulin at 8:00 PM or Apixaban at 9:00 PM on 12/10/24. Record reviews revealed Resident #174's blood sugar reading on 12/11/24 was 222 (normal blood sugar is 80 to 130 mg/dL). No concerns were documented related to blood sugar results on 12/11/24. An interview was conducted on 11/19/2025 at 12:30 PM with Nurse #6. She verified she worked on 12/10/25 from 7:00 AM to 7:00 PM. She stated she was not the floor nurse on 12/10/24 but she did assist with Resident #174's admission. She explained that the steps she normally would take when an admission comes in was she	F0760		

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F0760 SS = D	Continued from page 23 would call the on call provider to clarify the medication orders and then looked to see what medications were available in the Pyxis system. Nurse #6 indicated she then sends the medication list to the pharmacy and if it was past the pharmacy cut off time for submitting orders she would call the pharmacy to make them aware of the medications needed. However, for Resident #174's admission she only called the on-call provider to clarify the medication orders, she entered the medications into Resident #174's EMR and then sent the orders to the pharmacy. She did not check to verify if any medications were due on the evening of 12/10/24. She indicated that when she entered Resident 174's medications into the EMR the start date and time automatically scheduled the medications to start on 12/11/24 at 8:00 AM. Nurse #6 confirmed that she did not check the Pyxis system for the Lantus or apixaban that were to be administered at 8:00 PM/9:00 PM. She stated, "I did not think about it, I was only trying to get the medications into the EMR for Nurse #3". Nurse #6 also confirmed that she did not administer Resident #174 any medications on 12/10/24. An interview was conducted on 11/19/25 at 12:59 PM with Nurse #3. She stated she was the direct care nurse for Resident #174 for second shift 3:00 PM-11:00 PM on 12/10/24. Nurse #3 explained that since the medications were entered to start on 12/11/24 she was unaware Resident #174 had scheduled medications that should have been administered on 12/10/24 at 8:00 and 9:00 PM. An interview was conducted on 11/19/24 at 12:12 PM with the Director of Nursing (DON). She indicated she was unaware Resident #174 did not receive his 8:00 and 9:00 PM medications on 12/10/24. She explained when the orders were entered into the EMR the transcribing nurse (Nurse #6) should have verified the start date and time and changed the automatic response to begin on 12/10/24 at 8:00 PM. The EMR system scheduled the medications to begin at 8:00 AM on 12/11/24. She verified Resident #174 should have received his evening medications per the physician's orders. She stated the transcribing nurse (Nurse #6) should have reviewed Resident #174's medications to determine if he had any upcoming medications due and then obtain them from the Pyxis system if they were available. If the medications were not available, the nurse should call pharmacy to have the medications sent. The DON also stated in this case the medications were available in the Pyxis system. An interview was conducted on 11/19/2025 at 11:26 AM with Physician #1. He stated he did not recall Resident #174 however he would expect medications to be administered on date of admission if they were	F0760		

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F0760 SS = D	Continued from page 24 scheduled. Physician #1 explained although there was the potential for negative outcomes to occur, none resulted due to Resident #174’s medications not being administered at 8:00 PM and 9:00 PM on 12/10/24.	F0760		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow the planned menu for renal and diabetic renal diets, and for mechanical altered and pureed diets. Failure to follow the planned menu was observed during 1 of 1 tray line observation conducted. This affected 7 residents on renal diet, 3 residents on renal diabetic diet, 17 residents on mechanically altered diet and 12 residents on pureed diet.	F0803		

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F0803 SS = E	Continued from page 25 Findings included: a. The “diet spread sheet” for therapeutic diets for lunch meal on 11/18/25 revealed renal and diabetic renal diets were to receive 4-ounces (oz) of carrots. The “Diet Type Report” revealed there were 7 residents on renal diet and 3 residents on renal diabetic diet. Tray line observation on 11/18/25 at 12:10 PM, revealed the steam table had no carrots for the renal and diabetic renal diets. On 11/18/25 at 12:22 PM the Certified Dietary Manager (CDM) entered the kitchen and stated that renal diets would be receiving sliced cucumbers. Two renal trays were observed with sliced cucumbers. During an interview on 11/18/25 at 12:25 PM, the CDM indicated carrots were on the menu for therapeutic diets. However, the product shipment had not yet arrived by lunch time. She further indicated that cucumber salad was unavailable and the renal diets would receive sliced cucumbers. She stated spinach was prepared as alternate vegetable and was not renal diet appropriate and hence had to make the decision to serve sliced cucumbers on their trays. During an interview with the Assistant Dietary Manager on 11/20/25 at 9:30 AM, she indicated carrots were supposed to be delivered earlier in the morning and the shipment had not come in until tray line time. She further stated on 11/18/25 one of dietary cooks had called out and she was assisting the cook prepare for lunch meal. The Assistant Dietary Manager stated when she came to assist on the tray line, she did not notice there was no vegetable cooked for the therapeutic diets. She further indicated she thought there was cucumber salad prepared and placed in the refrigerator and was going to use it for the lunch meal. The Assistant Dietary Manager further stated the CDM does put out the daily meal sheets and the cooks and staff review them prior to the meal and cook accordingly. She indicated she had not seen any substitutions on it for carrots. However, the “the sample menu substitution sheet” approved by the dietitian indicated that “cucumber salad” would be substitution for “chips” as it was renal diet friendly. She reiterated that she was stretched too thin and did not ask what the substitution was for carrots. The CDM was reinterviewed on 11/18/25 at 2:00 PM. She stated she had not communicated to the staff what the substitution for carrots were for the therapeutic diet	F0803		

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F0803 SS = E	Continued from page 26 menu. The CDM indicated carrots were on the menu for therapeutic diets. However, the product shipment had not yet arrived by lunch time. The CDM stated that chips were never on the menu for therapeutic diets and unsure who had asked for the substitution for those. CDM stated due to miscommunication no vegetable was prepared for renal and renal diabetic diets. During an interview on 11/18/25 at 1:30 PM, the Registered Dietitian (RD) stated he was approached earlier in the day by a dietary staff member (name unknown) requesting permission to substitute chips for cucumber salad. He indicated he was not aware that carrots were the planned menu item for therapeutic diets. He was only informed later that the carrot shipment had not arrived. The RD indicated there were 7 residents on renal diet and 3 residents on renal diabetic diet. The RD further indicated few of the residents on renal diet were at dialysis and did not receive a tray for lunch. b. The “consistency spread sheet” revealed the planned menu for mechanically altered diets was 5 oz of baked chicken leg (ground with gravy) and the planned menu for pureed textured diets was 5 oz of baked chicken leg (pureed with gravy). The “Diet Type Report” revealed there were 17 residents on mechanically altered diet and 12 residents on pureed textured diet. During the meal preparation observation on 11/18/25 at 11:30 AM, the Dietary Cook was observed cooking hamburger meat. During an interview on 11/18/25 at 11:35 AM, the Dietary Cook stated the hamburger meat was cooked for mechanically altered diets based on the lunch menu for that day. The Dietary Cook indicated the CDM places the menu spread sheet and consistency spread sheet for the meal and staff would follow them accordingly. She further indicated she does look at the menu and consistency sheets prior to prepping for any meal. During tray line observation on 11/18/25 at 12:10 PM, ground hamburger meat and pureed hamburger meat with gravy were served to residents on mechanically altered and pureed diets. During an interview on 11/20/25 at 9:30 AM, the Assistant Dietary Manager indicated one of the Dietary Cooks had called out, and she was assisting the cook. The Assistant Dietary Manager indicated that prior to the scheduled tray line, the shipment had arrived, and	F0803		

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F0803 SS = E	Continued from page 27 she was ensuring all the products had come in. She further indicated she had noticed the Dietary Cook taking hamburger meat for altered texture diets and cooking it. She was unsure why hamburger meat was cooked, instead of ground or pureed chicken. The Assistant Dietary Manager stated the CDM does put out the daily menu and consistency sheets and the cooks and staff were to review it and prepare the food according to the daily meal and consistency sheet. If the meal item needed to be substituted, it would be indicated on the meal spread sheet. During an interview on 11/18/25 at 1:30 PM, the Registered Dietitian (RD) stated he was unaware that hamburger meat was served for mechanically altered and pureed diets. During an interview on 11/18/25 at 2:00 PM, the Certified Dietary Manager (CDM) stated she was unsure why the Dietary Cook had cooked hamburger meat for altered texture diets. The CDM stated she placed the daily menu spreadsheet for the meal out for the cooks and staff to know the meal that needed to be prepared and served to the residents. The CDM indicated hamburger meat was not on the menu for mechanically altered texture diets that day. During an interview on 11/20/25 at 2:00 PM the Administrator stated all meals should be prepared as indicated in the planned menu for the day. Prior to meal preparation the menu should be reviewed, and any substitutions should be approved if needed. All efforts should be made to ensure the planned menus were followed.	F0803		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812		

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F0812 SS = F	Continued from page 28 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to maintain the double door oven, the stove drip pan, the steam table backsplash and rack under the steam table clean. The facility failed to label, and date opened food and failed to separate raw meat from cooked food in 1 of 1 walk-in refrigerator, and in 1 of 1 walk-in freezer. The facility also failed to label and date resident's foods, failed to discard expired food, and keep nourishment refrigerators clean for 3 of the 4 nourishment refrigerators (200, 300, 400/500 hallway nourishment refrigerators) observed. The facility failed to ensure 2 of 2 dietary staff wore hair restraints and 2 of 2 male dietary staff had all facial hair contained in a face covering. The facility also failed to hold cold food (equal to or less than 40 degrees Fahrenheit (F)) on the steam table and remove chipped plates and dirty plates from the plate warmer during tray line observation. These practices had the potential to affect food being served to residents. Findings included: 1a. Initial Kitchen tour was conducted with the Certified Dietary Manager (CDM) on 11/17/25 from 9 :20 AM to 9:50 AM. Observation of the double door oven on 11/17/25 at 9:35 AM revealed black oil burnt stains inside of the oven. The floor of the oven had black layer of crust that appeared like burnt food. The oven doors had dark brown oil stains. 1b. Observation of the stove drip pan on 11/17/25 at 9:38 AM revealed black burnt food crumbles on it. 1 c. Observation of the steam table on 11/17/25 at 9:40 AM revealed the steam table backsplash had water and food stains on it. The rack below the steam table had dust, dirt, and water stains on it. There were a few bowls kept on the rack which also had food and water stains on them. During an interview on 11/17/25 at 9:45 AM, the	F0812		

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F0812 SS = F	Continued from page 29 Certified Dietary Manager (CDM) stated the dietary staff were scheduled to clean the equipment on Monday/ Wednesday/ Friday. Cleaning was usually done at night. She indicated the stove drip pan had aluminum foil which collected all the burnt food crumbs. The aluminum foil should be removed, and new aluminum foil should be placed on it. The CDM acknowledged that the steam table backsplash should be cleaned regularly, and the rack below should also be cleaned. The CDM indicated that the bowls on the rack below the steam table were used during activities. She further indicated the bowls would be moved to a rack in the dry storage area as these were not used frequently. 2a. Observation of the walk-in freezer on 11/17/25 at 9:48 AM, revealed a brown colored open cardboard box with raw frozen chicken breast in a clear plastic bag and a opened plastic bag containing slices of garlic bread in it. There was no label on raw chicken or on the garlic bread bag. During an interview on 11/17/25 at 9:50 AM, the CDM stated the dietary cook had placed the chicken in the brown box. This was the alternate meat option for lunch for the day. She did acknowledge that the raw chicken and bread slices should not have been placed together. 2b. Observation of the walk-in refrigerator on 11/17/25 at 9:50 AM, revealed a plastic container with green colored food in it with no label. Two open packages of sliced deli meat that were not labeled. Two opened packages of deli cheese slices that were not labeled. During an interview on 11/17/25 at 9:52 AM, the CDM stated the sliced deli meats were sliced turkey and sliced ham. The packages should be closed and labelled. The CDM further stated plastic container with green colored food was dietary employees' lunch. The CDM indicated dietary staff should not be placing their food in the walk-in refrigerator. 3 a. Observation of the nourishment refrigerator #1 on 200 hallway on 11/17/25 at 9:55 AM revealed an opened half empty 16-ounce orange flavor soda bottle, opened 23.9-ounce mango flavored juice bottle. The freezer of the nourishment refrigerator had a frozen 16-ounce water bottle with slices of lemon in it. There were no labels on these bottles. The shelves of the nourishment refrigerator had standing water and were not clean. 3b. Observation of the nourishment refrigerator #2 on 300 hallway on 11/17/25 at 9:58 AM revealed a cup of cut fruit that was not labeled. A plastic grocery bag containing a sandwich in a brown bag with no label or	F0812		

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F0812 SS = F	Continued from page 30 date, and an opened store brought pepperoni 14-ounce package containing few sliced pepperoni that was not labelled. During an interview on 11/17/25 at 9:58 AM, the CDM stated the unlabeled food in the nourishment refrigerator was employee food and not residents' food. She further stated all resident's food should be labeled with resident's name and date when the food was placed in the refrigerator. All residents' perishable food should be discarded after 3 days. 3c. Observation of the nourishment refrigerator #3 on 400/500 hallway on 11/17/25 at 10:00 AM revealed an unlabeled clear plastic bag with 4 cartons of chocolate milk and a pair of gloves in them. A box of cut fruit with sell-by date 10/19/25 and a box of grapes with sell by date 10/13/25. There was also a 25-ounce grape juice bottle with no label or date on it. The nourishment room floor was dirty. There were 3 empty grocery bags, few packs of cookies and crackers and used paper towels on the floor. During an interview on 11/17/25 at 10:00 AM, the CDM indicated the nourishment refrigerators and rooms were cleaned by the housekeeping staff. The housekeeping staff were responsible for discarding any expired food when cleaning the nourishment refrigerators. During an interview on 11/18/25 at 10:30 AM, the Housekeeping Director stated that the housekeeping staff were responsible for cleaning the outside of the nourishment refrigerator and the nourishment room. Housekeeping staff were not responsible for cleaning the inside of the nourishment refrigerator or discarding any food. He indicated he did notice the nourishment rooms were not cleaned by his housekeeping staff. The staff was identified, and the rooms were cleaned. The Housekeeping Director acknowledged the housekeeping staff had not cleaned the nourishment rooms over the weekend. These rooms were to be cleaned daily. During an interview on 11/18/25 at 3:00 PM, the Director of nursing (DON) stated it was the responsibility of both nursing and dietary staff to keep the nourishment refrigerator and nourishment rooms clean. Both nursing and dietary staff should discard any expired food. DON stated the nursing staff should label and date all the food brought by visitors to the residents prior to placing resident's food in the nourishment refrigerator. All perishables' foods should be discarded after 3 days.	F0812		

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F0812 SS = F	Continued from page 31 4 a. On 11/17/25 at 9:30 AM Dietary Staff #1 was observed cleaning dishes near the dishwasher. The Dietary Staff member had facial hair that was not restrained in the facial covering. During an interview on 11/17/25 at 9:32 AM, Dietary Staff #1 stated he had forgotten to wear a facial hair covering. He indicated he was late for work and, in a hurry, forgot to wear it. 4 b. On 11/18/25 at 10:50 AM Dietary Staff #2 and Dietary Staff #3 were observed assisting with dish washing. Dietary Staff #2 was handling clean dishes and Dietary Staff #3 was handling dirty dishes. Both staff members were not wearing hair coverings. Dietary Staff #3 was observed having facial hair that was not restrained in the facial covering. During an interview with Dietary Staff #2 and Dietary Staff #3 both stated they had forgotten to wear their hair nets. Dietary Staff #3 indicated he did not wear facial hair restraints. During an interview on 11/18/25 at 11:01 AM, the CDM stated all dietary staff should restrain their hair using hairnets and use facial hair restrains to cover any facial hair. 5a. Tray line observation was made on n 11/18/25 from 12:00 PM to 1:20 PM. Twenty-five plates used to serve resident's food on the plate warmer were observed. Five of the 25 plates observed on the plater warmer were chipped and 5 of the 25 plates had dry food particles and food stains on them. During an interview on 11/18/25 at 12:10 PM, the Assistant Dietary Manager indicated the plates may have been chipped when passed through the dishwasher. The Assistant Dietary Manager stated all chipped plates should be discarded and not used on tray line to plate resident's food. 5b. The temperatures of food on the tray line were taken by the Assistant Dietary Manager using a calibrated thermometer on 11/18/25 at 12:00 PM. Tuna salad sandwich was the alternate meal option, and a bowl of tuna salad was near the steam table. Temperature of the tuna salad was 48-degree Fahrenheit (F). The tuna salad was removed from the tray line and placed in the refrigerator. The temperature of the tuna salad was rechecked at 12:30 PM using a calibrated thermometer and it read 54 degrees F. The dietary aide returned the tuna salad to the freezer and temperature was rechecked at 1:05 PM by the CDM using a calibrated thermometer. The temperature was 45 F. The tuna salad	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345291	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0812 SS = F	Continued from page 32 was removed from the menu and not served to the residents. During an interview on 11/18/25 at 2:30 PM, the CDM indicated the tuna salad should have been placed in smaller bowls and placed in the freezer or refrigerator so that the temperature was maintained below 40 degrees F. She said it was unfortunate that the temperature could not be maintained. The interview further revealed the tuna salad was substituted with a deli sandwich. CDM stated all food should maintain the appropriate temperature during tray line. During an interview on 11/20/25 at 2:00 PM, the Administrator stated all food should be stored at appropriate temperature, opened foods should be labeled and dated accordingly and all expired foods should be discarded appropriately. The Administrator indicated Dietary staff should wear appropriate hair covering in the kitchen and follow sanitation protocols. The Administrator stated all foods prepared for the residents should be maintained at appropriate temperature. The Administrator further stated the kitchen equipment should be cleaned as scheduled and the CDM should ensure that all equipment was clean and in good working condition. The nourishment refrigerators and rooms should be maintained clean; all residents' foods should be labeled and dated and expired food should be discarded. Employees were not allowed to place their personal food in resident's refrigerators.	F0812		